

Training for First Responders

Behavioral Health 101: A Trauma Informed Approach

Facilitator's Manual Training for First Responders

- Step-by-step guide for those who train First Responders to raise awareness and understanding about the signs and symptoms of individuals experiencing behavioral health challenges.
- Equips facilitators to help First Responders gain new tools and build resources to respond with a trauma informed approach.

Developed by Tracy L. Fried & Associates • June 2012

FIRST RESPONDERS

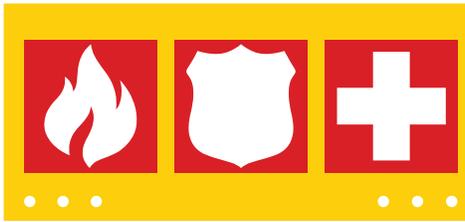


• • • **TRAINING** • • •

Behavioral Health Awareness



Live Well, San Diego!



Acknowledgements

First Responders are dedicated to protecting public safety and include law enforcement, fire/paramedics/emergency medical personnel, probation, parole officers, military fire and police, campus based enforcement, park and recreation rangers, lifeguards, and animal control officers. Their daily dedication and commitment to the preservation of public well-being through prevention of harm, despite their personal risk, is acknowledged and highly appreciated.

In the Spring of 2012, the County of San Diego's Health and Human Services Agency (HHS) Department of Behavioral Health Services Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) commissioned Tracy L. Fried & Associates to develop a unique training for First Responders. Because San Diego County highly values their noble effort, they realized that the nature of First Responder's on-call, readiness to respond to a crisis in a moment's notice, most likely prohibited their attendance at a typical training or conference format.

The initial training that was developed was delivered to First Responders in San Diego County from May – June, 2012 at or near their stations or other places of work, including military bases. Each First Responder who took time out of their busy day to reflect on increasing knowledge and contributed to their own and other's awareness are commended. The final version of the training contained in this facilitator's manual has incorporated their insights and contributions. Note that a subsequent version of this training was developed titled, *"Training for Military First Responders Behavioral Health 101: A Trauma Informed Approach"*. The second version of the training is based on the first and specifically addresses the unique situation and role of military First Responders.

Tracy L. Fried, consultant to the County of San Diego, established a core team to design, develop, and deliver the training and this facilitator's manual. Her team included an expert on instructional design, behavioral health clinicians, military veterans, highly skilled trainers, and an active duty fire paramedic, former navy seal. (Please refer to "Core Team Biographical Information", page 36 for background details regarding each team member.)

We would also like to acknowledge the contribution of key partners to this effort who include the San Diego Trauma-Informed (SD-TIGT) Guide Team and The Psychiatric Emergency Team (PERT). Representatives from the Trauma-Informed Guide Team had previously dedicated their time and expertise in working with Tracy L. Fried & Associates to create a user-friendly toolkit on building solutions using a trauma informed approach. This training and Facilitator's Manual drew heavily from that publication, and also from materials provided by San Diego County's Psychiatric Emergency Response Team (PERT). Representatives from PERT generously contributed their time, expertise, and complimentary materials that insured a duplication of effort did not occur, and the continuum of learning for First Responders was extended.

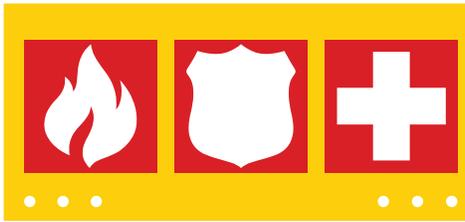


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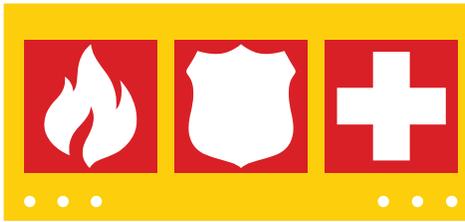
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Introduction

Every day First Responders encounter the impact of violence in our communities and also respond to life-threatening emergencies. They recognize that a commitment to healing and wellness holds promise for reducing its devastating effects. They know that the impact of violence and trauma can be reduced by First Responders who couple their professional repertoire with use of a trauma informed approach. This will likely begin with the recognition of the signs and symptoms of behavioral health challenges, and will enable a First Responder to engage and de-escalate any given situation, while protecting public and personal safety.

A trauma informed approach means using a holistic framework that focuses on health and wellness by addressing the root causes of violence and trauma. San Diego County's commitment to becoming a trauma-informed organization is reflected in *Live Well, San Diego!*. This initiative is the blueprint for improving community health and quality of life of San Diego residents over the next decade. In 2011 the County recognized the pressing need to engage in dialogue across sectors to promote prevention and intervention strategies to respond to the impact of violence and the County of San Diego Behavioral Health Services sponsored the *"Impact of Violence and Trauma in Our Community: Building Effective Community Solutions"* Conference.

The County of San Diego determined to build on the concept of their previous successful effort by tailoring the material specifically for First Responders. The *"First Responders Training Behavioral Health 101: A Trauma Informed Approach"* and the *"Military First Responders Training Behavioral Health 101: A Trauma Informed Approach"* thus drew heavily from the work that preceded it, yet developed new materials and activities that are particularly relevant to First Responders.

Background

Mental Health Services Act (MHSA)

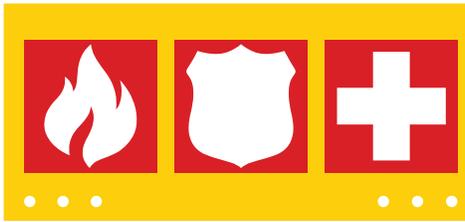
In January 2005 the Mental Health Services Act (MHSA), originally Proposition 63, was implemented. The Act combines prevention strategies with treatment strategies as an innovative approach to improve the public mental health system and thus enhances the quality of life for individuals living with serious mental illness. The voter-approved MHSA initiative provides for developing, through an extensive stakeholder process, a comprehensive approach to providing community based behavioral health services and supports for California residents.

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI), a component of MHSA, focuses on programs and interventions for all individuals before a serious emotional or behavioral disorder or mental illness occurs. It emphasizes the need for prevention efforts, giving special attention to children and youth, as well as multicultural and multilingual communities where it is evident there is health inequity. This inequality can be seen through the availability of mental health services, quality of received care, and outcomes of their mental health support and services.

Training, Technical Assistance and Capacity-Building (TTACB)

In 2007, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved five PEI Statewide Projects including the Training, Technical Assistance and Capacity Building (TTACB) Project. The primary goal of the TTACB is to enhance the knowledge and skill set of local partners such as educators, law enforcement, and primary health care providers, who provide services outside the behavioral health system.



The First Responders Training and Facilitator's Manual

The “*First Responders Training Behavioral Health 101: A Trauma Informed Approach*” training is a two hour course. It was designed to introduce First Responders to how a trauma-informed approach could be applied to a wide variety of situations they may encounter on the job. The course was developed with principles of adult learning in mind and therefore is highly dynamic and interactive, honors the knowledge and expertise participants bring with them, and recognizes that the new information or approach must be directly relevant to the learner in a significant way. The training was developed to be aligned with requirements for Continuing Education Units (CEUs). CEU's can be extended to trainees upon request.

The ideal training group size is 12 – 24 participants so as to allow for peer exchange and direct engagement with the trainers or facilitation team. In consideration of ease of access for First Responders, the training was designed to be comprehensive yet brief, and was delivered at or near their duty stations or other places of work.

Training Goal

The “*First Responders Training Behavioral Health 101: A Trauma Informed Approach*” training is intended to assist First Responders to raise their awareness and understanding of the signs and symptoms of those experiencing behavioral health challenges. First Responders who attend the training are afforded the opportunity to gain new tools and build resources to respond to various situations they may encounter using a trauma-informed approach.

Learning Objectives for the Training

Participation in the “*First Responders Training Behavioral Health 101: A Trauma Informed Approach*” training enables First Responders to:

- Define mental illness and understand prevalence
- Identify stigma and related myths to mental health
- Recognize frequently encountered signs and symptoms of behavioral health challenges
- Understand what trauma-informed care means
- Use a trauma-informed approach to engage and de-escalate while protecting public and personal safety



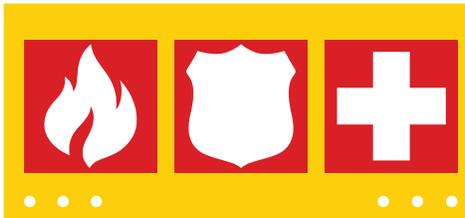
Training Delivery Overview

Timeframe	2 Hours
Format	Dynamic, Highly Interactive
Delivery	Team approach suggested
Trainer Requirements	<ul style="list-style-type: none"> • Able to apply principles of adult learning • Deep understanding of behavioral health challenges and trauma informed care
Advance Preparation-- Trainer	<ul style="list-style-type: none"> • Review Facilitator's Manual • Prepare personal training delivery notes • Watch video trailer and prepare to lead discussion/debriefing
Advance Preparation— Logistics and Materials	<ul style="list-style-type: none"> • Arrange for a suitable training venue that has internet access, screen, LCD projector • Circulate training announcement • Refer to “Training Support Materials” and duplicate all handouts and materials as indicated • Gather supplemental materials for the Resource Table
Trainer Preparation— Day of Training	<ul style="list-style-type: none"> • Arrive early and set up laptop and LCD projector interface. • Test video and sound clarity • Greet participants as they arrive and gain a sense of their interest in the training • Allow time for one-on-one interaction following the training
Logistics-- Day of Training	<ul style="list-style-type: none"> • Arrive early and set up hospitality/refreshments (if any) • Set out sign in sheet • Distribute training packets • Set up Resource Table with supplemental materials

Facilitator’s Manual

This Facilitator’s Manual is designed to be used by highly skilled professional trainers who have a deep understanding of behavioral health challenges and trauma informed care. Although not required, a team approach is suggested. A team approach brings the benefits of multiplied engagement with participants, extension of knowledge and expertise, and style/energy diversity. When using a team approach, it is suggested that the team identify one member as the lead for each section, largely based on expertise. Rather than simply “hand off the baton” to the next trainer “up”, an engaging, effective team approach will be interactive. Trainers will thus function as a “Greek Chorus” to one another, adding relevant talking points and examples as appropriate.

The Facilitator’s Manual is intended to provide trainers with all of the materials necessary to conduct and deliver the “*First Responders Training Behavioral Health 101: A Trauma Informed Approach*” training. The Facilitator’s Manual was developed for experienced trainers to be able to “pick up and go”.



How to Use The Facilitator's Manual

The Facilitator's Manual for the "*First Responders Training Behavioral Health 101: A Trauma Informed Approach*" training was uniquely designed to support anyone tasked with training First Responders who work with individuals, families and whole communities exposed to traumatic experiences. The goal is to help First Responders reduce and prevent violence and to support peaceful communities. The Facilitator's Manual is intended to serve as a guide for trainers to disseminate key information to First Responders and in helping First Responders to build skills related to applying a trauma-informed approach in their work.

The Facilitator's Manual is not strictly prescriptive, but does reflect an approach to training first responders that has been demonstrated to be effective. Trainers who use this manual are invited to adapt the materials for their own needs and purposes, as the training manual is amendable and flexible.

For a step-by-step guide to preparation and delivery of the training, please see "Training delivery Overview" on previous page.

The following materials are provided for your use:

1. Plan of Instruction

The plan of instruction lays out the organization and flow of the training in an at-a-glance format. For each section of the training, the suggested timing is offered along with the method or description and a listing of the media and/or materials needed for that section. (A full list of media and materials needed for the training is provided in the "Training Support Materials" section.) Note that trainers will need to adjust times to reflect their actual start and end time.

2. Power Point Slides/Trainer's Notes

In the power point slides/trainer's notes facilitators will find detailed notes on the purpose for each section, along with suggested slide-by-slide talking points and prompts to share content or introduce a video clip or activity.

A detailed description of how to prepare for each activity is provided in the power point trainer notes. The training activities instructions prompt the trainer on how to brief the participants, conduct the activity, and debrief to integrate learning.

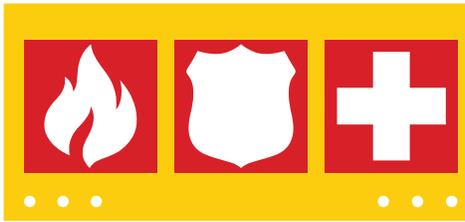
3. Participant Handouts

A full "camera ready" copy of each participant handout is provided here.

4. Training Support Materials/Supplemental Resources

A listing of materials needed to promote and conduct the training may be found in this section, along with suggested local resources to provide participants.

Note: Readers who wish to access further information on trauma informed care are referred to the "*Building Solutions Toolkit: Tools and Resources to Respond to the Impact of Violence and Trauma in our Communities Using a Trauma-Informed Approach*" prepared by Tracy L. Fried & Associates 2012.



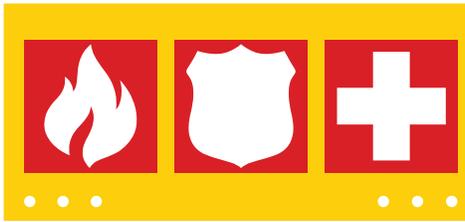
Plan of Instruction

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Note to trainers: Adjust the times below to reflect your actual start and end time.

*Denotes handout in participant packet

Time	Activity	Method/Description	Media/Materials
9:00 – 9:05 (5 min) Slide 1	Opening	Engage the audience and set the stage for a dynamic, interactive training. See PPT “Notes Pages” for trainer talking points/prompts. Training team introductions.	Laptop & LCD Sign in sheet Resource Table--Supplemental Materials Participant Handout Packets*
9:05 – 9:20 (15 min) Slides 2-5	Introduction/ Overview	<ol style="list-style-type: none"> 1. Welcome, learning objectives, agenda review 2. Participant introductions 3. Neen Video clip and brief discussion 	*Overview *Participant Agenda *Presentation slides (printed in 3 up format for note-taking) Neen video trailer *The Story of Neen
9:20 – 9:30 (10 min) Slides 6 - 13	Mental Health 101: Building Awareness	Provide general information regarding mental illness: <ol style="list-style-type: none"> 1. Definition 2. Facts/Myths/Stigma--Activity 3. Factors increasing risk 4. Prevalence of mental illness 	Top Ten Myths About Mental Illness Handout (to be distributed after activity; do NOT include in handout packets)
9:30 – 9:50 (20 min) Slides 14 - 19	General Signs & Symptoms; Introduction to Mental Illnesses; Schizophrenia	<ol style="list-style-type: none"> 1. Present considerations for first responders to identify general signs and symptoms of mental illness in mood, thought disturbance, and behavior. Distinguish hallucinations and delusions. 2. Provide an introduction to the three types of mental illness most commonly seen by first responders. 3. Walk through how to identify schizophrenia. 4. General tips for all first responders—LEAPS (Listen-Empathize-Ask-Paraphrase-Summarize) 5. Specific tips when schizophrenia suspected 	
9:50 – 10:00 (10 min) Slides 20 - 26	Major Mental Illnesses—Bipolar & Depression	Provide specific identifiers of Bipolar Disorder and Major Depression. Discuss general and specific tips for first responders. (Includes discussion of why some hospitals will accept 5150s while others are not equipped to and alternatives to incarceration, including drug treatments programs and psychiatric hospitals.)	*laminated pocket card
10:00 – 10:15 (15 min) Slides 27 -36	Trauma-Informed Approach	<ol style="list-style-type: none"> 1. Intro to TIC; definition of and types of trauma 2. Trauma and the Brain 3. ACE Study 	
10:15 – 10:25 (10 min) Slides 37 - 40	“Harvey” Case Example & Discussion	<ol style="list-style-type: none"> 1. Refer participants to the case example provided—“Harvey” 2. Conduct a brief group discussion on similar encounter participants have had in the field or on the job 3. Make the case for how a trauma-informed approach is useful 	*FRT Case Example—“Harvey” *First Responders Trauma Informed Care Implementation Checklist
10:25 – 10:45 (20 min) Slides 41 - 42	“Held Hostage” Vignette & Discussion	<ol style="list-style-type: none"> 1. Walk participants through the vignette, “Held Hostage” 2. Conduct a discussion focusing on application of a trauma-informed approach 	*“Held Hostage” Vignette
10:45 – 11:00 Slides 43 - 45	Wrap Up Evaluation Adjourn	Wrap up/Integration Neen Video Trailer—Closing (Optional) Participant evaluations	Neen Video Trailer--Closing *Commitment to Wellness Checklist *Fact Sheets *References *Course Evaluation”



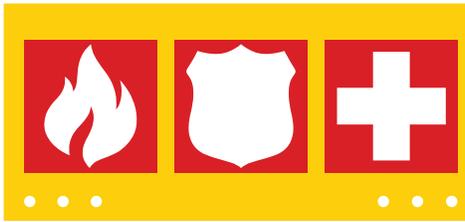
Power Point Slides/Trainer Notes

In the power point slides/trainer's notes facilitators will find detailed notes on the purpose for each section, along with suggested slide-by-slide talking points and prompts to share content or introduce a video clip or activity. The uniform resource locator (URL) for all suggested video trailers is also provided in the trainer's notes. (In advance of the training, facilitator's may download for viewing, or access directly from the internet during the training.)

A detailed description of how to prepare for each activity is provided in the power point trainer notes. The training activities instructions prompt the trainer on how to brief the participants, conduct the activity, and debrief to integrate learning.

In the trainer's notes, references are made to participant handouts, full copies of which are available starting on page 9.

Insert Power Point Trainer Notes Here



Participant Materials and Handouts

“Participant handouts” are materials designed to be distributed to attendees on the day of the training. They can be easily organized in a two pocket folder.

The following “camera-ready” participant handouts are available for duplication and should be placed in the folder in the following order:

Placement	Document Title
Front cover	Folder label template
Right inside pocket (Top to bottom)	<ol style="list-style-type: none"> 1. Overview 2. Participant Agenda 3. Presentation Slides (3 per page format for note taking)“FRT Participant PPT” 4. The Story of Neen 5. Fact Sheets
Left inside pocket (Top to bottom)	<ol style="list-style-type: none"> 1. Laminated First Responder Pocket Card* 2. Case Example “Harvey” 3. First Responders Trauma Informed Care Implementation Checklist 4. “Held Hostage” Vignette 5. Commitment to Wellness Checklist 6. References 7. Course Evaluation
Distribute after Myths” activity	Top Ten Myths About Mental Illness

***Note:** The resources provided on the First Responder Pocket Card are specific to San Diego County. If you are conducting this training outside of San Diego, you may wish to develop a similar tool in partnership with others who support First Responders.

FIRST RESPONDERS



• • • TRAINING • • •

Behavioral Health 101: A Trauma Informed Approach

Presented by Tracy L. Fried & Associates

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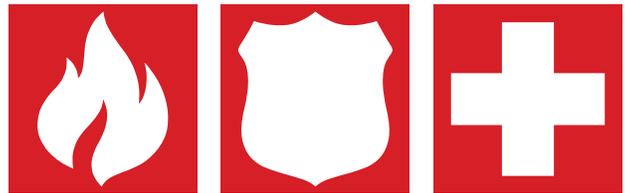
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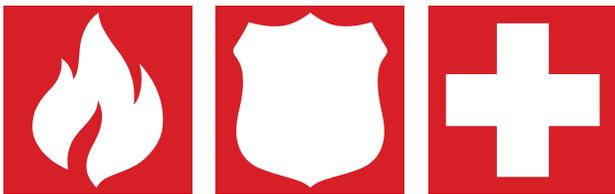
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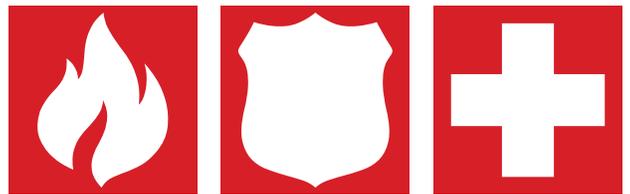
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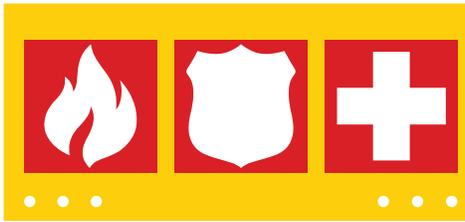
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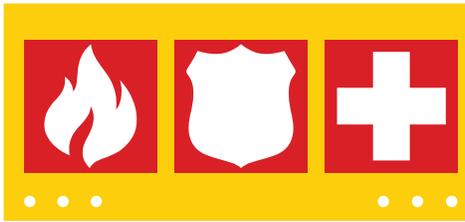
Overview

First responders are dedicated to protecting public safety and include law enforcement, fire/paramedics/ emergency medical personnel, probation, parole officers, military fire & police, campus based enforcement, park and recreation rangers, lifeguards, and animal control officers.

This training is designed for first responders to raise awareness and understanding of the signs and symptoms of those experiencing behavioral health challenges. First responders will gain new tools and build resources to respond with a trauma-informed approach.

Part 1 focuses on recognizing the signs and symptoms of mental illness in individuals experiencing behavioral health challenges.

Part 2 explores a trauma-informed approach to de-escalating mental health emergency situations. Public safety and the safety of the first responder are paramount.



Participant Agenda

Goal: This training is designed for first responders to raise awareness and understanding of the signs and symptoms of those experiencing behavioral health challenges. First responders will gain new tools and build resources to respond with a trauma-informed approach.

Learning Objectives:

By the end of the training, first responders will be able to...

1. Define mental illness and understand prevalence
2. Identify stigma and related myths to mental health
3. Recognize frequently encountered signs and symptoms of behavioral health challenges
4. Understand what trauma-informed care means
5. Use a trauma-informed approach to engage and de-escalate while protecting public and personal safety

AGENDA

9:00AM **Welcome & Introductions
Agenda & Materials Review**

Tracy L. Fried
Tracy Fried & Associates

Building awareness of mental health challenges

Introducing a trauma-informed approach
-Discussion of situations you may encounter

Review of tools for your use

11:00AM **Adjourn**

Insert Participant PPT Copy Here



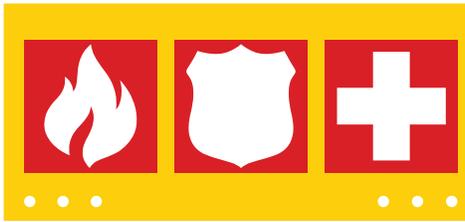
The Story of Neen

As the oldest of nine brothers and sisters in Annapolis' Clay Street community, from the age of 9 Tonier “Neen” Cain lived as the “protector”, while her alcoholic and abusive mother was absent, passed out, or otherwise occupied. Sexual assaults at the hands of her mother's male friends were frequent. Even after social services placed Cain and her siblings with relatives, Cain herself turned to alcohol and drugs, eventually leading to 83 arrests and 66 convictions--for prostitution, possession, a life of addiction, 19 years of homelessness, and a stint in the Maryland Correctional Institute for Women in Jessup. Neen has been given many labels over the years including, “criminal, crazy, whore, slut, worthless, homeless, junkie, dirty and a dangerous...” Not anymore.

Incarcerated and pregnant in 2004, treatment for her lifetime of trauma offered her a way out and up. Her story illustrates the consequences that untreated trauma has on individuals and society at-large, including mental health problems, addiction, homelessness and incarceration. Today, she is a nationally renowned speaker and educator on the devastation of trauma and the hope of recovery.

“83 arrests and 66 convictions, they told me I was going to spend the rest of my life in prison or die on the streets. And I had become...comfortable... with that.”

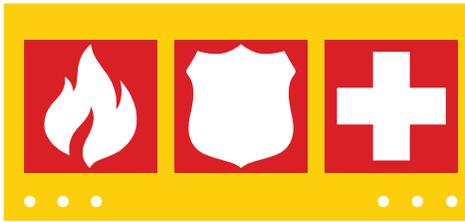
-Tonier



Fact Sheets

- 1 Promoting Peace
- 2 Gang Involvement
- 3 Bullying in Schools
- 4 Domestic Violence
- 5 New Lens
- 6 Keys to Responding
- 7 Systems Response
- 8 Commitment to Wellness





Fact Sheet 1

Promoting Peace

In working to offset the impact of violence and trauma in our communities the desired outcome is peace. In this context, “peace” is being used to represent health and wellness for staff, providers, community partners, and for any individual or family who is directly or indirectly impacted by trauma. Peace is what gives us confidence and hope that individuals and families can become resilient and thus overcome the devastating effects of violence and trauma.

A Few Faces of Violence: Unique Contributors to Trauma

It is widely recognized that there are common underlying dynamics that link multiple forms of violence including child maltreatment, animal abuse, elder abuse, suicide and homicide. This Toolkit focuses on three forms of violence that are similarly linked: gangs, bullying in schools and domestic violence. Each form of violence contributes to trauma at the individual, family, and community levels in unique ways.

The Scope of the Problem

It is necessary and beneficial to understand how much and what types of violence we are confronted with. Knowing the statistics helps to focus our attention on contributing factors to violence and trauma. When we compare two neighborhoods that are similar in many ways, except for relative violent incidences, we can begin to look at what the one community is doing successfully to reduce its impact. As lessons learned are shared, we have a baseline from which to measure our progress towards a peaceful future.

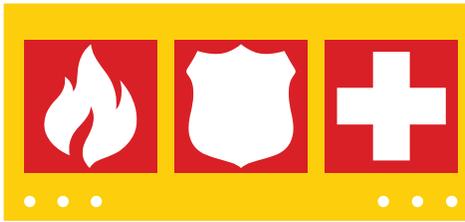
The Problem Reframed

The “divide and conquer” approach to viewing the complexity of issues families present when in crisis and seeking services and support is no longer viable. The field is rapidly shifting to a culturally proficient, cross-sector collaborative team approach that views “issues” as normative and integrated, rather than isolated. Trauma Informed Care is a lens that affords the opportunity to see individuals, families and communities as resources.



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Fact Sheet 2

Gang Involvement

Why do people join gangs?

Cultural, societal, and economic factors play a major role in creating a climate of risk for youth involvement in gangs. Failures in the educational, welfare, and immigration systems, including social upheaval, poverty, income inequality, and racism are examples of how inequality and social disadvantage may occur. In addition, the effects from gang culture, early substance use, antisocial/hostile/aggressive behavior, limited attachment to community, family history of gang involvement, parental neglect, low academic achievement or school dropout, and unemployment are contributing factors. Those who join gangs may desire a sense of power, respect, belonging, money, or social status, turning to gangs that initially appear to be able to meet these needs.

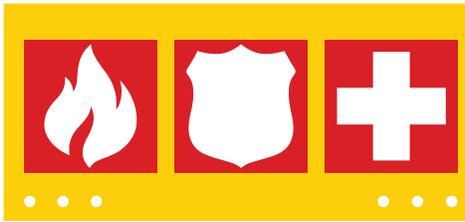
What is being done to address youth gangs?

Research generally agrees on a three pronged approach. Preventative measures include intervention for youth at risk, education of the public, persistence of youth social workers with youth gang members or those at risk, and specific school policies and procedures i.e. dress code, zero tolerance, etc. Intervention involves employment and skills training and recreational activities for individuals involved in gang activities. Suppression consists of “law enforcement, legislative action, punishment and removal of members from community, specialized gang units, and the development of systems to track gang information and activities, such as the Integrated Gang Task Force. Critically, cooperation of all members of the community is required to create an effective solution. Effectively addressing youth gangs requires attention to the specific risk factors that lead to gang involvement and which take gender, ethno-cultural, economic, and social considerations into account at their core.

Warning Signs for Gang Involvement

- Experimenting with drugs; Rebelling at school and home
- Dropping school grades, particularly if it is rather sudden
- Cutting classes regularly or just not going to school at all
- Avoiding family gatherings or share regular meals
- Changing friends, especially if the new friends don't hang around at your home
- Poor family bonding; Violating family curfew standards
- Having large sums of money or new expensive items of which you were unaware





Fact Sheet 3

Bullying in Schools

Bullying, is a problem that affects many youth, and is a problem that has also left scars on adults. Over 90% of teens that get bullied say it affects them greatly emotionally, mentally, and physically. The trauma that a single or repeated incident of bullying can cause on an individual can be long lasting and have adverse effects on an individual's overall health and well-being. As technology continues to develop at a rapid pace, there are new and equally concerning venues for this kind of violence, including cyber bullying. Suicide rates, already staggeringly high in adolescents, is on the rise, particularly among youth who are victims of bullying, with rates of suicide among lesbian, gay, bisexual, transgender and queer (LGBTQ) youth who are bullied at the highest rates of all.

Bullying can occur in person or through technology (electronic aggression, or cyberbullying). A young person can be a bully, a victim, or both (bully-victim).

Who is at risk for bullying?

Some of the factors associated with engaging in bullying behavior include:

- Impulsivity (poor self-control)
- Harsh parenting by caregivers
- Attitudes accepting of violence

Some of the factors associated with victimization include:

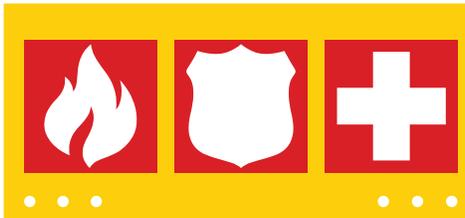
- Friendship difficulties
- Poor self-esteem
- Quiet, passive manner with lack of assertiveness

How can we prevent bullying?

The ultimate goal is to stop bullying before it starts. Research on preventing and addressing bullying is still developing. School-based bullying prevention programs are widely implemented, but infrequently evaluated. Based on a review of the limited research on school-based bullying prevention, the following program elements are promising:

- Improving supervision of students
- Using school rules and behavior management techniques in the classroom and throughout the school to detect and address bullying, providing consequences for bullying
- Having a whole school anti-bullying policy, and enforcing that policy consistently
- Promoting cooperation among different professionals and between school staff and parents





Fact Sheet 4

Domestic Violence

Domestic violence is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another. It is an epidemic affecting individuals in every community, regardless of age, economic status, race, religion, nationality or educational background. Violence against women is often accompanied by emotionally abusive and controlling behavior, and thus is part of a systematic pattern of dominance and control. Domestic violence results in physical injury, psychological trauma, and sometimes death. The consequences of domestic violence can cross generations and truly last a lifetime.

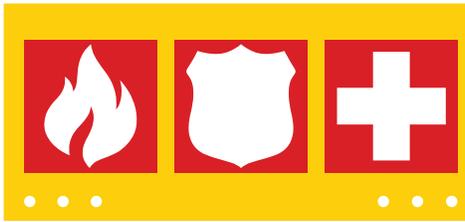
Children who witness: Witnessing violence between one’s parents or caretakers is the strongest risk factor of transmitting violent behavior from one generation to the next. Boys who witness domestic violence are twice as likely to abuse their own partners and children when they become adults. 30% to 60% of perpetrators of intimate partner violence also abuse children in the household.

The Economic Impact: The cost of intimate partner violence exceeds \$5.8 billion each year, \$4.1 billion of which is for direct medical and mental health services. Victims of intimate partner violence lost almost 8 million days of paid work because of the violence perpetrated against them by current or former husbands, boyfriends and dates. This loss is the equivalent of more than 32,000 full-time jobs and almost 5.6 million days of household productivity as a result of violence. There are 16,800 homicides and \$2.2 million (medically treated) injuries due to intimate partner violence annually, which costs \$37 billion.



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Fact Sheet 5

New LENS

We need a new lens through which to view the impact of violence and trauma so that new perspectives and emerging evidence-based or evidence-informed practices may be integrated and incorporated into our work. It is important for those implementing trauma-informed care to understand the impact violence and trauma has on the brain and lifespan development, particularly when coupled with early adverse childhood experiences.

Adverse Childhood Experiences (ACE)

Traumatic life experiences in the first 18 years of life can lead to serious impacts on later well-being, social function, health risks, disease burden, health care costs, and life expectancy. Adverse childhood experiences are common and powerfully influence health and well-being outcomes as adults.

Generational Cycles

Behavior patterns and risk for violence and trauma can be “passed down” from parent to child through powerful and intense role modeling. When a child is terrified, or in a heightened state of arousal during an adverse event, “learning” how to stay safe and what is expected comes quickly.

Trauma and Brain Development

According to Dr. Bruce Perry when trauma occurs in a very young child, there are significant and lasting changes in their brain development. As a result, the child’s understanding of what is normal becomes distorted. Chronic exposure to violence and trauma can result in the following changes in one’s brain functioning: (1) Frontal lobes shut down or decrease activity leading to instinctive responding; (2) high levels of irritability with increased sensitivity to “triggers”; and (3) ability to perceive new information decreases.

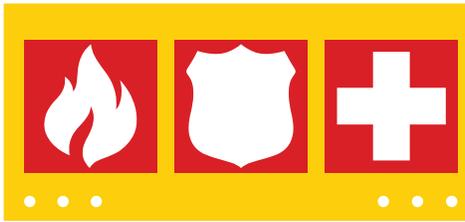
Reducing the impact of Violence and Trauma

Fortunately, biology is not destiny. Despite adverse childhood experiences, generational cycles, and changes in brain development brought on by trauma, wholeness, health, and peace are still very much possible. The impact of violence and trauma may be overcome by applying a trauma informed approach.



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Fact Sheet 6

Keys for Responding

To be trauma-informed is to incorporate a universal assumption that everyone is affected by trauma to one degree or another. It is important to keep in mind that each individual will respond to the traumatic experience in different ways. When first assessing an individual with a trauma history, a trauma-informed service provider needs to be sensitive to the possible “triggers” of a person who has been traumatized. (A “trigger” is anything that reminds an individual of the trauma they have experienced and can take the form of sights, sounds, smells, specific places or words.) Community partners must also express the same sensitivity.

**Trauma-Specific
Care**

Provided by a trained clinician who treats the actual trauma and trauma symptoms. Examples of trauma-specific treatment modalities include, Trauma Focused Cognitive-Behavioral Therapy (TF-CBT), Child-Parent Psychotherapy (Lieberman & Van Horn, 2005) and Seeking Safety etc.

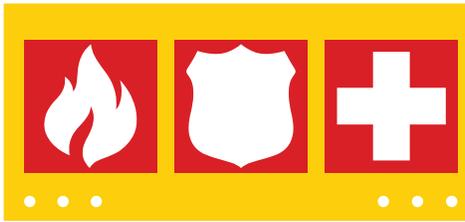
**Trauma- Informed
Care**

Making services available to all people across systems and agencies. To be trauma-informed is to be aware that trauma in society is a reality, not a rare exception.

To truly accomplish implementing a universal trauma informed approach a change in our thinking, or paradigm shift needs to take place. Individuals/clients are to be assessed through a trauma informed lens with close attention paid to their trauma history, understanding of this history, then allow services to be delivered, facilitating consumer participation in treatment and fostering a sense of safety.

Principles of Trauma Informed Care

1. Recognize the impact of violence and victimization on coping skills.
2. Establish recovery from trauma (or trauma-specific referral) as primary goal.
3. Employ an empowerment model to elicit and build on strengths.
4. Partner with the individual/client (relational collaboration).
5. Design the meeting environment to ensure safety, respect and acceptance.
6. Highlight strengths and resiliency.
7. Be culturally competent by understanding the individual/client from the context of his or her life experience(s).



Fact Sheet 7

Systems Response

Most communities, families and individuals are dealing with not just one, but a multitude of integrated dynamics that include both challenges and strengths. Viewing a family or individual from a trauma informed lens is one of the best practices that can be used by community organizations, schools, and governmental agencies.

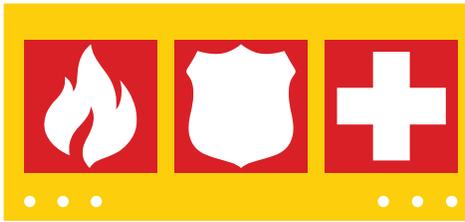
Any organization that provides services to clients or the community will see benefits at both staff and client perspective as a result of adopting trauma-informed care practices. Systems that are comprised of multiple agencies which create an atmosphere “from the front door to the back door” of awareness of a trauma survivor’s need for safety, respect and acceptance can foster improved client interactions, collaboration and can lead to improved outcomes.

Benefits of Traumaformed Services:

- Evidence-informed and effective
- Cost-effective
- Humane and responsive to real needs
- Aligned with over-arching goals
- Highlights glitches in the systems and offers solutions
- Works with other best practices

Recommendations for implementing a traumainformed approach

1. **Design** programs based on trauma theory (safety, mourning, connection).
2. Focus on **client safety always**.
3. Screen for lethality (Danger Assessment by J. Campbell).
4. **Reduce** rules, make client policies positive.
5. **Train staff** on trauma theory and motivational interviewing plus ongoing training and review!
6. **Listen** to comments and complaints from the person you are working with.
7. Use the **No Services Available Form**. If you can’t find a services/program, analyze trends.
8. **Cross-train** and develop tools to keep informed about local programs, eligibility requirements and referral processes.



Fact Sheet 8

Commitment to Wellness

Wellness is an active process of becoming aware of and making choices toward a more healthy and holistic lifestyle. It is developmental in that improvement is always possible. Individuals can increase their own wellness by engaging in reflection as well as direct actions that increase their sense of wellbeing.

Vicarious trauma is a natural response to hearing about violence, trauma and adversity experienced by others. Additionally, professionals need to recognize the variables that increase their risk for compassion fatigue and burnout. Vicarious trauma often changes basic assumptions about yourself, others, and even the world. Further it can interfere with self-care or the provision of care to others. Fortunately it is possible to restore wellness by increasing resilience and positive coping.

The signs and symptoms of vicarious trauma include:

Preoccupation with the other person's traumatic events.	Avoiding thinking about certain things and "numbing" out when certain topics come up.	Not functioning as well in life as one used to.
Decreased ability to handle everyday frustrations.	Intrusive thoughts related to the trauma survivor's "story".	Dread of being around or working with survivors.
Feeling subjectively that you are not personally safe.	Feeling that you are not helping at all.	Less able to focus on the purpose or meaning of what you are doing.

Among the best ways to care for yourself when you are providing trauma informed care are:

1. Be aware of your limits, emotions you are experiencing, and resources you have available. Awareness and reliance on one's intuition are important tools for recognizing symptoms of compassion fatigue.
2. Maintain balance personally and professionally.
3. Stay connected to your inner self, others and your faith.
4. Stay connected to others, which breaks the silence of unacknowledged pain.

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- Paradise Valley (619) 470-4141
- Pomerado (858) 613-4671
- Scripps Mercy (619) 849-4801
- Sharp Grossmont (619) 740-6165
- Tri-City (760) 940-3509
- UCSD Hillcrest (619) 543-2154
- V.A. La Jolla (858) 552-8585

5150 Hospitals: Psych Only

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Client Warm Line (4-11PM) (800) 930-9276
211 or www.211sandiego.org

It's Up to Us Resources
www.Up2SD.org

USMC DISTRESS Hotline (877) 476-7734
Veteran Crisis (800) 273-8255 - Press 1
National Alliance on Mental Illness (NAMI)
(800) 523-5933 or www.namisanadiego.org

Survivors of Suicide Loss (SOSL)
(619) 482-0297 or www.soslsd.org

Common Spellings of Medications

Anti-psychootics **Anti-depressants**
Risperdal, Serquel Prozac, Paxil
Geodon, Abilify Celexa, Wellbutrin
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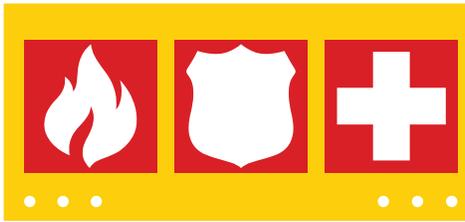
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Training for First Responders Case Example

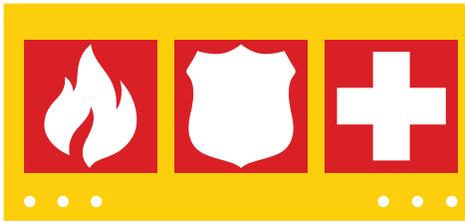
"Harvey"

Training for First Responders Case Example "Harvey" A 43 year old Caucasian homeless male, "Harvey", arrived at a walk in mental health clinic with his dog. He had visible signs of poor hygiene and was demonstrating erratic behavior. Harvey was brought in by his HIV case worker after he made threatening statements about wanting to "kill his children if he ever saw them." The PERT team was called to the scene and began asking Harvey questions. Harvey grew increasingly more upset, began yelling and would not cooperate with law enforcement or the clinical staff on site. A new officer, "Ben Roberts" arrived at the scene, reporting that he had dealt with Harvey before and had happened to hear his description over the radio.



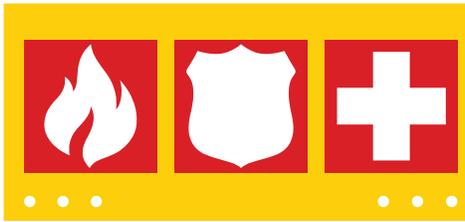
Because Officer Roberts had previous contact with Harvey and had established rapport with him, he was able to diffuse the situation by engaging Harvey in conversation about what brought him into the clinic earlier, referencing past interactions with him and using humor to diffuse situation. With a sense of trust in Officer Roberts, Harvey disclosed that he had been on his way to a campsite in which he would be able to live, but realized he did not have his ID.

Officer Roberts asked if Harvey still had the ticket he had issued him earlier that month. Harvey produced the ticket, Officer Roberts called the campsite and arranged for the ticket to serve as Harvey's ID. Harvey did not meet criteria for hospitalization as his threats were generalized with no plan or means. Once calmed down and assured he could continue to his destination with his case manager, Harvey was able to leave the clinic safely with his dog, to his new safe place to live.



First Responders Trauma-Informed Care Implementation Checklist

- ✓ **Focus on safety always.** Safety must be addressed proactively and at all times during intervention.
- ✓ **Screen for lethality.** Part of establishing and maintaining safety involves gaining a formal understanding of the potential for deadly or lethal outcomes if not managed.
- ✓ **Train staff.** A key aspect of implementing a trauma-informed approach is staff training. Training must be ongoing and reviewed frequently to reinforce learning.
- ✓ **Educate yourself and keep informed of local resources** that may assist you in times of need. This will allow you to connect to appropriate referrals in an efficient and beneficial manner during a crisis.
- ✓ **Show transparency and offer choices.** Partner with the individual by taking an equalitarian approach to de-escalate the situation and avoid resistance. Prepare the individual for your actions. Offer choices when possible.
- ✓ **Show sensitivity to the individual's needs.** Consider where the person is coming from and what they have gone through. Treat the individual with the respect you would want to receive. Take a non-judgmental and compassionate stance.
- ✓ **Respect diversity.** Be aware of cultural differences that allow individuals to maintain their dignity. Realize that you are seeing this person in their most vulnerable state. Allow them to educate you on their needs.
- ✓ **Be accountable.** Remember that you are accountable for your actions and are expected to act with integrity and professionalism. What you do can make a significant difference in the outcome of the event.



Training for First Responders

Vignette for Discussion

“Held Hostage”

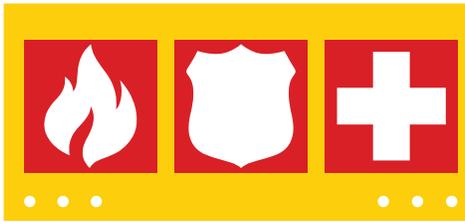
You arrived for work early last Tuesday and after parking your car heard crying and screaming coming from a home located adjacent to your station. As a first responder, you called for back-up and approached the scene where you learned that Richard, a middle aged married male who has his three children and wife barricaded in their home is threatening to kill his wife, three children and then himself with a gun. He has been in the house for the last 3 hours unwilling to come out, or let his family free. His speech is rapid and pressured, and he is speaking incessantly.

SWAT has been engaged, police and the fire department are also present. The cities' designated Psychiatric Emergency Response Team (PERT) arrives on scene to further assess the situation and intervene as needed. The PERT team is comprised of a PERT Clinician and a police officer. John, the PERT Clinician, immediately consults with the first responders on site, obtaining pertinent identifying information about Richard. John takes this information and scans the electronic medical record system for additional data and psychiatric history.

John finds a safety alert and psychiatric history of Richard. Richard has been diagnosed with Bipolar Disorder and when manic has history of erratic, violent behavior, volatile mood swings and extreme paranoia. John reads on to learn that Richard was recently prescribed Seroquel for symptom management.

Discussion Questions:

1. As the first responder who discovered this situation, what are your initial thoughts about effective ways to respond to the situation?
2. Did you think of mental illness as a contributor to Richard's behavior initially?
If so, elaborate on your thoughts. If not, why not?
3. Did you think of substance abuse as a contributor to Richard's behavior?
If so, elaborate on your thoughts. If not, why not?



John then consults with the hostage negotiator, sharing the recently learned psychiatric history. John initiates conversation with Richard via telephone in a calm, respectful and nonjudgmental tone. John explains his role as a PERT Clinician and tells John that he is aware of his diagnosis of Bipolar Disorder. John then asks if Richard knows where his medication is, particularly his Seroquel. John explains further that Richard's actions are symptoms of his illness and the medication may help him to calm down. John convinces Richard to "just try it and see if the medication works." Richard agrees to locate his Seroquel and takes one tablet.

Discussion Questions:

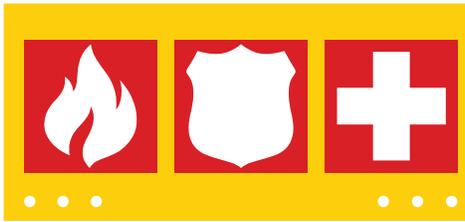
1. Do you have access to resources in the community you work in to utilize during a crisis call such as this? If not, where can you obtain resources? If so, what are they?
2. What else could you do to de-escalate the situation?
3. How could you use your new knowledge of Mental Health 101 and trauma-informed care in this situation?

End Note:

Within 30 minutes of the PERT Team's arrival, Richard let his family go free and surrendered to the police. Richard was later hospitalized for danger to others. Richard's family was safe and the situation was stabilized.

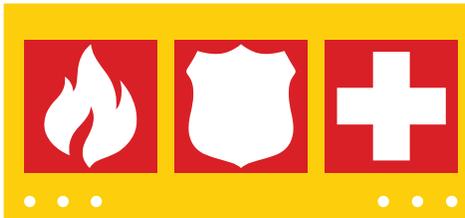
Discussion Questions:

1. What struck you as the most effective response in this vignette?
2. What might you do to further prepare yourself to use your new knowledge of Mental Health 101 and trauma-informed care to be better prepared for future First Responder calls similar to this?



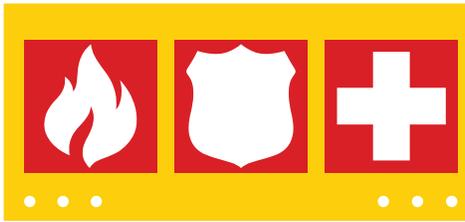
Commitment to Wellness Checklist

- ✓ **Acknowledge the trauma.** Within the bounds of confidentiality, speak openly about the violence and trauma you have observed and been told about. It is also important to “process” (share) your feelings and reaction to what you have experienced.
- ✓ **Maintain a normal schedule.** Avoiding work or working a significant number of extra hours could be indicators that work and personal/family life are out of balance.
- ✓ **Create balance and separate work and your personal life.** If you are a professional, what happens at work, should stay at work. For community partners, it can become more complicated when social and helping roles intersect. Keep them separate whenever you can. Professionals are encouraged to manage their caseload to include a variety of clients and issues.
- ✓ **Pay attention to basic self-care.** Make sure you give yourself the opportunity to get a good night's sleep and eat healthy, nutritious foods. Do things you enjoy doing on a regular basis, including regular exercise.
- ✓ **Do not “numb out”** with excesses of alcohol, gambling, eating, shopping, TV, etc.
- ✓ **Minimize your exposure to traumatic stimuli**, including, movies, newscasts, etc.
- ✓ **Play! Nurture yourself.**
- ✓ **Know your red flags and warning signs.**
- ✓ **Debrief (talk) with colleagues.** Seek further assistance after a few weeks. Consider personal counseling.
- ✓ **Know whom you can't work with.** If working with a particular issue is too uncomfortable, or “pushes” your own discomfort, consider referring them to a colleague or community agency.
- ✓ **Engage in continuing education.**
- ✓ **Confide in colleagues and those you trust**, while maintaining confidentiality. Talk about what you are feeling, thinking and experiencing.
- ✓ **Express emotions.** Don't “stuff” your feelings. Take mental health breaks.
- ✓ **Seek appropriate support.** Obtain supervision and consultation. **Instill hope and meaning in your work.**



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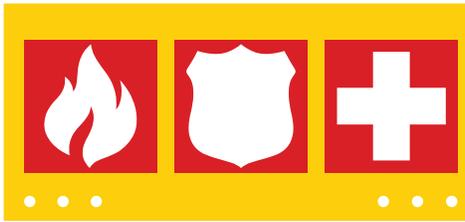
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Top Ten Myths About Mental Illness

Myth #1: Psychiatric disorders are not true medical illnesses like heart disease and diabetes. People who have a mental illness are just "crazy."

Fact: Brain disorders, like heart disease and diabetes, are legitimate medical illnesses. Research shows there are genetic and biological causes for psychiatric disorders, and they can be treated effectively.

Myth #2: People with a severe mental illness, such as schizophrenia, are usually dangerous and violent.

Fact: Statistics show that the incidence of violence in people who have a brain disorder is not much higher than it is in the general population. Those suffering from a psychosis such as schizophrenia are more often frightened, confused and despairing than violent.

Myth #3: Mental illness is the result of bad parenting.

Fact: Most experts agree that a genetic susceptibility, combined with other risk factors, leads to a psychiatric disorder. In other words, mental illnesses have a physical cause.

Myth #4: Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.

Fact: Depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function, and medication and/or psychotherapy often help people to recover.

Myth #5: Schizophrenia means split personality, and there is no way to control it.

Fact: Schizophrenia is often confused with multiple personality disorder. Actually, schizophrenia is a brain disorder that robs people of their ability to think clearly and logically. The estimated 2.5 million Americans with schizophrenia have symptoms ranging from social withdrawal to hallucinations and delusions. Medication has helped many of these individuals to lead fulfilling, productive lives.

Myth #6: Depression is a normal part of the aging process.

Fact: It is not normal for older adults to be depressed. Signs of depression in older people include a loss of interest in activities, sleep disturbances and lethargy. Depression in the elderly is often undiagnosed, and it is important for seniors and their family members to recognize the problem and seek professional help.

Myth #7: Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just a part of growing up.

Fact: Children and adolescents can develop severe mental illnesses. In the United States, one in ten children and adolescents has a mental disorder severe enough to cause impairment. However, only about 20 percent of these children receive needed treatment. Left untreated, these problems can get worse. Anyone talking about suicide should be taken very seriously.

Myth #8: If you have a mental illness, you can will it away. Being treated for a psychiatric disorder means an individual has in some way "failed" or is weak.

Fact: A serious mental illness cannot be willed away. Ignoring the problem does not make it go away, either. It takes courage to seek professional help.

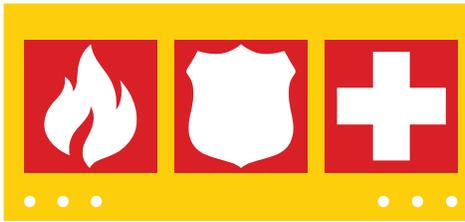
Myth #9: Addiction is a lifestyle choice and shows a lack of willpower. People with a substance abuse problem are morally weak or "bad".

Fact: Addiction is a disease that generally results from changes in brain chemistry. It has nothing to do with being a "bad" person.

Myth #10: Electroconvulsive therapy (ECT), formerly known as "shock treatment," is painful and barbaric.

Fact: ECT has given a new lease on life to many people who suffer from severe and debilitating depression. It is used when other treatments such as psychotherapy or medication fail or cannot be used. Patients who receive ECT are asleep and under anesthesia, so they do not feel anything.

<http://thyroid.about.com/library/news/blmentalmyths.htm>



Training Support Materials

The following materials will support training implementation and delivery:

- **Outreach:** First Responder Training Announcement
Insert your own contact information, date, time, and location of training

- **Sign In Sheet**
Some organizations will prefer to use their own sign in sheet format, however this is provided for trainer's use in the event it is needed.

- **Supplemental Resources**
Prior to the training, contact your county's Department of Behavioral Health, Prevention Early Intervention Coordinator to request resources applicable to First Responders. Place on a resource table on the day of the training. Examples include:
 - ◇ **Stigma reduction campaign materials**

 - ◇ **Suicide Prevention materials**

 - ◇ **Community Health and Wellness promotion materials**

Training for First Responders

Behavioral Health 101: A Trauma Informed Approach

JOIN US FOR A UNIQUE TRAINING ON Recognizing Mental Illness and people experiencing Mental Health Challenges

Trauma Informed Approach - De-escalating mental health emergency situations and keeping you and others safer

- A training designed for first responders to raise awareness and understanding about the signs and symptoms of those experiencing behavioral health challenges.
- First responders will gain new tools and build resources to respond with a trauma informed approach.
- Trainings will be offered on select dates April - June, 2012 at various training venues across the county.

WHO SHOULD ATTEND?

- Fire / Paramedics / EMS
- Law Enforcement
- Probation
- Parole Officers
- Corrections Officers
- Military Fire & Police
- Campus Based Enforcement
- Park & Recreation Rangers
- Lifeguards
- Animal Control Officers
- other groups as identified*

FIRST RESPONDERS



••• TRAINING •••

Behavioral Health Awareness



FREE 2 HOUR TRAINING

Resources and Refreshments Provided
to all Participants

Sponsored by:



Live Well, San Diego!

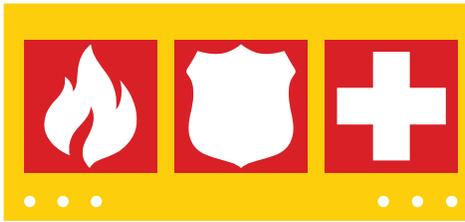
Sponsored by the County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services through Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds and the County's *Live Well, San Diego!* initiative.

TO SCHEDULE YOUR TRAINING

contact Tracy Fried, MSW
at Tracy Fried & Associates

760.476.0670

Tracy@tracyfried.com



Core Design Team

Most important efforts require a team approach. When invited by the County of San Diego to develop a unique training for First Responders, Tracy L. Fried made the decision to mirror the team approach required for training delivery in the very development of the training itself. She brought together a team of experienced trainers and curriculum developers to create the very best training possible. Her team included an expert on instructional design, behavioral health clinicians, military veterans, highly skilled trainers, and an active duty fire paramedic, former navy seal. Their biographical information is provided on the next page.



Tracy Fried and Associates Team Bios



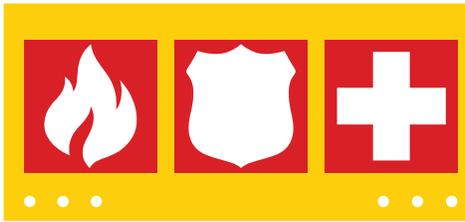
Tracy Fried is one of the top five experts in California on education rights of foster youth and has over fifteen years experience instituting successful K-12 and postsecondary education outcomes for underserved youth in the foster care and probation systems. In the past 10 years, Tracy has been a leading advocate and change agent for enhanced educational opportunities and equal treatment for underrepresented students. She served as the Director of the Peace Colors Violence Prevention Program at the Southern California Youth and Family Center in Inglewood, and soon became coordinator of the Gang Risk Intervention Program (GRIP) with the Los Angeles Conservation Corps. Since 2006, Ms. Fried has worked with the California Community College Chancellors Office to establish and implement the statewide Foster Youth Success Initiative (FYSI). Tracy obtained her Masters of Social Work with an emphasis in Community Organizing, Planning, and Administration, USC. In 2005, Tracy created a successful consulting firm wherein, as Principal of Tracy L. Fried & Associates, she promotes education, advocacy and equality for current and former foster youth through systemic change.



Lori Scott Clarke serves as Strategies' Statewide Quality Assurance Specialist for training and technical assistance. Through her own consulting business, Convergent Horizons, she provides consultation to the California Child Welfare Council co-chaired by California's Secretary of Health and Human Services Diana Dooley and Justice Vance Raye of the California Supreme Court. Since 2001, she has coached and mentored trainers across a broad spectrum of topics in human services locally, regionally, and nationally. From its inception, she was the chief facilitator, and a consultant for California's Child Welfare Services Stakeholders Redesign Group, a governor's project designed to propose strategies for improving California's child welfare system. Ms. Clarke has served on the national faculty for the California Breakthrough Series Collaborative (BSC) on Differential Response, as well as the California Evidence-Based Clearinghouse for Child Welfare Practice.



Kimberly Shultz is an LCSW currently working as the Older Adult Lead Clinician at MHS Inc North Coastal Mental Health Center in Oceanside. Her focus and professional passion are aimed at providing trauma informed clinical individual and group therapy to the geriatric population, the chronic and pervasively mentally ill adult and TAY populations. Kimberly graduated from UCSD with a BA in Communication. She went on to pursue her MSW at SDSU, Graduate School of Social Work. Kimberly began working for Mental Health Systems Inc. in 2008 as a Clinical Case Manager. In 2009 she became one of the founding members of the San Diego Trauma Informed Guide Team (SDTIGT), a grass roots community based group, focusing and disseminating core competencies of systemic trauma informed services.



Gina Bongiorno is a full-time clinician with the UC San Diego Bridge to Recovery Program and Adjunct Faculty at the University of San Diego. At UCSD, Gina provides treatment to individuals with co-occurring substance use and mental health disorders. Her ongoing clinical work includes performing assessment, diagnosis, individual and group psychotherapy in an acute psychiatric setting. Gina is also the lead family therapist and trainer for her program. She specializes in trauma-informed care and has been a member of the San Diego Trauma-Informed Guide Team since 2010. She regularly serves on panels and provides trainings and workshops to mental health providers, law enforcement and community members.



Brian Woolsey is a counselor and instructor at Grossmont College. He meets regularly with students from historically disadvantaged backgrounds, with a primary emphasis on helping former foster youth make the incredibly quick transition they're forced to make from foster care to independent living. Collectively, the students he counsels have suffered every kind of childhood trauma imaginable. As a Foster Youth Success Initiative Liaison, he created the county's first unit-bearing college course designed to help these students overcome legacies of trauma and realize college success. Brian also serves students with disabilities in the college's Life Coaching program, and routinely meets with students who have depression, anxiety and PTSD.



Catherine Butler is a marriage and family therapist in private practice in La Mesa, CA with a focus on military and first responders. She is a veteran of the Canadian Navy, a Navy spouse, and is currently assigned to an Army National Guard unit in El Centro, CA as their embedded therapist. Additionally, she is the therapist for the La Mesa Police Department, and a trainer for the California Peer Support Association. Previously she has designed training on veteran awareness for the County of San Diego. Currently a doctoral candidate, she is conducting a treatment based study at Veteran's Village of San Diego for veterans with military related trauma. Her clinical specialty and passion is the treatment of PTSD and trauma, and the support of first responders and their families.



Michael Meoli is a firefighter, tactical paramedic, field training officer and preceptor with the San Diego Fire and Rescue Department. He was one of the founders of the San Diego Special Tactics and Rescue (STAR) Team and continues to support SDPD SWAT as well as other government tactical teams in the U.S. SEAL Operator Chief Meoli continues to serve in the US Navy Reserves and has been very involved in his secondary specialty as a SOCOM Advanced Tactical Practitioner (ATP). He was mobilized for two years after 9/11 mostly in the middle east and serving a third year in Iraq as a government contractor. Due to many experiences with personal and professional losses, Mr. Meoli has responded to a calling to help others in crisis. He served for several years on the SDPD Crisis Intervention Team and continues to serve as a Casualty Assistance Calls Officer (CACO). Among numerous other qualifications, Mr. Meoli has California State teaching credentials, Navy Operational Medicine Instructor certification and has trained thousands of civilian and military personnel in the U.S. and numerous foreign host nations.