Crisis Intervention Partners (CIP) Program for Ozaukee CIT
A Proposal for 2016

What is Crisis Intervention Partners (CIP)?

Crisis Intervention Partners training is (typically) a two day-16 hour of training currently modeled after some of the training components of Crisis Intervention Team (CIT) programs. Alternatively, CITs are five-day, 40 hour sessions based on (and faithful to) the "best practices model," *i.e*. "*The Memphis Model.*"

To understand how CIP constructively differs from CIT, we must understand first that CIT is intended to enhance communication, identify mental health resources for the assisting of people in mental illness based crisis and also to ensure that law enforcement officers get the training and support that they need to do so. Moreover, Crisis Intervention Team (CIT) training program is a 'trauma-informed' model for community policing that brings together law enforcement officers, mental health providers, hospital emergency departments and individuals with mental illness and their families to improve by collaboration the responses to people in crisis. However, rather than narrowly focusing on law enforcement officers, CIP is designed for wider ranging audiences who are interested in better understanding and improving interactions with people who experience mental health crises. Accordingly, a CIP should be designed for and dedicated to individuals who work in professions related to crisis services (i.e. corrections officers, EMS personnel, fire fighters, social workers, community crisis intervention oriented, or educators, hospital and emergency room personnel, etc.)

Why so? Many people, such as those identified above already practice trauma informed care but often times 'they don't have a name for what they do.' By infusing TIC into mental illness crisis intervention programs we give the approach a name, hence a common language, TIC protocols and a better understanding of how to make our practice better.

However, there is no "best practice" model as of yet --such as the "*Memphis Model*" for CIT to structure CIP program educational elements. Rather, CIP is still left to local training deliverers to craft a program that meets its identified community needs. Yet, an overarching philosophy that has emerged that underscores all CIPs is to deliver a training program to reorient participants to use changed attitudes, beliefs, and verbal/non-verbal skills as part of their response to crisis situations, having learned how to "do no more harm" in the process.

CIP Programming Development for Ozaukee CIT

The planning phase of any educational program is very important in course development.
In an environment, meaningful and measurable goals and objectives help students to understand what you expect of them and help them organize their time and efforts so they can meet those expectations. It is also important to know your audience and to evaluate the suitability of your materials for use. The key to delivering materials successfully lies in clearly

stated course goals and objectives. By clearly defining the goals and objectives of any course, you can stay on track.

Two models of CIP exist in our State, one resides with NAMI Wisconsin and the other a working and successful model of CIP being offered by John Wallschlaeger's *Gold Stripe Consulting LLC*. The NAMI Wisconsin version of CIP does not provide learning goals; however, it offers for developers only what it refers to as CIP Key Elements Checklist:

	CIP Key Elements Checklist	
1	Presentation from person living with mental illness or family member	
2	Hearing Voices Simulation	
3	Impact of Trauma	
4	Self-care	
5	De-escalation techniques	
6	Role-play crisis situations	

The presumption once can make is that the undefined "key elements" of NAMI Wisconsin identify but do not specify the "goals" of CIP program design and should guide local the program development. On the other hand, Gold Stripe LLC clarifies the goals of CIP somewhat.

Program Learning Goals for CIP: (Taken from Gold Stripe LLC)

Overview of various mental illnesses (symptoms, treatments).

1. Basic education on human development & the impact of trauma.
2. Presentation & discussion with person living with mental illness.
3. Education on safe, effective crisis de-escalation and active listening skills.
4. Self-care, building support networks, and resiliency.
5. Interactive role-plays on crisis de-escalation with feedback from trainers.
6. Auditory hallucination (hearing voices) simulations.

My (respectful) critique of both models (NAMI Wisconsin & Gold Stipe) is that each is derivative of a CIT. The standard CIT 40-hour plan is the basis for each CIP model. Each model is a simply a "two day" shortened version of CIT. Targeted but "cobbled together" elements of a CIT are assembled to fill a 16-hour training schedule. CIP should be a standalone 2-day workshop that has a specific focus to the needs of EMS and little if any appeal for law enforcement officers. Whereas we discourage corrections and other EMS personnel from applying for CIT, as it has little bearing on what they do; hence, we should then create and offer a CIP that specifically focuses on the bridging linkage between their EMS work and their role in the trauma informed care paradigm.

Making the CIP Salient and Germaine to its Audience

CIP is designed to appeal to the training needs of non-enforcement persons; however, those of whom are still in immediate contact with people in a mental illness based crisis. This means the "workshop" training must be sufficiently different from the immersive experience of CIT; yet, still help "partners" to deal with crisis before the enforcement persons arrive on the scene. Therefore, CIP training needs to introduce the participant to their role in "trauma informed care" as that relates to their professional interactions with mentally ill people on a day to day basis, within their special and different institutional settings.

Learning Goals: At the end of the workshop, the partner will be able to:

1. Understand the connection of mental illness to trauma as that affects the human brain as it develops. Understand the types, manifestations and prevalence of trauma in the general population.
2. Understand the significance of the Adverse Childhood Experiences (ACE) study as an emergency services oriented public health concern.
3. Understand what Trauma Informed Care (TIC) is for the emergency oriented professions, what it looks like when manifested; and how it differs from the medical model.
4. Learn to how apply TIC in working with the affected populations
5. Understand what Vicarious or Secondary Trauma is. (i.e. The experience of learning about another person's trauma and experiencing trauma-related distress as a result of this exposure).
6. Principles of Deescalation

Major Learning Objectives converted into Learning Modules for the purposes of this proposal:

1. ***Major Mental Illness, Human Development & the Impact of Trauma*** (Revision)
    a. MMI (Revised)
    b. Human Development (New)
    c. The Impact of Trauma (New)
2. (What is) ***Trauma Informed Care*** (New)
3. ***Trauma Informed Care and Building Resilience*** (New)
    a. What is Vicarious or Secondary Trauma
    b. Building Resilience
4. ***Principles of Deescalation*** (from CIT)

Major Mental Illness (MMI)
Rename and Reconstitute to:
MMI, Human Development and Impact of Trauma
(150 Minutes – 2.5 Hours)

Element: Major Mental Illness (Standard Unit in CIP)

- At the end of this Unit, the participant will know:
- The basics of human brain functioning and development
- The basics of severe and persistent mental illness, by way of presentations of mood and thought disorders, review of issues related to children and youth, examination of cognitive disorders, special focus on issues such as PTSD and suicide
- The basics of substance abuse as a co-occurring disorder in mental illness
- The basics of psycho-psychopharmacology.

Element: Human Development
***New Unit Rationale*:**

A variety of studies have pinpointed the impact of trauma on key structures of the developing brain. These includes the hippocampus, which helps us with memory and spatial navigation; the amygdala, which enables us to process emotions; and the cortex, which plays a role in complex cognitive behaviors, personality expression, and moderating correct social behavior.

- **Learning Goal 1**—At the end of the training, the participant will know:
  - How the Human Brain Develops from infancy to adulthood i.e. the Physiology of Trauma
- *Rationale:*

  In the short-term trauma causes an intense, biological "alarm state," including a rush of adrenaline, cortisol and other hormones as well as intense fear. We stop thinking so that we can fight against or flee the dangerous situation. We have trouble processing information. In children repeated exposure to traumatic events can overload this alarm state and begin to short-circuit healthy neural connections, and disrupt the brain's basic architecture. Ultimately, the brain adapts towards surviving this trauma. This in turn compromises core mental, emotional, and social functioning and normal, healthy development.

Element: The Impact of Trauma

- **Learning Goal 2** – At the end of the training the participant will know:
  - The effects of Abuse and Maltreatment on brain development
- *Rationale*:

  The societal effects of these early developmental insults are manifested in a variety of troubling ways, challenging and extending our human services systems. Several studies confirm that as many as 90% of people receiving public mental health services diagnosed with major mental illness have experienced physical and/or sexual abuse as children. Other studies have shown that as many as nine out of ten boys and seven of ten girls in juvenile detention reported traumatic experiences in their childhood. As one

director of a drop-in center for adults who experienced trauma as children has put it, "The brains of adult survivors are fragmented and resemble a hard drive on a computer drive that has crashed."

Possible Element

- **Learning Goal 3**: At the end of the training the participant will know
    - From Science to Society
        - Know the Implications for public policy and practice
- *Rationale*:
  The effects of trauma can be severe, but science also tells us they can be reversed. Biochemical and brain imaging studies are demonstrating that the brain has a powerful ability not only to survive trauma, but to heal itself as well. Multiplying Connections and a variety of other programs across the country are validating new strategies that undo or at least decrease the effects of childhood trauma. The core principles underlying these approaches include recognizing the family as the constant in a child's life; providing children with close and consistent positive relationships; creating rich environments and predictable routines that are conducive to learning; and offering developmentally appropriate, safe, and individualized opportunities to develop new skills and express emotions.

Trauma Informed Care
(120 Minutes - 2 Hours)
Proposed New Unit

What is Trauma Informed Care?

Adverse childhood experiences (ACE) are important societal problems and have far-reaching mental and physical consequences. Since the 1990s, there has been a considerable amount of accumulating scientific literature concerning the relationship between ACEs and adult mental illnesses, i.e. anxiety, depression and also substance abuse in adulthood. The rates of posttraumatic stress disorder suffered by many people by way of exposure to violence are much higher than among those in the general population. Child abuse, substance abuse and parents' divorce were found to be very frequent risk factors.

The occurrence of emotional, sexual and physical child abuse has been found to be the most important risk factor for the development of depression. The greatest risk factors for anxiety disorders were sexual child abuse and family violence. Strong correlations exist between family violence or physical neglect and substance abuse. Strong correlations also exist between various ACEs and later symptoms or diagnoses of depressive and anxiety disorders in persons abusing drugs or alcohol. It seems to be mainly child abuse and family violence which have a major impact on the victims, future mental illness or substance abuse sufferers.

In recognition of all of this, a new EMS approach that views people who suffer with mental illness, called trauma-informed care, (TIC) has been developed. For instance, Crisis Intervention Team training emerged in the 1980s as one response to this recognition. TIC aims to identify trauma and its symptoms among those in the community (as well as ourselves) and then train emergency service providers to understand the impact of trauma in order to minimize re-traumatization, maintain sensitivity to triggers of trauma, and identify how traumatic dynamics may, without intent, repeatedly play out in our service environment.

Therefore, TIC is trauma-informed practice based on what we know from research about the prevalence of trauma in our society and about how affects people. Within the U.S., trauma-informed practice is usually referred to as *Trauma-Informed Care (TIC).*

New Unit Description:
Trauma informed care (TIC) is a paradigm shift from Traditional Care model and seeks to ‘do no more additional harm” through the provision of services to the participants (who likely have experienced trauma themselves). A trauma informed system ensures that providers have a basic understanding of trauma and its effects; while understanding the paths to resilience. This understanding of trauma is fully integrated into the practices and policies of the organization. SAMHSA describes the paradigm shift in service provision from one that asks “What’s wrong with you?” to one that seeks to understand: “What happened to you?”

Learning Goal 1 – At the end of the training, the participant will:

- Know what the Traditional approach to TIC was for emergency services personnel
- Will know what the Trauma-Informed Approach to Care paradigm is and --their relative role as emergency services providers within that paradigm.

Rationale:

- A majority of persons served in public mental health and substance abuse systems have experienced repeated trauma since childhood; they have been severely impacted by this trauma; ignoring and neglecting to address trauma has huge implications for use of services and costs incurred.

Learning Goal 2- At the end of training the participant will:

- Understand the widespread impact of trauma and understands potential paths for recovery.
- ***Rationale:*** Evidence exists for effectiveness of trauma-based integrated treatment approaches and promising practice models designed for, and providing renewed hope of recovery to, clients with complex, severe, and persistent mental health or addiction problems.

Learning Goal 3 – At the end of training, the participant will

- Understand the signs and symptoms of trauma not only with their "clients," but their families, co-workers and staff, and others involved with the system.

- ***Rationale:*** Many individuals have developed extreme coping strategies in childhood, adolescence and adulthood, to manage and hide the impacts of overwhelming traumatic stress. These coping strategies can hide such things as suicidality, substance abuse and addictions, self-harming behaviors such as cutting and burning, hallucinations, emotional numbing and dissociation, hypervigilance, somatization, aggression and rage, re-enactments such as abusive relationships, and serious health risk behaviors

Learning Goal 4 – At the end of training, the participant will be able to

Appropriately respond by fully integrating knowledge about trauma into policies, procedures and practices

Rationale:

- The primary goals of TIC are to stabilize and improve psychological symptoms of distress and to engage individuals in the most appropriate course of treatment. In contrast to the traditional hospital inpatient-based care settings available to individuals in need of immediate attention for psychiatric or substance abuse symptoms, crisis services include an array of services that are designed to reach individuals in their communities through telephone "hotlines" or "warmlines," and mobile outreach; and to provide alternatives to costly hospitalizations —such as short - term crisis stabilization units and observation beds.

Learning Goal 5- At the end of training, the participant will

- Be able to actively resist re-traumatization."

Rationale

Concepts…

Trauma overwhelms

- Can be single event.
- More often multiple events, over time (complex, prolonged trauma).
- Interpersonal violence or violation, especially at the hands of authority/trust figure, is
- especially damaging.
- Trauma is an event that is extremely upsetting and at least temporarily overwhelms
- internal resources (Briere, 2006)

Prevalence of Trauma
High in Community Samples

- National Violence Against Women (NVAW) Survey (NIJ, 1995-96)
- 52% of women report lifetime history of physical assault; 66% of men.
- 18% of women reported rape or attempted rape at some time, many before age 18.
- 22% of women reported domestic violence; 7% of men.
- Adverse Childhood Experiences study (CDC, 1995)
- 17,337 Kaiser enrolled adults
- ACE score cumulative based on 10 experiences in childhood.
- Includes but not limited to violent trauma.

ACE score includes :(www.ACEstudy.org)

- Lack of nurturance and support (emotional neglect).
- Hunger, physical neglect, lack of protect ion (homelessness).
- Divorce in the home.
- Alcoholism or drug use in home.
- Mental illness or attempted suicide among household members.
- Incarceration of household member.
- Score highly correlated with:
- Prostitution, mental health disorders, substance abuse, early criminal behavior.
- Physical health problems, early death.
- Chronic trauma interferes with neurobiological development (see article by Ford, this issue) and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole.
- Developmental trauma sets the stage for unfocused responses to subsequent stress.
  (Van der Kolk, http://www.traumacenter.org/products/pdf_files/Preprint_Dev_Trauma_Disorder.pdf)

Impact of Trauma

- Emotional React ions
- Feelings – emotions, Regulation
- Alteration in consciousness
- Hypervigilance
- Psychological and Cognitive React ions
- Concentration, slowed thinking, difficulty with decisions, blame
- Behavioral or physical
- Pain, sleep, illness, substance abuse,
- Beliefs
- Changes your sense of self, others, world
- Relational disturbance
- And person who has survived meets the system…….
- I think applying TIC principles in practice will:
- Improve our desired outcomes (dependent on system)
- Decrease vicarious trauma or compassion fatigue
- Support trauma recovery by
- Reducing re-traumatization
- Providing "corrective emotional experience"

Trauma Informed Care

> "Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors to rebuild a sense of control and empowerment." (Hopper et al, 2010)
>
> "Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization." (SAMSAH)

TIC and Building Resilience
(New Unit: 120 Minutes – 2 Hours
(Substitute for Suicide Risk Assessment)

Description: Trauma is pervasive and that the impact of trauma is often deep and life-shaping. Violence and trauma is often at the center of an individual's criminal or juvenile justice involvement, work/school problems, mental health challenges and substance use. This means, whether or not it is fully recognized, a "human service" oriented staff works with the survivors of trauma. A system or organization that is trauma-informed has at its center the core principles of safety, trustworthiness, choice, collaboration, and empowerment and understands that these principles need to be present for both the recipient of services as well as the staff. This training will introduce participants to the essential elements of a trauma informed system of care and how that understanding can be applied to the policies and practice that shape service delivery.

Violence and trauma affect not only affect those exposed, but also those who provide services to them. Symptoms of "vicarious trauma" (VT) resemble those of trauma: high physiological arousal, fear, panic attacks, feeling insecure, intrusive images, nightmares, avoidance, numbing and even depression.

At risk for VT are people who are close to trauma survivors, EMT/EMS, Dispatchers, Jailers, School Security other emergency oriented paraprofessionals are affected. Ironically, the more sensitive and openhearted they are for the person who suffered the trauma directly, the greater is the possibility that we become (vicariously) traumatized themselves. In this module we will discuss the origins and effects of VT, and explore ways of working with it.

We will also discuss ***vicarious resilience***, a concept which explores how we can be transformed by our 'clients' strengths and resilience. Our guiding question will be how to stay compassionate towards the traumatic experience of clients while maintaining strength, resilience, and confidence.

Learning Objectives Series One

As a result of this training, participants will be able to:

- Identify key differences between a traditional human services paradigm and a trauma-informed paradigm.
- Specify the core principles of a trauma-informed approach to care.
- Understand the prevalence of trauma, the impact of that trauma, and how a more trauma-informed approach will enhance work and outcomes with clients.
- Recognize compassion fatigue and burnout and key elements to respond to stress in the workplace.

- Understand how to assess the extent to which current service approaches in their agency or program are trauma-informed.

OR -

Learning Goals Series Two:

Learning Goals: At the end of the training, the participant will be able to:

- Describe Vicarious/Sympathetic/Secondary Trauma and how it differs from definition of Trauma/PTSD
- Understand the effects of vicarious trauma on the body, feelings, behaviors and relationships
- Recognize signs of vicarious trauma in themselves and others
- Know how to assess one's personal risk of vicarious trauma
- To practice body-based skills to resolve vicarious trauma symptoms
- To increase resiliency in the face of vicarious trauma

Principles of Deescalation
120 Minutes – 2 Hours
(Same as and adopted from CIT)
No Roll Play

Description: Police tactics instructors, experienced CIT officers and mental health professionals collaborate to operationalize knowledge gained throughout this course. Specific attitudinal and behavioral characteristics have proven effective in managing crisis situations. Those characteristics will be described and sharpened for officers in preparation for the practical components of the course on the final day.

Learning Goals: At the end of the training, the participants will be able to:

- Use by increased awareness the verbal and non-verbal cues associated with communication in mental health emergencies.
- Improve upon existing skills in interactive role-play situations to solidify techniques and knowledge learned throughout the course.

Potential Units

Excited Delirium (Used by Gold Stripe CIP)

Description: A law enforcement professional with specialized training in identifying and intervening in this special medical circumstance will provide background regarding what variables may precipitate this particular crisis and the statistics regarding in-custody deaths from this unusual condition. While often related to a pre-existing mental health disorder, this medical crisis requires special intervention strategies different from most mental illness exacerbations. Approach strategies to increase survival of officers who must interview when this crisis arises and the importance of medical intervention prior to legal follow-up to increase subject survivability will be stresses.

Learning Goals: At the end of the training, the participants will be able to:

1. Know characteristic symptoms of excited delirium, a medical crisis in which accounts for numerous in-custody deaths, and which can be differentiated from mental health crises resulting from exacerbation of major mental disorders.
2. Understand the various pre-existing conditions and medical phenomena that may precipitate this medical condition to aid in identifying it when encountered “in the field.”
3. Understand the necessity of prompt and adequate medical intervention to increase the probability of the subject’s survival once subdued.

Unit 6 - Peer Support (Used by Gold Stripe CIP)

Unit 7 - Suicide Risk Assessment (Used by Gold Stripe CIP)
Description: An experienced mental health professional will discuss current research and accepted risk factors associated with suicidal behavior, differentiating between prediction of suicide versus assessment of risk. Suicide methodologies and lethality assessment principals will be introduced. Important concepts associated with uncovering suicidal ideation will be taught. Appropriate intervention options and strategies will be outlined in the context of suicide lethality assessment

Learning Goals: At the end of the training, the participant will be able to:

- Know the accepted lifestyle, situational and environmental issues that correlate with risk for suicidality in various socioeconomic groups.
- Describe the basic methods of assessing presence of suicide intention.
- Describe (at least three alternative) intervention strategies when presented with suicidal behavior.

CIP Tentative Two Day Schedule

Oz CIT Proposed Version CIP Element Planner					
Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00	*Welcome +*	*Housekeeping*			
:15	*Housekeeping*	*Q&A*			
:30					
:45		*Building Resilience*			
9:00	*MMI, HD&IT*				
:15	*Major Mental*				
:30	*Illness*				
:45					
10:00	*Break*				
:15	*Human Dev*				
:30					
:45		*Break*			
11:00	*Break*	*Open*			
:15	Impact of Trauma				
:30					
:45					
12:00	*Lunch*	*Lunch*			
:15					
:30	*Trauma Informed Care*	*Principles*			
:45		*of De-escalation*			
1:00					
:15					
:30					
:45					
2:00					
:15					
:30	*Break*	*Break*			
:45	*Open*	*Open*			
3:00					
:15					
:30					
:45		*Graduation*			
4:00					
:15					
:30	End	End			
:45					
5:00					

	Analysis of Time	
	Learning Objectives converted into Learning Modules	
		Minutes
1	MMI, Human Development & the Impact of Trauma	150
2	(What is) Trauma Informed Care (New)	120
3	Building Resilience	120
4	Principles of Deescalation	120
5	Exited Delirium	60
6	Video: The Community I Serve	60
7	Video: Unbreakable Minds	30
8	Other	60
	Total Minutes:	570
	Time Summaries	
	8.5 Hour Day (X 2 Days)	1020
	5 - 15 Minute Breaks	75
	2 - 30 Minute Lunch Breaks	60
	2 Housekeepings (1 Hour & 45 Minutes)	105
	2 Housekeepings (1 Hour & 45 Minutes)	105