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MARYLAND POLICE AND CORRECTIONAL TRAINING COMMISSIONS LESSON PLAN

COURSE TITLE: C.I.T.

LESSON TITLE: Addressing Stigma

PREPARED BY: Jennifer Brown, The Anti-Stigma Project

DATE: 12/30/20 | Revised: 2/19/21

TIME FRAME	**PARAMETERS**
Hours: 120 minutes Day/Time: Day 1, Lesson 3	Instructors: Facilitators trained by the Anti-Stigma Project of On Our Own of Maryland, Inc. Audience: CIT trainees Number: maximum of 25 Space: classroom
PERFORMANCE OBJECTIVES	**ASSESSMENT TECHNIQUE**
Participants will be able to: 1. Identify stigmatizing behaviors, beliefs, and attitudes about mental illness, addictions, and dual diagnosis—societally, individually, and in systems, through facilitated discussion, to the to the satisfaction of the facilitator. 2. Understand the impact of stigma on help-seeking behaviors, treatment outcomes, decision-making, opportunities, personal and professional relationships, and interactions with law enforcement, through facilitated discussion and an experiential	1. Facilitated group discussion 2. Experiential exercise and facilitated group discussion

exercise, to the satisfaction of the facilitator. 3. Describe two components of stigma reduction and how those strategies can positively impact their personal lives, their communities, and their work in law enforcement, through facilitated discussion and video analysis, to the satisfaction of the facilitator	3. Video analysis, facilitated group discussion, written evaluation

INSTRUCTOR MATERIALS

The Anti-Stigma Project training DVD
Lesson plan
Evaluation forms
Playdoh
Anti-Stigma Project pens and Distorted Perceptions eyeglasses or sanitizing wipes

EQUIPMENT/SUPPLIED NEEDED

TV with DVD player or computer with projector screen
Speakers
Laptop computer
Flipchart stand and paper with adhesive at top (or masking tape to adhere to walls)

STUDENT HANDOUTS

Title(s): The Anti-Stigma Project workshop evaluation

Needed: 1 copy for each student

METHODS/TECHNIQUES

Combination of PowerPoint presentation, experiential learning activities (paired exercises, facilitated group discussion), video analysis, and limited didactic teaching, co-facilitated by one civilian and one law enforcement personnel, both members of and trained by the Anti-Stigma Project workgroup

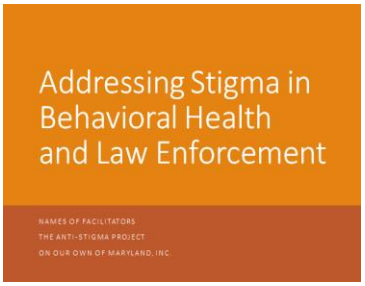
REFERENCE MATERIALS

https://onourownmd.org/projects/the-anti-stigma-project **https://www.distortedperceptions.org**
GENERAL COMMENTS This presentation can only be delivered by two Anti-Stigma Project workshop facilitators who have been trained in this model which has been tweaked for a law enforcement audience. Modifications and/or additions to this presentation are not permitted without permission. This curriculum is proprietary to On Our Own of Maryland, Inc and may not be used without their permission. This document and any attached materials are not to be disseminated, distributed, or otherwise conveyed to other organizations without the written permission of On Our Own of Maryland, Inc.

LESSON PLAN

TITLE: ADDRESSING STIGMA

PRESENTATION GUIDE	TRAINER NOTES
I. ANTICIPATORY SET Welcome! We are (name) and (name) and are here today as co-facilitators, one as a civilian and one from there at BPD. Both of us are members of the Anti-Stigma Project. We are delighted to be part of the CIT curriculum, as stigma is a topic that has a direct impact on your life, on your work, and on your community and yet we often don't take the time to really discuss it. This workshop is a bit different than others you may have attended. For instance, you may have noticed play doh sitting on the tables. Don't worry, there won't be an	**Time: 10 minutes**  **Instructor's Note**: This workshop is designed to be co-facilitated by a civilian member of the Anti-Stigma Project (ASP) and a BPD instructor who is also a member of the ASP.

exercise or a project with it. Many folks find that keeping their hands busy helps them concentrate. Ever sat next to someone clicking their pen all throughout a class as a way to keep their focus? Well, this is a quiet alternative, plus it's fun. We do have a few requests before we get started. Anyone ever heard of the Las Vegas rule? Well, that applies here. Feel free to share things you learned once you leave here, but we ask that any personal information that is said today stays here in this room. We realize this can be an uncomfortable topic and it's important to us to have an environment where you can honestly discuss this topic. Can everyone agree to that? The second is that, because this is a dialogue, not a lecture, --we're not going to be standing here talking at you for the next two hours--that conflicting opinions are going to come up. And that's a good thing! As long as discussion remains respectful, disagreements can be productive and positive. Everyone's perspective is important and is valued. Lastly, please make sure that your cell phones are off or on vibrate/silent. Since we won't be talking at you but rather with you, we'd like to know who is in the room. Can we take a moment to go around and get everyone's name? Just names --we don't need rank, assignment, etc.	 **Desired response**: What happens in Vegas stays in Vegas. **Desired response**: Yes.

Great, thanks! So let's take a look at what we'll be doing today. Would someone please read these out loud?

1. Identify stigmatizing behaviors, beliefs, and attitudes about mental illness, addictions, and dual diagnosis—societally, individually, and in systems

2. Understand the impact of stigma on help-seeking behaviors, treatment outcomes, decision-making, opportunities, personal and professional relationships, and interactions with law enforcement

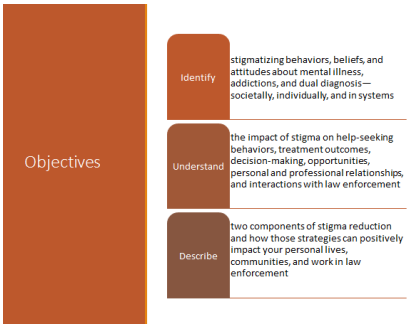
3. Describe two components of stigma reduction and how those strategies can positively impact their personal lives, their communities, and their work in law enforcement

Before we get started, I'm going to ask you to do something with me. I'm going to say a word, then we will all say it together, and then spell it. And we'll do that five times in a row. Then I'll ask you a question, and I want you to answer with the first thing that comes to your mind. No waiting, just the first thing. Okay?

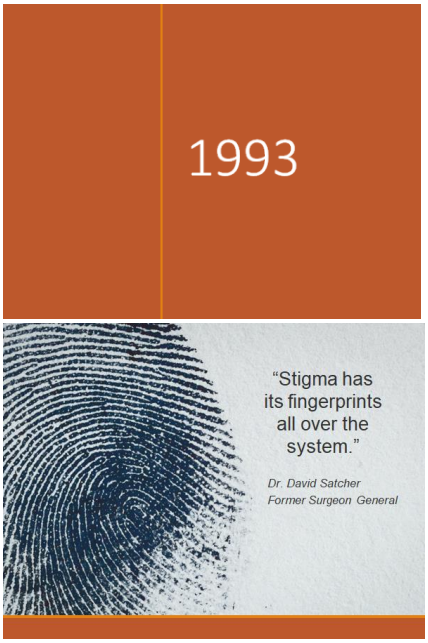
One version: Roast R-O-A-S-T, Roast R-O-A-S-T, Roast R-O-A-S-T , Roast R-O-A-S-T, Roast R-O-A-S-T

What do you put in a toaster?

Instructor note: People will often not follow the guidelines and instead give their title, rank, or job description. Make a mental note of it — you may want to refer to it later on as an example of labeling (identifying people by their roles) and how automatic a response it is for most of us. needing to know what "box" to put people in.



Why do you think so many of you came up with that answer?	**Desired response:** "Toast." Of course the correct answer is "bread" but we want them to come up with the incorrect answer of "toast." It's a way to show how automatic and hard-wired our responses can be to a stimulus. Given the opportunity to step back and think, most folks would have come up with the correct answer.
It's really easy to make quick connections between things that seem similar but in reality may not be. And that's what happens with stigma. It's like shorthand—it's a quick way of categorizing things and people quickly, and so it can masquerade as efficiency, particularly when time is tight. But it isn't based on the actual information being presented. Now in the case of a word exercise, it's no big deal. But the stakes are much higher when you're talking about healthcare or law enforcement. I'll give you a real example. Someone came into the ER complaining of "fire in the stomach" and was someone who clearly had some psychiatric issues as they were talking to people who weren't there. But they clearly kept talking about the pain and the "fire in the stomach." Rather than palpate her stomach, they pushed her aside to wait for a psych consult and assumed there was nothing physically wrong. The psychiatrist arrives—much later--palpates her stomach, and says her appendix is about to burst. That delay could have cost her her life. So it can play out in many ways --	**Desired responses:** ● word association--one triggered the other one automatically ● quick automatic reaction that we didn't actually think through

personally, societally, and systemically. It impacts what we believe, what we do, how we talk, what policies are in place. And we may not even realize it.	
II. INSTRUCTIONAL INPUT (CONTENT) It's important to give you some context. In 1993, some disturbing research came out of New York showing that people receiving mental health services felt that there were more stigmatizing attitudes and behaviors INSIDE of the mental health system than in the general public. In the words of Surgeon General David Satcher, "Stigma has its fingerprints all over the system." In response, the state of Maryland collaborated with On Our Own of Maryland to create a task force to address this. On Our Own of Maryland is a peer-run statewide behavioral health advocacy and education organization. They work with service providers, peers, and professional and community organizations to ensure that services and systems are trauma-informed, culturally responsive, and recovery-oriented by reducing stigmatizing practices and expanding consumer involvement in mental health and substance use policy and planning at local, state, and national levels. The composition of the task force was unusual and groundbreaking at the time. 25 people (consumers, family members, providers,	**Time: 90 minutes** 

administrators, educators, advocates) were selected from across the state to work on this, and they were asked to speak honestly, openly--and on a level playing field. It was tough. Many folks knew that there was stigma in the general public, and in the media, but many were surprised to learn that it was such a problem in the ***system that was designed to help.*** I mean, we were the "good guys!" People working in the field weren't doing it to make lots of money, we were trying to do something good in our communities. Believe me there were many tears, many raised voices, as this group of people who were chosen to fix this problem in the system had to confront the stigma that was right there in the room. When there is an issue that is hurting people tremendously what is the first thing we typically want to know? And we got caught in that. "Oh, if the psychiatrists weren't so arrogant," "if the consumers had some insight into their illness," etc. And people started to see their often-hidden preconceived ideas. As the group identified stigmatizing attitudes, behaviors, and practices within the system---*and within themselves*--it became clear that although the concentration was on the stigma faced by consumers, the truth was that stigma was playing out in many different directions—for example, psychiatrists being thought of as "not real doctors" by other medical professionals, folks with mental health issues seeing folks with substance use issues as morally weak, etc. We started calling stigma "the matrix from which no one	**Instructor note**: take a moment to solicit responses **Desired response**: Who is to blame?

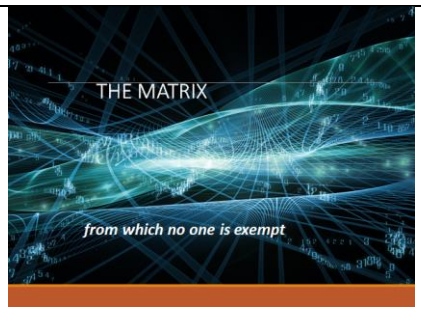
is exempt." Not only do we know how it feels to be stigmatized but we've all done it to other people. Everyone.

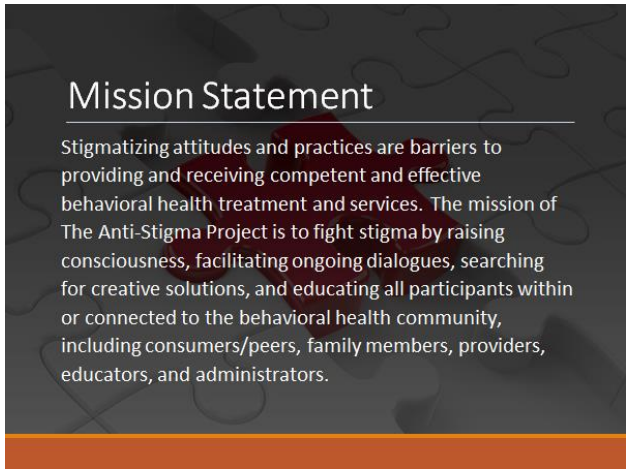
The good news is that after 18 months of meetings and research, the members of the group realized their attitudes and behaviors had changed---in our work, in our lives. So we decided to package what we learned into something that might be useful to others. And that's why we're here. We are NOT here as the "stigma police" to catch you saying something "politically incorrect,." we are NOT here to teach you to be "perfect like those of us who are members of the Anti-Stigma Project," ---we are here to share with you what we know and to learn from you and each other, so we can all catch ourselves before we do harm, and be part of creating more respectful and effective systems.

So here is our mission--would someone please read it out loud?

This could really be summed up as follows: Stigma is real, it impacts people tremendously, we all need to be at the table to figure it out. You'll notice it says "within ***or connected to*** the behavioral health community." That includes groups like the justice system (we just did a series of workshops for all of the administrative law judges in the state) education system, and law enforcement. By the way, this workgroup still meets and now includes a forensic psychiatrist and two law enforcement personnel.

I can't overstate how big of an impact stigma can have. It is not political correctness, it is

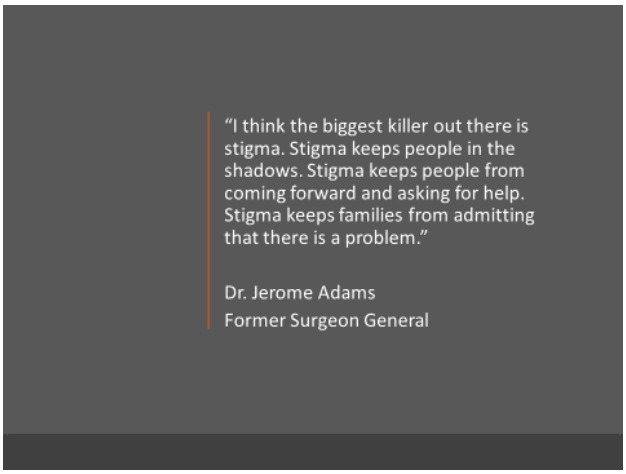




not people just getting their feelings hurt, or being too sensitive.
It kills people. It changes the trajectory of their lives. And it is the biggest impediment to recovery from a behavioral health disorder. There are 43 million Americans with a mental health condition and more than half of them don't receive treatment and services., and only 11% of folks with substance use disorders receive the services they need. Granted, there are myriad reasons –insurance hurdles, lack of access, etc. But this is a huge piece of it, according to many experts such as the WHO. Why would I want to put myself into a category of people who are scorned, scapegoated, and shunned?

Would someone please read this quote from the former Surgeon General?

So we know the stakes are high, so let's dive into exactly what this is and how it plays out. When you hear the word stigma, what comes to mind?

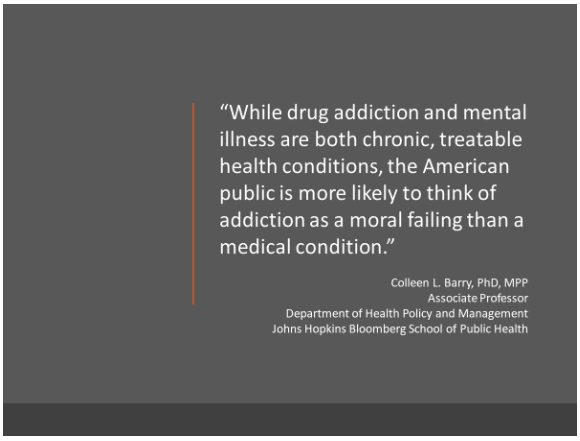


Instructor Note: Use flipchart and markers to record their input. Do NOT introduce this as an exercise. Simply begin by asking the brief question listed. Encourage them to share whatever comes to mind-- adjectives, synonyms, descriptions. Make sure you reference quick examples of stigma faced by behavioral health consumers as well as law enforcement personnel.
Desired responses:
prejudice, limiting, label, stereotype, isolating, fear, mark, assumption, bias, internalized

If the following do not come up in the course of the conversation, ask a question of the group in order to discuss the following:

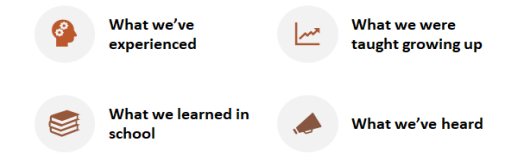
• Stigma as both blatant and subtle: It can be much more difficult to address when it is subtle, because it can be pathologized, as the credibility of someone with a behavioral health issue is often called into question

• Stigma as a pre-judgment, not a judgment: We must make decisions every day--it's the pre-decision we are talking about. Police, in particular, are required to assess people and situations in mere seconds for safety. It makes it that much more critical those assessments are accurate and not based on snap assumptions about an individual or group. (can refer back to initial word exercise)

We'd like to share with you the definition that the Anti-Stigma Project came up with. Would someone please read this out loud? So it encompasses much of what you came up with. It certainly gives a clear cerebral perspective of what we're talking about.	• Stigma as intentional or unintentional: Intent vs impact. Our intentions can be pure, but we still have responsibility for the impact. Knowing the intent, however, can influence how the situation may be best handled.
	
But then someone brought this one to our attention, and I'd like to share it with you. Would someone please read this out loud?	
Any reaction? What does that add to what we've already discussed?	**Desired response**: That stigma is painful, that it can be permanent, that it is the first thing people "see" about you, and that it is often seen as a punishment (in the mind of one doing the stigmatizing, not as an objective truth)
For example, we often hear this from people with substance use issues saying that they are often treated as not worth helping because they "get what they deserve." Or they've internalized that message, and so they don't seek help.	

The stigma can come from many places---what we've actually experienced, for example. People who work in acute care psychiatric settings –where they see people at their worst—often don't have the luxury of seeing the larger picture—the truth--which is that people can actually recover and do well. And in your work, you're often called in when there is violence or a threat of violence. But if the only contact you've had with someone with a serious mental health challenge was in that kind of situation, how might that impact your ability to see the true picture, which is that someone with a mental health issue is much more likely to be the victim of a crime than to perpetrate one, and that people with those challenges commit only 4% of the violent crime in this country. And think about this: what if the only interaction someone with a serious mental health issue has had with law enforcement was when they were in crisis and were transported to the hospital against their will? How might that impact their stereotypes about law enforcement personnel? Stigmatizing ideas may also come from what we learned growing up, what we learned in school, or what we've heard or seen, such as in the media.

PAIRED EXERCISE:
I'd like to ask you to pick out someone in the room you either don't know, or don't know well, and go sit next to them. You've got 60 seconds. You don't need to take your belongings with you, as you will be coming back to your seat shortly.



Where does it come from?

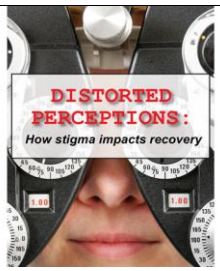
Instructor note:
Do not introduce this as an exercise and do not give the instructions until after folks are paired

Okay, good. At this point we have a pretty good idea of what stigma is, right? Now we'd like to ask you to think about a time in your own life, in which you were stigmatized. It doesn't have to have anything to do with mental illness, substance use, or even law enforcement. We are stigmatized for lots of reasons---race, ethnicity, gender, gender identity, income, religion, occupation, etc. , so look through the catalogue of your own life and just pick one story. It can also be from any time in your life. It could be when you were 6, when you were in middle school, or yesterday. Select just one story (most of us have many) to share with your partner. And they will do the same with you. Please listen carefully to your partner, because when we come back together again, we're going to ask you to share your partner's story with the larger group, not your own. Now, that is WITH THEIR PERMISSION. This is not group therapy, and you don't have to share your story at all if you don't want to. But the more stories we hear, the more robust and helpful a discussion we'll have. If you can't think of an incident- (and in more than two decades of doing this work, I will say that I've never met someone who had never been stigmatized) but if you must, you could share a stigmatizing incident that you witnessed, or one in which you were the one with the stigmatizing views or actions. We'll give you about 6-7 minutes. Are there any questions? If not, go!	up. Stay upbeat! The previous segment tends to be fairly serious and pensive, so this is a good time to interject a change of tone and pace (we recommend you switch facilitators at this point) **Instructor Note**: Gauge the amount of time they need by the quality of the conversations, body language, overall affect, etc. You may want to circulate around the room to get a better sense of how things are going. Before moving on, ask if anyone needs additional time. We tell participants we will give them 6-7 minutes; however, we typically allow about 15 minutes.

FACILITATED DEBRIEF: (approx. 15-20 min)	It forces people to get right to it rather than thinking they have additional time.
Would anyone like to get us started and share their partner's story? And again, that is with their permission.	**Instructor Note**: There is no specific script for this section, as the stories will be different each time. These stories need to be very carefully debriefed, validated, and then themes selected to make congruent points about stigma regarding behavioral health and law enforcement. Hours of practice and scores of examples will be taught in the facilitator training, as this is a crucial piece of this training that cannot be scripted. The size of the group will dictate how many stories are shared. Try to de-brief at least 10. However, if there are 12 people in the group, for instance, don't leave two people out, do all 12. Make sure with each story that you reiterate that it is being told with their partner's permission. It is rare that someone does not wish for it to be shared. Once someone has shared their partner's story, immediately ask if the other would like to reciprocate. It's helpful to have both stories side by side, as there are often commonalities that the audience may not have anticipated hearing.
So we can see that it plays out in many ways---in behavior, in language, in environment, in policies. It impacts our lives in many different arenas—our relationships, the decisions we make, what opportunities we have, etc.	Draw parallels between the stories that are told and ways in which stigma plays out regarding behavioral health--eg. on help-seeking, decision-making, health outcomes, opportunities, relationships, including with law enforcement.
We did this at a conference where, unbeknownst to us, the two people who paired up were 1) a gentleman who had just been released from prison and 2) a police officer. It was a wonderful opportunity to find out how much they had in common and to examine their own assumptions about the other. Both talked about what an amazing experience it was.	
Thank you so much for sharing your stories. We've seen how stigma plays out in lots of different arenas and now we want to narrow that down specifically to behavioral health and law enforcement. We want to share a video with you , which includes interviews with people here in Maryland discussing their experiences with stigma from both the consumer perspective and the law enforcement perspective.	**Instructor Note**: Reference examples that came up

VIDEO ANALYSIS:

See Appendix B for the plan for the law enforcement chapter of the video.



Instructor note:
Our current video, "Distorted Perceptions: How Stigma Impacts Recovery" is a 40 minute training tape divided into 7 chapters. The law enforcement chapter will create chapter 8. Because this workshop is significantly shorter than our regular one, we plan to show only the new law enforcement chapter.

Desired responses:

- didn't realize how many similarities exist between the stigma that consumers face and the stigma that we face as law enforcement
- heartened to see that change could really happen,
- surprised to hear consumers talk about their stigma about police

How did you feel about what you just saw? Which individual could you relate to the most? With whom did you agree? …disagree? Were you surprised by anything?

How do I get involved in solutions?

Personally

In communities

Agency/ Law Enforcement

Of course the million dollar question is "So what do we do about this?" For instance:	**Desired responses:** Use it as an opportunity to engage the person directing the stigma at me through constructive dialogue.
	Become aware of my own stigmatizing beliefs and behaviors, many of which I may not have realized before
● What can you do when it happens to you? We've seen clearly that we can all be stigmatized for many reasons, and that includes our occupation.	Consciously make an effort to challenge them by placing myself in situations outside my comfort zone, such as dropping into an On Our Own wellness and recovery center (or volunteering at one), visit a Soup Kitchen, or even just walk up to folks on the street and starting a conversation to reduce the fear and the stigma that is associated with the uniform. So this can help to reduce the stigmatizing assumptions about us as well.
● What can you do about your own preconceived ideas?	Ask myself if I am making a judgment or pre-judgment.
Indeed. The more we are aware of our own pre-conceived ideas, the more we will recognize our initial reaction before it becomes a stigmatizing action. However, in any situation we can ask ourselves if we are making a judgment based on real-time facts or if we are making a pre-judgment. We've found it helpful to constantly check ourselves by asking "Am I seeing this person clearly?"	

• How can you address it within a group even if it seems you are the only one who is concerned about it? That could mean a group of friends, colleagues, your squad, division, or even entire agency. Addressing change is certainly easier if you are in a leadership position but it can be done by anyone within an organization. Informal leaders wield a great deal of power and influence in an organization and can be useful in shifting attitudes. And we will give you materials today (and information about how to order more) that you can share	**Desired responses:** Have the moral fortitude to address concerns with the disinterested group, (for example, the longer the pandemic continues, the greater the increase of behavioral health struggles. So this could become a topic to discuss at a family dinner, or at a staff meeting) Model desired behavior, (for example, clearly not laughing if someone makes joke that is stigmatizing; modeling respectful and person first language) Share resources and information to learn about it.
What partnerships can you create to address it? How can you proactively establish partnerships/relationships to build trust and teamwork to improve services?As an example, in Frederick, they formed a behavioral health collaborative working group comprised of groups such as the Mental Health Association, a local behavioral health provider, the local hospital, the health department, the local On Our Own wellness and recovery center, the City of Frederick Community Action Agency, and more. They would meet as needed, either monthly or quarterly to discuss specific situations involving individuals and/or providers where they critiqued responses to recent situations. That allowed them to not only brainstorm ways to improve collaboration and services, but also to address examples where they saw stigma as a roadblock or deterrent to being able to connect with an individual's needs. That also created an opportunity to address the stigma	**Desired responses:** Seek out opportunities to engage persons/groups in my assigned work area to build trust and relationships. For instance, what discussions are taking place about behavioral health issues that law enforcement personnel face themselves, formally or informally? Have representatives from the police department proactively reach out to individuals, groups and organizations that provide behavioral health services in the community to discuss any current or potential future issues. For instance, the police lieutenant in the video who joined the board of a local organization that provides peer support and services.

present within the behavioral health community where some providers viewed other providers as less critical. So yes, having police representation among such groups demonstrates a desire to work together to tackle issues collaboratively. Establishing partnerships builds trust and reduces stigma through mutual respect and understanding. Right! Not only as collaborative teams among officers but also collaborating with stakeholders in the community. We all have a common desire to provide the necessary supports for folks with BH challenges so we can prevent involvement with law enforcement, and also be part of creating a crisis response system that involves the least amount of police involvement. These are all great ideas. Let's take a look at a framework for looking at this even further. When you look at the international and national research on stigma reduction, you consistently see two effective strategies that must be used together: education and contact. So what do we mean by education? It can be either formal (such as what we're doing today) or informal (someone says something, I respond, we end up in a dialogue where we both learn something). In true education, no one is exempted from the process. I've had situations in which we've been asked to come "fix the stigma" with some particular	The nature of the CIT teams themselves is a good example of partnerships.

group of staff, like nurses, but not think the rest of the staff needs it.

So education is important but by itself, **it is not enough.**

Going to one class doesn't make someone culturally competent, reading a book on getting in shape doesn't make you in shape.

There is another crucial component --- contact. Contact must allow people to get to know each other on several levels (not just as patient/ doctor or police officer/ community member, but rather activities that allow for getting to know each other on different levels. For instance, this group here is volunteering to do something in their community. It is also enhanced when the activities are based on cooperation and not competition. So we'd like for you to think about how you can create or be a part of more opportunities for contact and education.

You've already come up with some great ideas—how can you push that even further? For example, could you be part of supporting community organizations that deal with behavioral health—supporting them on social media? Joining walks or fairs? Disseminating their materials?

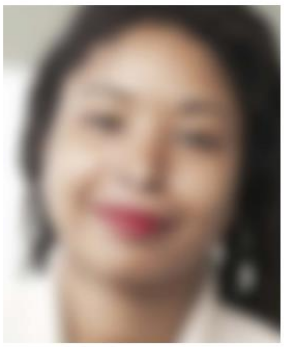
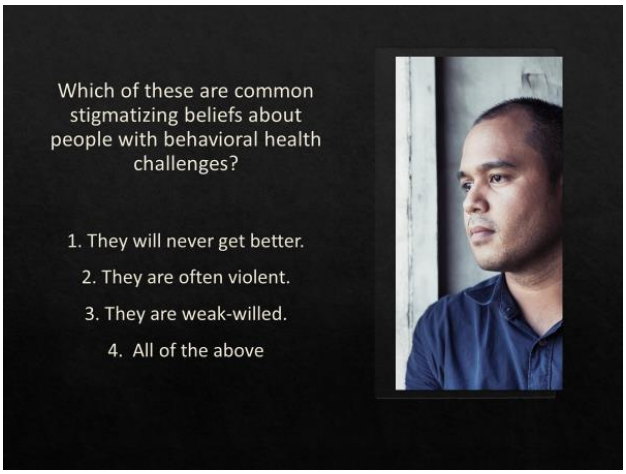
For instance, a number of years ago we started a companion public education campaign that asks: "Does learning that someone has a mental health or substance use disorder change the way you see them?" And is that vision of them correct, based on facts, real time facts about this particular person, or is it based on something else?

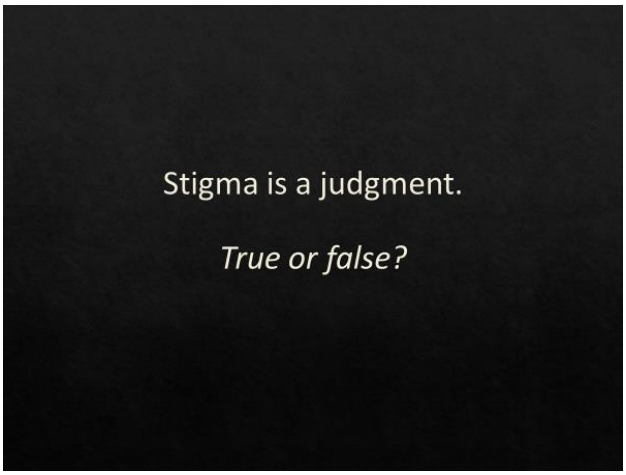
Education

- Formal or informal
- Reciprocal
- No one is exempt

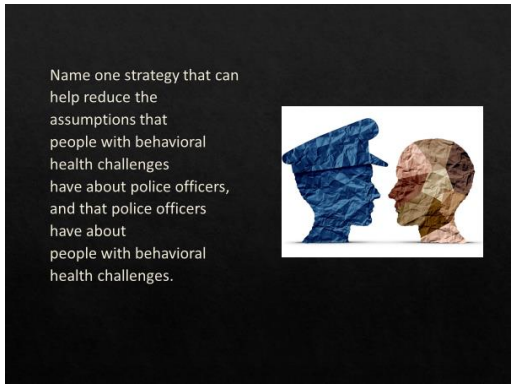
Contact

- Examine barriers
- Get to know one another on several levels
- Cooperation, not competition

And we designed a few tools to spark conversation and create opportunities for contact and education. And we'll give you some of those today. They're free and you can always request more. Particularly in this time of COVID-19, offering someone a hand sanitizing wipe may not only help their physical health but challenge them to think about the mental health of someone they know, someone they love, or even themselves.	 Distorted Perceptions Campaign *Does learning that someone has a mental health or substance use disorder change the way you see them?* **Instructor Note**: depending on the size of the audience, etc. we may bring eyeglasses wipes or hand sanitizing wipes
III. EVALUATION/CLOSURE Let's wrap things up with a quick quiz.	**Time: 10 minutes**  **Desired response: All of the above**

	 **Desired response: False. It is a pre-judgment**  **Desired response: It can impact access to healthcare, quality of care, undermine relationships that are necessary for recovery, undermine their credibility, create internalized stigma that leads to hopelessness (and many more)**

Desired response: 1 and 3



Desired response:
Seek out situations outside of my comfort zone, such as dropping into a recovery center to see what they offer and what they do in the community, or visiting a soup kitchen and having a conversation with someone you have a pre-conceived idea about. (and many others)

Do you have any final questions?
If not, we, as promised, we have some information and goodies for you to take with you. Please take a moment to fill out the evaluation form, as we really appreciate your input. ---we use that input to make the program better and it also helps us to keep our funding! There is no need to put your name on it--it's anonymous. There are no right or wrong answers. We'll give you a few minutes to fill them out and you can just

leave them upside down on the table and we will collect them. The pen is yours to keep. Thank you all so much for your time, honesty and participation today. We really appreciate it and encourage you to continue to think about this as you continue with the rest of the CIT training, as stigma influences every topic you'll be learning about. We challenge you to think about how you can be part of the solution in a significant way.	

Evaluation: *Addressing Stigma in Behavioral Health and Law Enforcement*

1. How would you rate this workshop overall? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
2. What did you like best? _____
3. How would you make this workshop better? _____
4. How would you rate the workshop leaders? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

   Comments on the workshop leaders: _____
5. How safe did you feel participating in the group?

   ❑ Very safe ❑ Somewhat safe ❑ Neutral ❑ Somewhat unsafe ❑ Very unsafe

   What made you feel this way? _____
6. List three things you learned about yourself in today's workshop:

   a. _____

   b. _____

   c. _____
7. What will you do differently after attending this workshop—personally, in your community, and/or your work?

   _____

   _____
8. Do you think you will share this information with other people (coworkers, family, friends)?

   ❑ Yes ❑ No
9. Would you recommend this workshop to someone else? ❑ Yes ❑ No