Behavioral Health Training Schedule: 911 Specialist and Police Emergency Dispatch

Lesson Title	Duration	Time	Facilitator
Welcome, Introductory Activity: Video/discussion	10 min	0800 – 0820	911/ Behavioral Health
A. History of Mental Health Treatment	10 min	0820 – 0835	Behavioral Health
B. CIT and Law Enforcement	10 min	0835 – 0845	Behavioral Health
C. The BPD's Behavioral Health Crisis Dispatch Policy	45 min	0845 – 0930	BPD
BREAK	10 min	0930 – 0940	
D. Stigma Exercise	20 min	0940 – 1000	Behavioral Health
E. Trauma-Informed Practice	30 min	1000 – 1030	Behavioral Health
BREAK	10 min	1030 – 1040	
F. Behavioral Health Overview	90 min	1040 – 1155	Behavioral Health
G. Peer & Family Perspectives Panel	30 min	1155 – 1225	NAMI (BH)
LUNCH	45 min	1225 – 1305	
H. Engaging and De-Escalating Over the Phone	40 min	1305 – 1345	911
I. Scenarios (3)	60 min	1345 – 1445	911/all
BREAK	10 min	1445 – 1455	
J. Self-Care for 911 Specialists and Dispatchers	45 min	1455 – 1540	Behavioral Health
Evaluation/Closure : Q & A, Wrap Up	25 min	1540 – 1600	all

MARYLAND POLICE AND CORRECTIONAL TRAINING COMMISSIONS
LESSON PLAN

COURSE TITLE: Behavioral Health: A Training for 911 and Police Dispatch

LESSON TITLE: History and Behavioral Health Overview

PREPARED BY:	Elizabeth Wexler, LCSW-C	**DATE: 5/4/2020**
	Paul Mincarelli	Revised 10/20/2020
	Paul Mincarelli	Revised 12/17/2020
	Paul Mincarelli	Revised 2/17/2021

TIME FRAME	**PARAMETERS**
Hours: 8 hours Day/Time: Various	**Audience**: 911 Specialists and Police Emergency Dispatchers **Number**: maximum of 10 **Space**: BPD Communications Training Center **Facilitators**: Co-facilitated with one behavioral health content area expert and one trainer from BCFD or BPD
PERFORMANCE OBJECTIVES	**ASSESSMENT TECHNIQUE**
1. Specialists and dispatchers will demonstrate an understanding to the satisfaction of the facilitators of the history of mental health treatment and how it has led to the prevalence of first responders in crisis intervention. 2. Specialists and dispatchers will be challenged in their individual and collective biases and assumptions through facilitated discussion to the satisfaction of the facilitators about behavioral health disorders, and understand the impact of stigma.	1. Facilitated discussion & associated presentation. 2. Role-playing scenarios. 3. Practical exercises. 4. Case study analysis.

3. Specialists and dispatchers will define concepts and identify tools of trauma-informed crisis response to the satisfaction of the facilitators. 4. Specialists and dispatchers will recognize the signs, symptoms and behavioral indications to the satisfaction of the facilitators of mental illness, substance use disorder, developmental disabilities, and cognitive impairments. 5. Specialists and dispatchers will define the principles of diversion, the "least police-involved response," the critical importance of connecting individuals to appropriate community resources when needed and, to the satisfaction of the facilitator, will describe through a listing exercise the community resources available to divert individuals in crisis.	

INSTRUCTOR MATERIALS

_____ Overheads
__x_ Slides
_____ Posters

_____ Videotapes/DVD:

__x__ Reference Documents:

BPD Policy 715 dated 7/3/19

EQUIPMENT/SUPPLIED NEEDED

___x__ Flipchart & Stands
___x__ Flipchart Markers
_____ Masking Tape
_____ Slide Projector (Carousel)

_____ Videotape/DVD Player
_____ Videocamera
____x__ Televisions
_____ Videoshow

_____ Overhead Projector	___x__ Computers
__x___ Projector Screen	___x__ Speakers
___x__Extension Cords/Powerstrips	

STUDENT HANDOUTS

# Needed	Title:
10	Policy 715, *Behavioral Health Crisis Dispatch*
10	Community Resources

METHODS/TECHNIQUES

1. Facilitated discussion & associated presentation.
2. Role-playing scenarios.
3. Practical exercises.
4. Case study analysis.

REFERENCES

The following books and other materials are used as a basis for this lesson plan.
The instructor should be familiar with the material in these reference documents
to teach this module effectively.
Video for opening of training: https://www.youtube.com/watch?v=fSekdGHJTwM

- BPD Policy 715, *Behavioral Health Crisis Dispatch* (dated 3 July 2019)

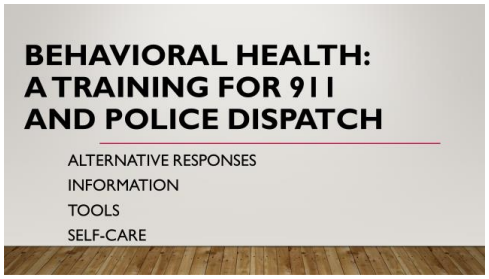
GENERAL COMMENTS

In preparing to teach this material, the instructor should take into consideration the following comments or suggestions.

This lesson plan is intended for use with experienced instructors who have teaching experience and deep familiarity with Crisis Intervention Team and Behavioral Health Awareness training.

LESSON PLAN

TITLE: Behavioral Health: A Training for 911 and Police Dispatch

PRESENTATION GUIDE	TRAINER NOTES
I. ANTICIPATORY SET **Activity: Telephone Game Video** **911 INSTRUCTOR** Remember playing "Telephone" when you were a kid? Since we cannot actually play, we are going to watch this video.	 **Time: 10 minutes** 
How close was the end result to the original message? What did you notice as the message was passed from person to person? What do you think contributed to the message changing?	**Desired responses:** *That the final message was not close to the same as the first. *That there were multiple factors that changed the message each time it was relayed.
What does this have to do with what you do in your job?	*That we have a lot going on in our senses, especially in these jobs, and that can cause difficulty in fully understanding a message and relaying it as it was meant. *****The majority of a Specialist or Dispatcher's job is listening, understanding, and relaying messages; often there is not a lot of information, and the person calling is experiencing or witnessing some type of emergency.

	Listening is fundamental to this job.
Any questions or other thoughts? **BEHAVIORAL HEALTH INSTRUCTOR** This training is related to the Crisis Intervention Team (CIT) model for law enforcement, which is a model that has been adopted throughout the nation, including the Baltimore Police Department. **Ask class**: Why do you think they would initiate a program teaching crisis intervention to first responders in law enforcement?	**Expected/ desired responses:** - Law enforcement personnel regularly encounter people with behavioral health disorders - Someone died as a result of a police-involved shooting and the person had mental illness but the police did not know this - Understanding signs and symptoms would help emergency personnel better handle these situations and have better outcomes.
This training is designed to help you identify when someone is in behavioral health crisis and give you some tools to intervene effectively. It is not designed to try to make you into therapists, psychiatrists, or people who diagnose behavioral health disorders. The main goal of Behavioral Health Training, and CIT training, is so that you are better able to identify when someone needs ASSISTANCE rather than LAW ENFORCEMENT, and then to get the appropriate support engaged with the caller, whether that be BPD, Crisis Response or Referral. The BPD and the City of Baltimore recognize that currently, police are sent to calls when a police response is not needed, and that this outcome often does not	**Instructor's Note:** We want to emphasize to the specialists and dispatchers that this training is to offer them tools to enable them to be a more active and engaged part of the crisis response continuum.

assist a person in getting the support they need and also drains BPD resources. BPD and the City of Baltimore are working with the community behavioral health system to decrease law enforcement involvement in calls where law enforcement is not needed and individuals need assistance for a behavioral health crisis. As specialists and dispatchers, you are in the unique position to identify these calls and opportunities to connect individuals to services. Currently, the City has some crisis response services available, but they are not yet sufficient to respond in all situations. As a result, the City is still relying on BPD officers to supplement crisis response while also working to expand appropriate crisis services. This training will provide you with the necessary building blocks to: - Begin to identify when community resources might better resolve an emergency call for service, and when calls could be diverted to other resources - For 911: Determine when a police response is not necessary and the required steps when that is the case, - For 911: begin to identify what information to provide to Dispatch with regard to diversion, and for Dispatch, the same for information to provide to officers dispatched - Familiarize yourself with the long-term goals of Baltimore city, and how it will become better-resourced to move forward in responding to individuals in crisis or with behavioral health needs. Eventually, the City will be able to provide further and more detailed guidance on when mobile crisis response should be dispatched, in addition to or instead of a police response. However, those resources and policies have not yet been fully created; this training helps prepare you to use your judgement to divert crises as much as possible to the non-police resources that are available. Your feedback following this training is vital to ensuring that our emergency response system better serves our neighbors that experience disabilities in the future, so please ask questions and complete your survey at the end of the session today.	

II. INSTRUCTIONAL INPUT (CONTENT)

Time: 15 minutes

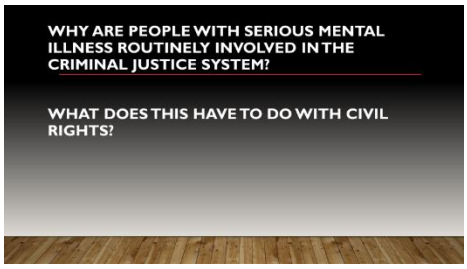
A. History of Mental Health Treatment

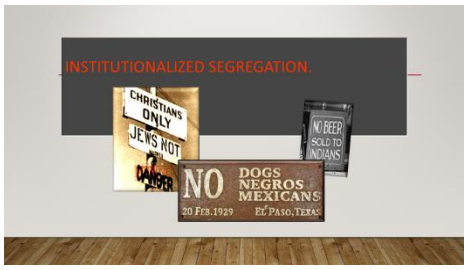
BEHAVIORAL HEALTH INSTRUCTOR

Let's take a step back and discuss WHY we are talking behavioral health disabilities in the context of emergency services.

While we go through the following slides, keep these three questions in mind:

- Why are people with serious mental illness routinely involved in the criminal justice system?
- How does this interact with our historical understanding of civil rights reform movements in the United States?
- How does this connect with current movements around reforming law enforcement responses to behavioral health needs?

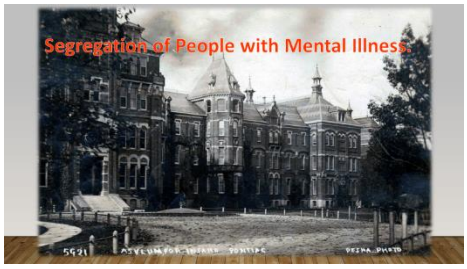




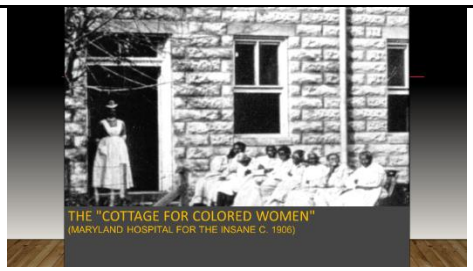
Let's start with some historical perspective.
Prompt: How do these signs make you feel? What do they remind you of?

Anticipated Responses: Unfair, unjust, violation of civil rights, segregationist, bigotry.

There is a parallel history of segregation in the United States for individuals with serious mental illness. By the 1950s, over half a million Americans were locked away in psychiatric institutions, with no hope of returning to their communities. South of Baltimore, at Spring Grove, over 3,000 patients were institutionalized in places that looked like this. And while these institutions segregated people with mental illness from their community, even within these institutions existed further segregation along the lines of race and diagnosis.



Here in Maryland, at the Hospital for the Insane, there was a separate building for women of color.



"The Back Ward" existed for individuals who didn't seem to respond well to treatment and were deemed "hopelessly insane." They were segregated from patients that staff thought had a chance of getting better. The thinking was that it was a waste of resources to invest in services for them. In hospitals' Back Wards, individuals sat in a room, and that was pretty much the extent of their treatment; left in a room to sit with no active treatment and no hope of returning to their communities. Of the nearly half million individuals institutionalized, the overwhelming majority were placed in Back Wards. Many people who were admitted to psychiatric hospitals as adults grew old and died after decades of being segregated as Back Ward patients.

These large institutions were expensive to operate, and in turn, conditions deteriorated. In 1946, LIFE magazine released an exposé on the conditions of American mental hospitals that began to turn attention and public opinion towards these institutions. In 1949, the Baltimore Sun published a series of articles called "Maryland's Shame," which was described as the "worst story ever told" by the Sun. It featured pictures of rows of female patients in padlocked chairs, where they stayed all day because there were not enough attendants to handle them. It showed children sleeping two to a bed and men lying nude in their own filth.

In the 1970s, the United States was in the midst of the Civil Rights movement, which helped to accelerate the disability rights movement.

The Civil Rights agenda of the 70s sought to ensure that

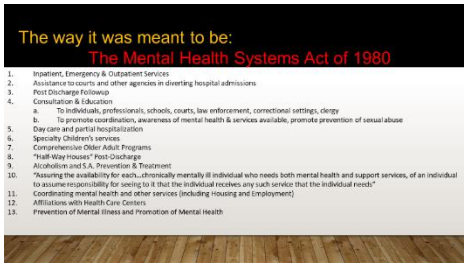
hospital conditions were not abusive, and that people had the right to be treated for their conditions and to live with dignity and respect.

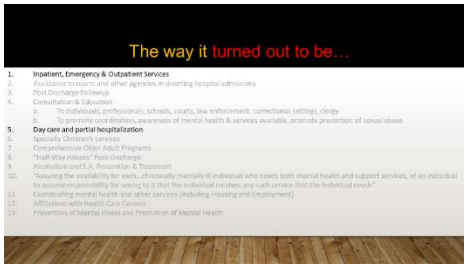
The shift in public opinion and the Civil Rights movement led to policy discussions at the national level around what is called “de-institutionalization” –shifting away from segregation of people with mental illness in hospitals to a new model of community-based care. De-institutionalization and the development of this new model were supposed to be two sides of the same coin.

For instance, in 1980, under President Carter, the Mental Health Systems Act was enacted to provide community-based care with wrap-around services for individuals with mental illness. The promise of the Mental Health Act of 1980 was that a new system of community-based mental health services would be developed to allow people with mental illness to live successfully outside of institutions. Through this law 40 years ago, Congress expected the development of a long list of community mental health services, including alcohol and substance abuse services, and consultation with courts, law enforcement, and correctional settings.

But this promise—which was really a civil rights promise to people with mental illness-- was not kept. Following the 1980 election, the majority of the Act was unfunded. Only inpatient, emergency & outpatient services, and day-care and partial hospitalization were realized from the Mental Health Systems Act of 1980.

As state institutions began to shutter, many of the people who were discharged from hospitals or who were diverted away from hospital care therefore never received the community-based services that they needed. In reality, deinstitutionalization was replaced with “transinstitutionalization” which means that individuals with serious mental illness who left psychiatric facilities instead received acute care in





emergency departments or nursing homes; trading one institution for another at far greater costs.

Far greater numbers of individuals with mental illness began to live on the street following the closure of these institutions and the failure of the nation to provide the expected services.

We are here to talk about Behavioral Health Crisis Intervention today because, as specialists and dispatchers, you will routinely interact with individuals who experience mental health disorders, or patrol officers responding to crisis scenes. In a very real sense, the criminal justice system has inherited the broken promises of de-institutionalization. Obviously, police and criminal justice systems were not designed to be mental health providers. When individuals with mental illness are involved with law enforcement or the criminal justice system, terrible results can occur. In the system, individuals experiencing mental illness cannot access treatment, have a hard time following the rules facilities impose, and live in terrible environments.

Things have changed since the broken promises of 1980 though.

In 1990 Congress passed the Americans with Disabilities Act or the ADA, which is the civil rights law protecting people with physical or mental disabilities.

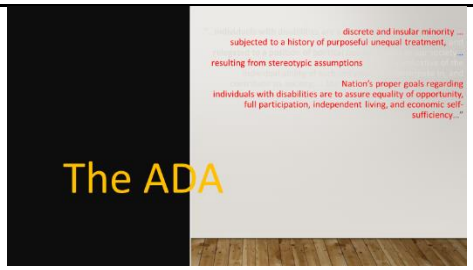
The ADA guarantees people with mental health disabilities the right to receive services in the most integrated setting appropriate to their needs. That usually means services that enable people to be integrated in their communities and to lead full lives with the supports they need. In fact, there are many, many people with behavioral health disabilities living,

working, and thriving in Baltimore. The people you will talk to and need to help are the people whose needs are not being met at the moment. Your role will be to de-escalate the immediate crisis situation and, when possible, to help ensure that the individual is connected to a behavioral health resource.
Additionally, the ADA – Title II – requires that public entities make reasonable modifications in their policies and practices when necessary to avoid discrimination on the basis of ability. This principle should be applied in all aspects of your work.

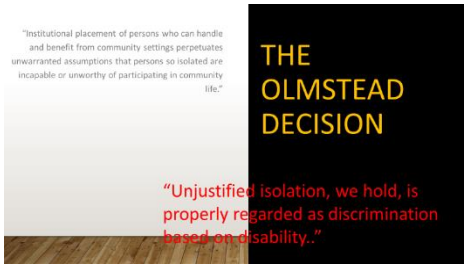
For example, what this means is: you might be required to connect someone experiencing a disability to medical services or transportation, away from a law enforcement response. Specifically, this includes 9-1-1 dispatchers who are considered a governmental entity. For example, if a caller advises the dispatcher that there is a person in need of transportation (be it medical or otherwise) that uses a wheelchair, it is the duty of the dispatcher to make sure that the individual is connected with wheelchair accessible transportation. Or, if a person in crisis may be better able to interact with a trained mental health professional in order to resolve their crisis, that person should be dispatched rather than or along with law enforcement.

Another example could be that you may need to modify a call taking script in order to effectively communicate with someone with a cognitive or intellectual disability.

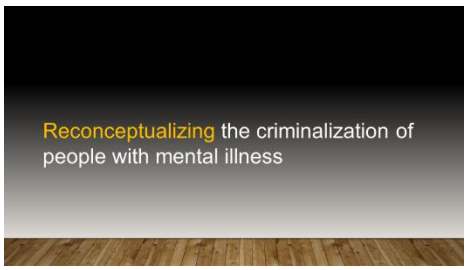
The Supreme Court ruled that individuals with mental illness shall have their rights protected under the ADA. The Olmstead Decision has become a key lever to bring the services that should have occurred in the first place for individuals with serious mental illness. The reform work that we're seeing around the country and here in Baltimore has everything to do with Olmstead. It's not about making better institutions; it's about ensuring that people with serious mental illness have the supports and services that are needed to allow them to be successfully integrated in their communities.



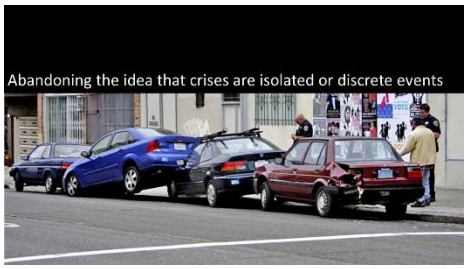
Note: Read the portions in red out loud to the group and pause prior to the lecture notes on the left.



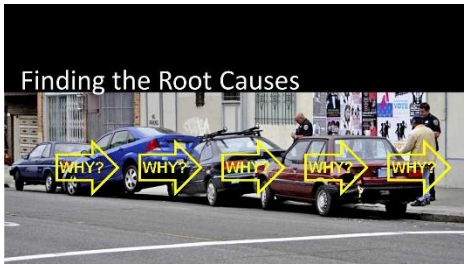
Although Baltimore's goal is to work toward a system in which the behavioral health system (instead of the police) will respond to a greater number of behavioral health crisis calls, police officers, specialists and dispatchers will always have a significant role in aiding people with mental illness. Criminalization of individuals with mental illness is a failure of our community system, and it highlights our inability to identify and address root causes. We currently operate in a crisis response system, which only addresses symptomatic events.



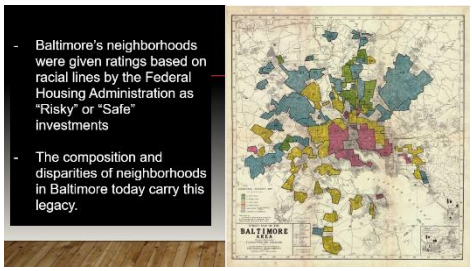
Consider these images:
If you arrived on this scene, would you only look at the crash between the blue cars at the front of the line? Is this accident one driver's fault? Of course not. The driver in the maroon was probably texting, the green driver hit gas instead of brake, the first driver was trying to park, and who knows what's going on with that blue Focus.



The point is: the fact that you are interacting with individuals who experience mental illness, and dispatching officers to those individuals, is not the fault of the individual or the fault of law enforcement. Decisions were made decades ago that allowed for the current environment to exist.



If this type of background sounds familiar, it is because there is also this kind of history with regard to race in the city of Baltimore, specifically the practice of red-lining. Baltimore's various neighborhoods, the disparities in resources and life-expectancy, and the fates of those who live in those neighborhoods still carry on the legacy of this racially discriminatory practice. Long ago, decisions were made that have long-reaching effects into today.



It is important to address before we go on that most people with mental illness are not violent. The vast

majority of individuals with a mental illness pose no greater risk of violent behavior than do people without mental illness unless they are also using non-prescribed substances.[1] Only 3%-5% of violent acts in the United States can be attributed to individuals living with a serious mental illness.[2] In fact, people with mental illness are far more likely to be **victims** than perpetrators of violent crime.[3] That misconception is important for us all to understand because it can affect how we interact with someone with mental illness.

Let's take a moment and reflect on that last slide. Would someone like to share what they think about recent events in this country that tie-in to the issue of criminalization of mental illness and the modern Civil Rights advocacy agenda?

This is a timely training: you've no doubt seen news stories related to demonstrations and marches related to this topic. In Baltimore, this past June, we had weeks of demonstrations following the in-custody death of George Floyd in Minneapolis. Among the demands of the demonstrators is a call to rethink the budgetary priorities of municipal governments away from law enforcement towards community-based services.

In Baltimore, this movement isn't a capricious trend. The Consent Decree agreement requires the "least police-involved response" for behavioral health calls for service while preserving public safety. The City is moving towards implementing resources that will address the gaps in the behavioral health system to realize that goal. Unfortunately, there was a police-involved shooting in July 2020 where an individual was experiencing a behavioral health crisis. I do not raise

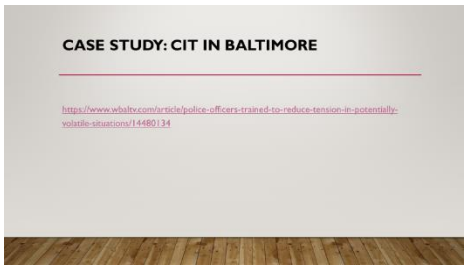
Desired Response: There has been a nationwide movement around rethinking law enforcement's response to behavioral health crises in favor of community-based services.

1 Institute of Medicine, Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC: Institute of Medicine, 2006, available at http://www.ncbi.nlm.nih.gov/books/NBK19831/#a2000e8e1ddd00068

2 *Id*.

3 Appleby, L. et al,, Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study. The Lancet, 358 (2001) 2110-12; Hiday, V.A. et al. Criminal victimization of persons with severe mental illness. Psychiatric Services (1999) 50, 62-68 (finding that people with severe mental illnesses are twice as likely to be attacked, raped, or mugged as the general population).

this incident to cast blame on any 911 operators, dispatchers, or officers on scene. But the incident was emblematic of the failings of the city's behavioral health system, and why all of the key players within that system need to coordinate and improve. Recall the slide with the 4-car-pile-up: a chain of decisions were made that led to that incident. Reforming 911 call intake and dispatch is one step towards breaking that chain and promoting better outcomes. We are here to today to take the first step towards moving in the right direction where individuals' behavioral health needs are better-met with stabilizing services, and law enforcement can continue to preserve public safety and not be placed in situations for which they may not be properly trained. Recall the 3 questions I posed at the beginning of this section: - Why are people with serious mental illness routinely involved in the criminal justice system? - How does this interact with our historical understanding of civil rights reform movements in the United States? - How does this connect with current movements around reforming law enforcement responses to behavioral health needs? I want you all to keep that context in mind as we complete today's training. But first, let's take a break. **BREAK**	Open the discussion and facilitate, ensure the below responses are made.  **Desired Responses:** - Lack of adequate supports, frequent misinterpretation of behavioral health needs with criminal actions. - Mental health advocacy is robust and ensures that public institutions accommodate individuals' constitutional rights. - There's broad support for rethinking how crisis events are responded-to, and to what extent law enforcement should or should not be involved given the potential for inappropriate outcomes.

B. CIT and Law Enforcement **BEHAVIORAL HEALTH INSTRUCTOR** There has been some form of Behavioral Health training in BPD since 2004. It has been both voluntary for experienced officers, and mandatory as part of the Academy and in-service curriculum. This training will give you information and skills to recognize if a caller is in behavioral health crisis, not simply "acting weird" or not cooperating. Being able to detect behavioral health issues is vital in first response, so that you can make dispatch or diversion decisions based on that assessment rather than simply sending a patrol officer out without this context. Just as vital is de-escalating rather than escalating a situation when someone is in crisis. This will, in most cases, enable the responding officer to avoid use of force or the need to arrest someone who actually needs help, often emergency medical help. Here is a case study in BPD's CIT: This video is a news story that aired on WBAL about an officer who put their CIT training to work shortly after they took the training. What I'd like you to pay attention to is how the officer interacts with the citizen, how the other officers back him up, and the response of the citizen. Take note of what may surprise you, or seem different, in how this officer interacts with the citizen. This is a great example of behavioral health awareness in action on patrol, with a client who is very ill and really needs assistance. What might this call come through to you as? I show you this for two main reasons: the first is to see how these kinds of calls for service can actually play out on the street, which you don't get to see as a	**Time: 10 minutes**  **Case Study:** https://www.wbaltv.com/article/police-officers-trained-to-reduce-tension-in-potentially-volatile-situations/14480134 **Desired Response:** Drunk, disorderly, loitering, behavioral health case.

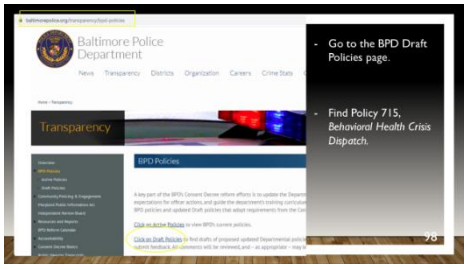
specialist or dispatcher. The second is for you to understand in a different way, a more visual way, that the initial call or code does not necessarily prepare the officer for what they will encounter. Any questions or comments so far? "Behavioral Health" (BH)is the term used to describe **emotions, behaviors and biology** relating to a person's mental well-being, their ability to function in everyday life and their concept of self. This includes these major categories: Mental illness, substance use disorder, intellectual/developmental disabilities, and cognitive impairments. These people are in need of assistance. This training is designed to help specialists and dispatchers IDENTIFY people in behavioral health crisis and decide how they might be best-served: - Diversion towards community resources? - With law enforcement?	**Answer questions as able** **Instructor Note:** Since training will combine 911 and Dispatch, it's important to discuss how 911 speaks with the caller, and can effectively divert low-acuity calls to community resources. They are often the first point of contact in the continuum of crisis response that presents an opportunity to prevent people in crisis from having to encounter law enforcement when what they need is help getting services. BPD's Dispatchers – upon receipt of a crisis call that requires law enforcement – have to assign that call to a CIT officer or to CRT. Both are being trained together because it's crucial to understand what each side is responsible for. **Time: 45 Minutes**
<u>C. The BPD's Behavioral Health Crisis Dispatch Policy</u> BPD DISPATCH INSTRUCTOR During this training, you will be introduced to the signs, symptoms, experiences, and historical context of individuals with behavioral health disabilities. As public safety employees, we are not expected to diagnose an individual; that is the role of a clinician. We are, however, expected to understand the larger system of behavioral health care in Baltimore City, and the role that public safety currently plays in that system. For	

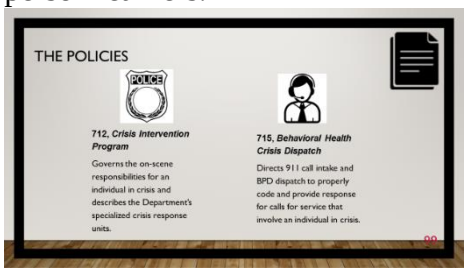
now, the police and fire departments still play an important role in city-wide crisis response. The city is working towards creating additional crisis response resources that can be utilized to appropriately respond to crisis events and connect individuals to the care they need with no involvement from law enforcement or the criminal justice system. Ideally, crisis response would not be a public safety function. For now, it is, and given the importance of our role currently, it is essential to your job as a public safety officer to be appropriately prepared to respond to individuals in crisis.

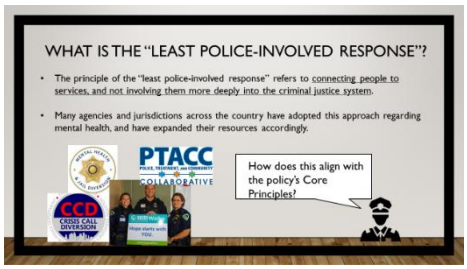
For the next forty-five minutes or so, we're going to explore the policy and procedures of the BPD as they govern your interactions with individuals experiencing behavioral health disabilities or are in crisis, and how they connect with some of the additional resources in the city. These policies have been newly revised to incorporate BPD's expectation that calls that do not require a police response will be diverted away from law enforcement, and that you – call taker specialists and dispatchers – are aware of how to identify and de-escalate behavioral health crises and connect people to the right resources.

Let's start by first identifying the policy that governs the call intake and dispatch protocols for behavioral health and crisis calls for service. To do that, we're going to utilize some resources at our fingertips. I know you're under strict instructions not to use your phones during training, but today we're going to need them.

Pull up the BPD website, click on Transparency, Draft Policies, and scroll down to 715, *Behavioral Health Crisis Dispatch*.



Take a few moments to read through the Core Principles and Directives sections of the draft policy. As you can see on this slide, this policy works in conjunction with the BPD's main crisis intervention policy, and offers guidance on distinct parts of the city's public safety agency response to individuals in crisis or experiencing behavioral health disabilities: • Policy 712 governs the on-scene responsibilities for an individual in crisis and describes the Department's specialized crisis response units. • Policy 715 directs 911 and BPD dispatch to properly code and provide response for calls for service that involve an individual in crisis. For this lesson, we're going to focus on Policy 715, *Behavioral Health Crisis Dispatch* as this policy provides guidance for properly assigning calls for service and explains the BPD's commitment to the least-police involved response necessary for persons with Behavioral Health Disabilities or in Crisis. First, let's discuss "why" this policy was created. Think back to the first part of today's training, where we discussed the historical context of mental health treatment in America? Specifically, do you remember what happened following "deinstitutionalization"? Routine encounters with law enforcement don't often lead to positive health outcomes for individuals experiencing behavioral health disabilities or in a state of crisis. This policy represents a change in how we'll operate moving forward. While we have a duty to provide emergency and public safety services when requested, often times we receive calls where such a response is not necessary. Can you think of a few calls you might	**Note:** Distribute paper copies to in-person learners.  **Desired Response:** Individuals with mental illness began to live outside of community care or wrap-around services, and thus, became subject to routine police encounters.

remember off the top of your head that you thought "this person needs someone/something that isn't police or fire"?	**Desired Response:** There should be a number of responses, not necessarily related to behavioral health, but use this to highlight how frequently 911 gets calls that are better-served elsewhere.
Thank you for sharing. Indeed, a lot of what you shared highlights the need for more public education on when to call 911, and when to call an additional resource. We do have the opportunity, though, to divert calls that aren't necessarily appropriate for a public safety response. This policy empowers us to do just that. Let's walk through how.	
Call and Response: First, I'd like a few volunteers who can share with me what they think the term "least police-involved response" means. [NOTE: what it *doesn't* mean is that officers are not allowed to intervene or officers must be standoffish. This point should be made immediately in case such a response is given.]	**Desired Responses:** keeping people away from the criminal justice system, finding people appropriate care, not arresting/criminalizing people with behavioral health needs.
Essentially, the "least police-involved response" is the principle that refers to connecting people to services, and not involving them more deeply into the criminal justice system. This concept reflects the reality that individuals in crisis or those with behavioral health disabilities often experience interactions with law enforcement – with or without observed criminal behavior – when they need supports and resources beyond the police or the emergency room. The least police-involved response is often the most effective response for everyone involved. Another reality we face is that Baltimore, like many jurisdictions, is still building its infrastructure to respond to and support these vulnerable populations, and more often than not, it is the police that end up responding to calls that could be more appropriately	

addressed with support services. While the city develops new resources, it's important that we train our specialists and dispatchers to be aware of the additional response resources that can be used.

Can I have a few volunteers share with me some mental health resources that you've either learned throughout the course of this training, or have come to be familiar with before.

BH INSTRUCTOR MAY CONTRIBUTE HERE
Let's examine some community-based services that currently have a relationship with the BPD, and can be used for diverting individuals to appropriate care.

BCRI – Operates a 24/7 Here2Help Hotline, a 24/7 Mobile Crisis Team (within available capacity), and offers residential treatment for substance use and behavioral health care counseling. BCRI works closely with BPD to provide officers with the opportunity to consult with a mental health counselor regarding behavioral health situations and additional community resources. **410-433-5175**

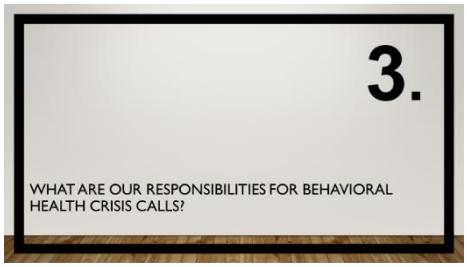
BCARS – youth community stabilization provider serving Baltimore City youth and families. BCARS offers urgent care appointments and 2-4 weeks of in-home/community/school stabilization services, depending on program eligibility, for youth and families. They also provide limited mobile crisis response services to the public school system and youth in foster care. BCARS services are accessed through the CIR line at: **410-433-5175**

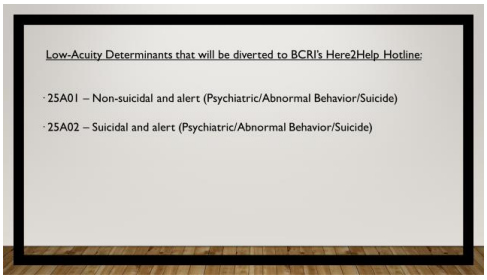
CRT – A specialized BPD unit that pairs certified officers with licensed mental health professionals that respond to crisis events. The CRT serves as backup support to members and to assist in peacefully resolving complex situations with the least restrictive techniques, interventions, and resources possible while maintaining the safety and wellbeing of the individual or family and others involved in the crisis. **Citywide Channel.**
Bear in mind, though, that this *is* a police response. So, CRT should be dispatched in instances of acute crisis

Listing Exercise: Write "Community Resources" on the top of a piece of chart paper, and affix it to the wall in front of the room. Ask the learners to share any community resources that they know of, or have learned about through the course of the BHA training. Ensure all of the resources on the slide 10 are listed, even if it means the facilitator offers them.

Continuously ask the learners if they had either heard of, supplied officers with these numbers, or have diverted individuals to this resource.

where there is a threat to public safety, and a specialized response is necessary. **Here2Help HotLine** – integrated (mental health and substance use disorder) behavioral health hotline that is available to the public 24 hours per day, 7 days per week, and 365 days per year. This hotline, 410-433-5175, is a part of the state's Maryland Crisis Hotline system and the National Lifeline Service. The Here2Help Hotline provides crisis counseling and suicide risk assessment, information on behavioral health services and other community resources, and linkage to services by scheduling appointments with behavioral health providers with the caller on the phone. The Here2Help call center can handle clients of all ages (over the phone). When individuals call for help, the call is triaged by a BCRI Hotline counselor. The Here2Help Hotline counselor can dispatch a Mobile Crisis Team to respond to people in crisis. As we will discuss, you will connect people to the Here2Help hotline when you determine that a call is related to a behavioral health crisis or disability, it is not a medical emergency, and police response is not necessary. If the call is not in need of crisis services, the caller will be transferred to a Specialist who can provide information about and referral to other behavioral health services. The Specialist will gather information about their needs, insurance and conduct a brief screening to determine the appropriate level of care. Their task is to provide information, screen and assess callers in order to more closely facilitate referrals and appointments with the appropriate mental health or substance use disorder services before the call is disconnected. A specialist will follow-up with programs within 24 hours of the appointment to determine if it was kept or not. **410-433-5175** This policy includes, on page six, directives for the city's coordinating CPIC body, which continuously evaluates Baltimore's crisis response system. We work with CPIC to make our system better and help implement a better system; one that envisions crisis response and services beyond our emergency services. While things are constantly changing, just remember the	Remind the learners of any CRT supervisors that may have participated in the BHA training. **Instructor Note:** BCRI's hotline operators are clinicians and they have their own triage process for dispatching a mobile crisis team. Non-emergency calls – on BCRI's end – may take longer for a crisis team to respond, but if emergency services are needed that cannot be provided by the mobile crisis team, BCRI can reconnect the call to 911. Remember: longer response time from a mobile crisis team is still preferred over law enforcement in most cases. Recall our commitment to the least police-involved response.

core principles of this policy and the BPD's mission and vision.	
If you still have Policy 715 in front of you, please turn to page four. You will see a list of Directives for 911 call intake and police emergency dispatch. Let's go through these together.	
1. When a call is received that appears to be related to a Behavioral Health Disability or Crisis **and is not a medical emergency**, the 911 call intake's responsibility is to collect as much information as possible to document behavior, assess needs, and prepare the appropriate response using emergency medical dispatch protocols (EMD).	
How do we know if a call is not a medical emergency?	**Desired Response:** No medical attention requested, no injury indicated, no immediate danger to self or others, and/or "information only".
Can I have a few volunteers who have the policy still open tell me what kind of information we are seeking from the caller?	**Desired Response:** Anything listed in sub-points 1.1. – 1.9. on p. 4, as well as anything else similar to those points which a caller may have experienced before. Allow for some anecdotes/conversation.
Can someone tell me *why* we're seeking this information?	**Desired Response:** To determine danger/risk. We need as much information as possible in a short timeframe to assess whether a police officer should be sent or not.
This information paints a totality of the circumstances for us to base our assessment of the appropriate resource in case this call can be diverted, or whether it should be forwarded to Police Emergency Dispatch.	
What does the policy direct us to do in the instance there's a call for service that is not a medical	**Desired Response:** Connect that

emergency, but involves an individual experiencing a behavioral health disability or crisis? And why do we suppose the policy directs us towards these responses? To recap: Where we have a call… …that doesn't indicate a medical emergency… …and, based on our follow-up questions, doesn't indicate imminent danger to self or others… …and we've identified a behavioral health need… We are diverting that call to the Here2Help HotLine where the caller can speak with a behavioral health professional 24/7, or receive the response of a mobile crisis team. On the 911 side specifically, Determinants 25A01 (non-suicidal and alert) and 25A02 (Suicidal, not threatening, and alert) are being reprogrammed to be transferred to the BCRI call line. You will receive a separate training on the 25 Card. While 25A01 and 02 don't represent *all* of the call-types included in those three criteria (non-emergency, no danger to self or others, and a behavioral health need), they are the first two call types that we're transferring to BCRI. The City and its behavioral health partners are using this initial pilot to determine how to expand to additional call types that should be diverted away from a law enforcement response. We expect those additional changes to occur in the coming year. Again, earlier we discussed the frequent encounters between law enforcement and individuals with behavioral health disabilities. Law enforcement has been asked to perform what essentially amounts to social services work; work for which they haven't necessarily been trained. And while our officers by and large do the best they can, they're still tasked with preserving public safety. By diverting calls where a public safety response is not required, we're both	individual to the Here2Help HotLine, who may then dispatch a Mobile Crisis Team during the hours of 0700-midnight. **Desired Response:** The core principles of the policy contemplate the least-police involved response to behavioral health and crisis calls for service where appropriate. 

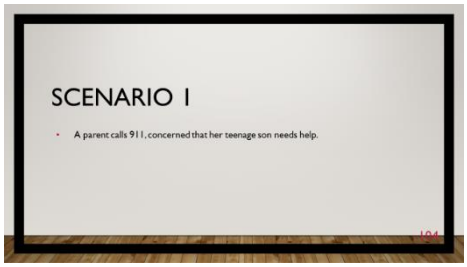
freeing up our officers to keep us safe, and connecting individuals to better care. Let's move to police emergency dispatch; instances where calls for service require a police response. Can someone refresh my memory on when a police response would be necessary for these calls?	**Desired Response**: When triggered by the protocol/threat to self or others, etc.
IF we do, however, determine that there are behavioral health/crisis elements to the call, and that a police/dual response is necessary, we have to assign that call a Priority "C." Can anyone tell me why that's important?	**Desired Response**: Depending on the totality of the call, the type may be assigned a number that isn't Behavioral Health or Suicide (85 or 28). By assigning a Priority "C" to the call, this alerts Dispatch that CIT should be assigned on the Police side.
2. When a call/incident involves an individual with a Behavioral Health Disability or who is in Crisis that requires a police response, the Police Emergency Dispatcher's job is to ensure that the call is appropriately coded and assigned to a CIT-trained officer. Can I have a volunteer scroll down to p. 5 of the policy and let me know what considerations should be made in properly assigning a call for service to a CIT officer? Later today, we will discuss the signs and symptoms of individuals who experience behavioral health disabilities, and the elements of a behavioral health crisis. This will be very important because, as dispatchers, you can monitor the air in your district, and proactively assign behavioral health resources to ongoing calls for service. As a real-world example: a call came out in the Northeast about a man discharging a firearm at passing vehicles. The call was assigned based on that preliminary information. As the officers responded and made contact with the suspect, it became clear that the individual was in a state of behavioral health crisis (not wearing any clothes, and describing a break from reality). The call, however, was closed as aggravated	**Desired Response**: Provide a minimum of 2 officers (one CIT, one back-up) for all 85 and 28 calls. CIT serves as primary. If a CIT officer is not available, assign two members to the call and determine if a CIT officer on a lower-priority call can be reassigned. Do not delay assignments to await a CIT officer. Dispatch via Citywide a CRT response when requested by an officer on-scene.

assault and the individual was taken to the emergency room for an emergency petition. We haven't gotten to the specifics yet, but let's discuss: based on what we've gone over already, could that dispatcher have assigned additional/specialized units to the incident given some of the information that was coming in over the air?	**Desired Response:** Yes, if informed by units on the scene that the suspect was experiencing a crisis, and that the units were seeking an EP, CRT could have been "raised up" to respond to the scene. This was an acute crisis where at least CIT officers should have been assigned. Based on the preliminary information, assigning the call Agg Assault was correct, however, as new information came out, behavioral health resources from BPD would have been appropriate to preserve public safety and see to the individual's behavioral health needs.
Here's another real-world scenario, this happened in Baltimore in 2018: *Mr. B calls 9-1-1 and explains that he just got off the phone with BCRI and they told him to call the police. He explains he needs a mobile crisis team because his son is very escalated and when he gets that way Mr. B becomes a target of aggression. He was told by BCRI to ask for a CIT officer to come out to help. He asked for a CIT officer, and that is not what he got. The officer did not de-escalate the situation, and there ended up being 9 different units responding and the son was taken to the hospital. The son is still traumatized and afraid of police.* I don't share this scenario to assign blame, or to provide negative reinforcement. On the contrary, there's a lot to learn here. Clearly we don't know all the facts and circumstances of this case, but what we do know is quite illustrative. Can someone tell me what could have happened differently?	**Facilitator's Note:** Remind learners that the former "BEST" designation is now CIT, and that callers may still request BEST officers, that request should be facilitated with a CIT officer. **Desired Responses:** The Dispatcher could have assigned a CIT officer, if

[After responses] Also, ultimately, the City of Baltimore's behavioral health system should and will have the capacity to respond to that crisis call, so that a police response is not needed. Thank you for your responses. Again, there's a lot we don't know, but I share this story with you to illustrate what we've learned today. The Communications Section of BPD is also responsible for maintaining an updated roster as provided of all CIT and CRT members who are logged-on and working each shift in each district, as well as maintain an updated list of Mobile Crisis Teams as provided or other service providers to which individuals may be diverted. I have distributed a list of the resources we mentioned in this section of the training. You are to keep this at your terminal and use it to divert individuals away from law enforcement when appropriate, as we discussed earlier. You may also pass along this information to units in your district who assess that an individual does not require police or emergency services, but community-based behavioral health support. So now we know the "what" "why" and "how" of this policy for assigning the proper response to calls for service with individuals in crisis or experiencing behavioral health disabilities. Let's try a few exercises. I'm going to read a brief scenario, and based on what you hear, I'd like you to share whether or not you think the call a) requires a law enforcement response, and b) if not, which community resource that we learned about would be the most appropriate. I note that 911 calls 25A01 and 02 are going to automatically divert to BCRI, and we not asking you to make real-time assessments on diversion, but this exercise is intended to get you thinking about the elements of calls that do require law enforcement response and those that could be diverted to more	available. The 911 specialist could have assigned the call as a behavioral health call, which would have tipped off the Dispatcher to assign the call to a CIT officer. **Note:** Distribute list of community resources to all.

appropriate resources. You will still need to make the judgements that result in a call being assigned 25A01 or 02. There will also be expansions of the pilot diversion project to include additional call types in the near future, so it's important to start thinking with a diversion mindset.

Read Scenario 1
A parent calls 911, concerned that her teenage son needs help, he hasn't left his room in a day and has not eaten or communicated his problems with her. He does not have access to any weapons or items with which he might harm himself, and the caller doesn't indicate a history of violence. How should the call intake employee assign the call?

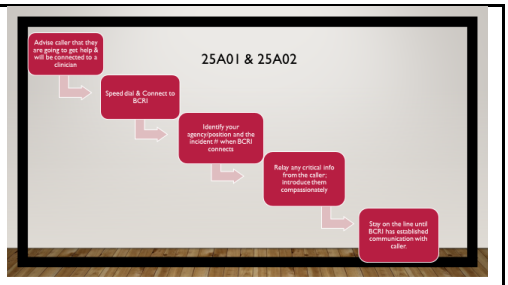
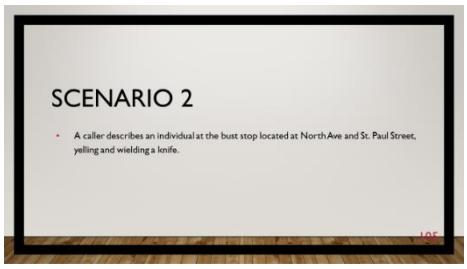
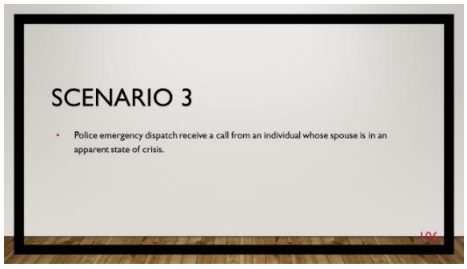


Desired Response: This call determinant is 25A01, which we are diverting to BCRI. Earlier, we learned about BCARS: a mobile crisis team that specializes in youth and adolescents. The caller did not indicate a threat to self or others, just that their child was undergoing a severe bout of depression and had self-isolated. A public safety response, particularly if the officer is not trained to handle this event, is almost certain to escalate the encounter. If BCARS is operating, this is the preferred response. BCARS may be contacted through the H2H line.

Here's the protocol specifically for diverting the call to BCRI:

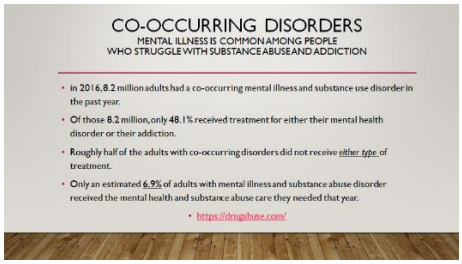
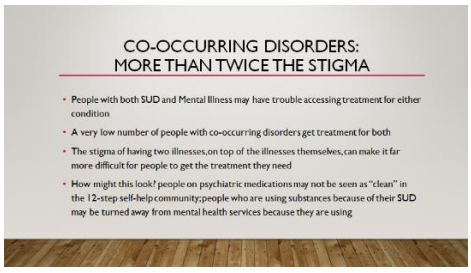
If the behavioral health-related call is determined to be coded 25A01 or 25A02, or requires the call to be transferred to the BCRI call center, the 911 specialist shall:

1. Advise the caller that we are going to get them help;
2. Advise the caller that that we are going to connect them to a clinician, and to stay on the line;
3. Speed Dial and Connect to BCRI;
4. Identify your agency, position number, and Incident Number to the receiving call center;

5. Relay any Critical information that the caller has provided (e.g., Name, Address, Phone Number, situation); 6. Introduce Caller compassionately; 7. Stay on the Line until the receiving call center has established communication with the caller and that the connection is stable. 8. Disconnect.	
Read Scenario 2 A caller describes an individual at the bus stop located at North Ave and Saint Paul, yelling and wielding a knife. Passers-by indicate that the individual is referring to auditory and visual hallucinations, and they feel threatened. How should the call intake employee assign the call?	 **Desired Response**: This call determinant would be 25D01W. This is an acute crisis event that should be coded as a behavioral health call, dual response. Meanwhile, Police Emergency Dispatch should assign the call to at least two CIT officers. If operating, CRT should be assigned as well.
Read Scenario 3 Police emergency dispatch receive a call from an individual whose spouse is in an apparent state of crisis. Upon arriving at the scene, the CIT officer sees that the acute symptoms that were described on the phone are no longer present, and the individual has calmed down considerably. At this point, Dispatch could...	 **Desired Response**: Dispatch could supply the CIT officer with the number for BCRI or the Here2Help Line so that the consumer can receive follow-up treatment.
Thank you for participating in these scenarios, hopefully they provided some extra context to the policy content that we covered. Are there any questions following this portion of today's training?	Answer questions as able.

BREAK	**Time: 10 minutes**
Stigma Exercise	**Time 20 minutes**
There are some Post-It notes in the middle of your table. There are three colors. Please grab some of each, and on the YELLOW Post-Its write the FIRST thing that comes to your mind when I say "mental illness." On the BLUE Post-Its write the FIRST thing that comes to your mind when I say "substance use disorder" (what we used to call addiction). These will not be associated with you, so you can be totally honest.	**Instructor's notes:** This is information used to bring awareness to the class about their own biases, as well as how powerful stigma can be. Instructor should draw a large "T" on the whiteboard, flip chart, or blackboard. On the top of the right column, write "mental illness", and on top of the left, "Substance Use Disorder."
I need one person at each table to collect all the Post-It notes and bring them up to me.	The Post-Its are collected and given to the instructor. The instructor (or designee) should separate the Post-Its to find duplicates, and write them on the board, and affix the Post-Its to the board under the "mental illness" and "SUD" columns. This is so the learners can get a visual both for what was said, and how much each term was said.
Now I'm going to ask you to write on the PINK post-its the very first thing that comes to your mind when I say "cancer." Same thing, don't think about it, just write what comes to mind. Again: These will not be associated with you, so you can be totally honest.	The instructor should then draw a vertical line to the right of the mental illness column, and extend the "T" so that a third column exists to the right. At the top, write "Cancer."
Okay, so let's take a look at all three of these columns.	Instructor/designee should write words in this column as they are heard.

From a medical perspective, all three of these are considered ILLNESSES. What do you notice as you compare the words under each column? So it seem that although all three of these are considered to be illnesses or diseases, we (as a society, this is not just you all) have a great deal more compassion for people with cancer than people with either mental illness or substance use disorder. Take a look at all of the words under "Cancer"- they could all apply to either mental illness or substance use disorder. And the words under SUD are even more negative and blaming than under Mental Illness Why is this?	**Instructor reads each of the columns, STARTING with Mental Illness:** **Expected response for Mental illness; terms like:** mental, psycho, depressed, suicide, dangerous, crazy, unpredictable **Expected response for SUD; terms like:** junkie, bad choices, alcoholic, crackhead, weed, behavior **Expected response for Cancer; terms like:** sick, frail, sad, unfortunate, victim, curable, frail. Remission, treatment, illness **Expected/desired response:** *the words under Cancer are much more compassionate *the words under mental illness are much more negative *the words under SUD are even more negative, and blame the person **Read all the words under CANCER** Point out how the words could also apply to MI or SUD. Point out how the words under SUD are the most negative, and generally blaming the person for their illness. **Desired/expected response: STIGMA**

Yes, exactly: There is STIGMA to having a mental illness or substance use disorder that there is NOT for having cancer. In what is stigma rooted? It is a deep bias that informs what kind of help we think people DESERVE. Here are some numbers for you: 1 in 4 people in the US will experience a mental health issue in their life. and 1 in 4 of THOSE people will ALSO have a substance use disorder. This is referred to as DUAL DIAGNOSIS or CO-OCCURRING DISORDER. We consider these statistics to be underreported because folks can have either of these, and never be diagnosed, and because only one or the other may ever be identified. These numbers from 2016 show us that of the 8.2 million people that were diagnosed with co-occurring disorders, only half of them received treatment for EITHER mental illness or substance use disorder, and the other half didn't get treatment for either one. And of those, only 6.9% received treatment for their co-occurring disorders. Having a dual diagnosis, or co-occurring disorder, means that a person is far less likely to get the treatment they need. And the stigma works in both directions. For example, many 12-step recovery groups don't view someone as "clean and sober" if they are on psychiatric medications. Also, many mental health treatment programs require people get "clean" before they can get treatment. So people with a co-occurring disorder may	• **Desired/expected response:** Fear Blame of the person for having the illness     Answer questions as able

have trouble accessing treatment for one or BOTH conditions Any thoughts, or questions? It's important to emphasize here that having a co-occurring disorder not only increases the stigma, it makes it that much more difficult to get treatment. We are going to keep referring back to how stigma impacts people with behavioral health disorders, especially when it comes to access to treatment, throughout the day.	
F. Trauma-Informed Practice **BEHAVIORAL HEALTH INSTRUCTOR** This is based on something we've been using in behavioral health for a while, which is called Trauma-Informed or Trauma-Sensitive practice. We call this the "universal precaution" for behavioral health.	**Time: 30 minutes**
What is "universal precaution" in the health care field? What does it mean?	things like wearing gloves, masks, preventing body fluids from mixing. (give response if it does not arise).
Why do we have these? Why don't we want body fluids to mix?	**Expected/desired response**: In case someone has a blood-borne illness, it won't get transmitted (give response if it does not arise).
Do we KNOW for sure if people have blood-borne illnesses?	**Desired response:** NO
Does it hurt the people that do NOT have blood-borne illnesses to use these precautions?	**Desired Response**: NO
That is what the TRAUMA-INFORMED model is like:	

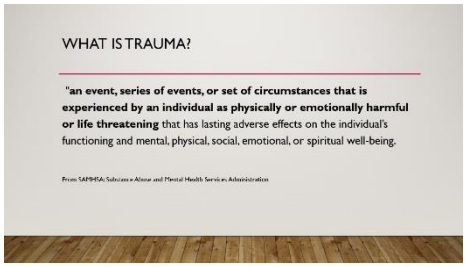
We treat everyone as if they MIGHT have a trauma history, and are affected by it. So if they do, we hope to avoid triggering the trauma, re-traumatizing, or adding more trauma. And if they DON'T, it doesn't hurt them. That's why we call it the *universal precaution* of Behavioral Health.

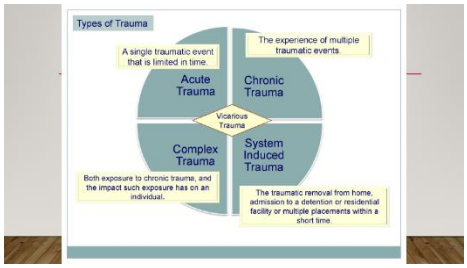
Trauma-Informed practices are based on a different basic premise than most of us are used to. The premise is that instead of wondering "what is wrong" with someone, we wonder "what has happened" to someone. That is, we look at people's behavior, especially people in crisis, through a lens of them possibly reacting to trauma rather than wanting to be in crisis on purpose, or by choice.

What IS trauma? How do we define it?

Desired response: an experience that is perceived by the person to threatened their life, health, or well-being, especially when it has lasting effects.

Yes, exactly.
A trauma is something that happens that the person perceives as being a threat to their life or well-being (or the life or well-being of a loved one).
The perception of the person, and the reaction they have to it, make it a trauma. Not the facts of the situation. What may be traumatic for one person may not be at all for another.





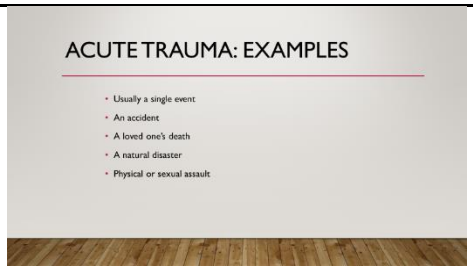
Let's talk about how we categorize trauma.
ACUTE TRAUMA refers to a single traumatic event.
CHRONIC TRAUMA describes an ongoing trauma, or multiple traumatic events.
COMPLEX TRAUMA is how we define exposure to chronic trauma, as well as the impact on the individual.
SYSTEM-INDUCED TRAUMA are traumas that are imposed by systemic factors.

Here are some examples of each of them:

An **acute trauma** could be:

An accident
A loved one's death
A natural disaster
A physical or sexual assault.

Can anyone else think of examples?

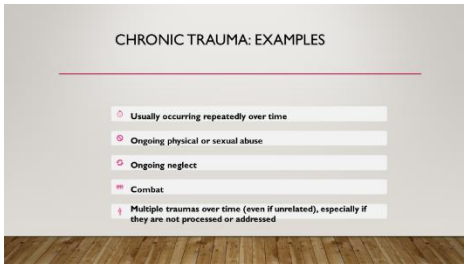


Expected/desired responses: any examples the participants can offer of acute trauma.

Examples of **chronic trauma** include:

Ongoing physical or sexual abuse
Ongoing neglect
Combat
Multiple traumas over time-especially if they are not processed (even if they are unrelated).

Can anyone else think of examples of chronic trauma?



Expected/desired responses: any examples the participants can offer of chronic trauma

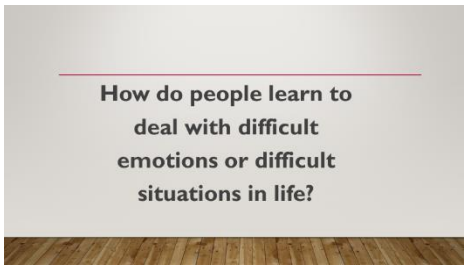
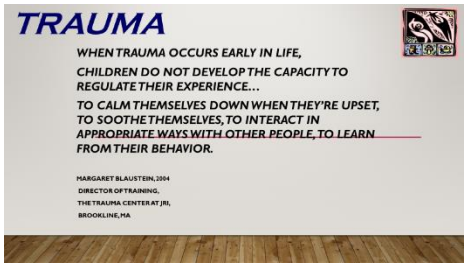
Complex trauma can include:
Uprooting, especially repeatedly

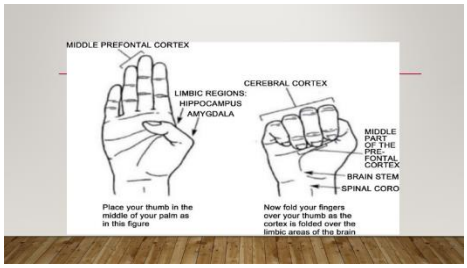
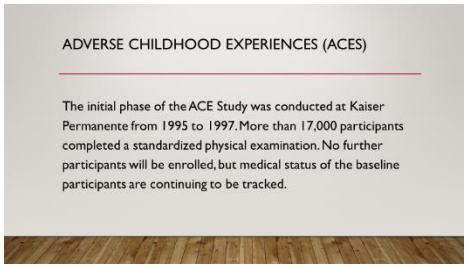
- Homelessness
- Human trafficking
- Being a refugee
- More than one type of ongoing abuse and/or neglect: for example, if a child is verbally abused by a parent or caretaker, and is also neglected by not being fed or clothed properly, or being forced to do manual labor rather than go to school.

Any other examples of complex trauma?

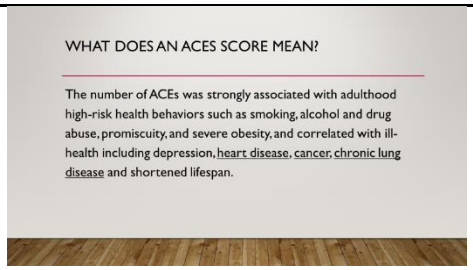
Desired responses: any examples the participants can offer of complex trauma

At the broadest level we have **system-induced trauma.** This can include:

Child removal from home to foster care • Multiple foster care placements • Sibling separation • Having to testify against family • Extreme poverty.	
Any questions about categories of trauma?	(answer questions as able)
Some experiences of trauma do not fall neatly into one of those categories, it just helps us to provide a general framework of the ways trauma can be experienced. It also shows us how many different experiences can cause or be related to trauma, and have long-lasting effects-which is what we are going to talk about next. In general, how does anyone learn to deal with difficulty in life?	 **Expected/Desired responses**: *from their family *from their teachers, church, etc *from their experiences
When there is trauma, especially early in life, people don't learn how to do what we call "regulate" their experience. That means calm themselves down, soothe themselves, and respond rationally to stressors. This may appear that they are being belligerent or non-cooperative on purpose.	
Is everyone familiar with fight, flight, or freeze? (if no one is, give this explanation) It's the response the brain has to perceived danger. It's the brain's way of getting the body ready to FIGHT or FLEE. What does the body do?	**Expected/Desired response**: Yes. Explanation of "fight, flight, or freeze."

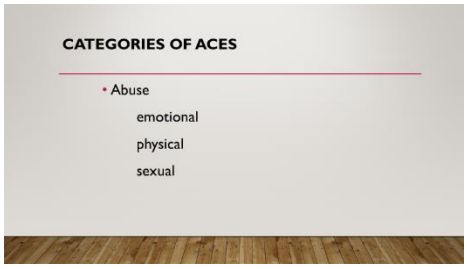
These body functions are activated by the very small part all the way inside the brain, the primitive part, called the amygdala.	**Expected/Desired response**: *increased heartrate and blood pressure *tunnel vision *auditory exclusion *tightened muscle tone.
Here is a model of the brain: The fingers folded over here is the rational thinking, decision-making part of the brain. It is what we use for solving problems. (open the fingers, wiggle the thumb) This is the amygdala, tucked under here, the SURVIVAL part of the brain. It's not activated until there is a PERCEPTION it is needed. It sets off the fight, flight, or freeze response we just talked about. Once the survival part of the brain is activated, it is running things. Rational thought and impulse control are not. When someone has a trauma history, and their trauma is triggered, the survival brain kicks in. There may or may not be an actual threat-but THE BRAIN DOES NOT KNOW THE DIFFERENCE. this is important to remember, because on a call you may encounter someone who is in fight-or-flight mode, and nothing external may be happening.	 **INSTRUCTOR'S NOTE**: Use your hand to make this model, fingers folded over thumb. Show the folded fingers as the pre-frontal cortex, and open the fingers to show the thumb, the amygdala.
Are there questions about that?	If there are students who have heard of this, ask them to share what they know about it. Answer questions as able
Has anyone ever heard of ACEs, in relation to trauma?	**Desired response**: yes **Anticipated response**: perhaps none
ACE stands for Adverse Childhood Experience. A study has been going on for the last 25 years (and they are still following the subjects) to keep track of the impact of ACEs on people through their lifespan.	

The higher number of ACEs a person has experienced has been associated with both high-risk health behaviors, such as smoking, alcohol and drug abuse, obesity-and also with health issues, including depression, heart disease, cancer, chronic lung disease, and earlier death.
The more ACEs someone reports from their childhood, the more likely they are to have one or more of these issues. It's not a guarantee, just a higher likelihood.

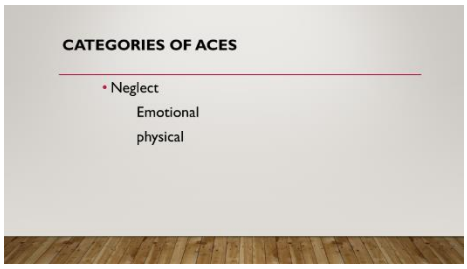


ACEs are divided into three different categories:

1. Abuse
   *emotional abuse
   *physical abuse
   *sexual abuse



2. Neglect
   *emotional neglect
   * physical neglect



3. Household Dysfunction
   *Violence
   *(untreated?) Mental Illness
   *Substance Abuse
   *Separation/Divorce
   *caregiver incarcerated

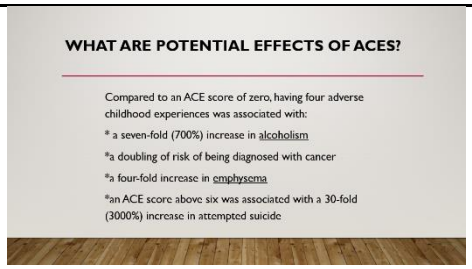
What do you think might be potential effects of people who experience ACEs?

Expected/Desired Answers:
*Lingering trauma
*substance use disorder
*medical problems

Take a look at these statistics:

They are from comparisons of those with no ACEs to those with having FOUR.
The people with four ACEs are seven times more likely to have alcoholism.

They are also twice as likely to be diagnosed with cancer.
They are four times more likely to be diagnosed with emphysema.
And for people with more than SIX ACEs have been found to have a 30-fold increase in attempted suicide.

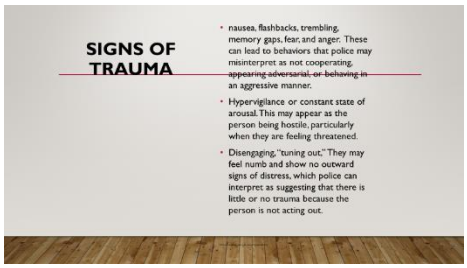


Why do you think having multiple ACEs puts people at risk later in life for mental illness, substance use disorder and health issues?

Expected/Desired responses:
*chronic stress on the system becomes toxic and leads to illness
*unchecked and untreated trauma can lead to physical, mental, and substance use illnesses
*victimization in early life makes continued victimization far more likely
*chronic stress and untreated trauma can make people more vulnerable to and less able to cope with stressors that many experience (i.e., loss, financial stress, interpersonal stress)

Yes, exactly-ACEs can set people up to have a much higher stress level, a much quicker fight-or-flight response, untreated trauma can leave people much less able to cope, it lowers their resiliency, and all of these things have a direct effect on health.

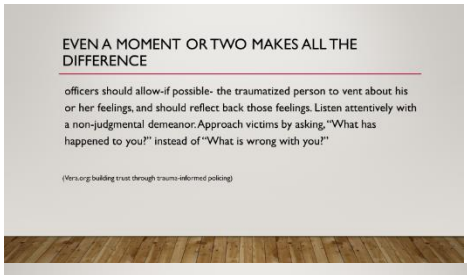
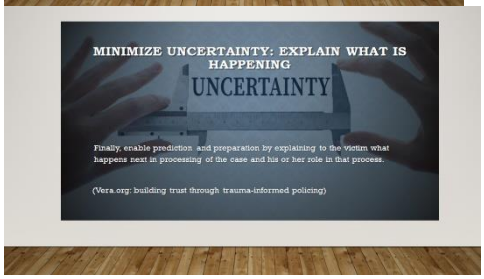
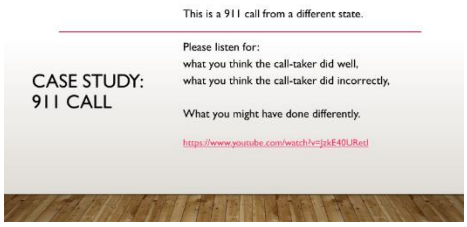
There are several signs that someone has experienced trauma, and may be re-experiencing it.
They can be shaking, have nausea, have gaps in their memory, or be fearful, or angry. Or any combination of the above.
This may very well appear that someone is being aggressive or not cooperating.
One feature that is very commonly associated with trauma is hypervigilance, or a constant state of waiting for danger (arousal of the nervous system).
This is the fight, flight, or freeze getting activated. So what does that mean, in the brain? Which part is running things?



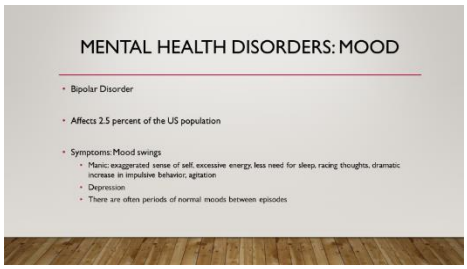
Desired response:
The survival part (amygdala)

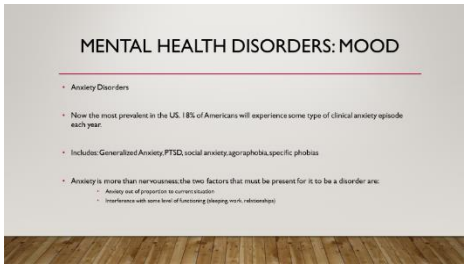
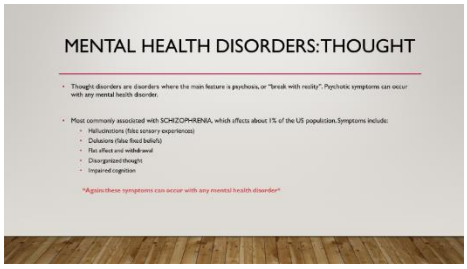
Yes-the survival part, the amygdala. That means that the person senses a threat, AND because that old trauma has been brought up, that they may likely not be able to calm down or think rationally. This can look or sound like the person acting aggressively, because they are in

fight, flight, or freeze. The third category of signs of trauma can be the most challenging, for first responders, and also for behavioral health professionals. It's **disengaging**. This is shutting down or tuning out, which is a way to protect against the brain from being overwhelmed. The person themselves will not be aware of it because they have disengaged and shut down. They will likely appear to be calm, showing no outward signs of distress. someone may interpret this to mean trauma is not present, but it may be. That is why it can present such a challenge to anyone trying to assess the situation or assist the person - it doesn't seem like anything is wrong. Any questions about how trauma effects the brain, and what the signs may be? When have you experienced this on calls-or in your own life, or someone that you know? This is important to keep in mind, because often the person calling is not the person in distress. But the caller themselves may also be in distress, having a trauma response. So how they describe to you why they are calling, and how you interpret that, can make a big difference. Listen carefully for indications of these signs of a trauma response. And be sure to communicate that to Dispatch. A bit later on we will go over some tools for de-escalation on the phone. Keep in mind as we talk about this that the person calling-whether they are the person in need of intervention or not—may likely benefit from a trauma-informed response from the 911 call taker. How do you think you can, as a call specialist or dispatcher, reduce the risk of triggering an existing trauma or contributing to a new traumatic experience if you are talking to someone who seems to be showing symptoms of trauma? Yes: ask what is happening, or what happened allow them to vent feelings	Answer questions as able Allow learners to share experiences of fight-or-flight, whether it's them, a caller, or a loved one. **Desired response**: *ask what is happening, allow them to vent feelings *reflect back what you hear *reflect back what you understand to

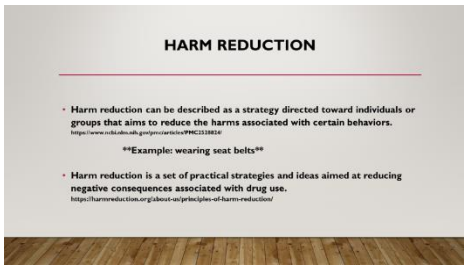
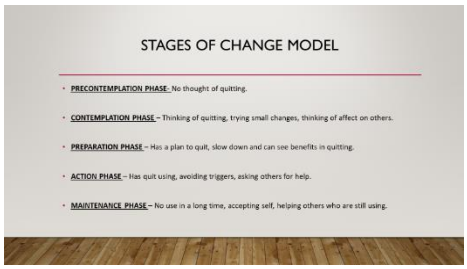
reflect back what you hear Reflect back what you understand, to make sure you do understand	make sure you do
A moment or two can make a big difference One of the most significant ways as Specialists/Dispatchers you can be trauma-sensitive is to enable prediction. This means to explain what is happening, or what they can expect next (ex: an officer or ambulance arriving). This is because when someone is affected by trauma, that means that they, by definition, had no control and may still feel as if they have no control. Giving them the information of what is going to happen will lower your chance of adding more trauma trigger, or even a new traumatic experience.	 
Any questions about trauma-informed responding?	Answer questions as able
G. Behavioral Health Overview Before we get started with the content, let's listen to a 911 call that involves a behavioral health emergency. **911 INSTRUCTOR** What is your response to this call? What do you think the call specialist did right/ What do you think she did wrong? What might you have done differently? What from what we just talked about-trauma-can you pull from this call? What did you hear that might indicate a trauma response? BEHAVIORAL HEALTH INSTRUCTOR	**time: 75 minutes** **Case Study:** https://www.youtube.com/watch?v=JzkE40URetI  Play case study These responses may vary. The desired response is a dialogue about learners' different responses to this case study

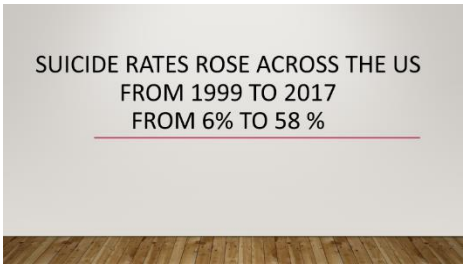
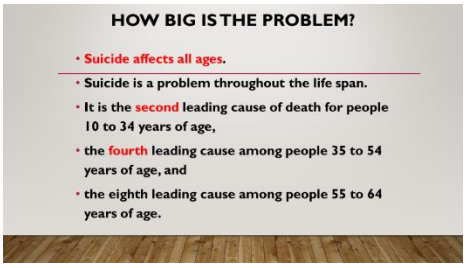
Behavioral Health Disorders are illnesses whose symptoms are most observable as behavior, and can affect mood, thinking, relationships, and ability to function in daily life. The four categories we are going to address in this training are: * mental illness (ex: depression) *substance use disorder (used to be called addiction) *developmental disabilities (ex: autism), and *cognitive impairments (like dementia)	
First we are going to talk about mental illness, and some of the most common diagnoses. **Depression** We'll start with depression. What's the difference between just having a down day/feeling blue, and having clinical depression?	 **Desired response**: clinical depression does not change when circumstances change, and can also be debilitating for long periods of time.
Here is a case study: a very short film made by someone to depict how he feels when his depression is at its worst. The signs and symptoms we typically associate with depression are sadness, tearfulness, big changes in sleep and appetite, and social isolation. Lesser-known symptoms include: *difficulty with memory and concentration *loss of interest in things usually pleasurable *separation from emotions, or "numbing out" *anger and agitation (more common in males) *suicidal thoughts, that abate when the depression responds to treatment Any questions about depression? Does anyone have anything they'd like to share?	 Answer questions as able.

	Also allow for discussion.
Mood disorders: Bipolar disorder **Now we are going to talk about biploar disorder.** Here is a case study to watch from the show Homeland on Showtime. The main character, Carrie, is a law enforcement officer (CIA). While you watch this, note the captions at the top, which point you to her symptoms.	**Case Study:** 
What symptoms did you notice in the manic part of the scene? How about the part that showed depression?	**Desired response**: agitation, talking too fast, thoughts racing, agitation Desired Response: hopelessness, self-injury Answer questions as able
Here is another case study, also of Bipolar Disorder, from the movie Silver Linings Playbook. Keep an eye out for what you would consider signs of bipolar disorder in Bradley Cooper's character:	 
what symptoms did you see? Did you see anything else besides manic symptoms?	**Case Study:** https://www.youtube.com/watch?v=2ceG37UZvzQ **Desired response**: exaggerated mood, agitation, sleeplessness, excess energy, racing thoughts

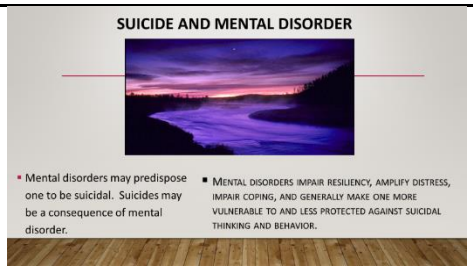
Keep in mind that people with bipolar disorder can have mania and depression close together, cycle between them, or have long periods of time between those phases, and also long periods of stability.	**Desired response**: mood instability (going from yelling to crying), flashbacks (trauma)
Any questions about Bipolar Disorder?	Answer questions as able
Anxiety disorders Recently passed depression as the most commonly diagnosed mental health disorder. This includes the whole spectrum, from simple phobias (anxiety about one particular thing) to generalized anxiety disorder (anxiety about everything). It also includes: agoraphobia (fear of open spaces), PTSD, and social anxiety disorder - which often looks like people being rude, or just weird.	
Anxiety responses are often fight, flight, or freeze responses. Remember what we talked about earlier regarding trauma? The thinking brain is not running things. The fight, flight, or freeze is.	
Any questions about anxiety or anxiety disorders?	Answer questions as able
Let's talk a little about **thought disorders, also called psychosis.** This means a break with reality, whether it's thoughts being disorganized, hallucinating, or having delusions. And psychotic symptoms can occur with ANY disorder. The most commonly known disorder that we associate this with is schizophrenia, which is actually relatively rare; it occurs in about 1% of the US population. If someone is not diagnosed with Schizophrenia, they may still experience psychotic symptoms.	
Here is a case study example of someone with a thought disorder. It is from the film "The Soloist." This is based on a real person, who was a world-class musician at Julliard when he had his first psychotic break. And this	

film portrays him many years later, living homeless in LA. A newspaper reporter (played by Robert Downey Jr) tries to help him, and he thinks it will help to get him a concert playing at the symphony hall. As you watch this, watch for his symptoms of psychosis-as well as anything else we've covered so far. What did you notice? Any comments or questions about thought disorders or symptoms? An important thing to remember with mental illness is that often there is more than one present. And that trauma can be present with any mental illness-sometimes as a result of the treatment or life disruption the illness brings. **Substance Use Disorder** is what we used to call Addiction-I'm sure you guys know all about this. Remember our exercise with the Post-It notes earlier today? Do you recall the statistics on individuals who do not receive treatment for their disorder? The important thing for this training is this: From a medical perspective, SUD is an illness in which a person has a brain disorder that manifests as compulsive behavior. People who have this illness experience tolerance to the substance, possible withdrawal when use it is stopped, and continued use despite negative consequences. Therefore, BPD expects that you treat people with SUD the same way we would treat anyone else who has an illness, and the same way we've discussed that the policies require we handle calls related to any other behavioral health disability. What this means is that in the behavioral health field –	 **Case Study**: https://www.youtube.com/watch?v=R2n0ZDq1N2c **Desired response**: he was hearing voices, having flashbacks, thinking his sister would poison him, his pills on the floor (so perhaps not taking meds), sensitive to being touched Answer questions as able 

and in your roles – we should all be using a Harm Reduction framework-is anyone familiar with this? What does it mean?	**Desired response**: a strategy that reduces possible risks associated with a behavior
	
Harm reduction is a strategy that reduces possible risks associated with a behavior - in this case, substance use. Can anyone give me an example of this?	**Desired response**: needle exchange, use of Naloxone to revive people from overdoses, diversion to treatment rather than jail.
Within the Harm Reduction model, we use a Stages of Change Model that offers a perspective on how we make long-term, difficult changes. Is anyone familiar with Stages of Change?	**Expected response** is no, but if folks are, ask them to explain it
Here are the stages: Precontemplation Contemplation Preparation Action Maintenance	
How do understanding these stages help you as a specialist or dispatcher?	**Desired response**: to have a better understanding of SUD, and how people go through stages of recovery and cannot “just stop.” Think back to the stigma exercise we worked on together earlier.

Any questions about substance use disorder? Information related to substance use disorder should be considered as part of identifying the behavioral health/crisis elements of a call. If public safety is in danger, we will assign calls including SUD elements to a CIT officer. If we determine law enforcement not to be necessary, or an officer on-scene arrives at that determination, then we should use the same behavioral health resources we discussed earlier. BCRI, for instance, offers substance use treatment in-house, with connections for further community-based treatment. Much like our conversation at the beginning of this training, we're not looking to criminalize addiction, and have the opportunity to connect individuals to more sustainable care. Let's talk about **suicide**, which is not associated with any one behavioral health condition but is a very real issue that is having a major impact on our community. No doubt you have a lot of training and experience in suicidal crises. So we'll just go over some important basics. To get an idea of the extent of this impact, let's briefly look at some of the statistics. From 1999 to 2016, the rise in suicide rates varied by state, anywhere from 6% to 58%. They all increased. Suicide is a significant public health issue, and likely underreported. *10th leading cause of death in the United States *in 2016, there was approximately one death from suicide every 12 minutes *It affects people of all ages. It is the second-leading cause of death for people 10-34 years old (yes, that age range starts at TEN years old) *fourth-leading cause of death for people 35-54yo *many more, an estimated 14 million people, thought about or attempted suicide in 2016-again, likely very underreported. Let's talk about the relationship between mental illness and suicide. Mental disorders may predispose one to be	answer questions as able.  

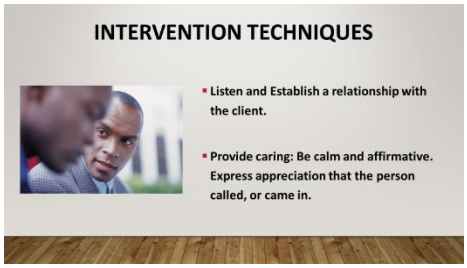
suicidal. Suicides may be a consequence of mental disorder.



Substance use also raises the risk of suicide, especially in adolescents, as reflected in the data included on this slide.

Facilitator Note: Mention the statistics referenced on this slide:

How do we assess the immediate risk of suicide? The most immediate risk factors to consider are: specificity of the plan, availability of means, prior attempts, family/friends completion, substance use



Intervention techniques include: Listen and establish a relationship with the caller. Be caring and affirmative.

Other tips: Reflect, validate and acknowledge feelings

Assess lethality

Focus on one issue, precipitating event and here and now. Help regain control.

It is vital in suicide prevention to recognize that everyone in a suicidal crisis has some level of ambivalence. This means that they have mixed feelings about dying by suicide. They may just want to end their pain and suffering, but not leave their families. They may see no way out, but feel sadness and guilt about what they may leave behind, such as loved ones or an important work role. They may not truly want to die, but just want the pain to end. This is a point of opportunity for intervention.

There are also some responses that have been found not to be helpful when intervening with someone who is having suicidal thoughts.

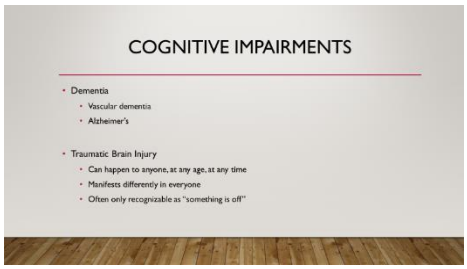
Refer to “Dont’s” mentioned on slide.

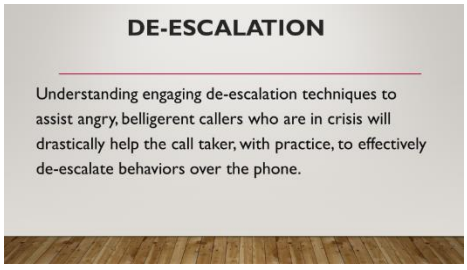
Intellectual and Developmental Disabilities (IDD) are behavioral health disorders that are NOT mental illness. These occur during brain development, before the age of 22. The most common we see is Autism Spectrum Disorder. Others include Down’s Syndrome, Cerebral Palsy, and Intellectual Disability. These latter three can be detectable on sight, whereas ASD may not be obvious, even after interacting with the person.
The biggest obstacle as first responders to folks in crisis with ASD is that it may not be immediately apparent and the behavior can look exactly like non-cooperation. With disorders like Down’s Syndrome, it is immediately apparent and so the initial response is often very different - more assistance is needed than law enforcement.

In all cases, there is STIGMA attached to I/DD, and people who do not have experience with it are often at a loss for what to do, or feel uncomfortable dealing with it.

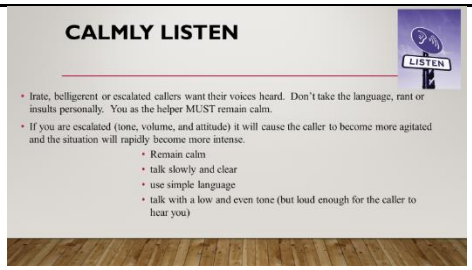
Tips:
ask the person if they have a disability. In most cases, they will be able to tell you.
Assume they have normal intelligence unless you see otherwise, and ask them questions just as you would anyone else.
**they will likely need more time to process and answer your questions. Take your time.

Any questions about IDD?

Cognitive impairments are conditions that interfere with thinking, such as memory and problem-solving. They are brain disorders like dementia, and brain injury. The challenges here are obvious, and I'm betting you have all dealt with many situations like this. Does anyone have an example of trying to manage a call, either on 911 or Dispatch, where the person in need was cognitively impaired? This is a situation that also requires patience, and to slow down. If someone seems confused, do not correct them (the date, etc). This may pose a challenge getting information about the call to make a decision-if you are not able to obtain that information, ask if there is anyone else there you can talk to, or contact. When in doubt, dispatch-AND INFORM DISPATCH OF THE CONFUSION. These are situations that can go south easily, because of the confusion. You want to give as much information as possible to dispatch, to get to the responding officer, so they know what to expect. Are there questions, or does anyone have a case to share that relates to cognitive deficits? Any comments or questions about the Behavioral Health issues we just went over? Or about anything thus far? **BEHAVIORAL HEALTH-NAMI** I. Peer & Family Perspectives Panel Today, you will hear from individuals with mental health conditions and family members about their experiences with 911/Dispatch. Their experiences are a real-world reminder of the impact your work has in the community. They will briefly share their stories and allow time for you to ask them questions.	Answer questions as able  Answer questions as able Allow learners to share experiences, focusing on intervention. **Questions/allow for sharing.** **Answer questions about any of the material thus far in the day.** **Time: 30 minutes** The NAMI Peer & Family Perspectives Panel is a 30 minute workshop that helps first responders, crisis workers, and mental health professionals work more effectively with individuals experiencing a

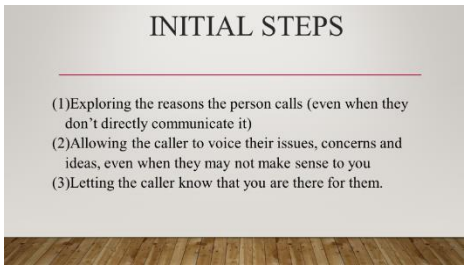
We encourage you to ask questions and engage with these volunteers, who are giving their time to interact with you today.	behavioral health crisis and their family members. Three volunteers, with a combination of personal and family experience with mental health will share their stories for 5-7 minutes each. Questions are encouraged throughout the panel and at the end of the workshop. As a result of this workshop, dispatchers and specialists will understand the impact of mental health on individuals, families, and communities. Trainees will also assess how they can improve their interactions with individuals and families experiencing behavioral health crises.
911 INSTRUCTOR J. Engaging and De-escalating Over the Phone It's necessary to talk, when we are talking about behavioral health crisis, about engagement and de-escalation. It's likely, especially for those of you who have been doing this work for a long while, that you not only have had this in training already, these skills are integrated into your job. We are going to go over some basics, and have an interactive discussion, about practical situations and skills for engaging folks and keeping the intensity level as low as possible. For those of you who are experienced, please share your experience of what works, and what has not worked for you. **Calmly listen** Many irate, belligerent or escalated callers want their voices heard. Don't take the language, rant or insults	  Allow for members to share experiences.

personally. You as the helper MUST remain calm.
If you are escalated (tone, volume, and attitude) it will cause the caller to become more agitated and the situation will rapidly become more intense.
When the opportunity presents, be sure to introduce yourself and ask the caller who they are. This is important because you want to call the caller by their name (whatever they give you).
Remain calm, talk slowly and clear, use simple language, talk with a low and even tone (but loud enough for the caller to hear you), and DON'T over talk or yell to get your point across.



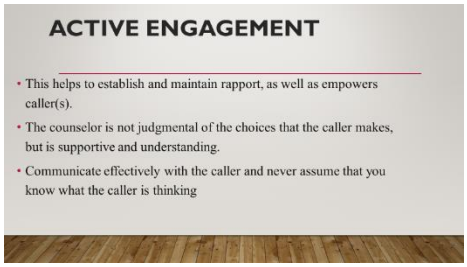
Recognize that every person in crisis over the phone sounds and reacts differently.
Different tones
Different levels of frustration
Different Language

(1) Exploring the reasons the person calls (even when they don't directly communicate it)
(2) Allowing the caller to voice their issues, concerns and ideas, even when they may not make sense to you
(3) Letting the caller know that you "are there for them" and willing to provide them with a reasonable, timely recommendation and/or refer them to the most appropriate type of services for their situation. While doing this enabling them to accept help from a counselor.



When a caller is escalated the specialist will provide:
Active Engagement: Involves the client/caller working along with you to find answer. This is a working collaborative effort.

- This helps to establish and maintain rapport, as well as empowers client/callers.
- The counselor is not judgmental of the choices that the client/caller makes, but is supportive and understanding.
- Communicate effectively with the caller and never assume that you know what the caller is



thinking until you have checked out the assumption in plain language; don't assume or predict how they will react or that they will accept or reject.

It's so important to give a person going through crisis a safe space to express themselves and let them know they're being heard.

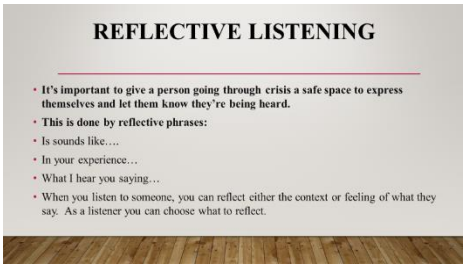
Allow the client/caller to explain their thoughts, feelings, and current behavior. SILENCE is ok. Listen to the caller, interject when the caller is at their calmest, if you MUST interject while the caller is escalated don't yell, say things like, "Can I ask you a question?" or "Can you tell me about . . .?"
It's important to let the client caller know that you are actively listening.

I recognize that, for the 911 Specialist members, your call volume requires you to keep calls brief and assign an emergency response as quickly as possible. And in so doing, you're going off of a decision tree based on an individual's response to certain questions.

When we talk about de-escalation on the phone with a caller potentially in crisis, we still need to have the tools to de-escalate the caller, and ensure they receive the proper attention. I'm sure those on the 911 intake side have some stories they could share about having to stay on the line with a caller, and how they were able to de-escalate or calm someone down. Perhaps the call wasn't forwarded to police emergency dispatch, even. Maybe you called an additional service.

Does anyone want to share a story of de-escalating over the phone?

This is done by reflective phrases:
Is sounds like….
In your experience…
From your point of view…
What I hear you saying…
When you listen to someone, you can reflect either the

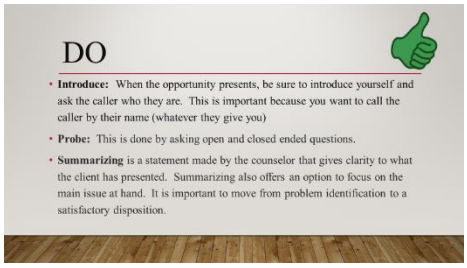


Facilitator Note: Allow members to share stories of perhaps repeat callers, individuals in crisis, or any other time where the call specialist member received a call that was outside of the decision tree and required a longer conversation in order to assign the proper care.

context or feeling of what they say. As a listener you can choose what to reflect.
Try to positively redirect the caller's thought process. The longer you can keep the caller engaged the more rapport you will build.

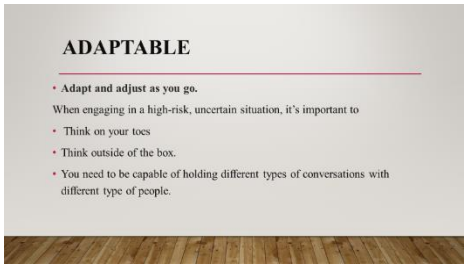
Probe: This is done by asking open- and close-ended questions.

Summarizing is a statement made by the counselor that gives clarity to what the client has presented. Summarizing also offers an option to focus on the main issue at hand. It is important to move from problem identification to a satisfactory disposition.

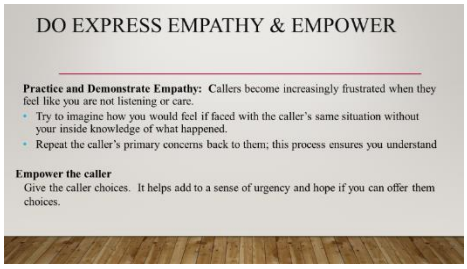


Adapt and adjust as you go.

When engaging in a high-risk, uncertain situation, it's important to think on your toes and outside of the box. You need to be able to hold a conversation about different topics with different people.



Empower the caller
Give the caller choices. It helps add to a sense of urgency and hope if you can offer them choices.



Never say, "I understand what you're going through."
Instead say, "I see you're going through a rough time." Every caller has their own story and way of coping and processing. People feel heard and recognized if you simply acknowledge their words and feelings.

Practice and Demonstrate Empathy: Callers become increasingly frustrated when they feel like you aren't listening or don't care. Try to imagine how you would feel if faced with the caller's same situation without your inside knowledge of what happened. Even if they

don't make sense or appear to have delusional thinking you can still empathize with the concern. Repeat the caller's primary concerns back to them; this process ensures you understand

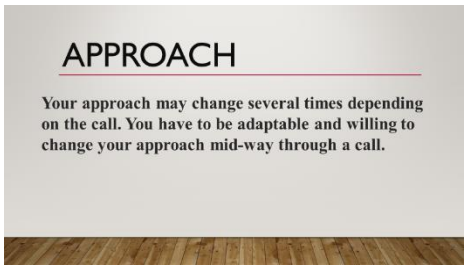
Your approach may change several times depending on the call. You have to be adaptable.

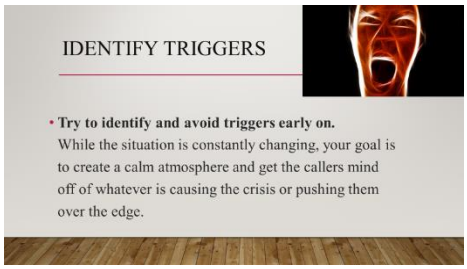
Try to identify and avoid triggers early on.
While the situation is constantly changing, your goal is to create a calm atmosphere and get the caller's mind off of whatever is causing the crisis or pushing them over the edge. Try to find out what that trigger is and direct the conversation to something else more positive or distracting.

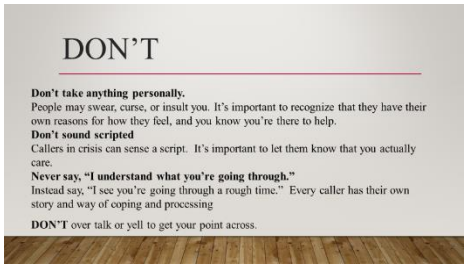
Don't take anything personally.
People may swear, curse, or insult you. It's important to recognize that they have their own reasons for how they feel, and you know you're there to help.

Don't sound scripted
Callers in crisis can sense a script. It's important to let them know that you actually care.

I know a lot of this involves skills you've been trained on before, and have mastered. Are there comments or questions on how they relate specifically to behavioral health/crisis calls?







Answer questions and allow discussion as appropriate.

911/WHOLE TRAINING TEAM **Okay-now we are going to take all of the things we've discussed and practice applying them. We have three scenarios today.** **SCENARIO #1** These are meant to spur discussion. We need six volunteers for this first one. (Once scenario is completed) So, let's talk about this. First, the role players. What was your experience? What felt challenging, and what was easier to navigate? What do you think you did well? What do you think you should have done differently? And now, the observers. Same questions. **SCENARIO #2** Let's take a break in the material to do a role-play scenario. We need FOUR volunteers for this first one. So, let's talk about this. First, the role players. What was your experience? What felt challenging, and what was easier to navigate? What do you think you did well? What do you think you should have done differently? And now, the observers. Same questions. **SCENARIO #3** We need FOUR volunteers for this first one.	 Read scenario #1 from Appendix Assign roles and have them role play this scenario. *****Feedback should be given by both the subject matter expert and 911 supervisor instructors, since each has a unique perspective on what needs to occur.** **attention should be paid to the calltaker process and protocol, but also to de-escalation***** Read scenario #2 from Appendix Assign roles and have them role play this scenario. Read scenario #3 from Appendix Assign roles and have them role play this scenario.

So, let's talk about this.
First, the role players. What was your experience?
What felt challenging, and what was easier to navigate?
What do you think you did well?
What do you think you should have done differently?

And now, the observers. Same questions.

BEHAVIORAL HEALTH INSTRUCTOR

Self-Care for 911 Specialists and Dispatchers

Time: 45 minutes

Last-but certainly not least how YOU are impacted by the work that you do?

Being a first responder is stressful.
There is a continuum of how job stress affects us:
Burnout
Secondary trauma:
Compassion fatigue:
Vicarious Trauma: we are going to talk more in-depth about that shortly.

There is a continuum of how we are affected by workplace stress. This includes trauma, even if secondary exposure.

Burnout: the most common across job duties, the broadest defined, and the easiest to remedy.
Ongoing dissatisfaction with one's job, a feeling of not having control of what is stressful, and feeling overwhelmed. Over time, this takes a toll.

Secondary trauma stress: this is just like a trauma response that is transient. Hearing about or witnessing someone else's trauma, or receiving the raw emotions of someone in trauma, can create a secondary trauma response.

Compassion fatigue:
This is when the cumulative effect of holding the trauma of others, whether by witnessing, call taking, or hearing details creates a decrease in your capacity to feel compassion. It begins to affect everything in your life, not just work. It's a protective mechanism, because to feel more compassion would deplete you.

Vicarious trauma at the other end of this continuum from burnout.
The signs and symptoms are similar to those who've experienced trauma: sleep and appetite disturbance, unable to "leave work" at work, withdrawal, and exaggerated mood changes or expression of feelings are a few of them.
Unlike burnout, vicarious trauma is not resolved by a change in shift, or partner, or job. It is a residue that will remain until treated.

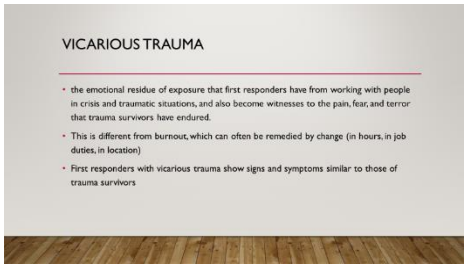
Can vicarious trauma (or any of the others, for that matter) be prevented?
We believe they can.
First, by accepting that you WILL be exposed to trauma. It is part of the job.
Second, by keeping an eye out for early signs that it's getting to you.

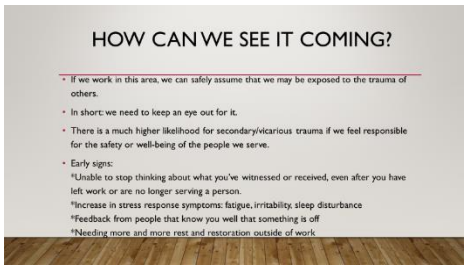
Third-and I realize this is a buzz-phrase that is often overused: SELF CARE.

What does self-care mean to you?
Just yell it out.

Self-care is very individual. We all use it to try to get to a certain mind, body, or emotional state-but what gets us there is different for everyone, and it can be different for the same person in different circumstances.

Most importantly:
It's what you need to re-charge, to replenish your





Facilitator Note:

Write down on a white board/flip chart what people say.
Go through the list and acknowledge and validate the methods (as long as they are not harmful).

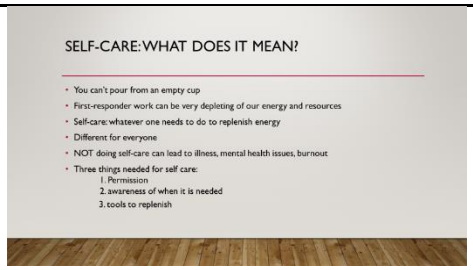
energy. Think about your energy like a car's gas tank - when it's empty, the car cannot run. When you are out of energy, you can't "run." Or it begins to take a toll on you, which can lead to illness.

We need three things for self-care to work:
1. Awareness - of when we need it
2. Permission - to allow ourselves to have it
3. Tools - what it is that actually refuels us.

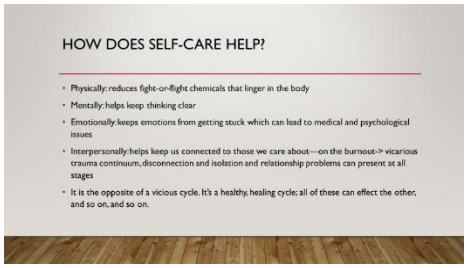
Examples of self-care:
Exercise.
Mindfulness (yoga, meditation, martial arts)
Hobbies
Time with loved ones
Spiritual practices (religious or not).

What are some of yours?

How does self-care actually help, besides feeling good?
-Slows down the fight, flight, or freeze response and the chemicals it releases from the brain into the body
-This helps keep thinking clearly
-It also keeps emotions from getting stuck, which can lead to mental and/or physical illness
-Interpersonally: it helps us stay connected to those we care about



As the learners call them out, also write these on the white board or flip chart.
This is a great opportunity for people to share ideas and talk about what self-care means to them.



ALL INSTRUCTORS Evaluation/Closure	**Time: 25 minutes**  Answer questions as able, ensure there are no lingering questions related to the new requirements, leave your contact information for any follow ups.

APPENDIX A: Scenarios

(partly adapted from the Cleveland PD 911 call specialist Training)

Scenario 1:

Instructor notes:
This will be a class of between 6 and 12. Ask for volunteers to be role players. It is up to the facilitators to determine if they want to have 911 specialists and dispatchers play their usual roles or mix those up so that learners can have a scenario experience in a different role. The remaining learners will observe and participate in the feedback and debrief after the scenario.

Role player needs:
Role Player One: (multiple) caller(s) [to be played by facilitator]
Role Player Two/Three/Four: 911 specialists
Role Player Five: BPD Dispatcher
Role Player Six: BPD officer

The facilitator will read the scenario to the group:
Multiple calls come into the 911 call center about an incident:
1. A person who does not know the subject in crisis calls, stating they are standing on the sidewalk, and watching someone walking in a haphazard way on MLK Blvd. The caller has tried yelling to the person, but the person does not respond. They state the person is occasionally yelling out things the caller is not able to understand. The caller states they do not feel safe wandering into traffic to try to help this person.
2. A person who does not know the subject in crisis calls and reaches a different 911 call taker, stating they just drove by someone walking zig-zag on MLK Blvd (same intersection as last call), and the caller had to swerve not to hit the person. Caller states that the person seemed not to know what was happening around them, and did not respond to the caller's yelling or laying on the horn.
3. A woman calls and reaches a third 911 officer, stating that her brother, who is staying with her, got out of her apartment. She cannot leave as she has several small children at home, but she can see out the window and thinks that her brother is wandering through traffic on MLK Blvd. She is very emotional as she is afraid she is going to see her brother get hit by a car, and she feels helpless to do anything. She is not offering more information, just yelling over and over "He's going to die! I can't get out there! Send help!"

Have the role players act out the scenario as they would in a real-life situation:

- 911 call specialists should answer the call, the caller should use the scenario to inform what they say.

- The 911 call taker has to then decide how to proceed. This call would be on the 25 card, **however** it will not be diverted to BCRI because it is a 25D01. The determinant 25D01 is due to the non-responsiveness of the individual in the street. This situation is an active emergency where a non-responsive person, the subject of multiple calls, is in danger of serious physical injury or death by walking through 6 lanes of traffic on a busy boulevard. 25D01 is a **dual-dispatch**, police and fire, and the goal is that the first unit to arrive will move the individual out of the street.
- The dispatcher then decides which officer to send, and the officer goes to the scene and begins to interact with the caller. This call will come to BPD dispatch as a Type 85, and as such, should be assigned to an available CIT officer.
- The dispatcher must make a decision each time a new call comes in about this same individual
- The officer can communicate back and forth with the dispatcher as needed. (see below)
- 911 specialists (role player 2,3,4) should attempt to get pertinent information from the caller, while also using techniques of de-escalation and rapport-building, and articulate how the call will be coded.
- Dispatcher should then send a CIT-trained officer, or possibly the Crisis Response Team, and give them all of the information given to them by the 911 caller.
- If an officer (6) does go out to the scene, they will need to use their skills of rapport-building and de-escalation to see how they might best resolve the situation.

<u>Points of feedback and evaluation:</u>
-how each of the 911 specialists handles the initial call they received
not agreeing with/disagreeing with what the caller is reporting, using de-escalation techniques with the caller: reflecting back, emotional labeling, offering reassurance
-how the 911 specialist codes the call
if sent to dispatch, what is communicated about the call
- how the dispatcher decides which officer to dispatch, particularly as more than one call comes in about the same incident, and what they communicate to the officer
- how the officer and dispatcher communicate during the call for service

<u>Scenario 2</u>:

Instructor notes:
This will be a class of between 6 and 12. Ask for volunteers to be role players. It is up to the instructor if they want to have 911 specialists play same, and dispatchers play same, or mix those up so that learners can have a scenario experience in a different role. The remaining learners will observe and participate in the feedback and processing after the scenario.

Role player needs:
Role Player One: caller [to be played by facilitator]
Role Player Two: 911 specialist
Role Player Three: H2H hotline operator
Role Player Four: **depending on the role player's response**]

Read the scenario to the group.

An older male calls 911 to complain about a voice in his head that sounds, as he states, a lot like his deceased aunt. He is upset because he wants the voice to stop, he can barely perform daily tasks, and his aunt is a triggering figure for him. The more he tells the 911 specialist about the voice, the more agitated he becomes. The caller indicates that he has not been able to refill his medication because he is worried about the new strains of the novel coronavirus, which he reads about every day. He is alert and responsive to the 911 specialist, who is able to de-escalate the caller except when the subject of his aunt's voice comes up.

Have the role players act out the scenario as they would in a real-life situation:
911 call specialist should answer the call, the caller should use the scenario to inform what they say. The 911 caller has to then decide how to proceed. The call determinant here is a 25A01: the caller is hearing voices, but he is alert, does not have any weapons, and is not threatening harm. **This call will be diverted to BCRI.**

911 specialist (role player 2) should attempt to get pertinent information from the caller, while also using techniques of de-escalation and rapport-building. The 911 specialist should determine that this is an appropriate call to connect with the Crisis Information & Referral Line, for their triage, which could include a referral to services or the dispatching of a mobile crisis team. The 911 Specialist will connect the caller to BCRI's Here2Help Hotline and conduct a warm handoff following these steps:

1. Advise the caller that we are going to get them help;
2. Advise the caller that that we are going to connect them to a clinician, and to stay on the line;
3. Speed Dial and Connect to BCRI;
4. Identify your agency, position number, and Incident Number to the receiving call center;
5. Relay any Critical information that the caller has provided. (Name, Address, Phone Number, situation);
6. Introduce Caller compassionately;
7. Stay on the Line until the receiving call center has established communication with the caller and that the connection is stable.
8. Disconnect.

Points of feedback and evaluation:
-how the 911 specialist handles the initial call
  staying calm
  using de-escalation techniques with the caller: reflecting back, identifying triggers, emotional labeling, offering reassurance
-how the 911 specialist makes a decision on coding the call? Does student consider whether/if the scenario indicates imminent danger to the caller or others? Does the student consider whether this is a behavioral health need and whether a medical emergency is indicated?
-if sent to BCRI, how the hand-off is conducted
-If the 911 specialist or dispatcher decide that police response is warranted because they believe the person is an imminent danger to self or others, discuss why they may have determined that – discuss whether this is stigma/bias as there are no threats in this scenario.

Scenario 3:

Instructor notes:
This will be a class of between 6 and 12. Ask for volunteers to be role players. It is up to the instructor if they want to have 911 specialists play same, and dispatchers play same, or mix those up so that learners can have a scenario experience in a different role. the remaining learners will observe and participate in the feedback and processing after the scenario.

Role player needs:
Role Player One: caller [to be played by facilitator]
Role Player Two: 911 specialist
Role Player Three: BCRI Call Specialist

Read the scenario to the group.

A young adult, who gave their address as student housing at Loyola University, called 911 stating that they are having suicidal thoughts. The caller is alert and does not have any weapons in their dorm or immediate means of self-harm, but they are expressing overwhelming feelings and the caller is scared because they've never had these thoughts before. The caller indicates that being away from home, the upcoming holiday season, travel restrictions, finals, and a new therapist are too much to deal with, and focusing on those issues makes them upset. They mention that they want appropriate help now and aren't convinced that the campus infirmary will help.
Have the role players act out the scenario as they would in a real-life situation:
911 call specialist should answer the call, the caller should use the scenario to inform what they say. The 911 specialist has to then decide how to proceed. This call should be coded as a 25A02: the caller is suicidal, but alert, and there are no weapons or immediate means. The 911 specialist should determine that this is also an appropriate

call to divert to the Here2Help Hotline, which will triage the call and may send a mobile crisis team.

911 specialist (role player 2) should attempt rapport-building to de-escalate the caller and keep their mind off of the identified triggers.
they will need to relay all information they are receiving on the call in order to conduct a warm handoff with BCRI. The 911 specialist should follow this protocol for connecting the caller with BCRI:

1. Advise the caller that we are going to get them help;
2. Advise the caller that that we are going to connect them to a clinician, and to stay on the line;
3. Speed Dial and Connect to BCRI;
4. Identify your agency, position number, and Incident Number to the receiving call center;
5. Relay any Critical information that the caller has provided. (Name, Address, Phone Number, situation);
6. Introduce Caller compassionately;
7. Stay on the Line until the receiving call center has established communication with the caller and that the connection is stable.
8. Disconnect.

Points of feedback and evaluation:
-how the 911 specialist handles the initial call using de-escalation techniques with the caller: reflecting back, emotional labeling, offering reassurance
-how the 911 specialist determines the call type and its appropriateness for diversion to BCRI. Does student consider whether/if the scenario indicates imminent danger to the caller or others? Does the student consider whether this is a behavioral health need and whether a medical emergency is indicated?
-If the 911 specialist or dispatcher decide that police response is warranted because they believe the person is an imminent danger to self or others, discuss why they may have determined that – discuss whether this is stigma/bias as there are no threats in this scenario.