Trainer's Agenda

Mental Health 101: A Trauma Informed Approach

Time	Activity	Method/Description	Media/Materials
9:00 – 9:20 (20 min) **Slides 1 - 6**	**Opening: Welcome, Agenda Review & Introductions**	Engage the audience and set the stage for a dynamic, interactive training. See PPT "Notes Pages" for trainer talking points/prompts. 1. Welcome, learning objectives, agenda review 2. Participant introductions 3. Neen Video clip and brief discussion	Laptop & LCD Participant Handout Packets* *Participant Agenda *Presentation slides Healing Neen Trailer http://healingneen.com/
9:20 – 9:40 (20 min) **Slides 7 - 16**	**Mental Health 101: Building Awareness**	Provide general information regarding mental illness: 1. Definition 2. Facts/Myths/Stigma 3. Factors increasing risk 4. Prevalence of mental illness	*Top Ten Myths about Mental Illness
9:40 – 9:50 (10 min) **Slides 15 - 16**	**Introduction to Signs & Symptoms**	Present considerations for first responders to identify signs and symptoms of mental illness in mood, thought disturbance, and behavior. Distinguish hallucinations and delusions.	
9:50 – 10:10 (20 min) **Slides 17 - 27**	**Major Mental Illnesses**	Provide specific identifiers of Schizophrenia, Bipolar Disorder, and Major Depression. Discuss general and specific tips for first responders.	
10:10 – 10:45 (35 min) **Slides 28 -47**	**Trauma-Informed Approach**	Intro to TIC—Slide 28, 41, 42 TKF Video—Slide 29 Trauma and the Brain—Slides 30 - 33 Case Example & Discussion—Slides 39 – 40 More on TIC—Slides 41-42 Group Discussion/Vignette—Slide 43 or 44 Wrap up/Integration	TKF Video Clip *FRT Case Example—"Harvey" *TIC Checklist *"Held Hostage" Vignette *FR Resource card Healing Neen Trailer http://healingneen.com/
10:45 – 11:00	**Wrap Up Evaluation**		*Wellness Checklist *Fact Sheets

Slides 48 - 49	**Adjourn**		*References

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.

Sponsored by the County of San Diego 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.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY
Live Well, San Diego!

Opening: Welcome, Agenda Review & Introductions (Slides 1 – 5)

Purpose of this section:

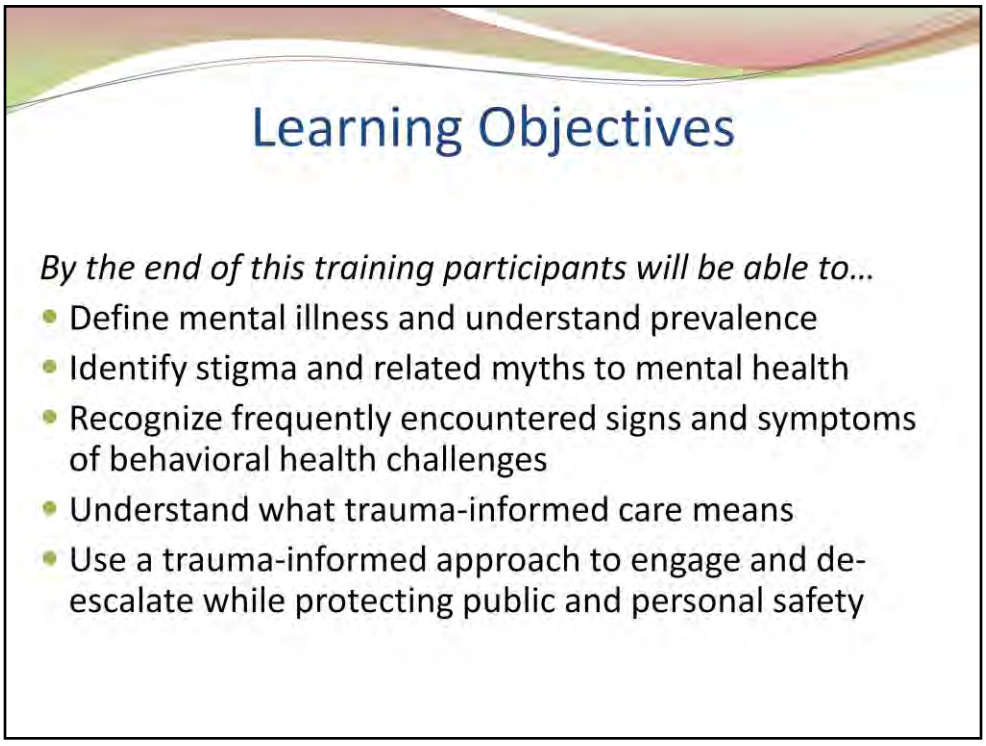
1. To welcome participants and set the stage for an engaging, interactive training.
2. To orient participants to their materials and how the training will be conducted.

Trainer talking points:

1. Welcome participants and continue engagement with the audience. (Greet them personally as they arrive.) **Honor and acknowledge First Responder's service to the community and nation.**
2. Create interest around the topic of mental health 101 and trauma-informed care. (Show personal enthusiasm for why <u>you</u> think this is an important topic.)
3. Describe Tracy L. Fried & Associates' (TLFA) mission. Tracy was commissioned by the County of San Diego to develop this training with a core team. (TLFA's mission is to create a shared commitment across systems to enhance the lives of underserved and underrepresented populations, strengthening support and success for all.)
4. Introduce other trainers present (briefly).
5. Acknowledge expertise First Responders bring with them into the room and invite sharing throughout.
6. Briefly tell why this training was commissioned by San Diego County Behavioral Health Services, and how it connects to *Live Well, San Diego*!

   The County of San Diego HHSA Behavioral Health Services recognized the need to support San Diego County First Responders by sponsoring uniquely designed trainings focused on mental health awareness, understanding trauma informed care and how to integrate a trauma informed approach when responding to situations.

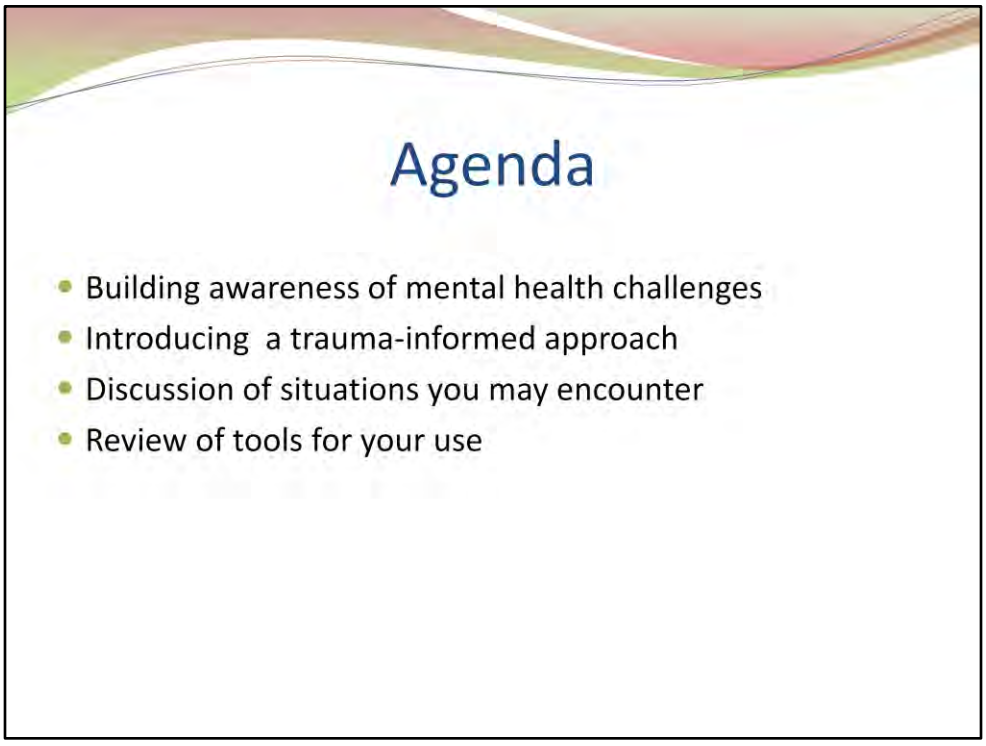
   Live Well, San Diego! is the County's 10-year plan to improve the lives and well being of our community with a vision of a county that is safe, healthy, and thriving. The MHSA PEI First Responders Training on behavioral health support the County's adopted *Live Well, San Diego*! initiative by building a better system, supporting positive choices, pursuing policy changes for a healthy environment.



-Review Learning Objectives

Let participants know the goal and objectives for this training.

Trainer option: Ask if there is anything else that the audience is hoping to learn from today's training. If so, write down on flip chart paper. If participants name topics that will be covered, let them know. If there are any topics they suggest that are beyond the scope of this training, let them know that as well. Refer back during the training to make sure agreed upon topics were covered.



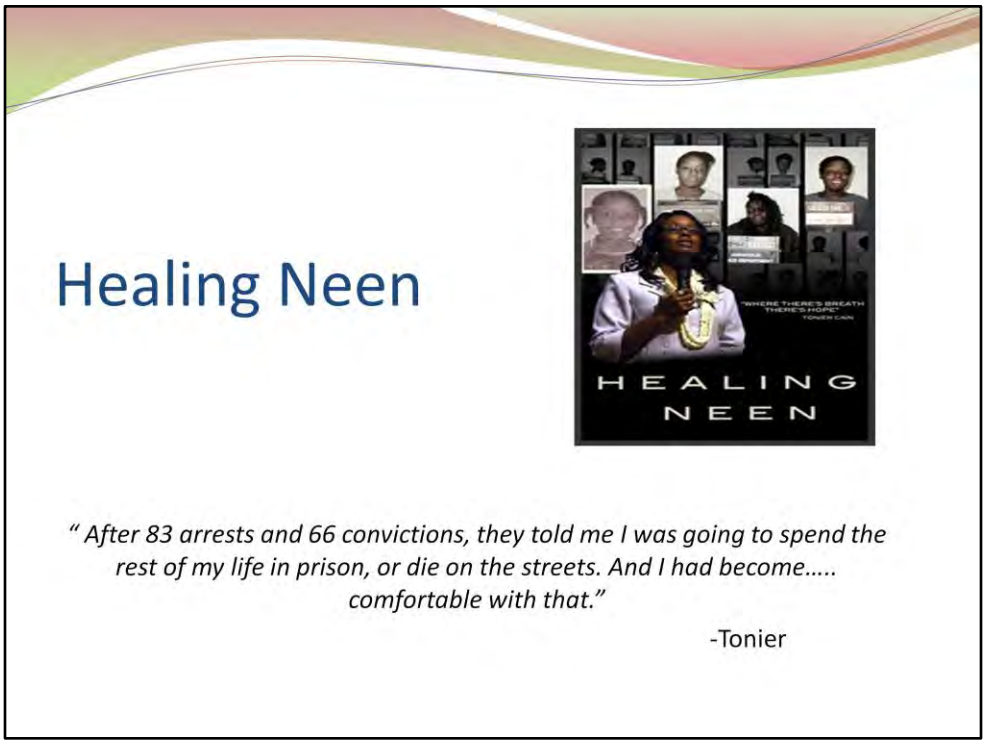
-Review the agenda (Participant Handout Packets and useful resources)

Refer participants to the handouts titled, "Overview" and "Participant Agenda".

1. Go over topics to be covered and the flow of the training.
2. Review basic housekeeping (i.e., location of restrooms, etc).
3. **Acquaint participants with their handout packet and the resource table.**
4. Let participants know you plan to use the term "first responders" as inclusive of the wide range of professionals such as law enforcement, fire/paramedics/ emergency medical personnel, probation, parole officers, military fire and police, campus based enforcement, parks and recreation rangers, lifeguards, and animal control officers. MODIFY LANGUAGE AS APPROPRIATE TO THE GROUP YOU ARE TRAINING.

-Introductions

One minute participant introductions by table (name, role, division/department).



-Healing Neen Video Trailer--Opening

Play the Healing Neen video trailer, available at http://vimeo.com/10791754 (length 3:26) then choose one of the following debriefing options below:

Refer participants to the handout titled, "The Story of Neen"

Option 1:

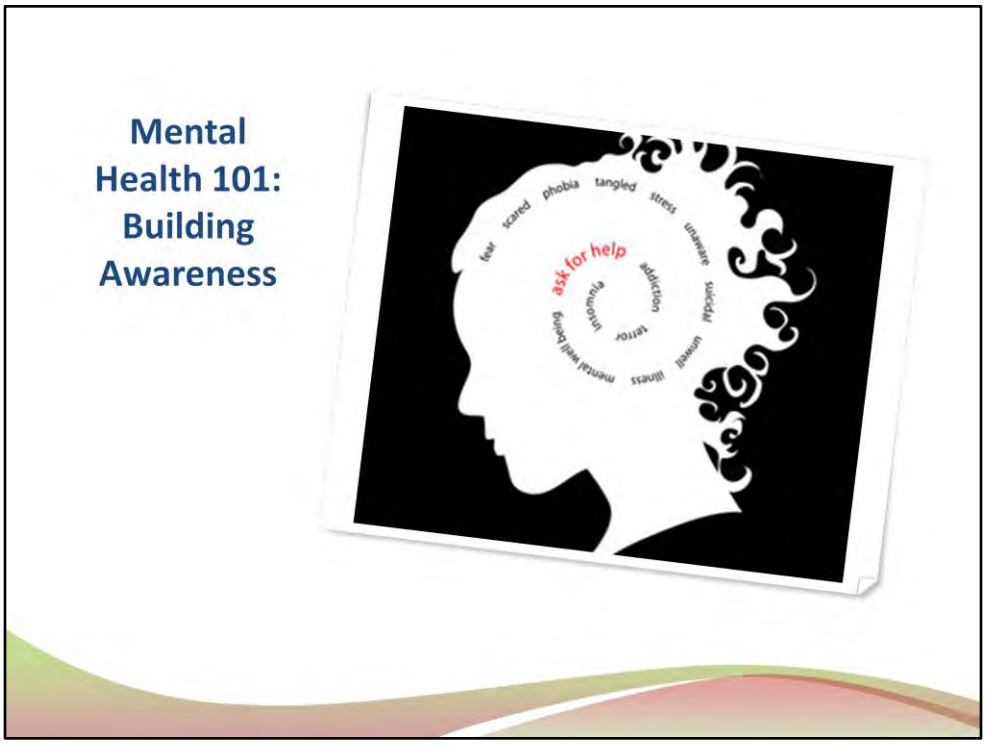
Scan the room for reactions. Incorporate participant's reactions right away.

Ask for general feedback on the trailer (list on chart paper).

Acknowledge the intensity and highlight the inspiring message.

Option 2: (O-R-I-D Discussion Method)

1. Objective—"What did you see or hear that stood out for you?"
2. Reflective—"What thoughts or feelings came up for you as you were watching this video clip?" "Do you know someone like Neen"?
3. Intuitive—"What messages (if any) does this hold for First Responders?"
4. OPTIONAL: Decisional—"Is there anything you might do differently as a result of this awareness?"



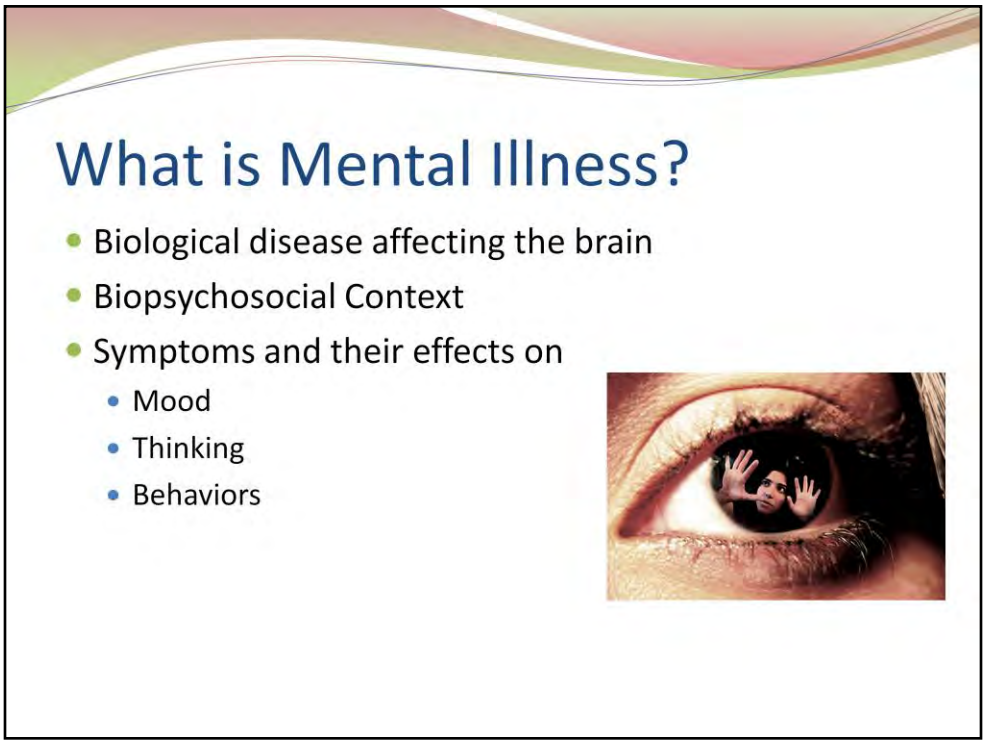
Mental Health 101: Building Awareness (Slides 6 – 13)

Purpose of this section is to build awareness of…

1. Definition of mental illness
2. Stigma and myths
3. Prevalence of mental illness

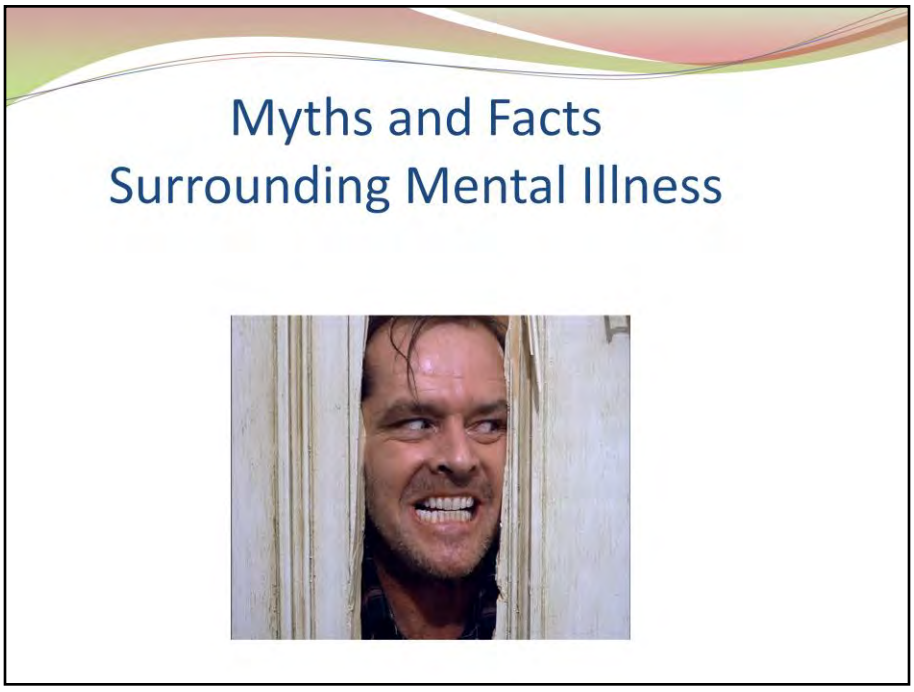
Trainer talking points:

1. Provide an introduction to the topic and brief outline of this section
2. Let participants know we will share facts and engage them in discussion for shared learning



-Definition of Mental Illness

1. Point out that there is a genetic component to mental illness, as well as environmental components.
2. Explain that the Bio Psycho Social model considers the influences of genetics, family history, mental health background and also the social functioning and social history of a person.
   Bio--body; physical effects and symptoms
   Psycho—thoughts and emotions
   Social—the context of family, friends and others
3. Symptoms of mental illness are evident in a person's mood, thinking and behaviors. (Note that more on this will be covered later in the training.)



-Stigma and Myths Related to Mental Illness

Briefing:

1. Let the group know that misconceptions about mental illness are pervasive, and the lack of understanding can have serious consequences for millions of people who have a psychiatric illness, according to the National Alliance for Research on Schizophrenia and Depression (NARSAD).
2. Misconceptions about mental illness contribute to the stigma, which leads many people to be ashamed and prevents them from seeking help. (Elaborate.)

Activity:

1. Prior to the training, the trainer reviews the handout "Top Ten Myths about Mental Illness".
2. Chose 3 – 6 statements and ask the group, "True or false?" and read a statement. (Note: Transpose at lease one statement to be true.)
3. "Poll" the group: Thumbs up = "True"; Thumbs down = "False"
4. Comment on the facts surrounding the statement you read.

Debriefing/Wrap up:

1. Dispelling these myths is a powerful step toward eradicating the stigma and allaying the fears surrounding brain disorders.
2. Working through stigma helps First Responders with a quicker, safer, and more effective response.
3. Individuals you may encounter also hold facts, myths, and stigmas regarding first responders—particularly those in uniform.
4. Distribute the handout titled, "Top Ten Myths About Mental Illness"
5. **Point out the Resource Table**: (1) Handouts available—See Facilitator's Manual . (2) SD County It's Up to Us Initiative
   -Important to raise awareness about how prevalent stigma associated with mental health is. That is why San Diego County dedicated large amounts of funds for AdEase, a media firm, to create a countywide outreach plan to reduce stigma and raise awareness of mental health / mental illness and how common it is.

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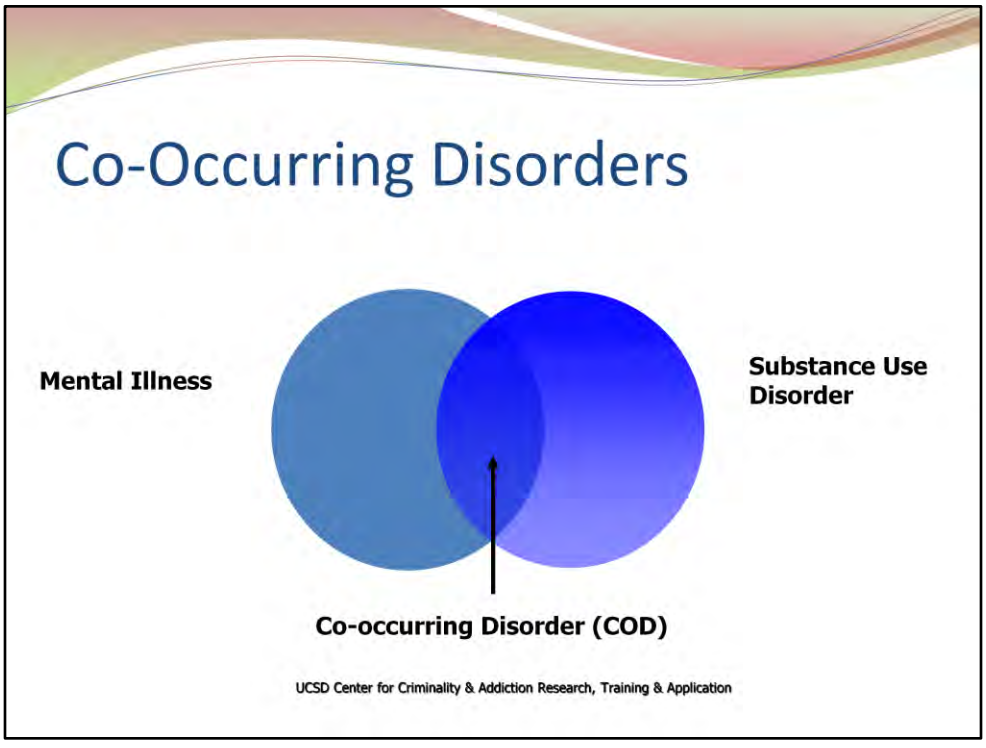
1. Read the facts.
2. Ask, “What is your reaction?” Do these facts fit your experience?

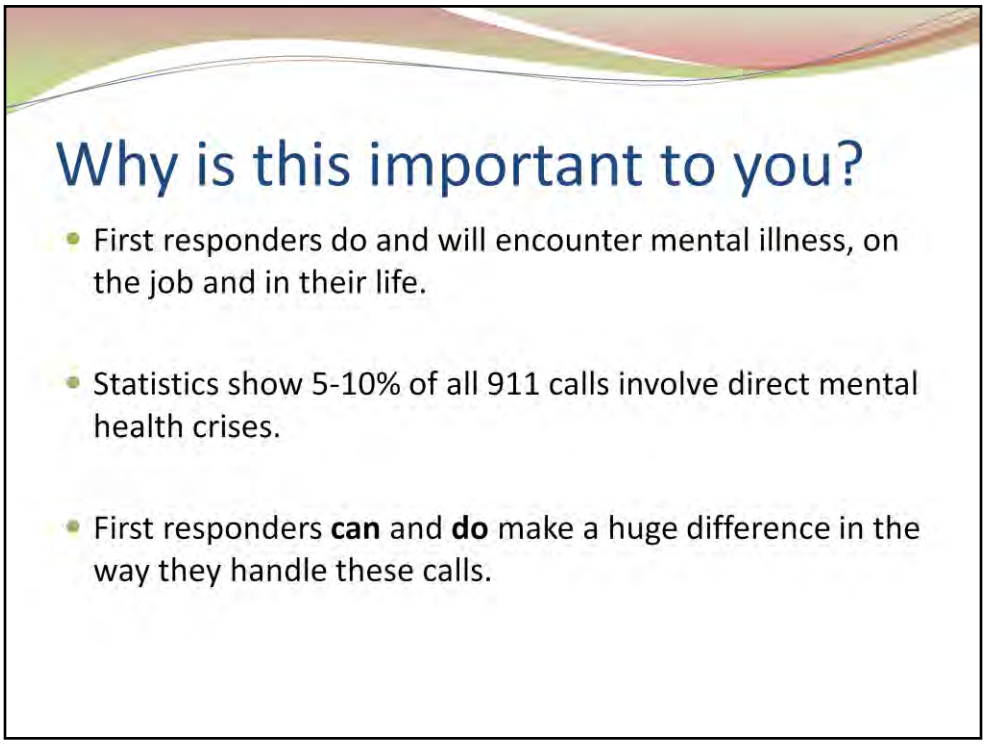
-Factors increasing risk

1. Highlight that when mental illness is co occurring with the use of drugs or alcohol it may be hard to determine which factor is contributing to an individual's behavior.
2. Co-occurring disorders might mean increased risk of violence and criminal behavior, exacerbation of psychiatric symptoms, and non-adherence.
3. Encounters with First Responders heighten stress on the part of everyone involved.
4. Ask the focus questions on the slide and engage discussion. ***(Optional if time is limited.)***



In support of statements made on the previous slide, this slide depicts the co-existence of interrelated major mental disorder and substance use disorder.

Drugs and alcohol can cause psychiatric symptoms which may last from days to weeks. They clear with abstinence.

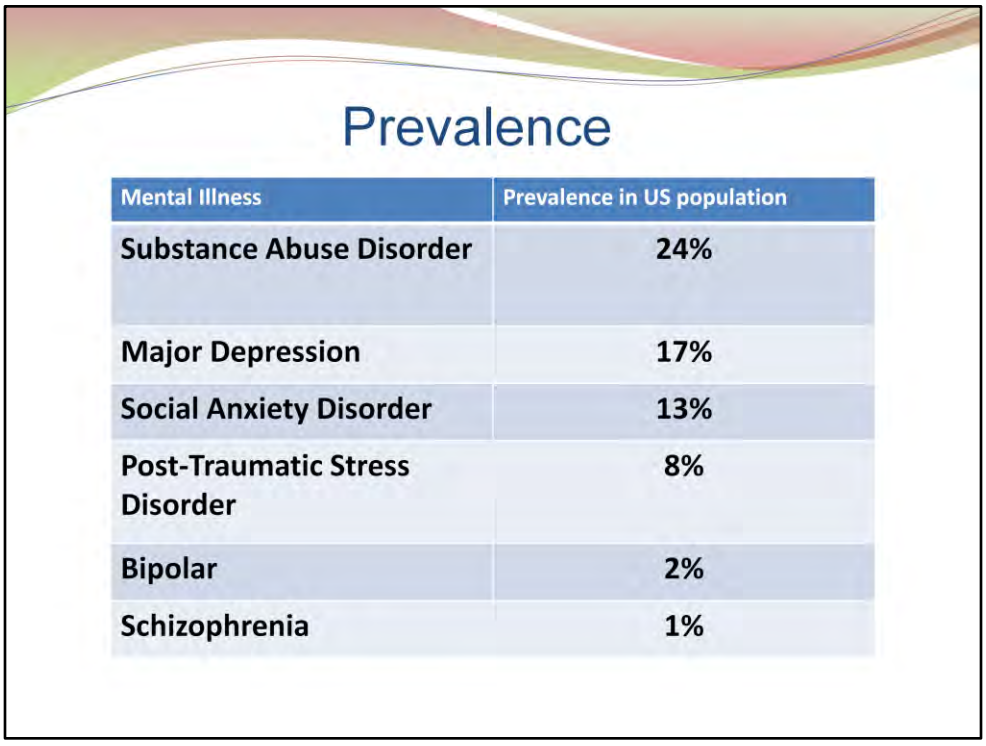


-Making a Difference

1. According to the National Alliance on Mental Illness (NAMI), of the 2 million plus individuals currently incarcerated in the US, 500,000 of them (1/4) have one of the following serious mental illnesses: Schizophrenia, Major Depression, or Bipolar Disorder. These are the behavioral health challenges First Responders are most likely to encounter.

2. Ask if 5-10% fits their experience. (Note: Most First Responders believe the actual number of 911 call involving mental illness is much higher.)

3. First Responders can significantly impact the outcome of each encounter by:
    1. Using mental health knowledge
    2. Applying a trauma-informed approach
    3. Educating themselves about resources and referrals available



-Prevalence

1. **Introduce the topic of prevalence** of mental illness with the following facts: (1) 1 in every 5 people have a mental illness; and (2) Fewer than 20% seek treatment.

2. **Briefly point out prevalence** to reinforce that First Responders are likely to encounter individuals with one or more of these challenges.

Signs and Symptoms (Slides 14 – 19)

Purpose of this section: This section will review the signs and symptoms of behavioral health challenges First Responders may encounter on the job. (Note: It is meant to be a very high level overview or refresher. Time allocated for this training does not allow for an exhaustive review. If more information is requested, please direct participants to resources including other more comprehensive trainings.)

Trainer talking points:

1. **Mood** You may observe an individual with…
    1. Flat affect
    2. Irritable mood
    3. Mood swings
    4. Anxiety
    5. Euphoria

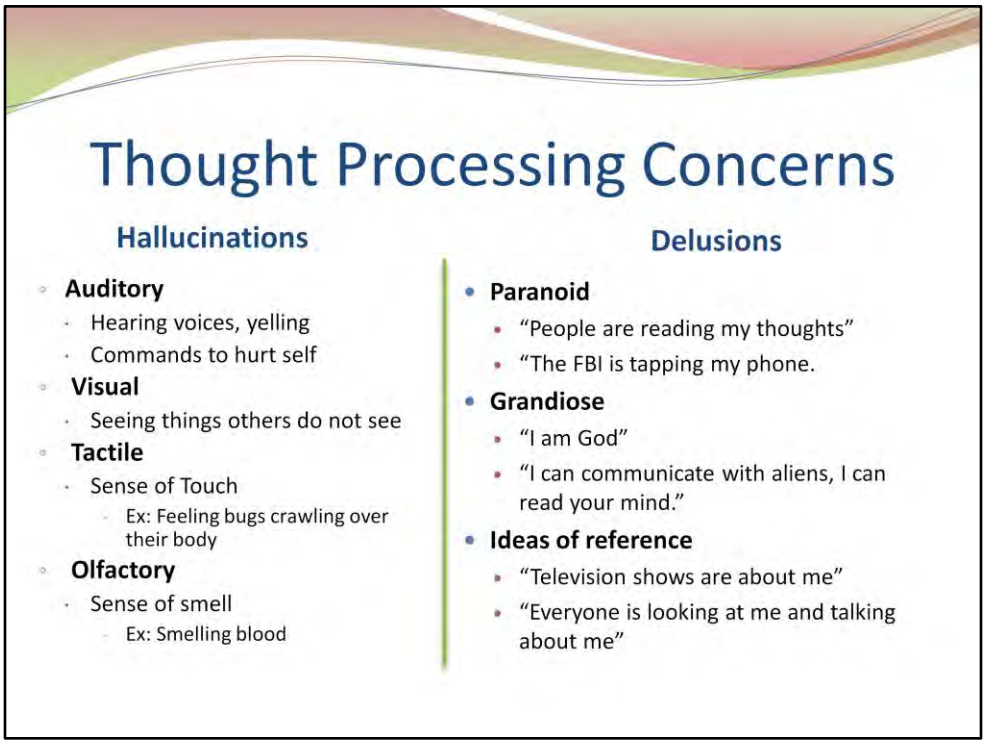
Act these out. Make them real.

2. **Thinking** You may observe an individual with…
    1. Thoughts (speech) that is not clear and coherent
    2. One idea does not logically follow another
    3. Sudden inability to finish a thought or recall train of thought
    4. Jumping from one topic to another
    5. Tangents

Give examples.

Two particular forms of thought content problems follow on next slides.

3. Behavior



-Thought Processing Concerns

1. Describe what a hallucination is (hearing, seeing, feeling, smelling something that is not real/not actually present, or processing in a distorted way).

2. Go over the types of hallucinations and how to tell if a person is experiencing a hallucination.

3. Define what a delusion is (a false belief that impacts self-perception and/or behavior).

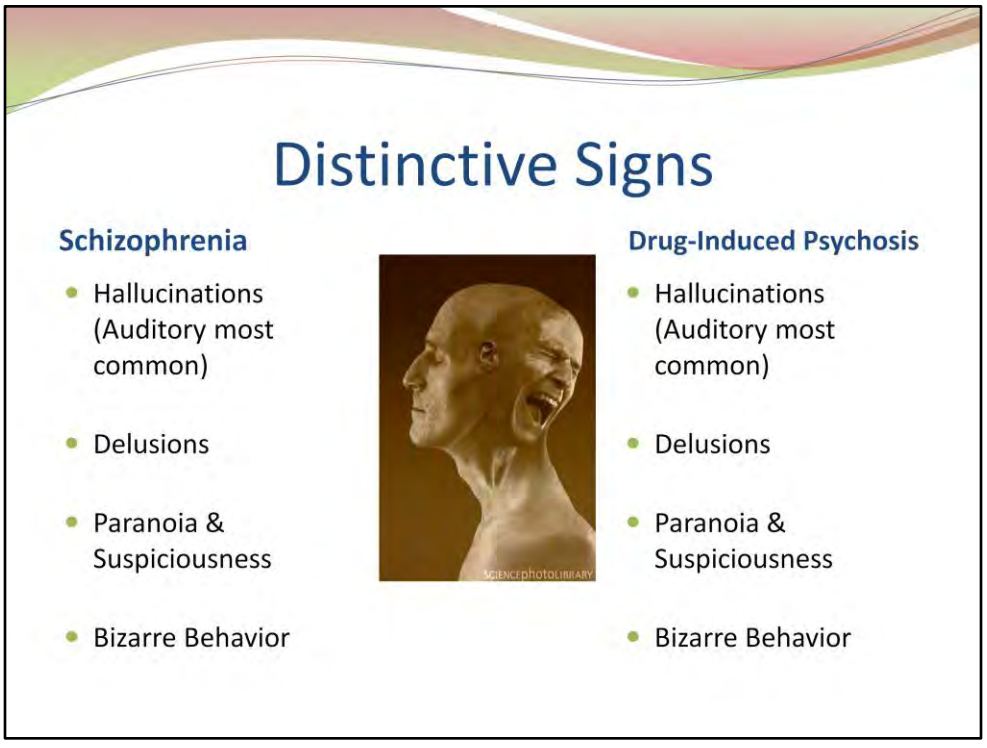
4. Go over types of delusions and how to tell if a person is holding delusions.

Major Mental Illnesses

1. There are many other types of mental illnesses, however this training is about the three most prominent in those that are served by First Responders: Schizophrenia, Bipolar Disorder, and Major Depression.

2. For all mental illnesses, there is no one sign or symptom that is definitive. Rather it is a cluster or pattern of signs and symptoms.

3. Also, the same symptom can be an indicator of concern in more than one type of mental illness.



-Schizophrenia

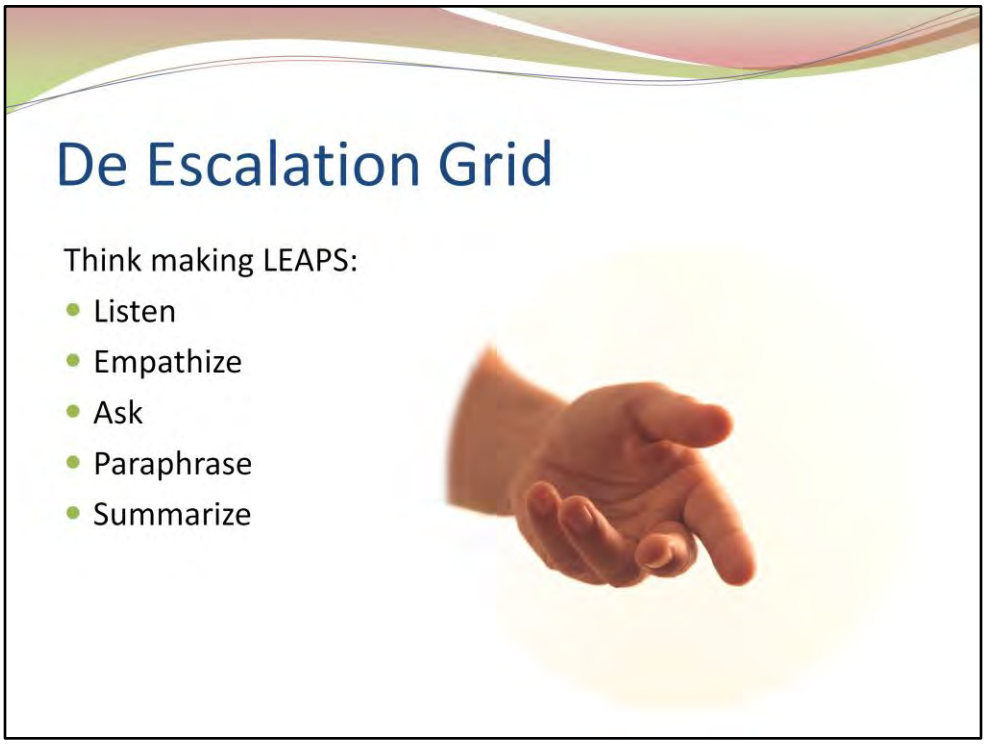
1. Considered a thought disorder; Commonly referred to as "psychotic disorder"
2. Approximately 1% of the population suffers from Schizophrenia; Usual onset is late teens to early 20's
3. High percentage of individuals with schizophrenia abuse substances; 20-50% attempt suicide, and of those 10% succeed in causing their own death.
4. Research shows that those diagnosed with schizophrenia have a lower life expectancy (by 25 years) than those not diagnosed with major mental illness.
5. Prognosis ranges from poor to excellent (when medication compliant). Can be treated successfully!

Substance use/abuse can have parallel effects.

Describe how first responders can differentiate between the two.

-It is not always possible to identify which or both co-occurring.

-Liquor bottles and/or drug related paraphenalia may indicate substance use.



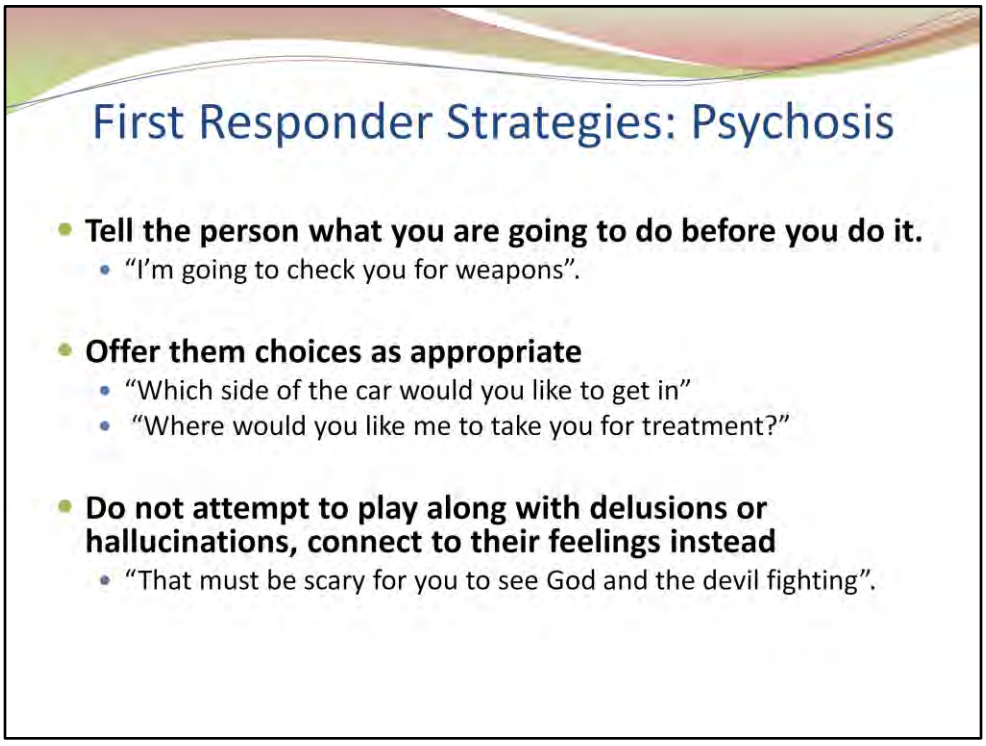
-De Escalation Grid

1. There are general strategies for responding to persons, regardless of their type of mental illness. Remind participants you acknowledge that their #1 priority is public safety, so some strategies may not be appropriate. We are not asking you to change your established protocols, but rather use these tools to further humanize your actions.
2. These strategies are designed to helping the individual feel safe, feel "human", and will likely increase cooperation and reduce agitation making your job easier.
3. One such strategy is known as "LEAPS". Think *making* LEAPS. (Go over what it stands for, using the slide.)
4. Give examples of how each strategy can be applied.

Examples might include: "We can come up with a solution"
"We can work this out"
"Stop and think about how this might turn out later"

Verbal pacing techniques:

Sensory: "I sense that you are angry"
Visual: "I see that you need help"
Auditory: "I hear what you are saying"



-First Responder strategies for dealing with psychosis/schizophrenia

1. This is beginning to weave in trauma informed approaches. It may be helpful to foreshadow the trauma informed piece that is coming after the Mental Health 101 here. Emphasizing the importance of safety for the public, themselves, and those they are responding to.

2. **Associated risk factors:**

   Medication Side effects

   Fear treatment

   Denial and lack of insight

   Isolation

   Lack of support

   Lack of services

   Inability to access limited resources

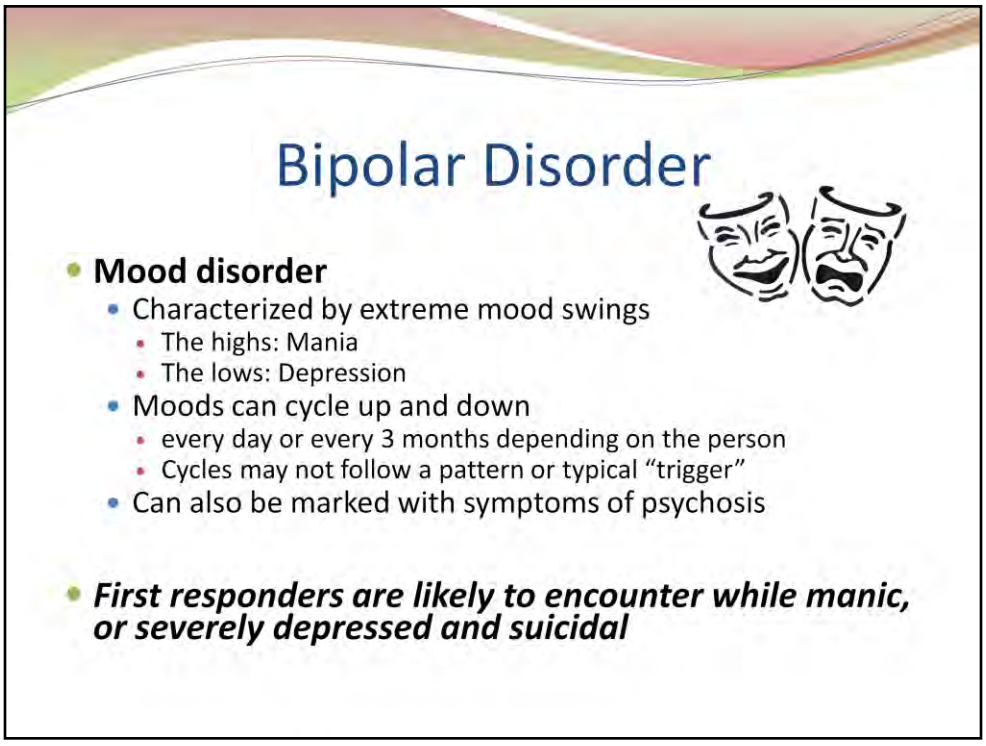
3. **General strategies**:

   Be calm and patient-the person may be having auditory hallucinations, thought blocking, etc.

   Decrease stimuli, turn down off lights, sirens, etc. they are already having too much stimuli from their psychosis.

   Develop rapport with the person.

   Obtain history from family or others if available.

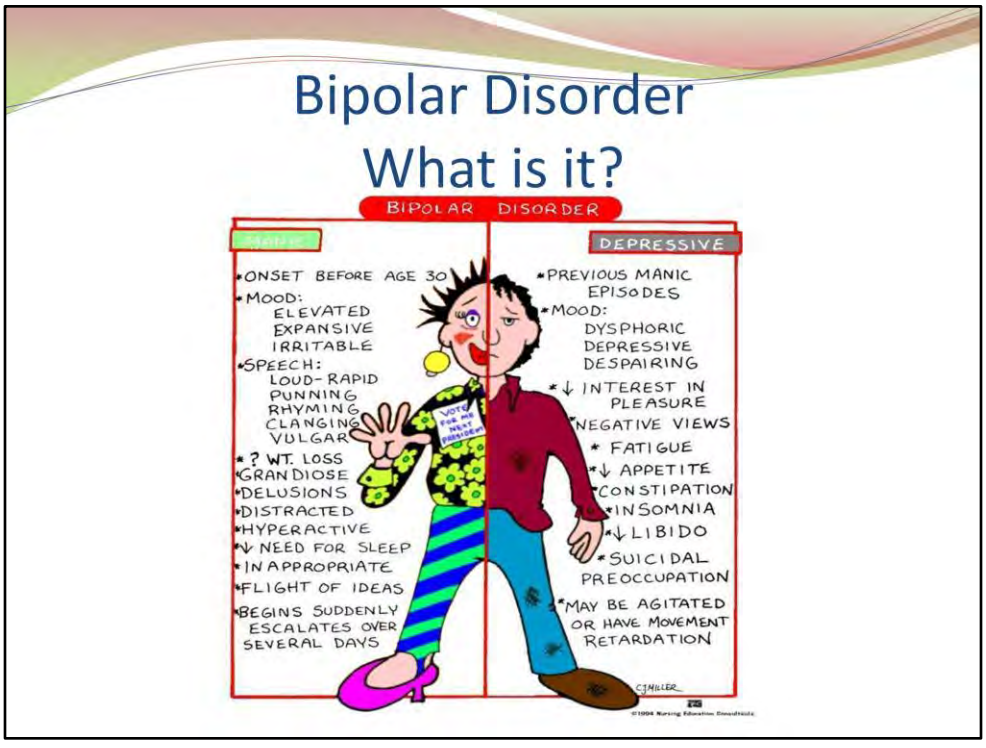


-Bipolar Disorder

1. Describe bipolar disorder from bullets on the slide.

2. Note that people with Bipolar Disorder tend to have the highest rate of medication non compliance. This is due to the manic symptoms. When manic there is a decreased need for sleep, feelings of euphoria and increased energy. Many people have compared it to being high on crack cocaine.

3. When a person is "coming down" from a manic episode they are higher risk for suicidal thoughts and depressive symptoms such as isolation, self mutilation, sadness, hopelessness and lack of motivation and/or over sleeping.



-Bipolar Disorder

1. Use this picture to make the point that in each state, the person can come off very differently. It is important for the First Responder to be aware what extreme the person may be experiencing at the time of interaction.

2. **Mania or manic episode-** An altered mental state which affects a person's mood and thought process:
   - Rapid changes in mood and behavior
   - Euphoric
   - Grandiose
   - Irritable or agitated
   - Increased energy
   - Decreased need for sleep
   - Impulsive and risky behaviors

3. **Risk & Prognosis**
   - Can be treated successfully with medications and therapy
   - In between episodes most people are fully functioning members of society
   - Some of the brightest and most creative people in history: Ernest Hemmingway, Ben Stiller, Tim Burton
   - Non-compliance can be due to medication side effects and the enjoyment of mania
   - Very high rate of substance abuse
   - Can be very high suicide risk

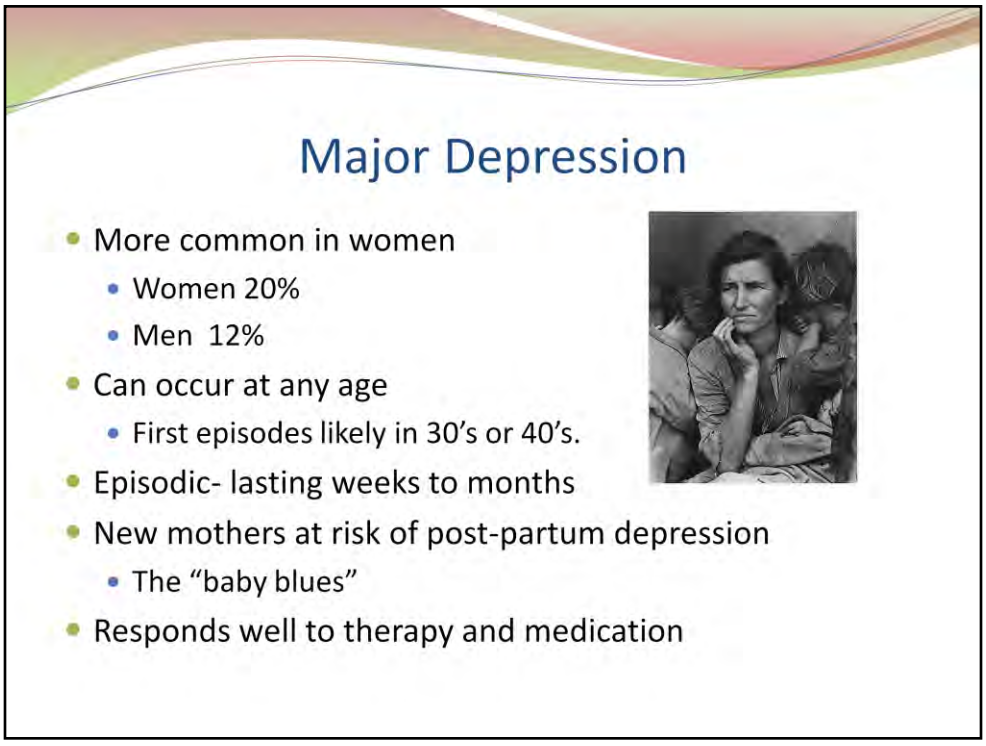
-First Responder strategies for dealing with Bipolar Disorder

1. Remind participants of general strategies:
   - Be calm and patient-the person may be having auditory hallucinations, thought blocking, etc.
   - Decrease stimuli, turn down off lights, sirens, etc. they are already having too much stimuli from their psychosis.
   - Develop rapport with the person
   - Obtain history from family or others if available

2. Provide specific tips for managing a person with bipolar disorder, using bullets from the slide

3. **Ask participants:**

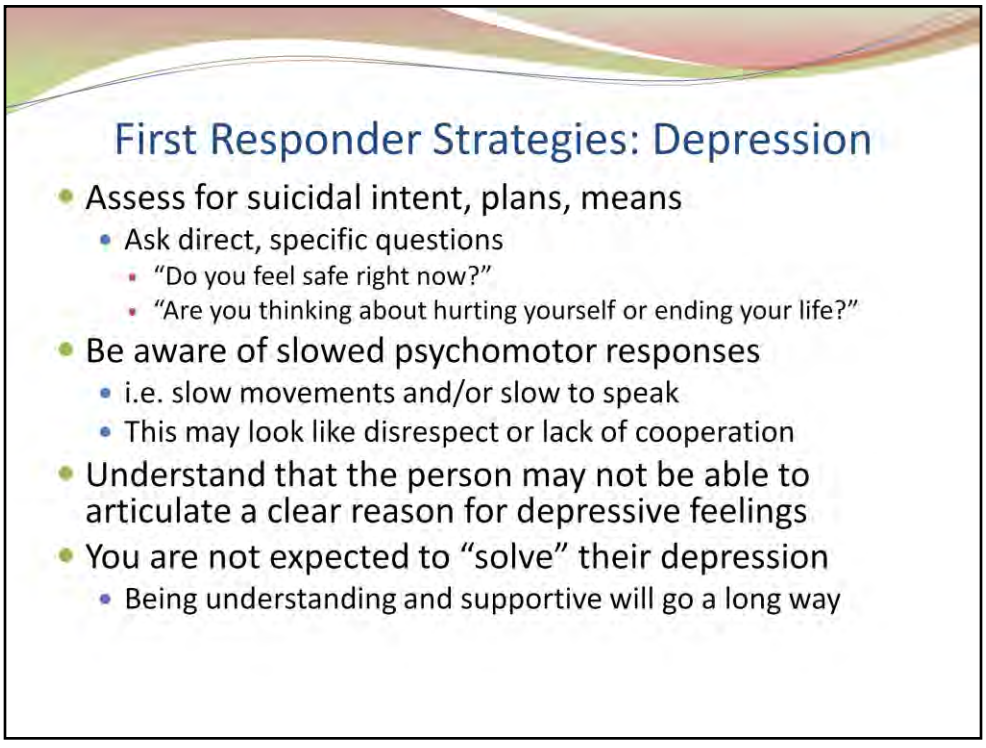
   - ***"Do these strategies seem reasonable?"***
   - ***"What else might you do that is not listed here?"***



-Major Depression

1. Go over general points from bullets on the slide
2. Classified as a Mood Disorder
3. Characterized by depressive episodes lasting from weeks to months at a time
4. Widespread: Nearly 1 in 5 people will experience an episode of major depression in their lifetime.
5. Key signs of Major Depression:

    - Profound feelings of sadness
    - Feeling hopeless and helpless
    - Increased crying spells
    - Decreased energy, lethargy
    - Sleep disturbances- +/-
    - Eating disturbances- +/-
    - Thoughts of suicide or death
    - Delayed response
    - Loss of interest in pleasurable activities



-First Responder strategies for dealing with Major Depression

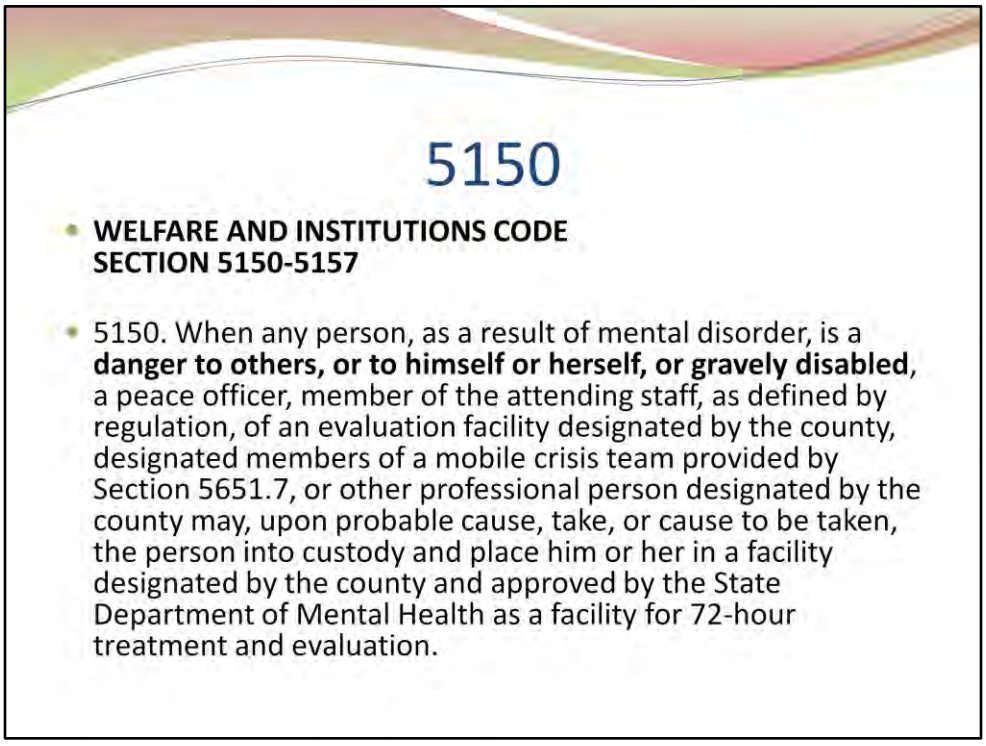
1. It is very important to emphasize the common need/desire to "solve the problem" but when a person is truly experiencing a high degree of depression, it is most effective to develop a rapport and offer empathic responses.

2. In crisis intervention it is customary to be directive and structured in your intervention, asking closed ended questions.

3. **Ask participants what their experience has been in assessing for suicidality. (This is a prompt for trainers to determine how much further information to go in to.)**

4. Remind participants of the three elements we typically assess for:

    - **Motive** "Yes, I don't want to live any longer."
    - **Method** "How do you plan to end your life?" "By shooting myself with a gun…"
    - **Access/Opportunity** Do they have the means to carry out plan? "Do you have gun? (Or plan to secure a gun?)



-Assessment and follow though on 5150 status

1. **A primary task of First Responders is to determine what needs to occur to protect an individual's safety and when to call for law enforcement.**
2. A First Responder who is a **sworn officer** who has cause to believe that a person is a danger to themselves, to others or is gravely disabled, must take the individual to a Mental Health facility to be evaluated and possibly held on a 72 hour hold. (Refer participants to the laminated 5150 Hospital Emergency Room cards.)
3. **What is gravely disabled**? When a person's mental condition prevents him/her from being able to provide for food, clothing, and/or shelter, and there is no indication that anyone is willing or able to assist him/her in procuring these needs.
4. The officer must sign a written declaration: *Form MH 302.* The declaration form will require information on the circumstances under which the person's condition was called to the attention of the officer.
5. **Other First Responders** *(*unsworn officers) may contact their local law enforcement, or PERT team to make further determinations on a possible hold.
6. The Mental Health facility will determine whether the individual meets the criteria for a 72 hour hold against their will, it is not the officer's job to act as clinician.
7. The sworn officer is not responsible to transport an individual to jail based solely on the unavailability of an acute bed.

-Transporting individuals with behavioral health challenges

1. Reassure participants that they are not expected to be the experts on mental health. They are they to make an informed judgment (often a split second decision) based on the information at hand.

2. If the individual is showing any of the previously mentioned signs and symptoms, consider drop off at a mental health facility, treatment program or detox center where they will likely be referred to long term resources, obtaining help and therefore off the streets.

3. Refer to laminated FRT Pocket Card with referrals in participant packet.

Trauma Informed Approach (slides 27 – 36)

Purpose of this section:

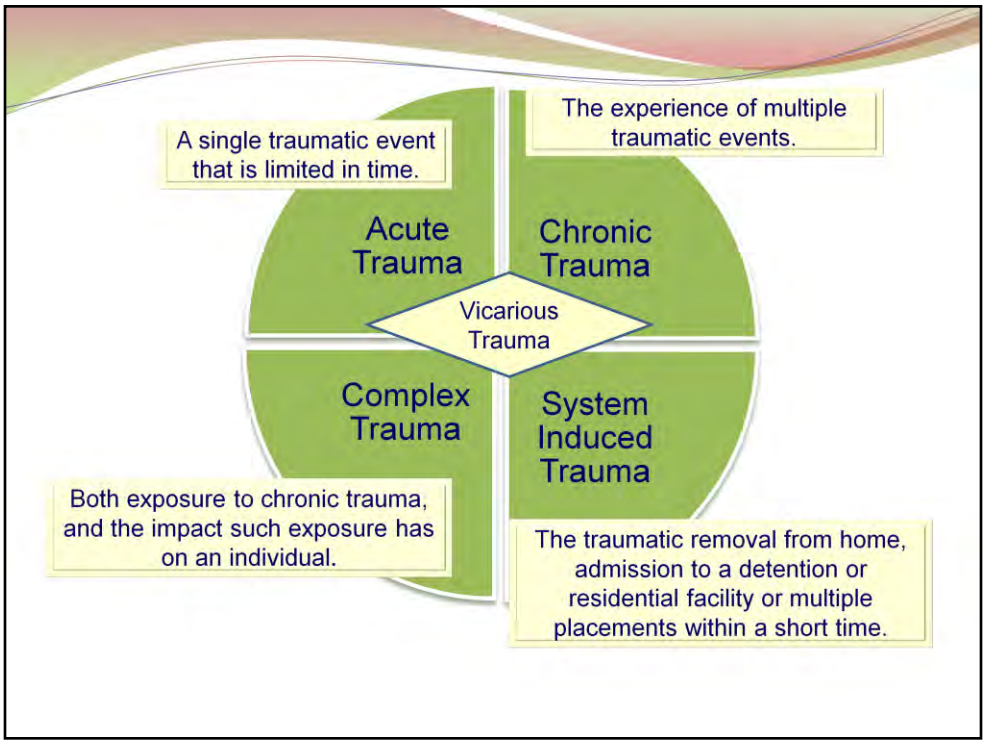
1. Define the types of trauma and their origin in brain development and early childhood experiences.
2. Describe how to respond to trauma using a trauma informed approach, building on previous de-escalation strategies offered.

Trainer talking points:

1. Introduce Trauma Informed Care (TIC). Explain that TIC is not a model but a philosophy. When using a trauma informed lens, all people that are served by First Responders are viewed similarly, crossing through ethnicities, gender, age and diagnosis. Trauma is unfortunately a reality in today's society. When utilizing a trauma informed lens a trauma survivor can be accommodated in a way that is respectful, dignified, genuine and sensitive.

2. A trauma is "any incident or situation that overwhelms a person's ability to cope."

3. A traumatic situation is one involving an actual or threatened death or serious injury. Sometimes when people experience an event so terrible and frightening that it is difficult for most of us to imagine, they suffer from shock. This can happen after a one-time natural catastrophe like a hurricane or a flood or after an experience like seeing a bomb attack or seeing someone shot. Sometimes this kind of shock can happen when an unpleasant experience occurs time and time again in a child's life, like being beaten or sexually abused repeatedly. Particular signs of stress can occur after experiencing an event directly, from witnessing an event, or even hearing about such an event in regard to a family member. People who suffer from a prolonged reaction to such shock may be diagnosed as having Posttraumatic Stress Disorder.



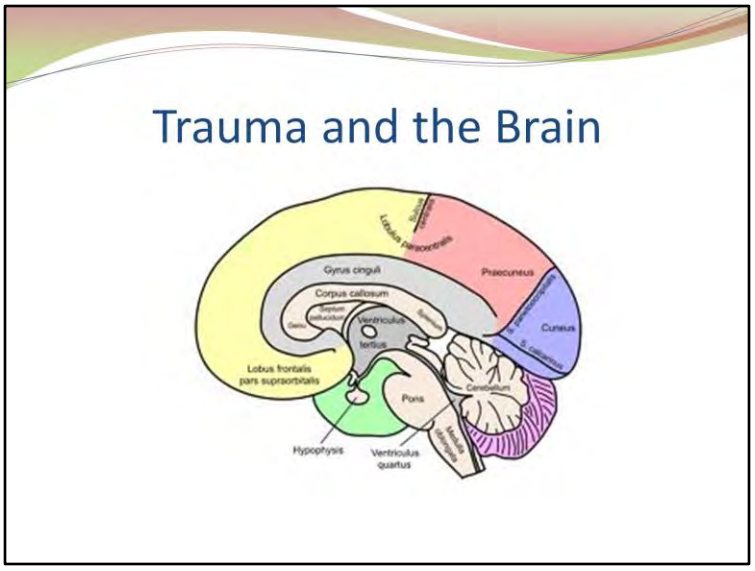
-Types of Trauma

1. Go through each type of trauma with special emphasis on Chronic Trauma and Complex Trauma. Complex Trauma- layering of chronic trauma that in turn effects brain development.

2. When describing vicarious trauma, state that it applies to First Responders directly. Encourage them to be mindful of their own level of health and wellness and take time to nurture it.

3. Mention the following types of trauma and how they relate to those on the slide:

   - Neglect
   - Domestic Violence
   - Witnessing DV
   - Childhood Sexual Abuse
   - Childhood Physical Abuse
   - Violent Loss of a Loved One
   - Sexual Assault
   - Human Trafficking
   - Criminal Victimization
   - Extreme Economic Depravation
   - Sudden Job Loss
   - Natural Disasters
   - War

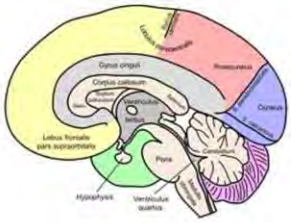


-Trauma and the Brain

1. Disclaimer that we are not neurologists. Explain that the way that a traumatized person's brain functions is very different than how a person that has not experienced trauma's brain works.
2. **Amygdala** This is the "Security Guard" of the brain, if there is any sense of threat this immediately responds in very primitive fashion. Fight, Flight or Freeze. When a person is traumatized, to survive, the amygdala may send adrenalin to the body to fight or may prepare the body to retreat, in extreme cases the person may dissociate. When a person is triggered later by a smell, sound, sight or touch, they will be "emotionally hijacked" meaning the amygdala will respond in the same way it did when the person was traumatized- causing aggression, flight or dissociation in the new situation that may not have been inherently traumatizing in the moment. Share useful interventions to de escalate the aroused amygdala.
3. **Limbic** Explain that this is the part of the brain that if not traumatized develops safe attachment to a primary care giver and social connection. For traumatized individuals this part of the brain may not develop correctly causing disregulated emotions, inability to connect, strong sense of abandonment and deep seeded sense of distrust.
4. **Neocortex/prefrontal** When the amygdala is aroused the Executive Functioning and Limbic system shut down, therefore the triggered person is no longer able to think sequentially or rationally. For example: The one person that seems to always have something bad happening to them. Traumatized individuals are more likely to be sexually assaulted, the victim of a crime, home fires, fatal car accidents. This is all due to the fact that they are walking around on a daily basis with a heightened stress response, they are unable to think consequentially and in a linear fashion because their executive functioning is not engaged. By calming the amygdala, the executive functioning, rational thought and limbic system can slowly be restored.

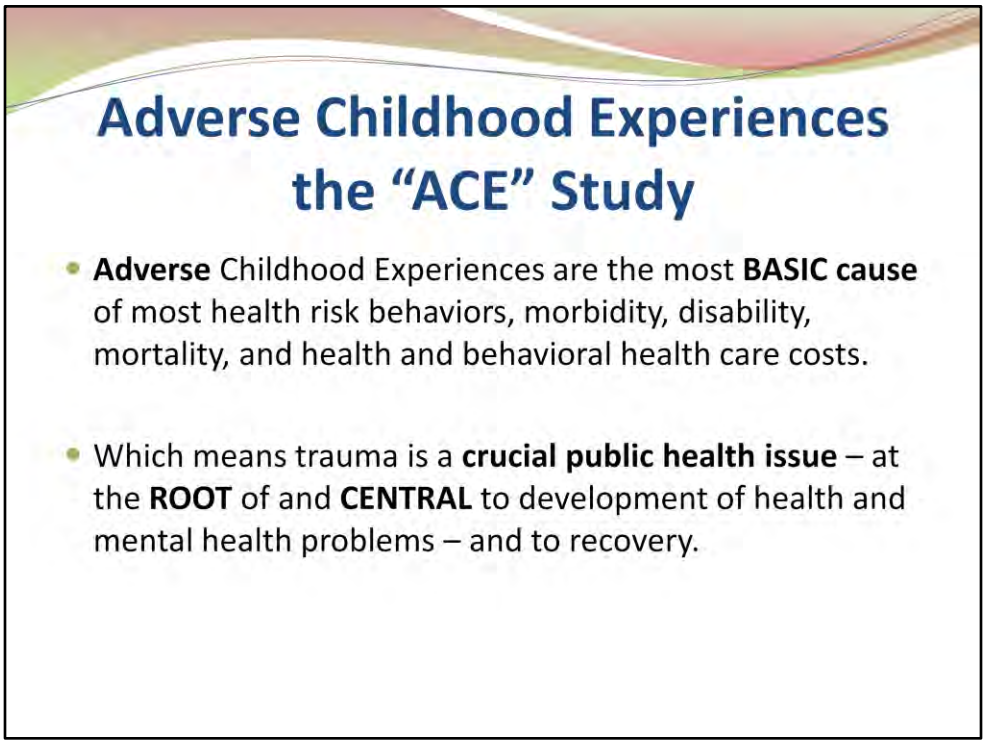
Trauma and the Brain

- People who are exposed to severe and chronic trauma are often unable to "shut down" their emergency response system.
- Executive functioning and Limbic system shut down
- Results in:
  - Hyperaroused state
    - Aggression
    - Violent/Volatile
  - Triggers
  - Body prepares for injury
  - Body prepares to fight for flee



1. **Optional**—Use the following quote: "Traumatized Individuals make unsafe choices in an unsafe world in an attempt to be safe" Gabriella Grant. This highlights the importance of safety especially when working with a triggered individual.
2. **Review the slide above briefly to illustrate points previously made.**

This visually illustrates the chaos in a traumatized individuals mind on a daily basis.



-The impact of early childhood experiences

1. Provide an overview of the ACE Study:

   - Conducted in San Diego over a 10 year period. 17,000 people involved through an HMO (Kaiser Permanente)
   - Largest epidemiological study ever done.
   - Participants asked to report adverse childhood experiences. (Name them.)
   - Revealed health and social effects of adverse childhood experiences over the lifespan.

2. ACE study views health risk behaviors as attempts to cope with impacts and ease pain of prior trauma, NOT as symptoms, bad habits, self-destructive behavior, or public health problems.

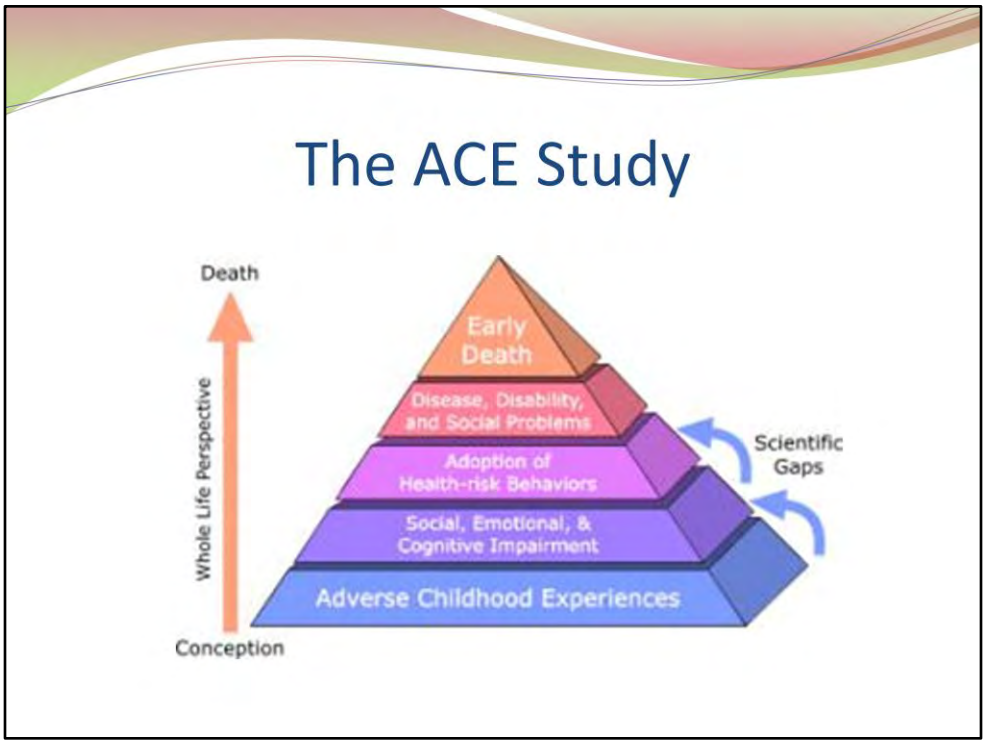
3. Of the 17,000 HMO Members:

   1 in 4 exposed to **2** categories of ACEs

   1 in 16 was exposed to **4** categories.

   22% were sexually abused as children.

   66% of the women experienced abuse, violence or family strife in childhood.



The ACE Study takes a whole life perspective, as indicated on the orange arrow leading from conception to death. By working within this framework, the ACE Study began to progressively uncover how adverse childhood experiences (ACE) are strongly related to development and prevalence of risk factors for disease and health and social well-being throughout the lifespan.

Adverse Childhood Experiences*	Impact of Trauma and Health Risk Behaviors to Ease the Pain	Long-Term Consequences of Unaddressed Trauma (ACEs)
Abuse of Child ▪ Recurrent Severe Emotional abuse ▪ Recurrent Physical abuse ▪ Contact Sexual abuse ***Trauma in Child's Household Environment*** ▪ Substance abuse ▪ Parental separation or divorce - ▪ Chronically depressed, emotionally disturbed or suicidal household member ▪ Mother treated violently ▪ Imprisoned household member ▪ Loss of parent – (best by death, unless suicide, - worst by abandonment) ***Neglect of Child*** ▪ Abandonment ▪ Child's basic physical and/or emotional needs unmet * Above types of ACEs are the "heavy end" of abuse.	***Neurobiologic Effects of Trauma*** ▪ Disrupted neuro-development ▪ Difficulty controlling anger-rage ▪ Hallucinations ▪ Depression ▪ Panic reactions ▪ Anxiety ▪ Multiple (6+) somatic problems ▪ Sleep problems ▪ Impaired memory ▪ Flashbacks ▪ Dissociation ***Health Risk Behaviors*** ▪ Smoking ▪ Severe obesity ▪ Physical inactivity ▪ Suicide attempts ▪ Alcoholism ▪ Drug abuse ▪ 50+ sex partners ▪ Repetition of original trauma ▪ Self Injury ▪ Eating disorders ▪ Perpetrate interpersonal violence	***Disease and Disability*** ▪ Ischemic heart disease ▪ Cancer ▪ Chronic lung disease ▪ Chronic emphysema ▪ Asthma ▪ Liver disease ▪ Skeletal fractures ▪ Poor self rated health ▪ Sexually transmitted disease ▪ HIV/AIDS ***Social Problems*** ▪ Homelessness ▪ Prostitution ▪ Delinquency, violence, criminal behavior ▪ Inability to sustain employment ▪ Re-victimization: rape, DV ▪ compromised ability to parent ▪ Intergenerational transmission of abuse ▪ Long-term use of health, behavioral health, correctional, and social services

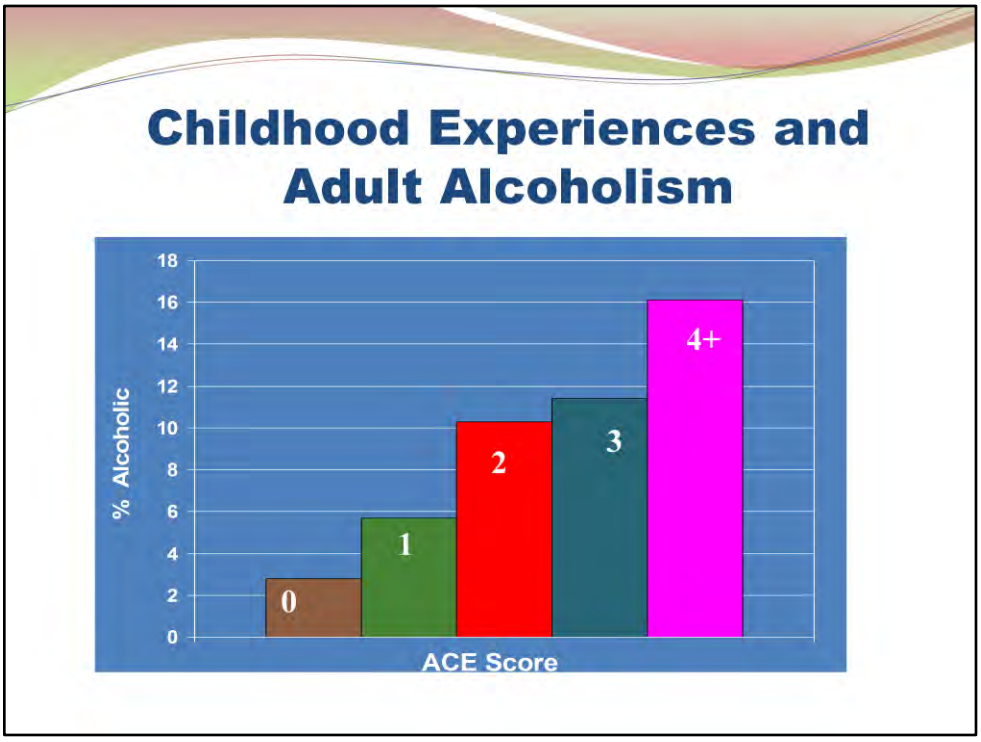
-ACE Comprehensive Chart

1. Tell participants that column 1 list the kinds of adverse childhood experiences that were looked at in the ACE Study.

2. Colum 2 represents the neurobiological impacts and health risks associated with ACES, and column 3 is the long term health and social problems associated with both.

3. The "take home" message is:

   "The more types of adverse childhood experiences, the greater the neurobiological impacts and health risks, and the more serious the lifelong consequences to health and well-being."



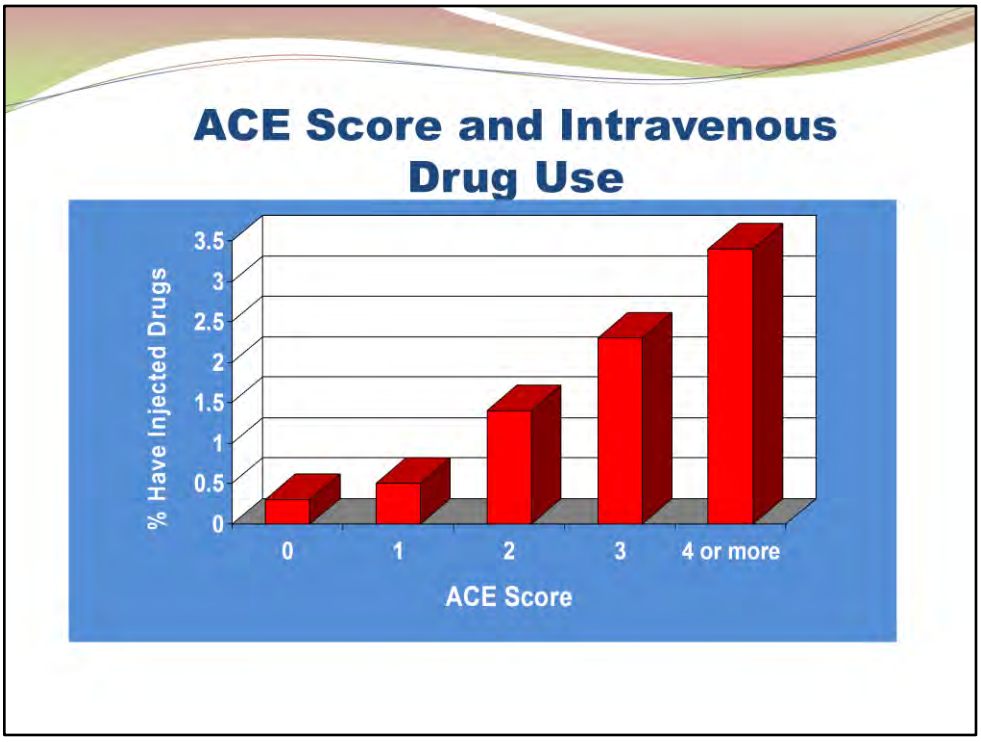
-ACEs and Adult Alcoholism

1. This chart depicts the percentage of individuals in the ACE study who became alcoholic as adults compared to the number of adverse childhood experiences they had.

2. The higher the ACE score, the higher percent who became alcoholic.

3. A **500% increase in adult alcoholism** is directly related to adverse childhood experiences.

4. **2/3rds of all alcoholism** can be attributed to adverse childhood experiences.

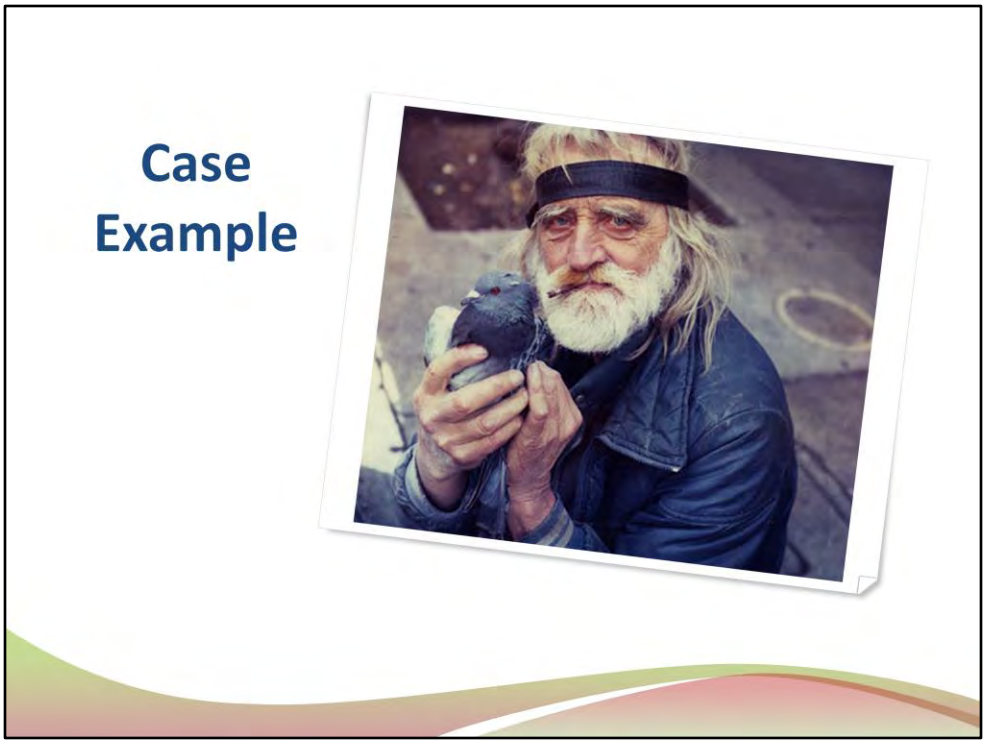


-ACE Score and Intravenous Drug Use

1. Note that the same pattern emerged from the research: The more adverse childhood experiences, the greater the risk for drug use/abuse.

2. A **male child** with an ACE score of 6 has a **4,600% increase** in the likelihood that he will become an **IV drug user** later in life.

3. **78% of drug injection by women** can be attributed to **ACEs.**



"Harvey" Case Example and Discussion (Slides 37 – 40)

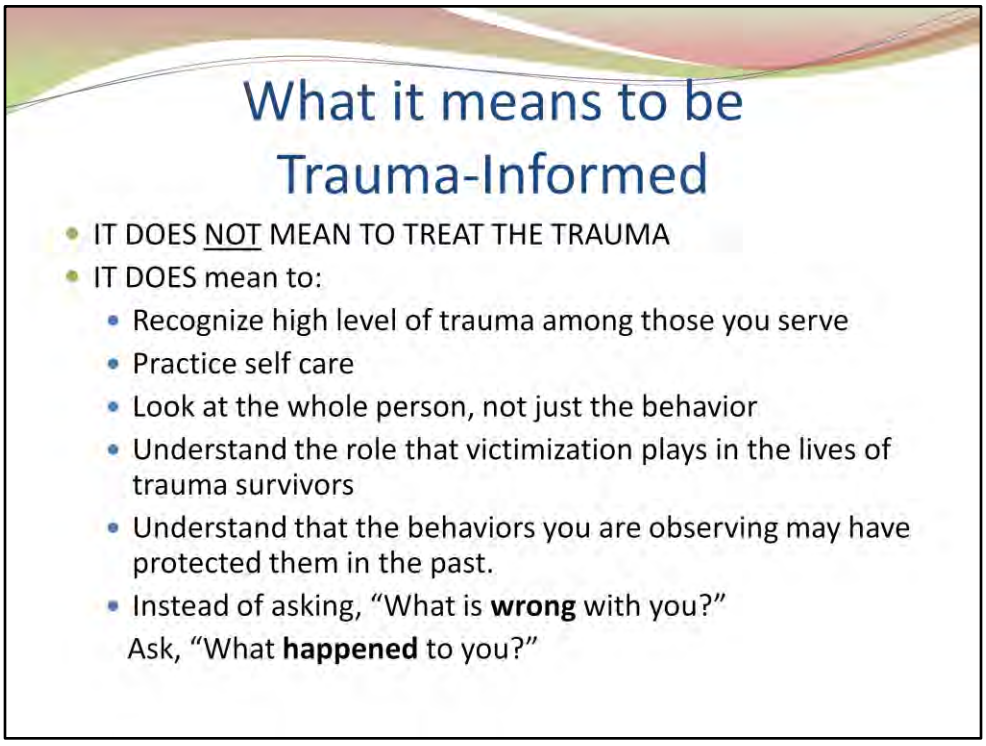
Purpose of this section: This section is designed to integrate and apply the facts surrounding behavioral health challenges previously discussed. It is also a way to "make the case" that using a trauma-informed approach can help de-escalate a crisis and lead to good outcomes.

Directions:

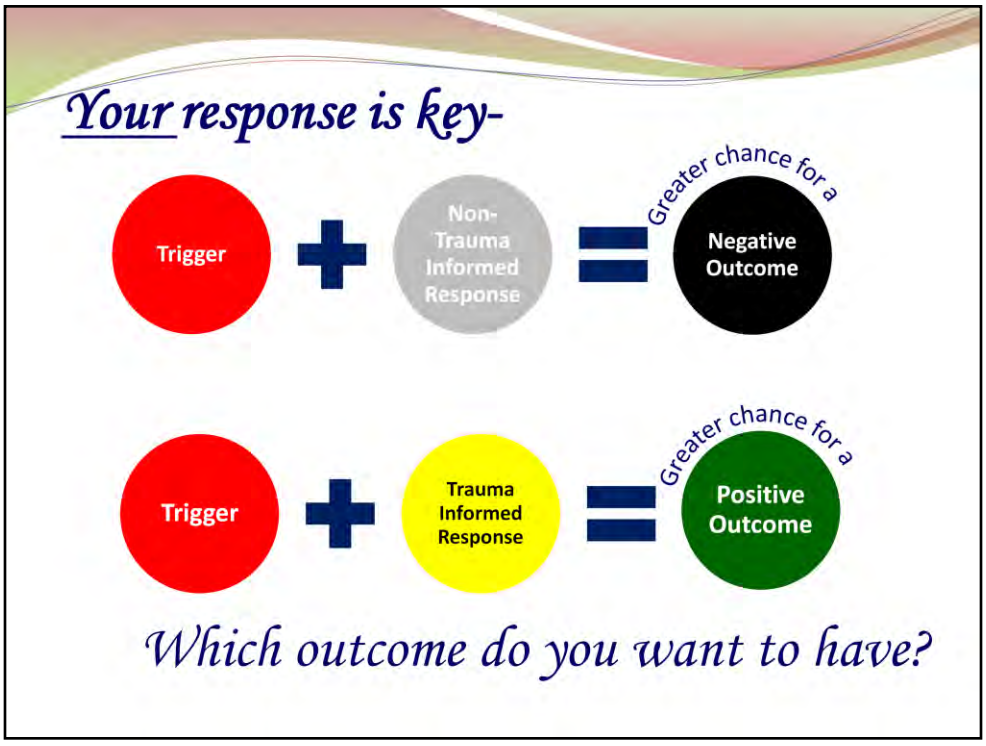
1. Refer participants to the handout titled, "Case Example Harvey".
2. Read through the case example: "Harvey".
3. Create a sense of possibility: "By taking the time out to respond sensitively to an individual (even if outside of his jurisdiction) and by knowing or learning their trauma history and related problematic behavior, a person can potentially avoid incarceration, retraumatization, loss of housing and compounded legal issues. "

- Can you share an example of a call you responded to where the person displayed symptoms of hyper arousal, a triggered anxiety response or violent behavior?
- Did you link this behavior to a possible trauma history?
- How might you respond differently now?

Depending on time encourage large group participation or small group discussions to then report back out.



1. Emphasize that they are not expected to fix or solve anyone's trauma or related symptoms. Trauma Informed Care is PRESENT FOCUSED AND AIMED AT INCREASING SAFETY.
2. Refer to the handout tiled, "First Responders Trauma Informed Care Implementation Checklist".



Link this in with their daily job, their desire to get a positive safe result from the person's they interact with.

"Held Hostage" Vignette and Discussion (Slides 43 – 45)

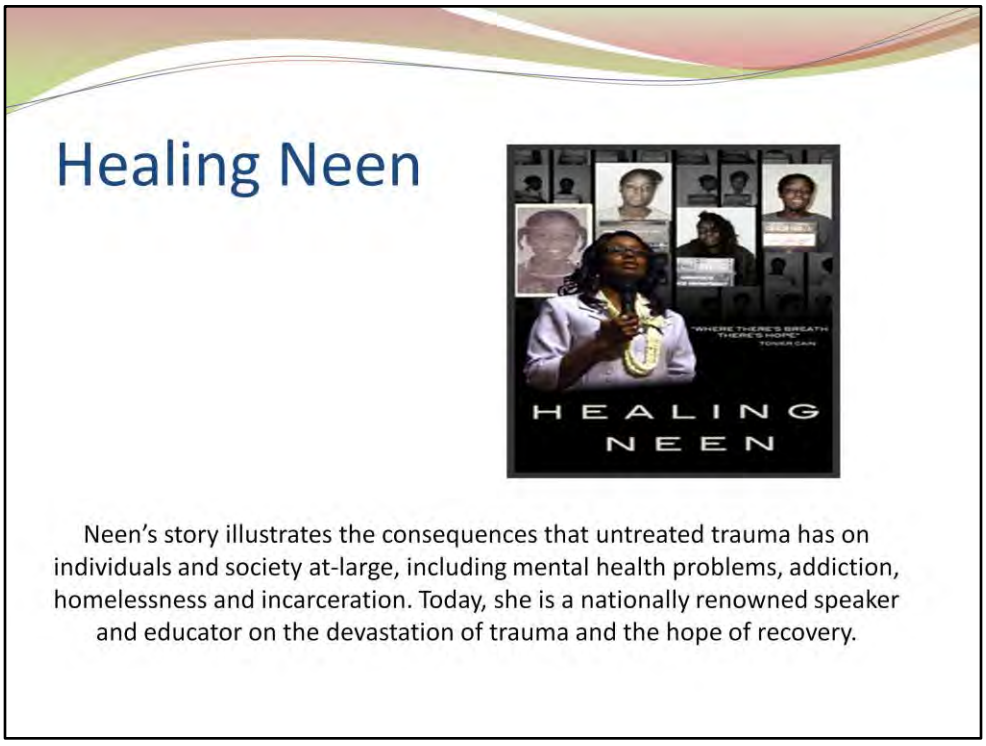
Purpose of this section: To conduct a discussion focusing on the application of a trauma informed approach.

Directions:

1. Refer participants to the "Held Hostage" handout.

2. **Read the first section and ask the focus questions that follow.** Encourage participation. Help with the language incorporating the trauma informed care core principles previously explained. Speak about changing language from "rules" to "expectations" etc. Engage audience in discussion about what they can do to change day to day interactions to become more trauma informed.

3. **Proceed with additional sections as time allows.**



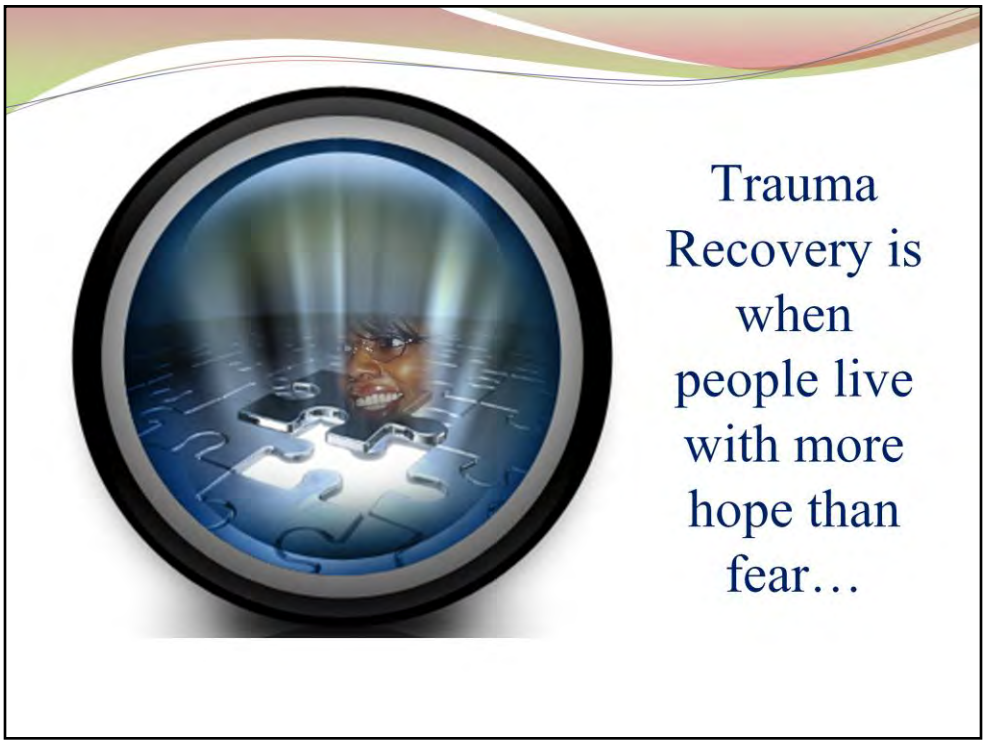
Healing Neen Video Trailer—Closing (Optional—use only if time permits)

Play the Healing Neen video trailer, available at http://vimeo.com/10791754 (length 3:26)

Purpose of this activity: The purpose of this closing activity is to reinforce concepts raised during the training.

1. Show the Neen video trailer again.
2. Read the statement on the slide aloud (or ask a participant to read aloud).
3. Focus questions:

- What was it like watching this video trailer again?
- Did you notice anything new the second time you watched it?
- Did you find that you had a different reaction to Neen's story the second time around?



-Wrap Up

1. Summarize key themes from the training.
2. Let participants know there are additional resources that may be useful to them. (Refer participants to the handouts titled, "Fact Sheets" and "References".)
3. Express your appreciation, again, for first responders and wish them success in using the tools that were discussed today.
4. As an end note, encourage First Responders, again, to be mindful of their own need for health and wellness. (Refer participants to the handout titled, "Commitment to Wellness Checklist".)

1. Invite comments and questions from the audience.

2. Confirm that additional topics suggested at the start of the training were covered.

3. Acknowledge sponsorship of the County of San Diego, Health and Human Services, Behavioral Health Services MHSA PEI funds.

4. Ask participants to complete their evaluation form.
   Refer participants to "Mental Health 101: A Trauma Informed Approach Evaluation"

For further information:

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760/476-0670

Refer participants to Tracy L. Fried for any further follow up.