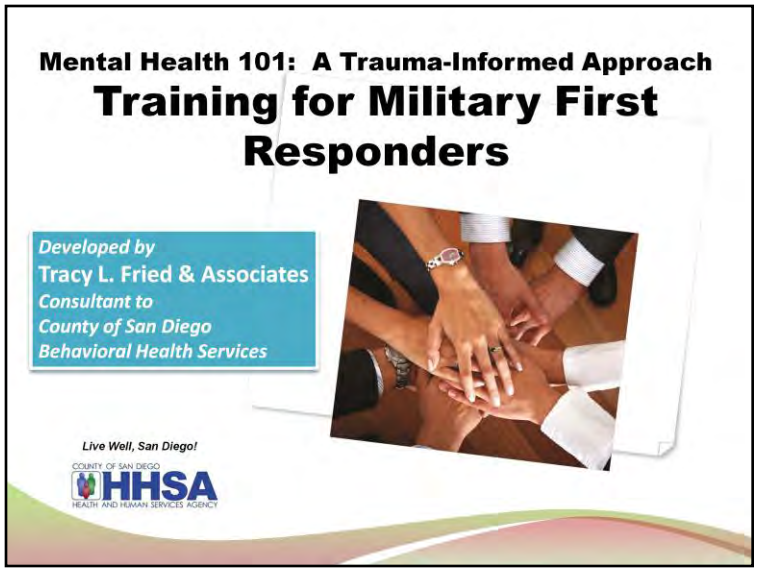


Opening: Welcome, Agenda Review & Introductions (Slides 1 – 8)

Purpose of this section:

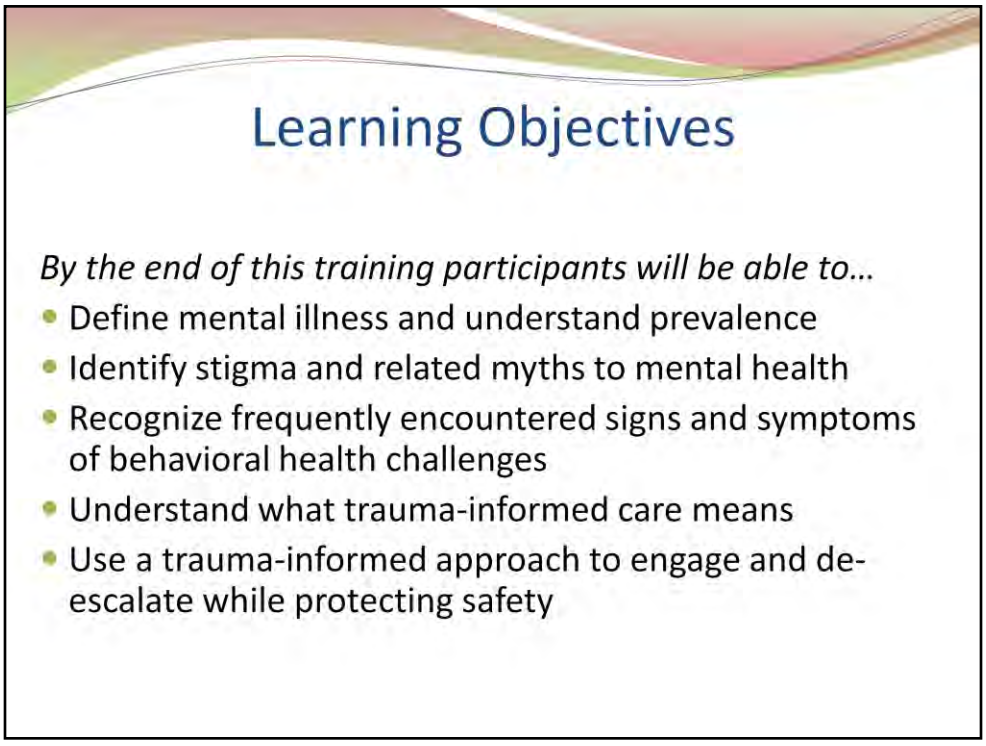
1. To welcome participants and set the stage for an engaging, interactive training.
2. To orient participants to their materials and how the training will be conducted.

Trainer talking points:

1. Welcome participants and continue engagement with the audience. (Greet them personally as they arrive.) **Honor and acknowledge Military 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.

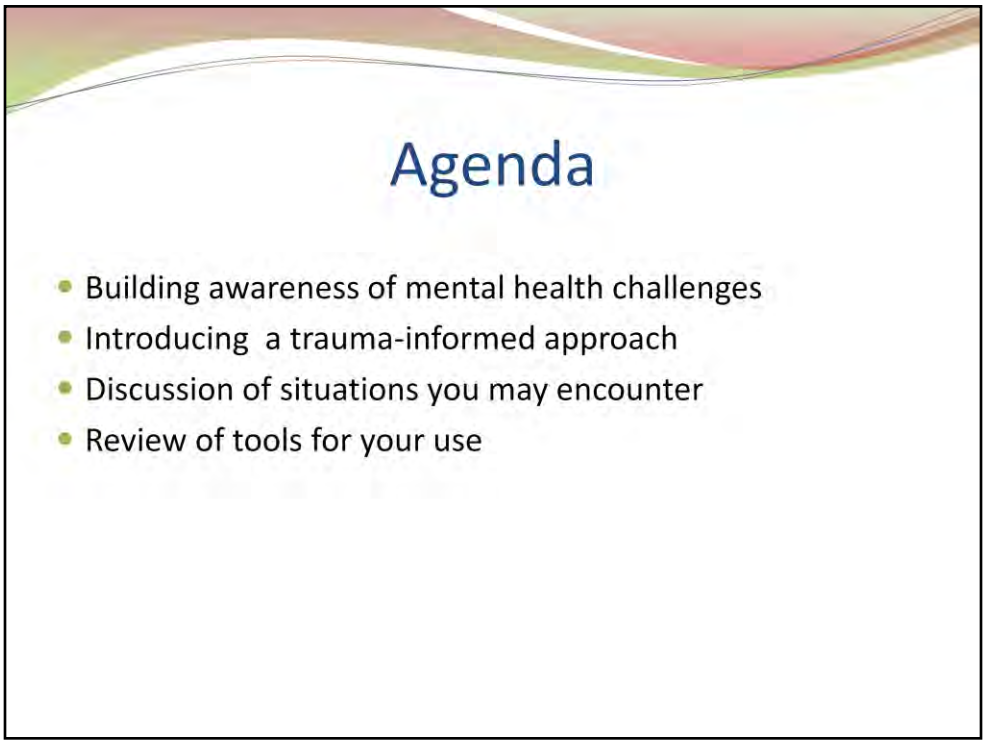
   Live Well, San Diego! is the County's 10-year plan to improve the lives and well being of our community with a vision of a county that is safe, healthy, and thriving. The MHSA PEI First Responders Training on behavioral health support the County's adopted *Live Well, San Diego*! initiative by building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



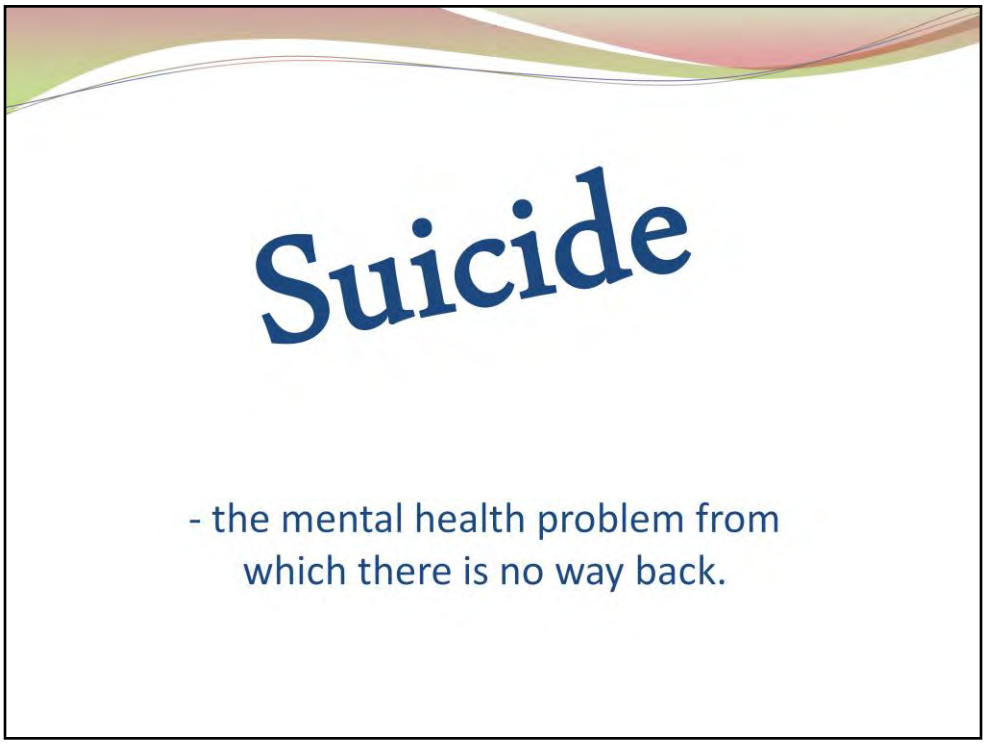
-Review the agenda (Participant Handout Packets and useful resources)

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 military fire and police. MODIFY LANGUAGE AS APPROPRIATE TO THE GROUP YOU ARE TRAINING.

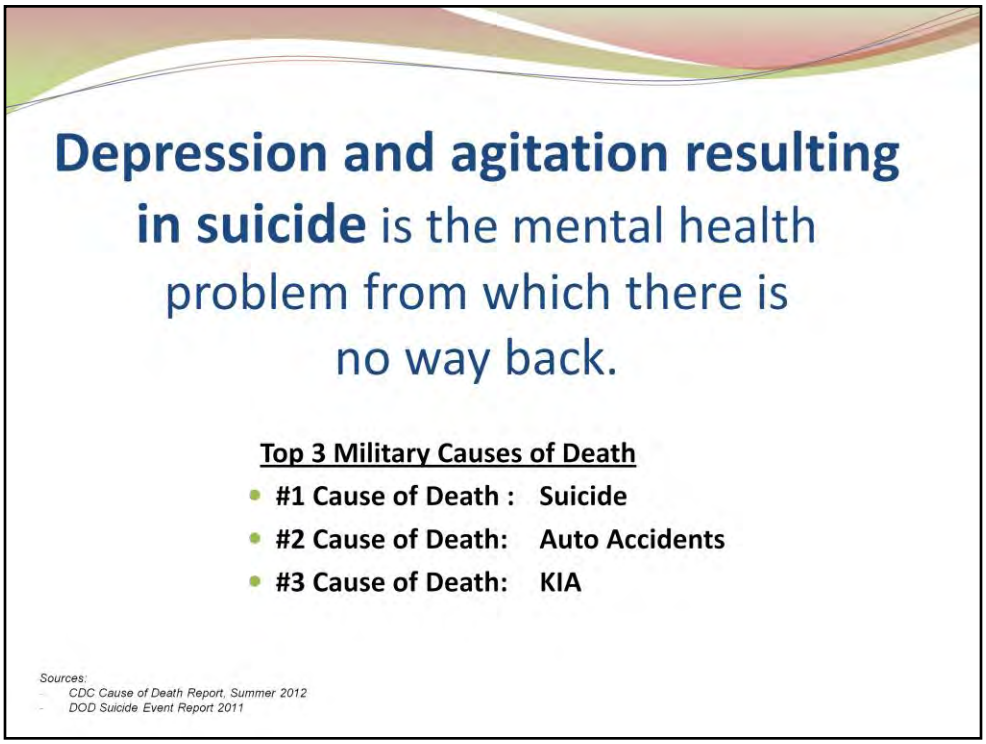
-Introductions

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



-Impact of Suicide on the Military

This course is not designed to be a comprehensive guide to suicide prevention, however suicide is on the rise, including among active duty and veteran military members. It is the one mental health concern from which there is no way back.



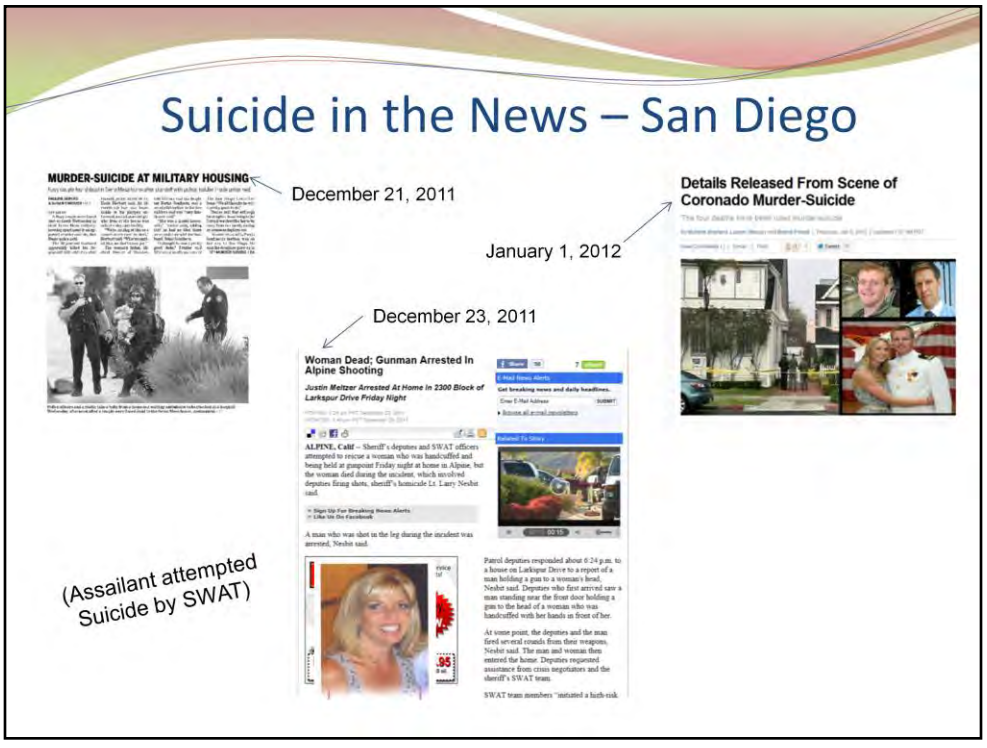
-Make the case for why it is essential to focus on suicide within the military culture

•Suicide is the 10th leading cause of death in the U.S. overall; However – it is the 2nd leading cause of death among 25-34 year olds.

•Since **2004, it is the #1 Cause of Death in the military.**

#2 is Auto Accidents
#3 is being Killed In Action

- 90% of completed suicides within the military suffered from depression (for various reasons).
- Holidays are the most dangerous times for military.
- Explicit news reports of violent suicides lead others to copy and carry out similar methods of suicide.
- Consider the following news within the last year in San Diego…



- Recent incidences:
  -On December 21, 2011 a murder-suicide occurred at military housing
  -Two days later on December 23rd another murder and attempted suicide took place
  -One week later yet another murder suicide took place

- Could it be a coincidence that such agitation resulted in tragic and fatal acts within days of one another?
- Explicit news reports of violent suicides lead others to copy and carry out similar methods of suicide.
- Do you think any of these individuals…
  …Wanted to commit suicide when they…

  joined the military?

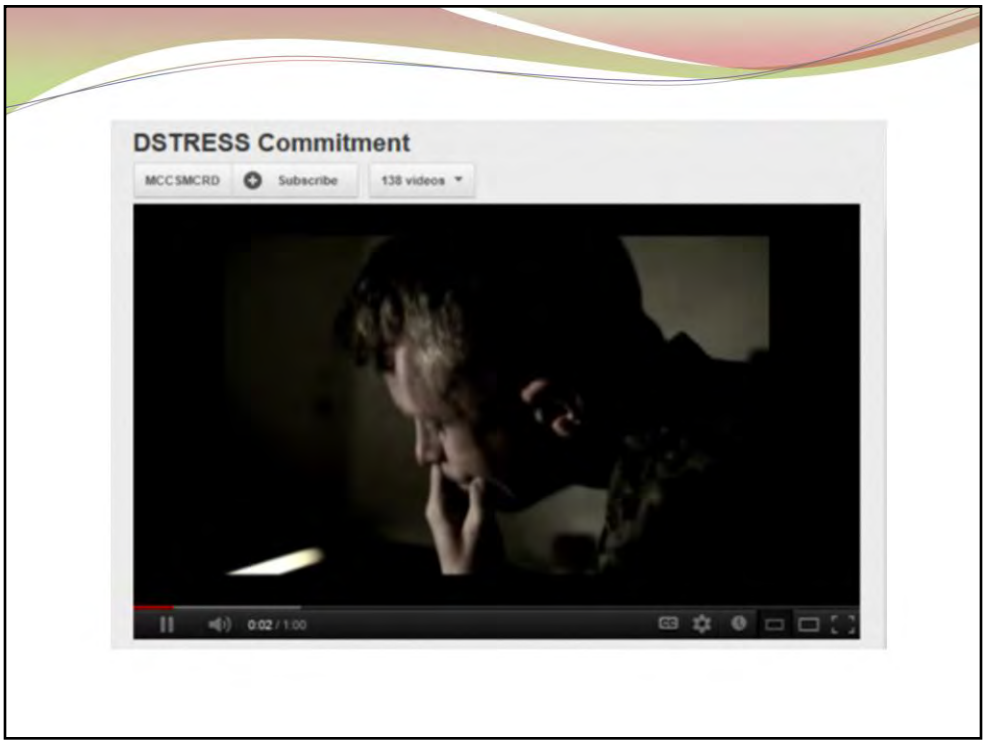
  completed flight school?

  ….Wanted to kill their wives when they…

  first got married?

  had their first child?

  Each experienced a series of increasing mental health problems until they felt like they ran out of options.

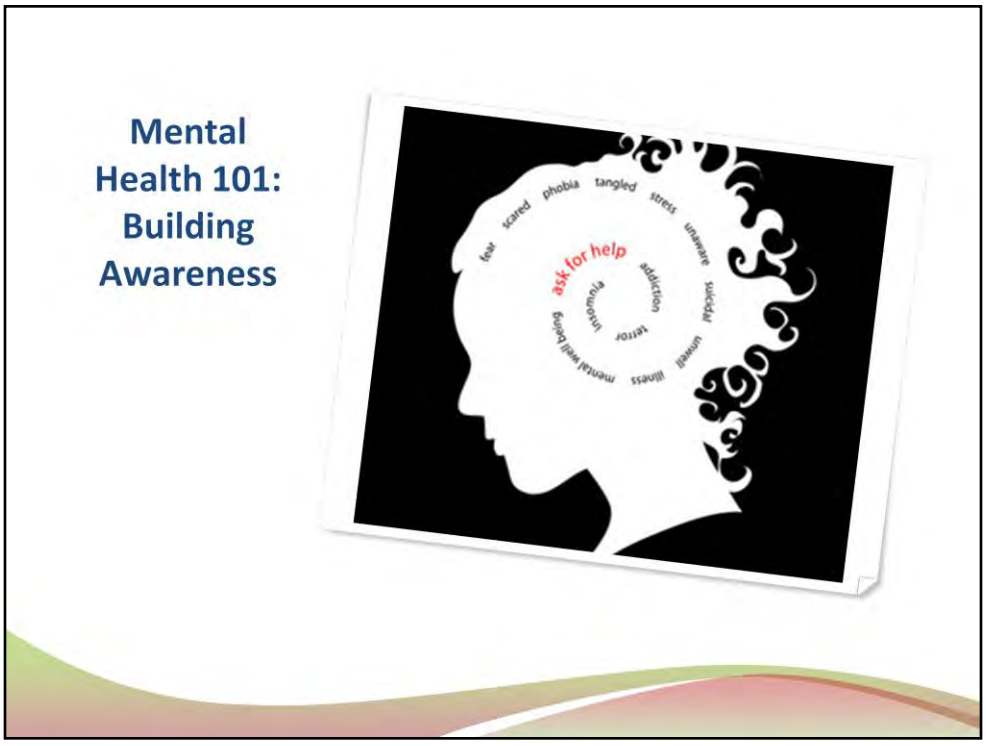


- The purpose of this class is to encourage you to use a “Trauma-informed” approach so you can recognize people with mental health problems and help them *before* they get to a point of no return.
- Play the “DSTRESS—Commitment” video clip: http://www.youtube.com/watch?v=gpoKos3a9gE
- The DSTRESS Line is a pilot program for active duty, Reserve, veterans and retirees, as well as their families, in the western U.S., Hawaii, and Alaska. Callers will speak with veteran Marines, former corpsmen, and licensed behavioral health counselors who have been specifically trained in Marine Corps culture and ethos. If successful, this pilot will be rolled out Marine Corps wide in 2012.
- WHO: The DSTRESS Line is available to all Marines (Regular, Reserve, veteran, or retiree), attached Sailors, and family members in the 'designated area.'

  Callers will speak with veteran Marines, former FMF corpsmen with years of experience on 'the green side', and licensed behavioral health counselors who have taken Marine Corps-specific training to understand military culture.
- WHAT: The DSTRESS Line is an anonymous behavioral health counseling service operated through TRICARE that gives Marines, attached Sailors, and family members a place to call and speak with "one of their own." It's a place to call and talk about stress in their lives-from the common everyday stressors to post-traumatic stress. It's non-medical. DSTRESS Line counselors won't diagnose symptoms, but they will work with callers to help with a way forward.
- WHEN: The call lines are open 24/7/365. During this test phase, Marine veterans and FMF corpsmen are typically available from 0700-2300. When Marine veterans and FMF corpsmen are not available, calls will be answered by counselors who have received Marine-specific training in our culture.
- WHY: Marines want to talk with someone who understands them as a Marine. The DSTRESS Line provides Marines, attached Sailors, and family members with a place to call and speak with 'one of their own.' It is a place to call and talk about problems before they turn into a crisis.

  The DSTRESS Line helps callers increase resilience and develop the necessary skills required to cope with the widely varying challenges of life in the Corps and the inevitable stress of combat operations.
- HOW: Callers can talk to DSTRESS Line representatives and counselors by phone or Skype, and can use the Chat feature found on www.dstressline.com.

  If participants would like more info about the DSTRESS Line they may call 703-432-9707 or email: dstressline@usmc.mil



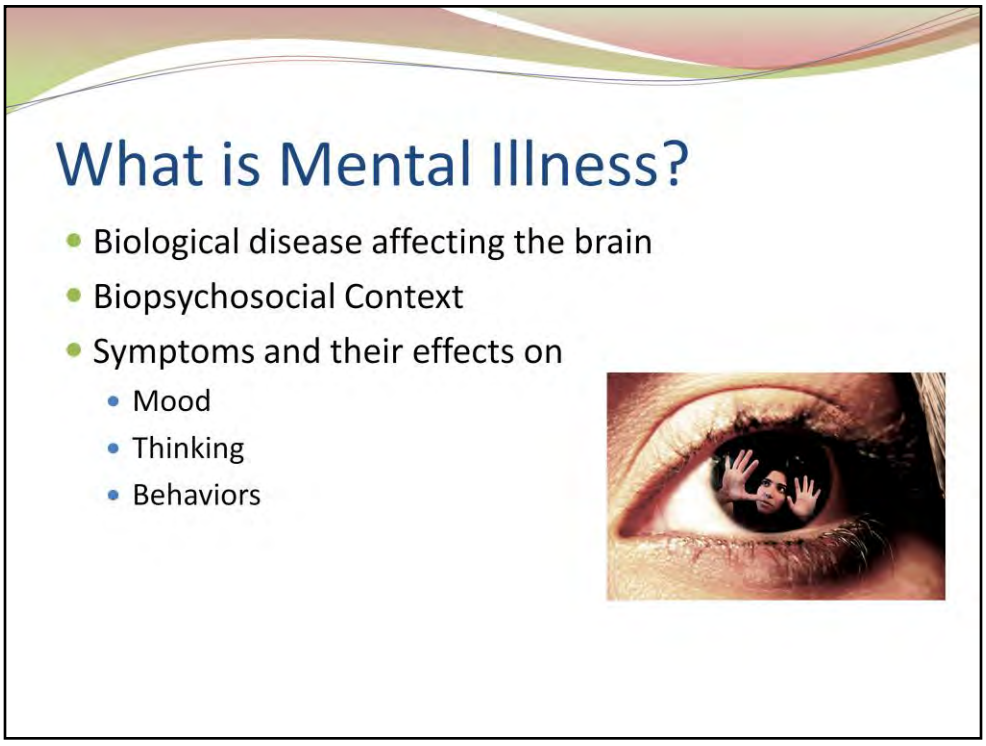
Mental Health 101: Building Awareness (Slides 9– 16)

Purpose of this section is to build awareness of…

1. Definition of mental illness
2. Stigma and myths
3. Prevalence of mental illness and suicide among military personnel

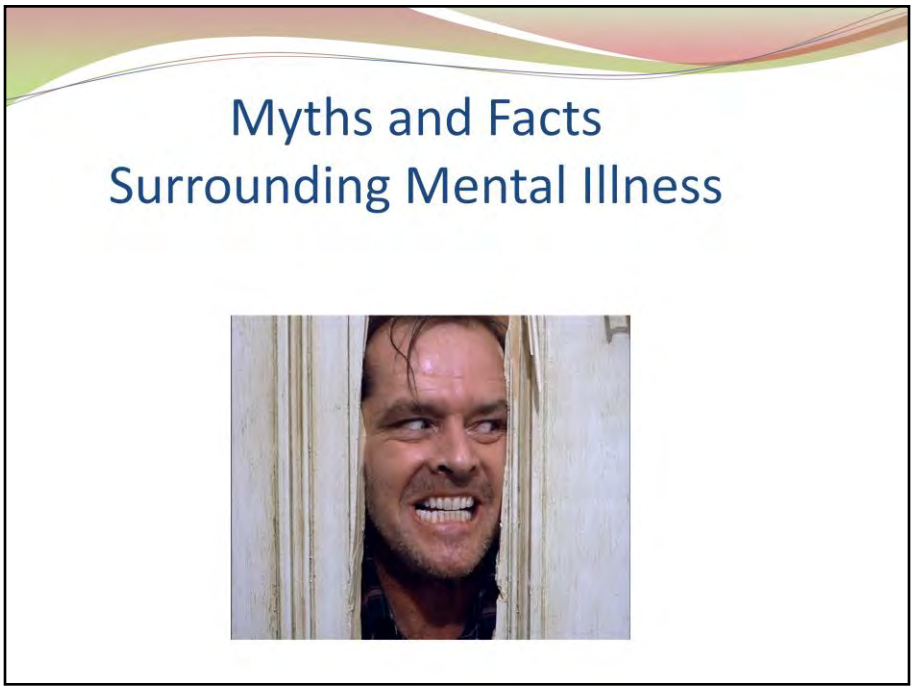
Trainer talking points:

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
3. Ask, “What comes to mind when you have a call?” “Do you automatically think it is likely to be a “415” or disturbance call?” “Are you ready for the possibility of a mental health crisis?”



-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

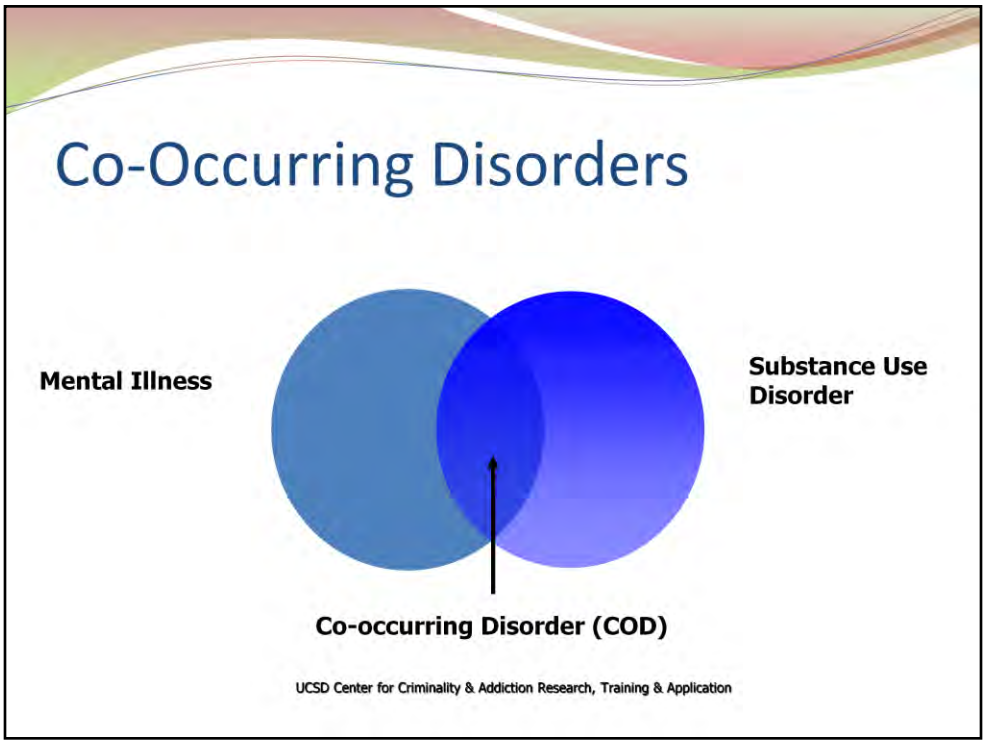
1. Let the group know that misconceptions about mental illness are pervasive, and the lack of understanding can have serious consequences for millions of people who have a psychiatric illness, according to the National Alliance for Research on Schizophrenia and Depression (NARSAD).
2. Misconceptions about mental illness contribute to the stigma, which leads many people to be ashamed and prevents them from seeking help. (Elaborate.)
3. Dispelling these myths is a powerful step toward eradicating the stigma and allaying the fears surrounding brain disorders.
4. Working through stigma helps First Responders with a quicker, safer, and more effective response.
5. Individuals you may encounter also hold facts, myths, and stigmas regarding first responders—particularly those in uniform.
6. **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.

.

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

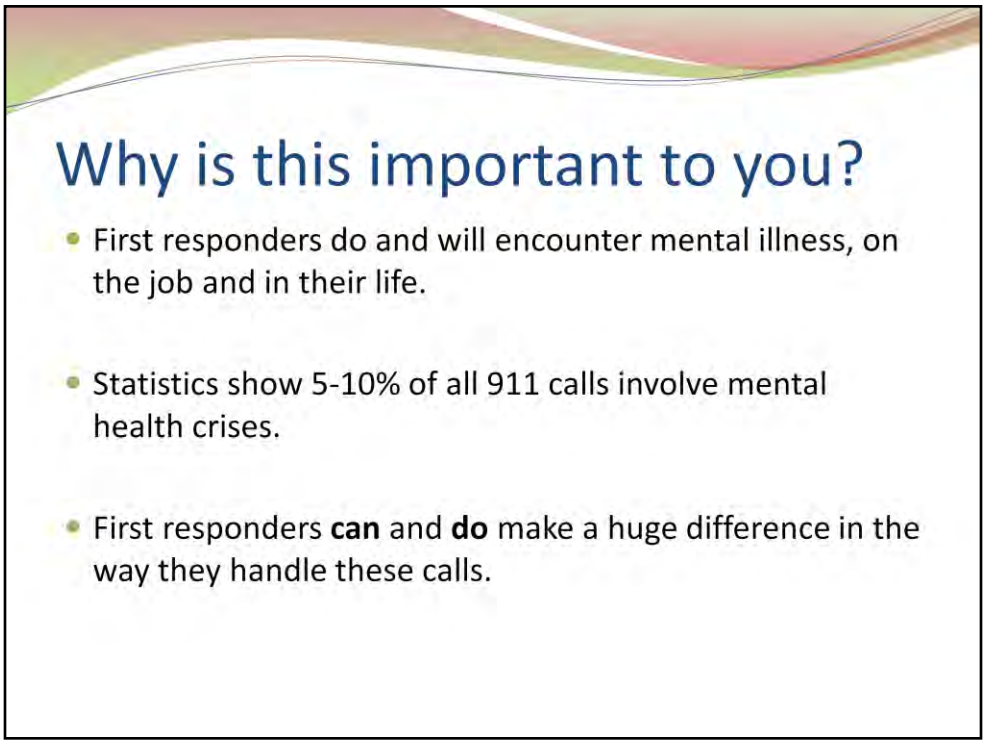
-Factors increasing risk

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. You often see people t their worst and have a "ring-side seat" for when things go south. Your presence says, "Stop!"
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.

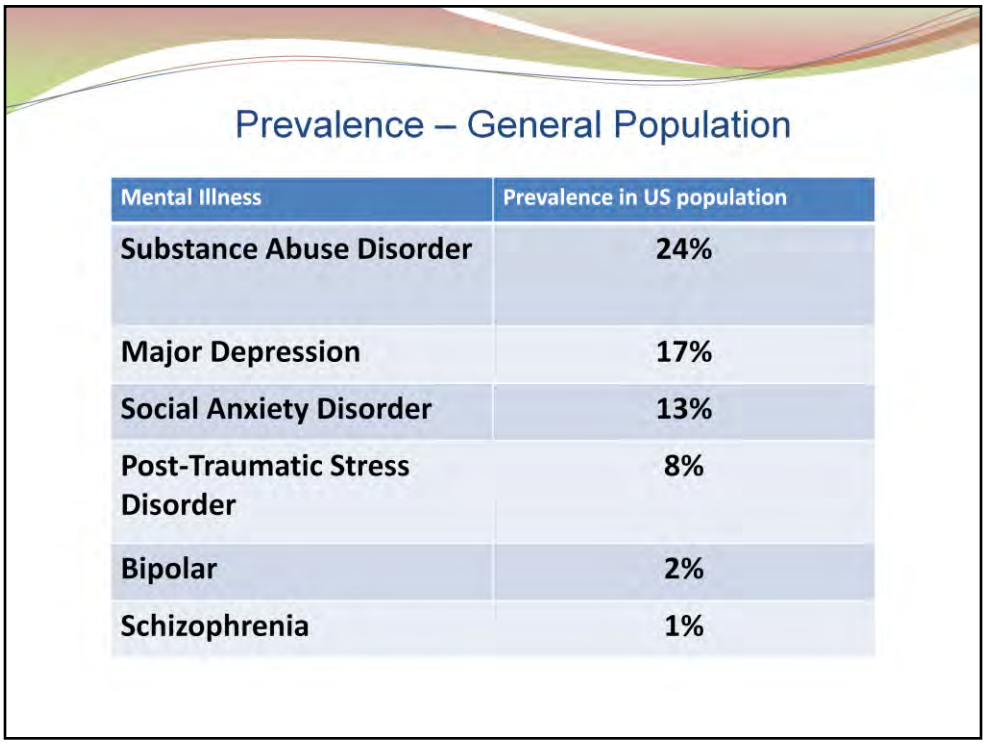


-Making a Difference

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.

2. Any first responder can confirm that most calls will include an emotional component, in varying degrees from generalized upset up to psychotic behavior.

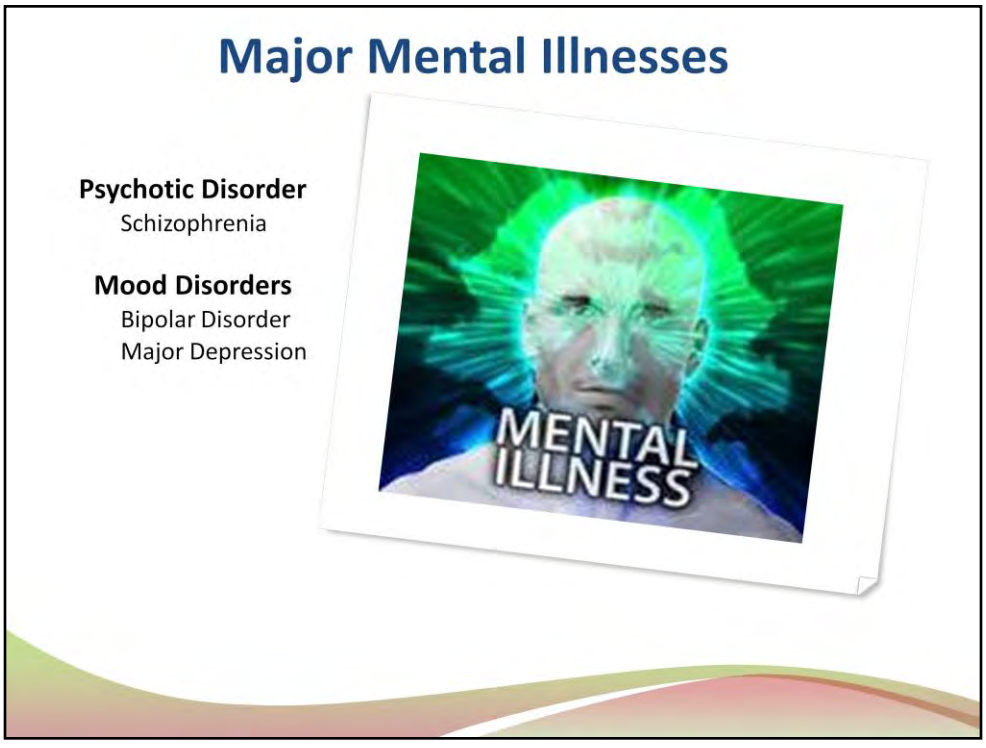
3. First Responders can significantly impact the outcome of each encounter by:
    1. Using mental health knowledge
    2. Applying a trauma-informed approach
    3. Educating themselves about resources and referrals available



-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.



Major Mental Illnesses

1. There are many other types of mental illnesses, however today we will speak 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.

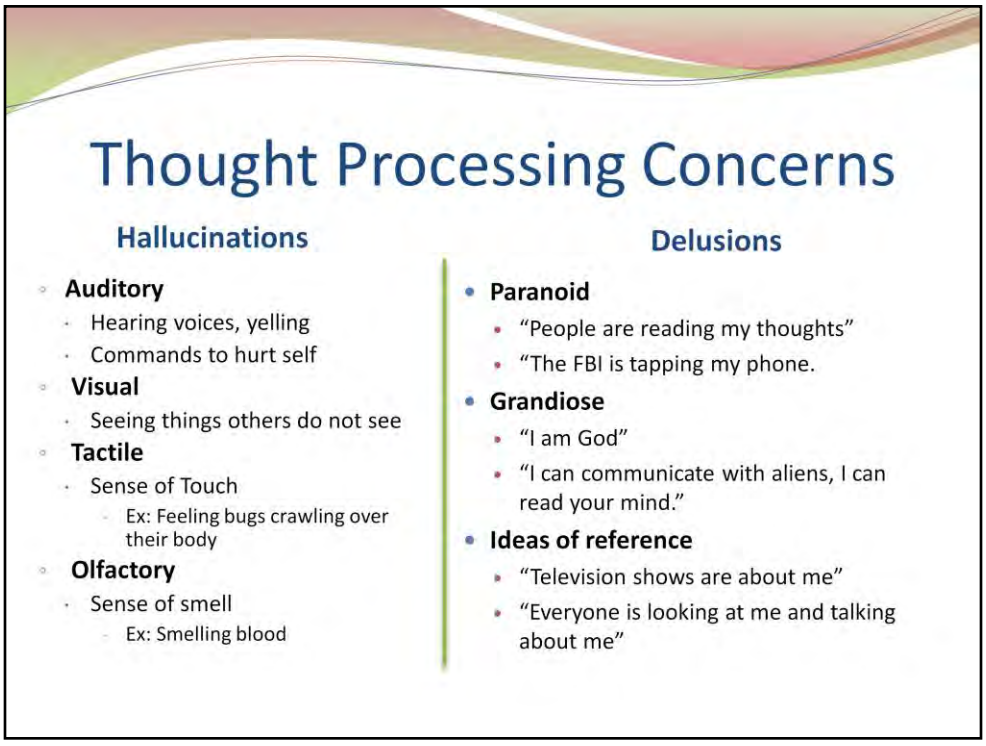
-Schizophrenia

1. Considered 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 abuse substances; 20-50% attempt suicide, 10% succeed.
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!
6. <u>It may be encountered in base housing, or with visitors to the base or suddenly become apparent in younger Marines.</u>
7. Substance use/abuse can have parallel effects.
8. 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 paraphernalia may indicate substance use.

<u>It is useful for the paramedic to determine whether there is an overdose because some of the treatment modalities will address that first as a health concern.</u>



-Thought Processing Concerns

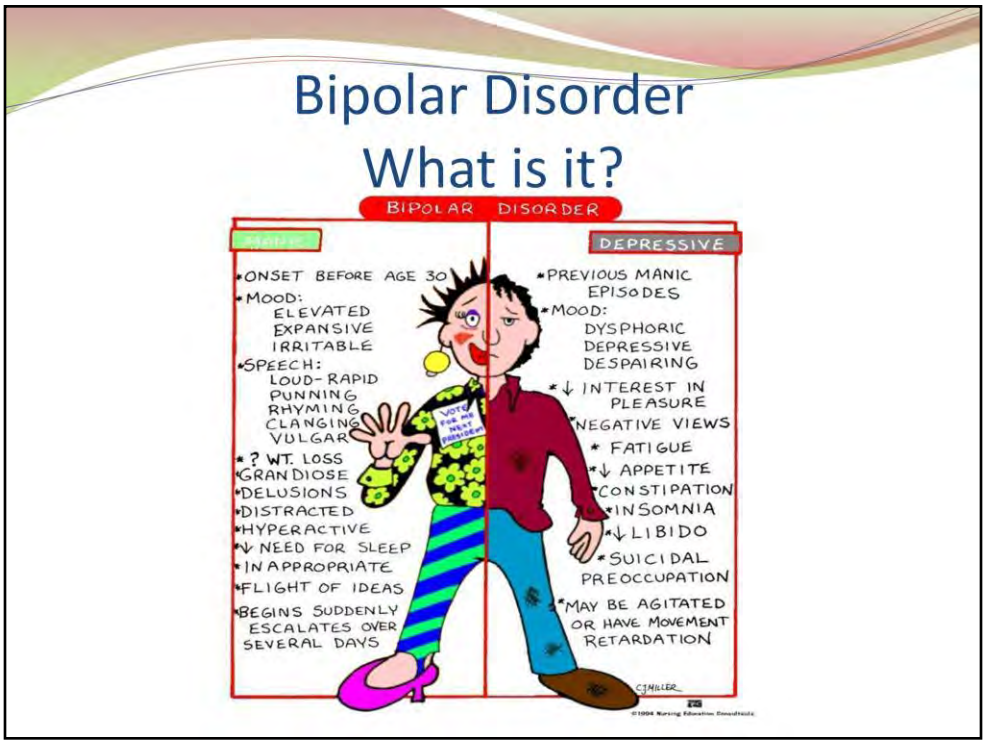
1. Describe what a hallucination is (hearing, seeing, feeling, smelling something that is not real/not actually present, or processing in a distorted way).

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.

5. May be occurring because of substance abuse

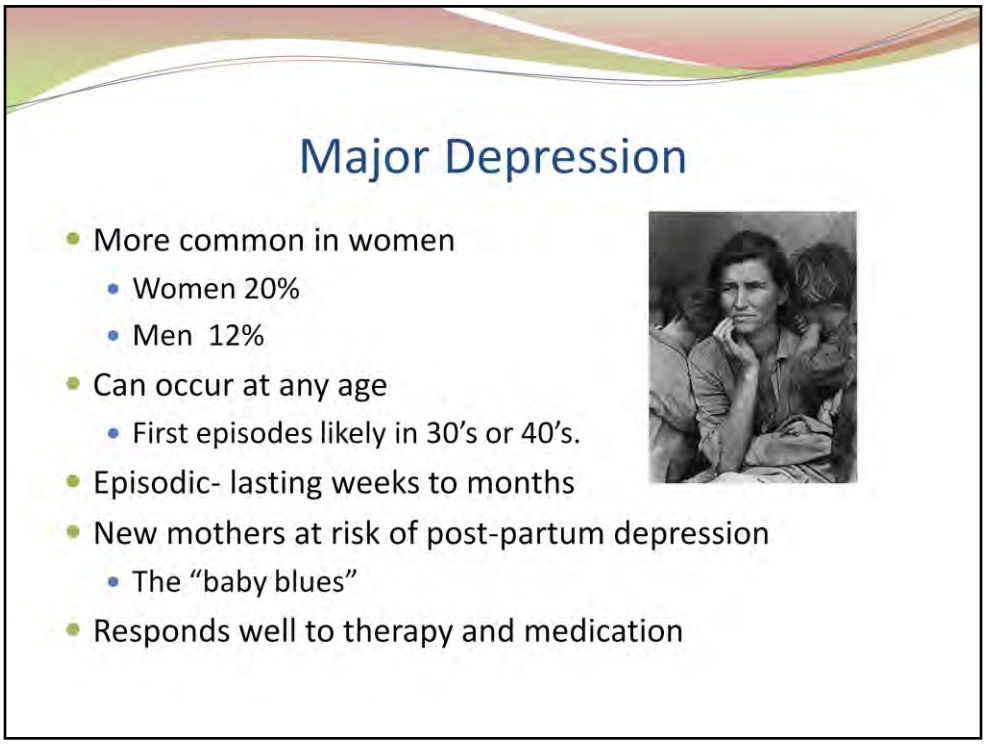


-Bipolar Disorder

1. Use this picture to make the point that in each state, the person can come off very differently. It is important for the FR 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

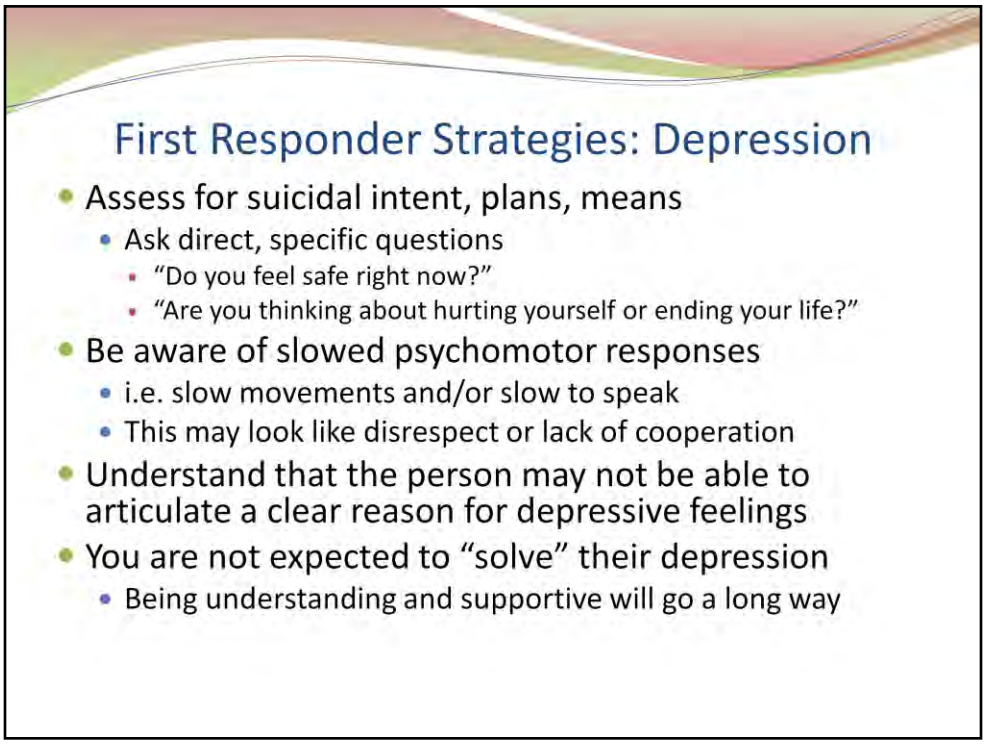
3. **Risk & Prognosis**
   - Can be treated successfully with medications and therapy
   - In between episodes most people are fully functioning members of society
   - Some of the brightest and most creative people in history: Ernest Hemmingway, Ben Stiller, Tim Burton
   - Non-compliance can be due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



-Major Depression

1. Go over general points from bullets on the slide
2. Classified as a Mood Disorder. Major depression is like having a constant, raging fever, as opposed to a low grade fever.
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 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?)

Play the "DSTRESS Line—Win your personal battles" video clip http://www.youtube.com/watch?v=yzGe7OKujfk (2:28)

Picture yourself in Gary's place talking to a Marine who has not committed a crime, is lawfully refusing transport or further help but you are still concerned that he may kill himself after you leave.

If You Think Someone Is Considering Suicide:

Trust your instincts that the person may be in trouble.

Talk with the person about your concerns; communication needs to include *listening*.

Ask direct questions without being judgmental, such as:

"Are you thinking about killing yourself?"

"Have you ever tried to hurt yourself before?"

"Do you think you might try to hurt yourself today?"

Determine if the person has a specific plan to carry out the suicide. The more detailed the plan, the greater the risk:

"Have you thought about ways that you might hurt yourself?"

"Do you have pills/weapons in the house?"

Do not leave the person alone.

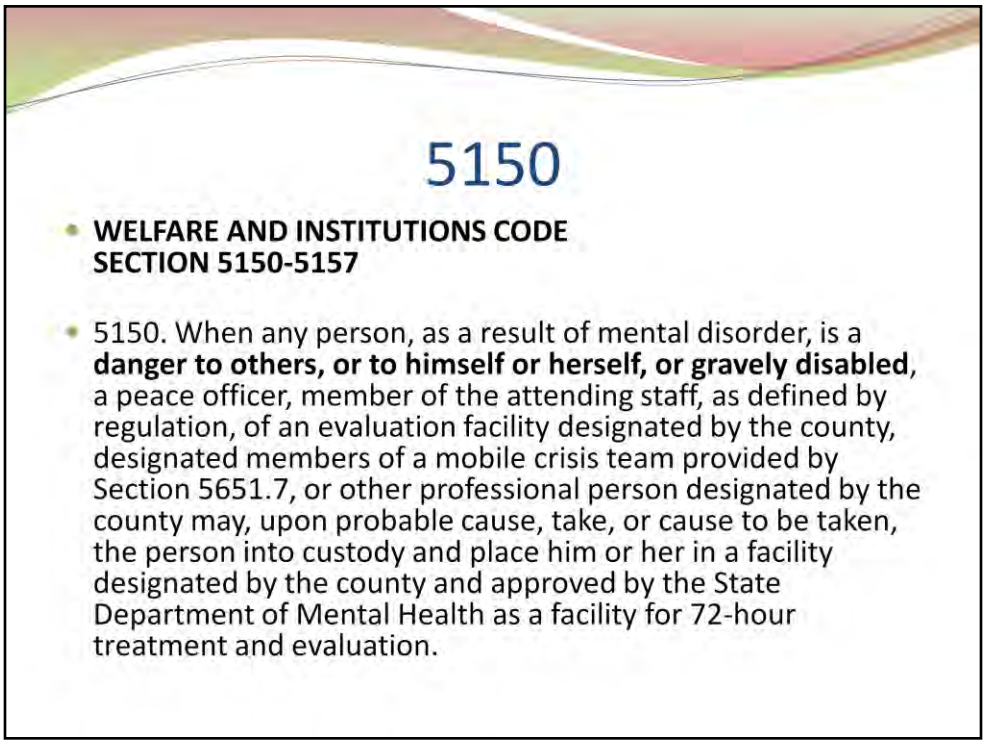
Do not swear to secrecy.

Do not act shocked or judgmental.

Do not counsel the person yourself .

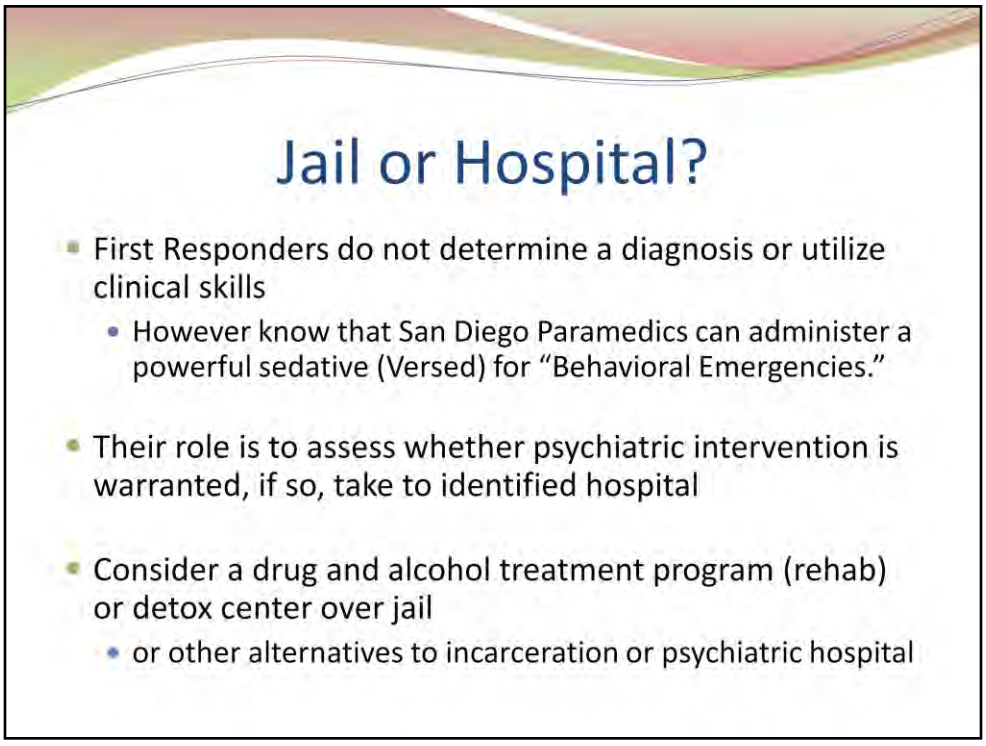
Get professional help, even if the person resists – consider 5150 hold.

Source: DOD/VA Psychiatric Center of Excellence Suicide



-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. (See Military Resources Pocket Card for resources.)
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 audience 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, follow established military protocol. If appropriate, 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 laminate MFRT Wallet Card with referrals in participant packet.

Drunk or Date Rape Victim?

- Be aware of male and female passengers in cars or other settings who are unresponsive.
- May be under the influence of a date rape drug.
- Military sexual trauma affects:
  - 1 in 4 females
  - 1 in 100 males
- Assess and assist!
  - This is being "trauma-informed".

1. View all passengers in the car, noting those who appear to be passed out.
2. Do not accept the assurance that they are just drunk and need to be put to bed.
3. Do not ignore male passengers and assume that they are drunk. They may also be sedated by a date rape drug.

STEPS TO TAKE:

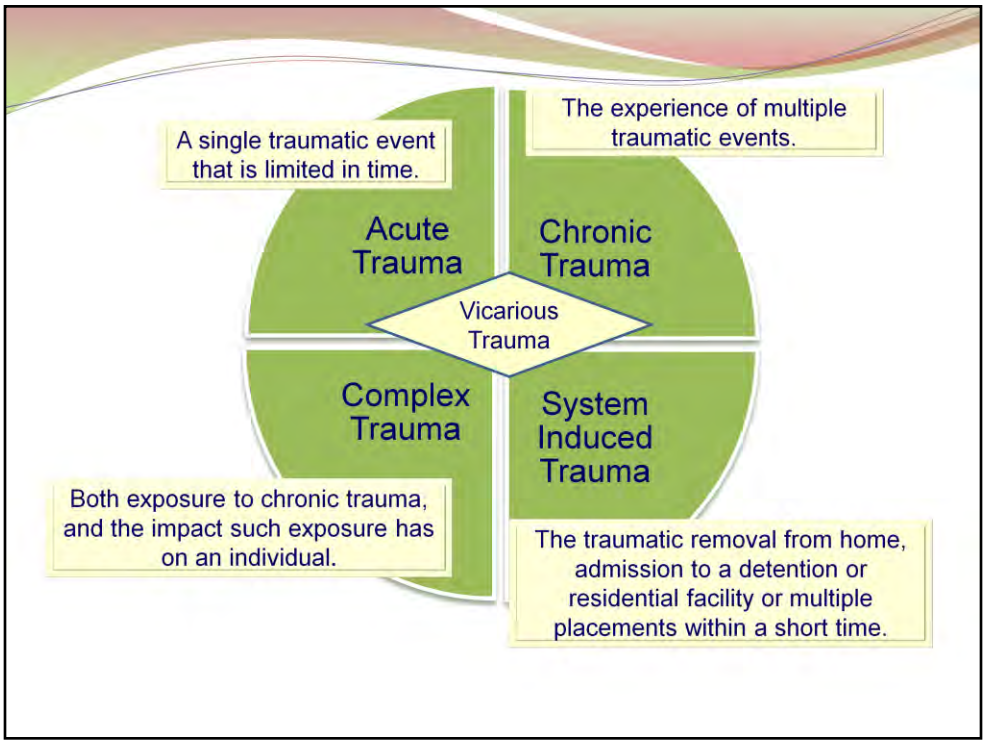
1. Ask the passenger to speak to you.
2. Is he or she "orientated x 3" (Do they know their name, date and where they are?)
3. If they can speak and answer those questions, use your judgment/intuition to decide if they can carry on.
4. If there is any doubt, ask them to get out of the car and walk.
5. If the passenger cannot do that, call for medical assistance.
6. Possible outcome could be severe alcohol poisoning or they are under the influence of a date rape drug and your intervention will save them from being assaulted.
7. You may want to consider a "well being check" if you are unsure, and get their address/barracks room number to check on them later.

Trauma Informed Approach (Slides 27 – 34)

1. There was a scene from the movie "Top Gun" in which one character said of another, "Ah, he's just that way 'cuz he was abused as a kid…" It is said all the time, but such adverse, traumatic experiences in childhood can have a profound impact on life course development.
2. Introduce Trauma Informed Care. Explain that TIC is not a model but a philosophy. When using a trauma informed lens, it serves as the unifying lens for all people that are served by FRs 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.

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

4. 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.



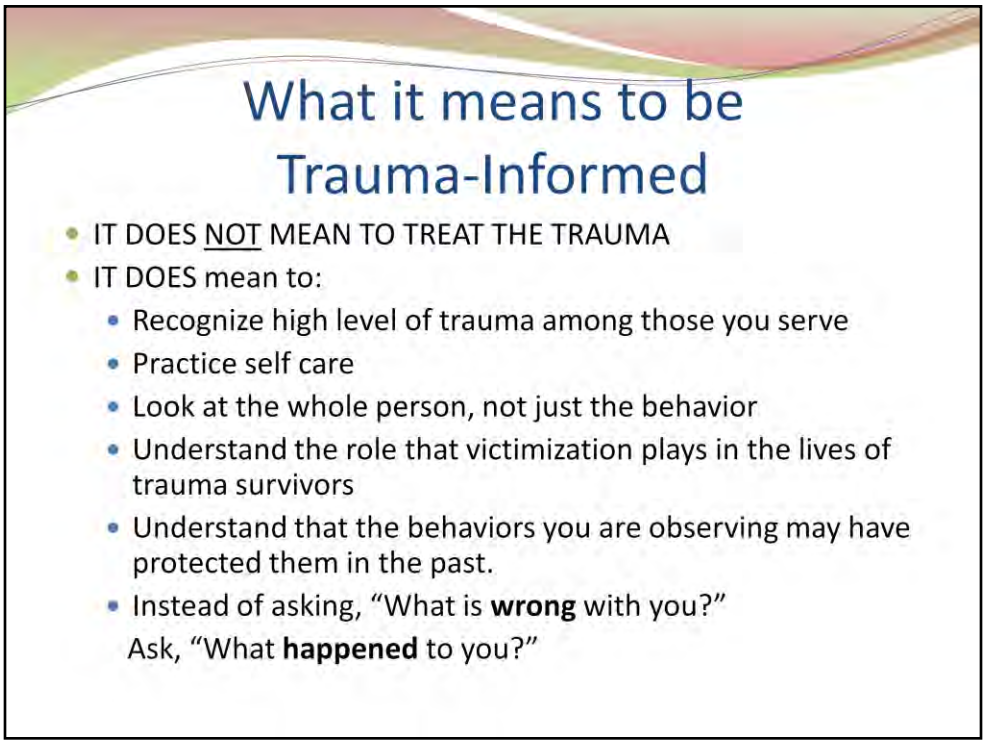
-Types of Trauma

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.

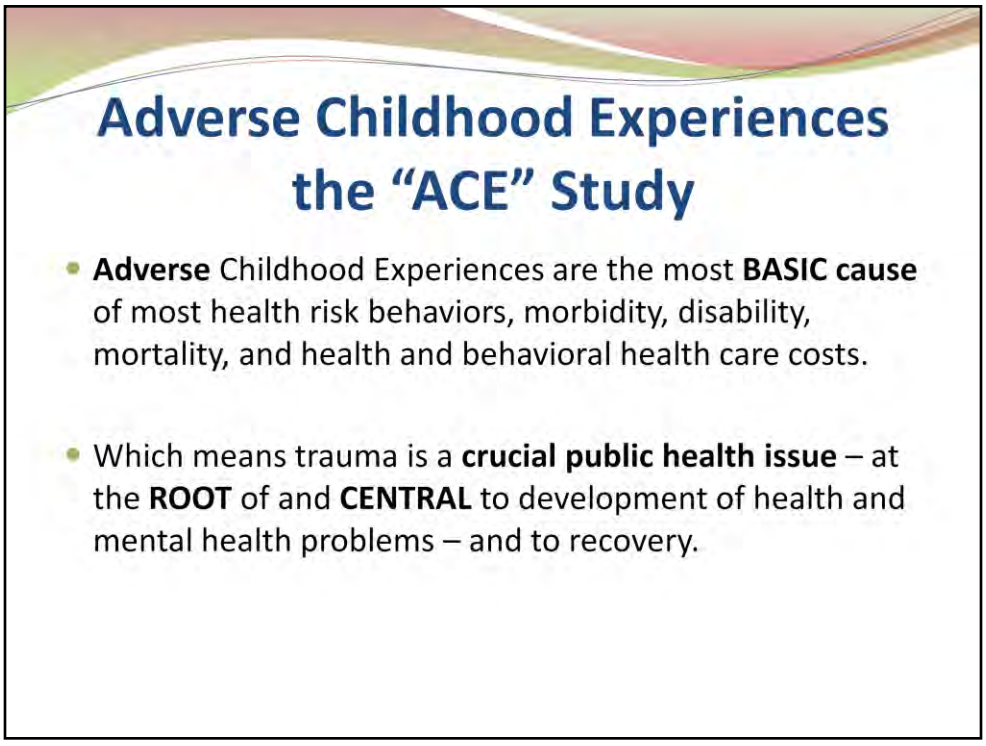
2. Be sure to highlight the importance of personal well ness for military first responders who frequently are subjected to vicarious trauma.

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



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".



-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.

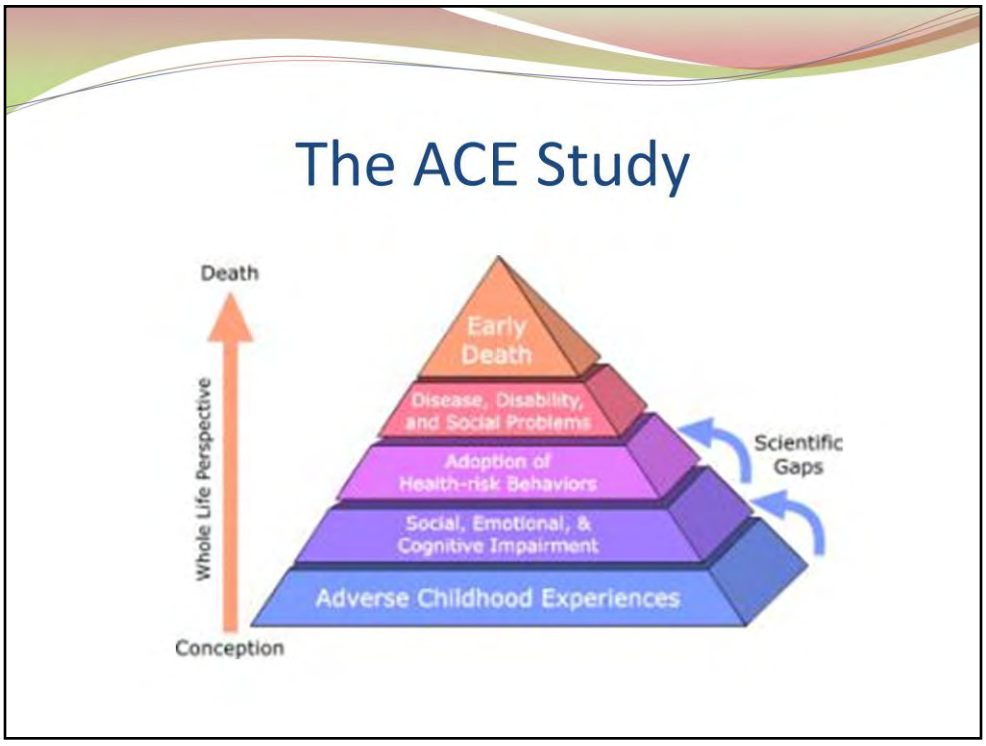
3. Of the 17,000 HMO Members:

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

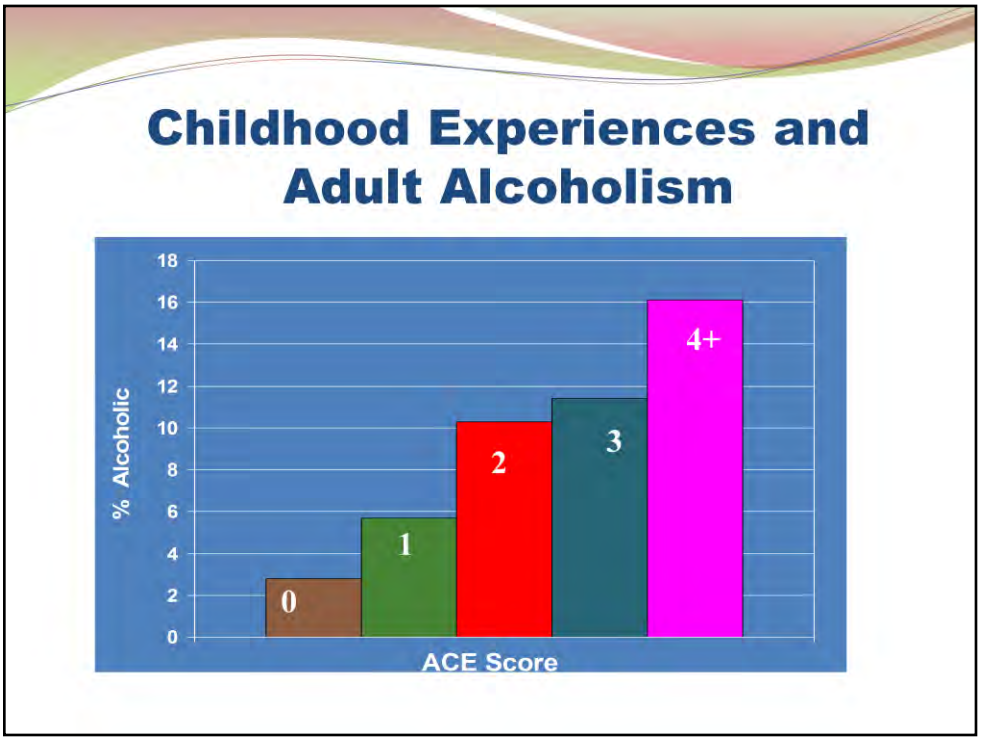
   1 in 16 was exposed to **4** categories.

   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.



-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.

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.

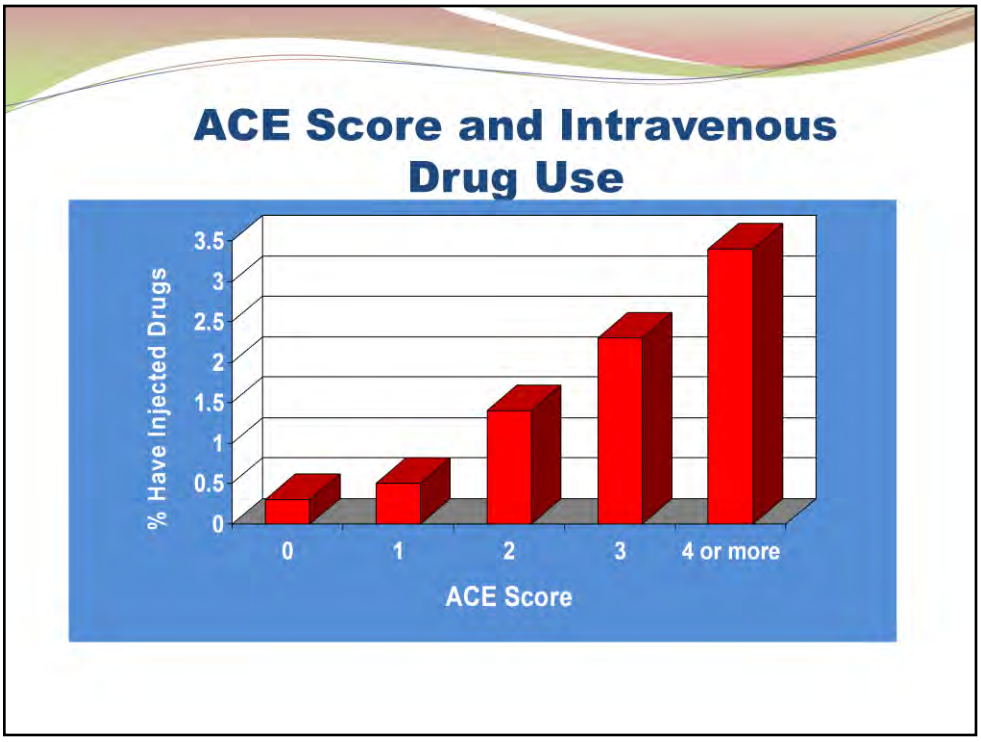
2. Colum 2 represents the neurobiological impacts and health risks associated with ACES, and column 3 is the long term health and social problems associated with both.

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."

TIPS FOR MILITARY FIRST RESPONDERS:

- Remember this for visits to base housing for domestic violence calls.
- Children are affected by deployments, PTSD, low income stressors, and single parenting.
- Do not overlook them and be sensitive to what might be happening to them or what they are hearing in their home.
- Make their physical and emotional safety a priority.

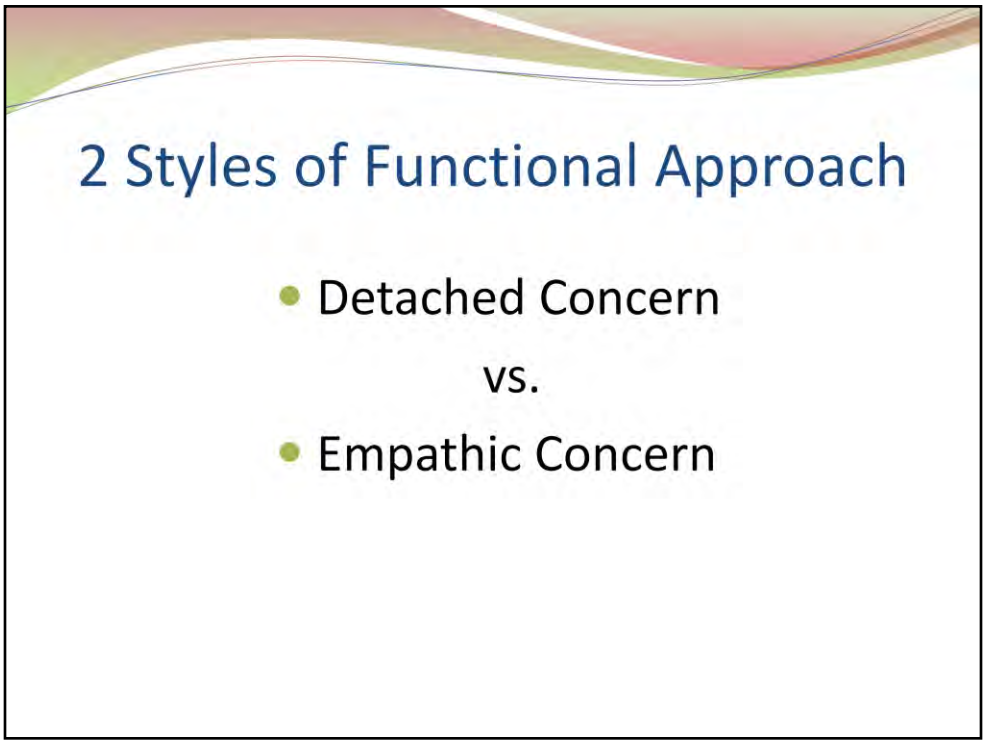


-ACE Score and Intravenous Drug Use

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**

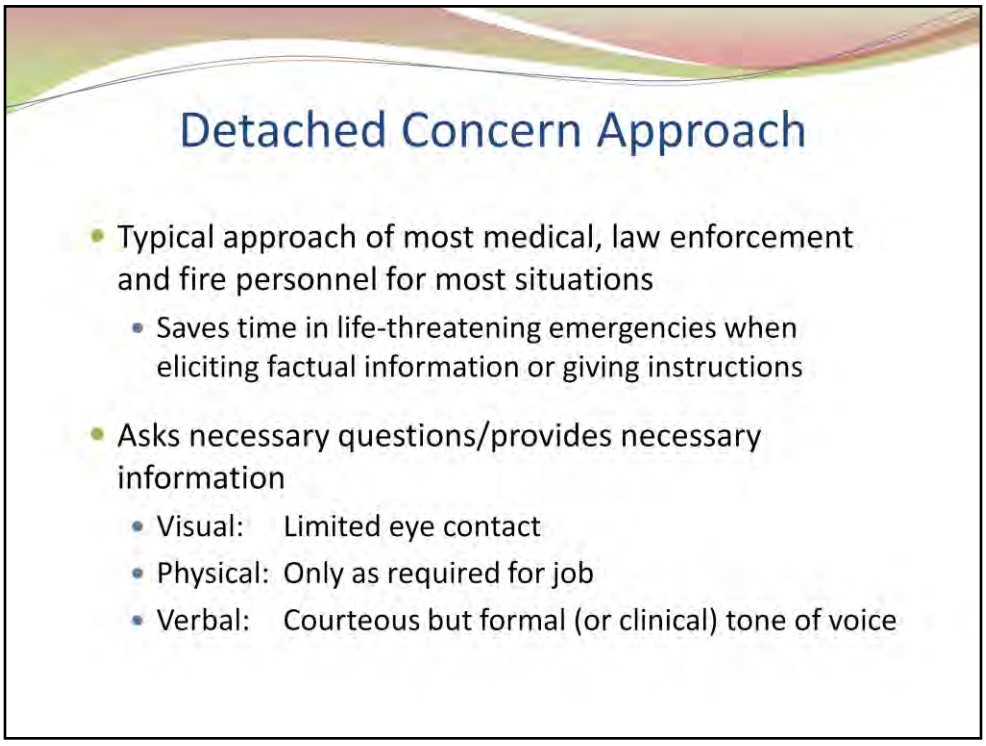


Detached vs. Empathic Concern (Slides 35 – 38)

Both of these manners of approaching the an individual who is the focus of a call are necessary skill-sets depending on the situation.

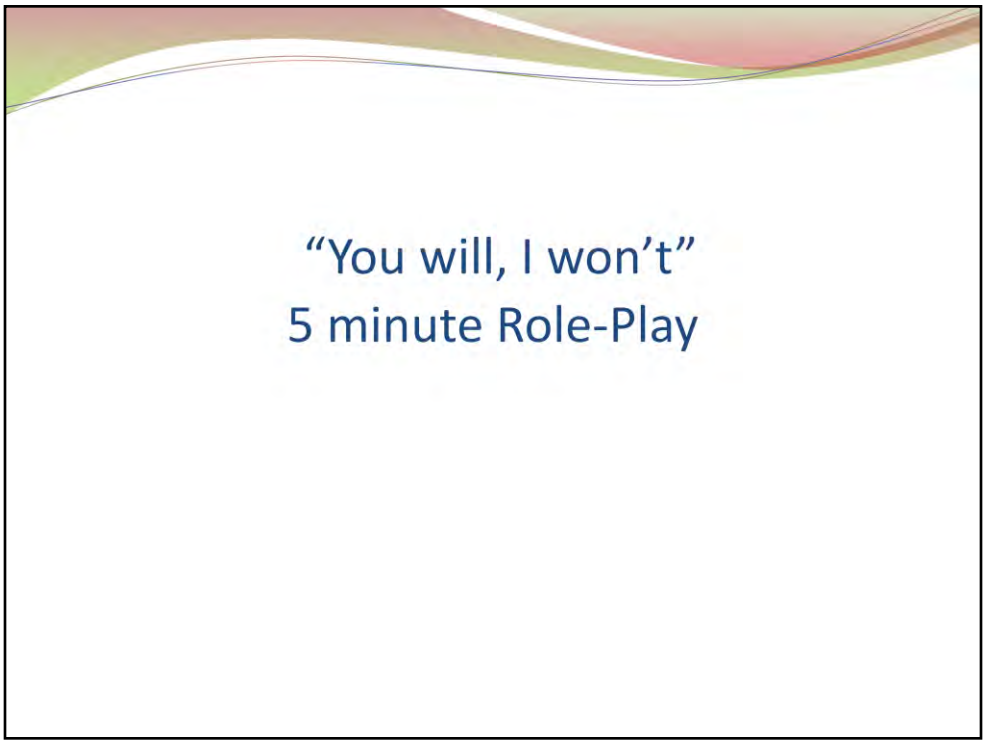
➢You can think of each approach in terms of 3 component parts:

1. Visual—Eye contact
2. Physical—proximity and touch
3. Verbal—words, tone of voice



- "Detached concern" is a term coined by medical schools. It is encouraged for doctors who have to see multiple patients and have no time for "unnecessary chit-chat."
- Works well in multi-casualty situations, high risk environments, life-threatening emergencies where you must make a point quickly, elicit information rapidly and get people to comply with your instructions immediately.
- Visual – only as much eye contact as necessary to make sure they heard what you said
- Physical – Only as required to do job (take a pulse or blood pressure, insert a needle, frisk a subject, handcuff, etc.)
- Verbal – Monotone "Joe Friday" – "Just the facts."

- When you only have one patient/subject and there is no high risk environment or life-threatening emergency and they are emotionally upset/frightened/depressed, "Detached Concern" does not come off as concerned at all – just detached.



-Activity: "You will, I won't" 5 minute Role Play

1. Quickly divide class into "1s" & "2s" (Count "1-2," 1-2" around room and join any "1s" that don't have a "2")
2. Direct participants to stand face to face, at least 1 foot apart, (no touching allowed). The ones simply say "You will." and the twos reply, "I won't" – Allow 30 secs
3. Next the twos sit down and the same drill commences for 30 secs
4. Next they switch roles – ones sit, twos stand, and say "You will," and ones reply "I won't."

1 minute debrief with the following questions:

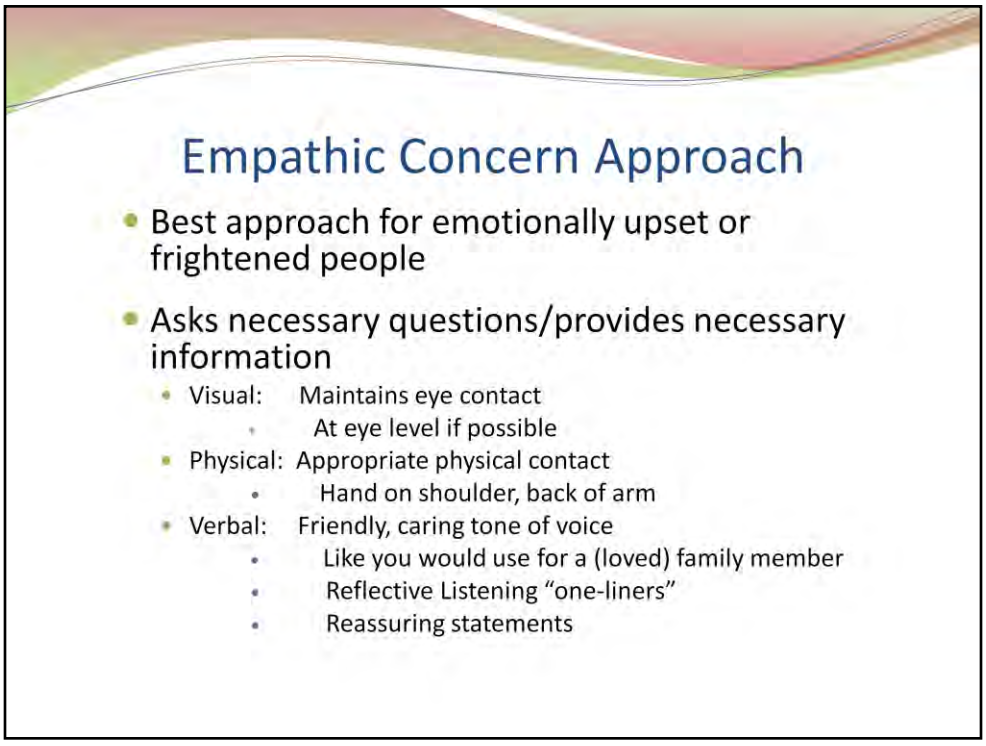
- "Twos, how did you feel when the ones were telling you 'You will." ?"

- "Did you feel like you wanted to do what ever it was they wanted you to do?"

- "How did it change when you sat down looking up at the one standing over you?"

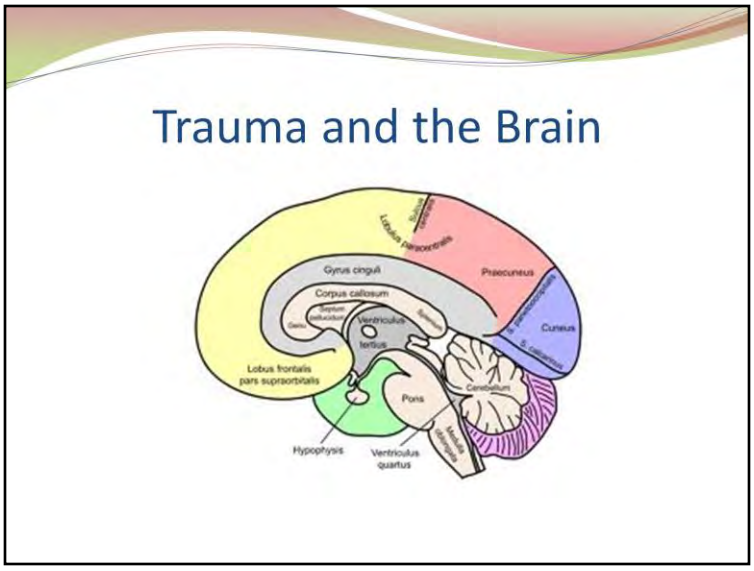
- "Ones, what was your response when your two told you they wouldn't do what you wanted them to do?"

- "Twos, when you reversed roles, what went through your mind as you were telling your one what to do?"



- Make sure scene/patient/subject is safe or employ "Contact/cover" tactics with partner
- Visual – Take a knee if you have to, remove sunglasses
- Physical – Only if patient is not paranoid and does not bristle. Can even be employed if patient is restrained or subject is in hand-cuffs
- Verbal – Reflective listening one-liners reflect back content and possible feelings behind content.
    - Example: She says, "He's all I had in life and now he's dead." You say, "So you are all alone now, that must feel very terrifying."

- Reassuring statements
    - Example: "We are here to make sure you are safe." Even during restraining or handcuffing: "We are only trying to help you…Relax, we don't want to hurt you…we are only doing this so you don't hurt yourself or others."

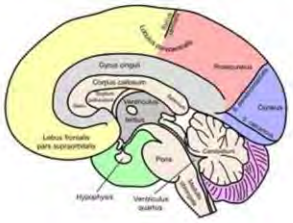


Brain Trauma PTSD/TBI (Slides 39 – 43)

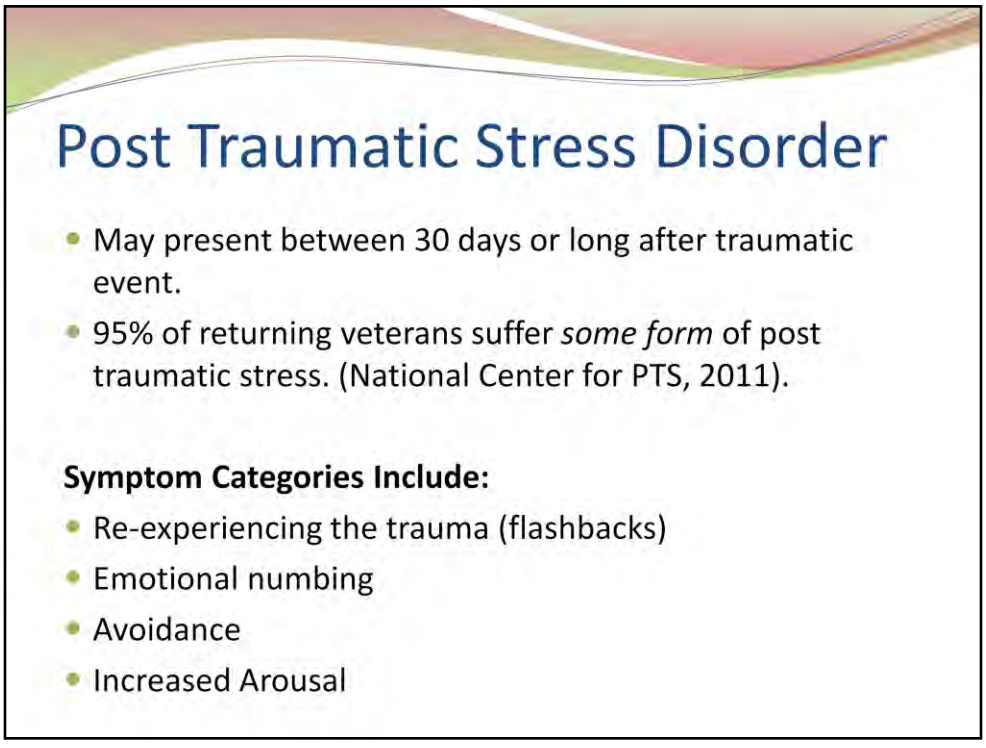
1. Disclaimer that we are not neurologists. Explain that the way that a traumatized person's brain functions is very different than how a person that has not experienced trauma's brain works.
2. **Amygdala** This is the "Security Guard" of the brain, if there is any sense of threat this immediately responds 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.**



-Post Traumatic Stress Disorder

1. PTSD may result when someone is exposed to a life threatening event or serious injury.
2. It can involve a threat to physical integrity, such as being the victim of abuse.
3. It involves intense fear, helplessness and horror .

COMMON SOURCES OF TRAUMA:

- Military experiences in war
- Rape or other personal assaults
- Natural disasters
- Terrorism
- Accidents
- Child molestation
- Childhood physical abuse *** May connect this to the ACE study slides.

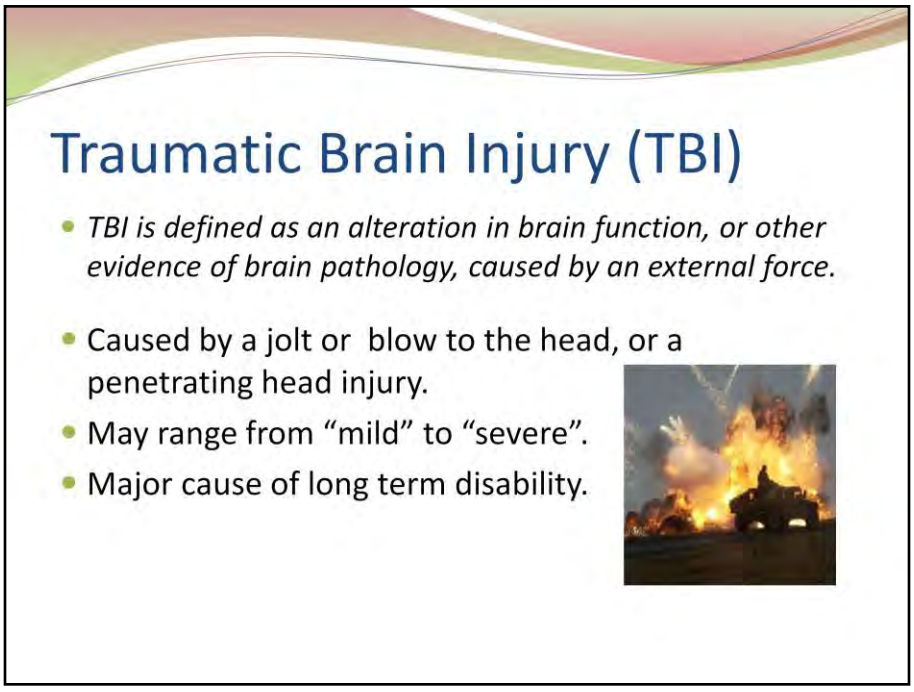
1. These symptoms, among others, are some that may be visible on the outside or able to be confirmed through questioning.
2. Some behaviors can be viewed as oppositional behavior or aggression if encountered.
3. Behaviors may be triggered by reminders of the traumatic event.

AUDITORY TRIGGERS TO BE AWARE OF:

- Fireworks (4th of July, New Year's Eve)
- Cars backfiring
- Guns going off
- Sudden loud noises.
- Crowds
- Temperature changes

INTERNAL TRIGGERS (may require some careful questioning to uncover)

- Anniversary of the event.
- Losses of any kind.
- An event that felt out of control or dangerous.
- The presence of substance use or abuse may be the attempt to avoid or numb the feelings when they are escalating.
- Extreme exhaustion due to lack of sleep and repeated nightmares increase the emotional potential.



-Traumatic Brian Injury

1. Common source of substance abuse and domestic violence.
2. May be the source of chronic debilitating pain (headaches and migraines) that rarely go away.
3. 21 more times likely to commit suicide, especially when paired with substance abuse and other psychiatric problems like anxiety, depression and PTSD.
4. If the behaviors noted below seem apparent, ask the soldier if he/she was involved in any explosions or accidents where they lost consciousness even for a few seconds. If so, ask if they have TBI.
5. TBI is generally considered to be an invisible disorder within an invisible injury with very visible implications.

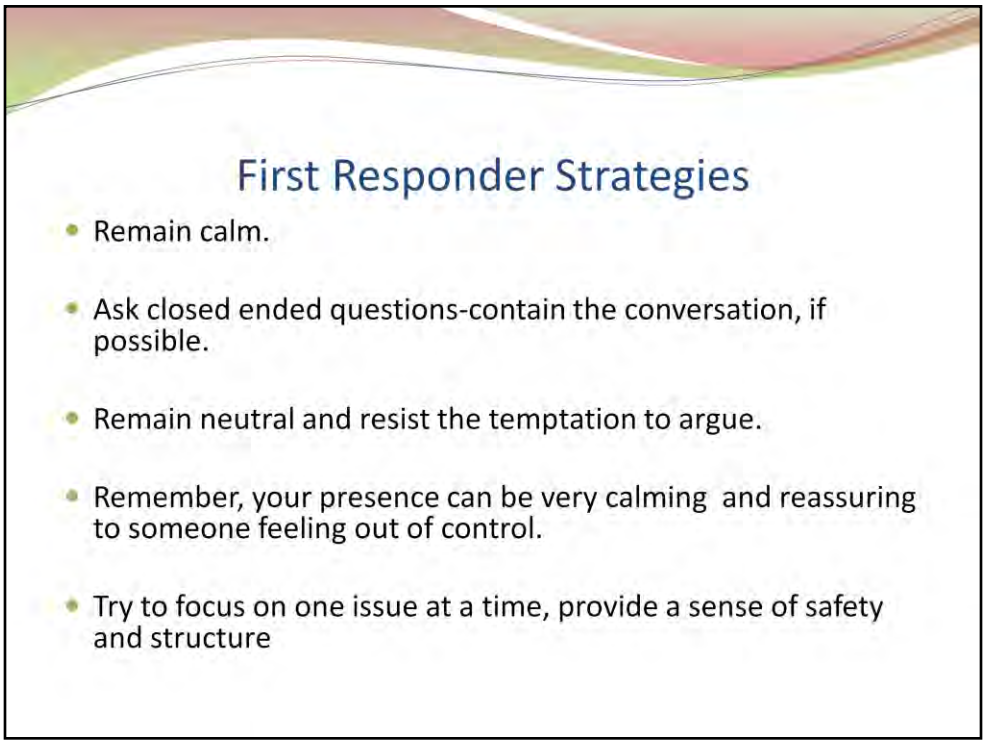
NOTABLE BEHAVIORS :

1. **Memory issues**
   - May not remember what they were told to do, which may appear as oppositional and defiant.
   - This can be seen if a return visit is made, and the soldier seems to be unaware that the officers were there before.
   - Slowness of speech or thought processes seem sluggish.
2. **Lack of inhibition.**
   - May make sexual or flirty advances or be suggestive.
3. **Impulsive**
   - May make a sudden move despite being told not to.
   - May try to run.
4. **Seems "clueless".**
   - May appear to be in denial or oblivious to the situation and the severity.
   - Doesn't seem to have any personal solutions to the problem.

Source: Brain Injury Association of America, 2011. http://www.biausa.org/index.htm

5. Moods

- Anxiety
- Depression
- Irritability
- Agitation
- Outbursts



First Responder strategies for bipolar disorder (Slides 44 – 50)

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?"***

-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

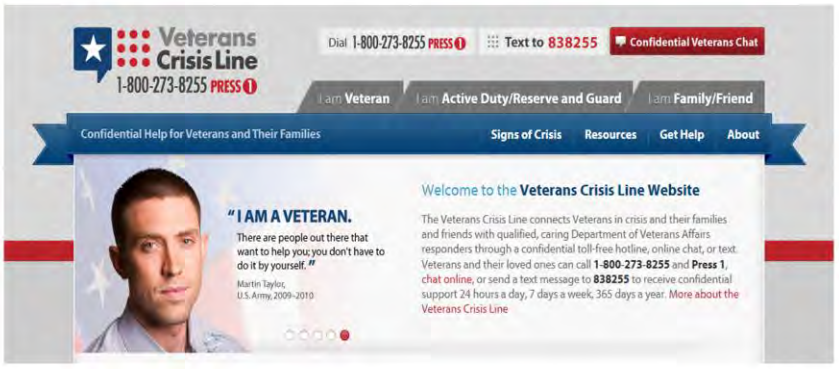
3. **General strategies**:

   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



24 hour crisis counseling for all vets and family
run by licensed mental health clinicians
who are veterans themselves.
Also connects vets to local VA Vet Centers and other services.
http://www.veteranscrisisline.net/

Ask class to pull out their "Veteran Crisis Lines" Handout.

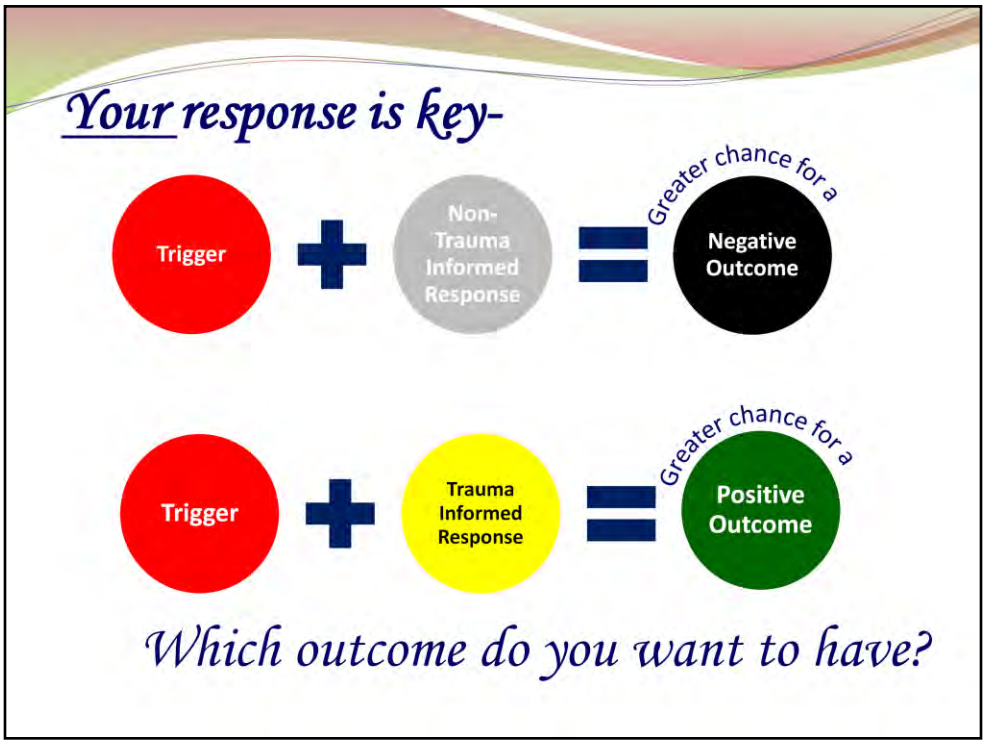
Review. Ask participants if they are aware of additional resources.

Peer support Crisis or Resource intervention for all Marines (Regular, Reserve, veteran or retiree) and attached sailors and family members
Anonymous (will NOT call CoC)
24 hr. mental health clinician on staff with peer counselor
http://www.dstressline.com/

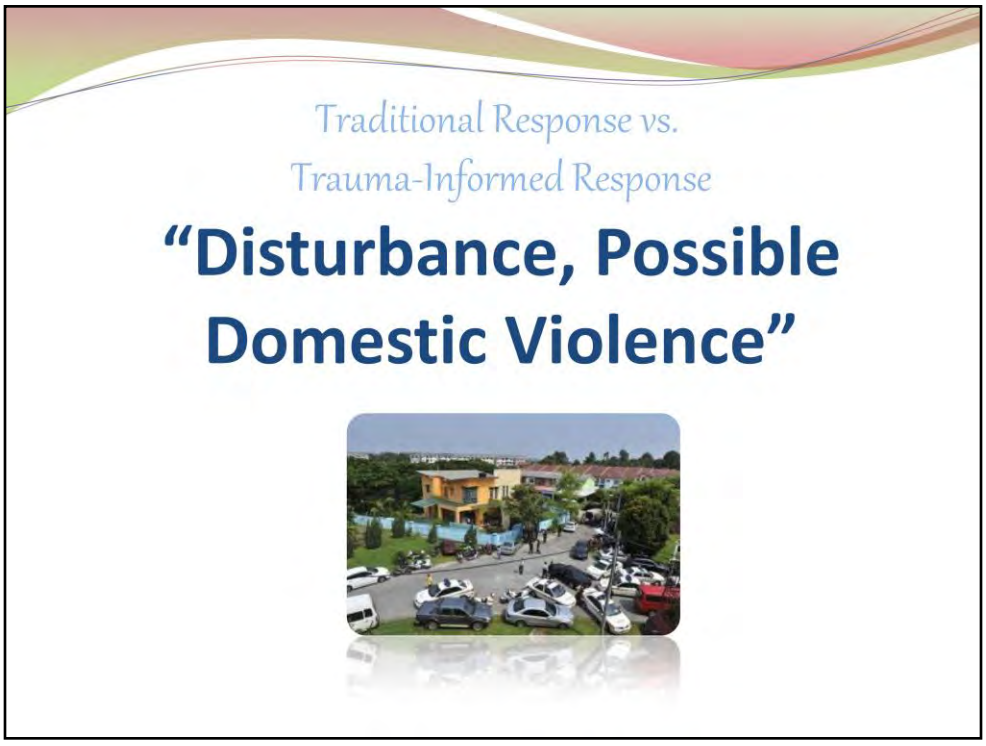
Marine-specific resources.

Peer support for combat veterans and their families with peer and clinician follow up calls. Caller may request to speak with a fellow combat vet of a specific conflict.

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

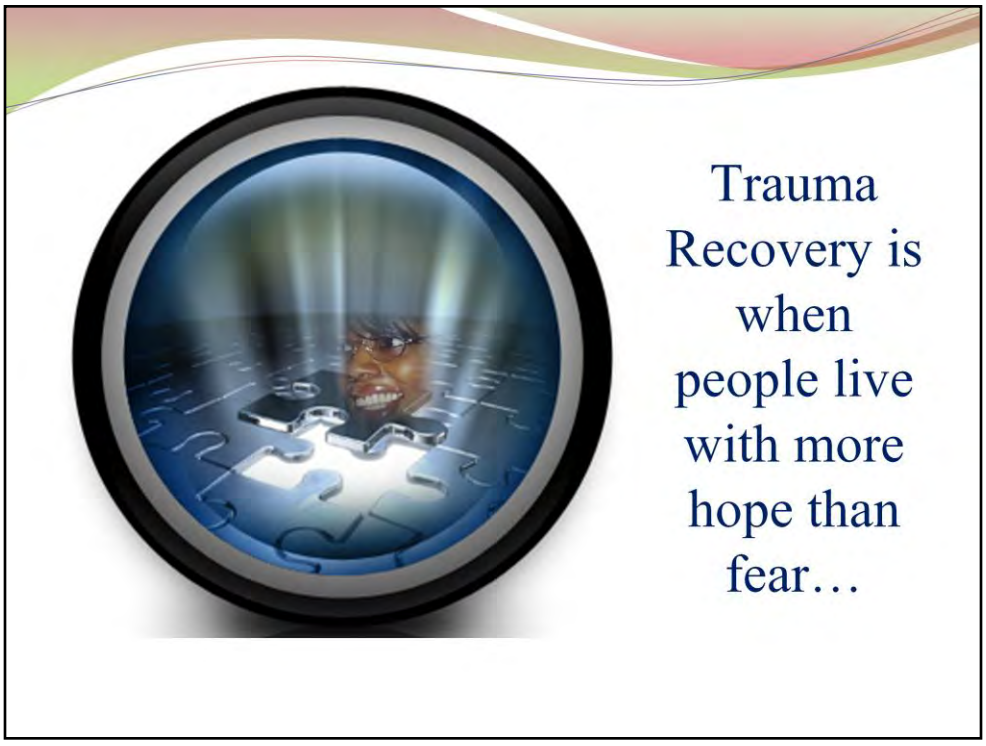


Link this in with their daily job, their desire to get a positive safe result from the person's they interact with.



Disturbance: Possible Domestic Violence Vignette & Discussion (Slides 51, 52)

1. 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.
2. **Refer participants to the "Disturbance: Possible DV" discussion vignette.**
3. **Read the first section and ask the focus questions that follow.**
4. **Proceed with additional sections as time allows.**



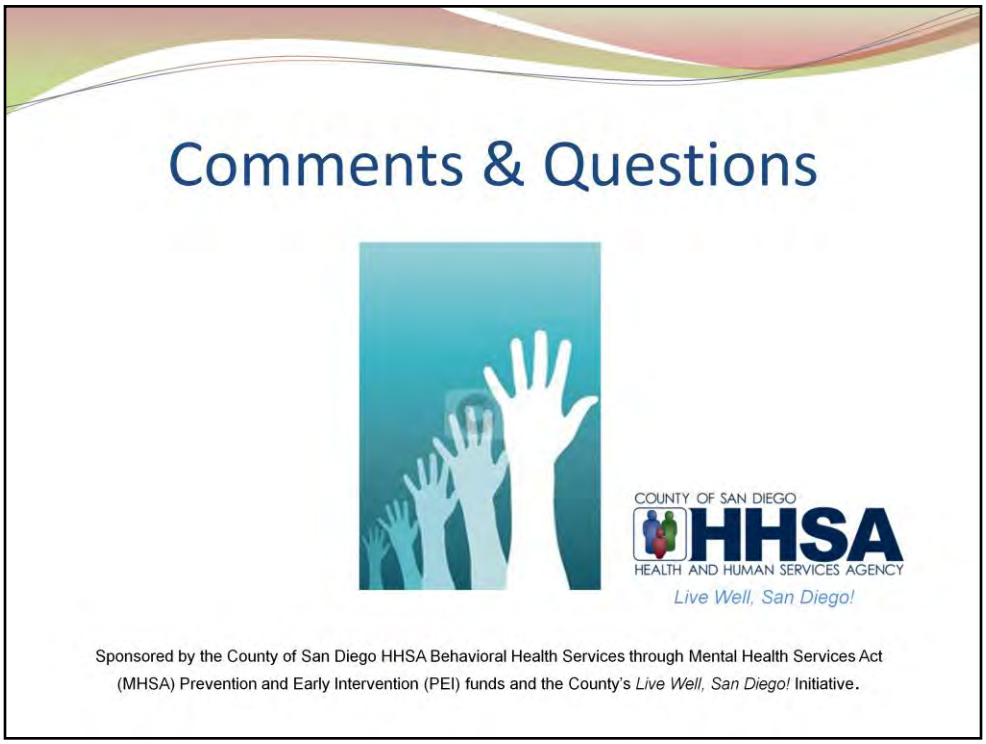
Wrap Up

1. Summarize key themes from the training.

2. Refer to additional resources provided in handout packet: Fact Sheets, references, Wellness Checklist.

3. Express your appreciation, again, for military first responders and wish them success in using the tools that were discussed today.

4. As an end note, invite military first responder to be diligent in self-care.



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 Tracy for any further follow up.