National Center for PTSD

POSTTRAUMATIC STRESS DISORDER

Posttraumatic Stress Disorder and Military Veterans: Training Manual for Police Officers

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ACKNOWLEDGEMENTS

This instructor manual, The Police Officer PTSD Toolkit was created by the National Center for PTSD of the US Department of Veterans Affairs to provide information about PTSD in Veterans for those who train police officers (e.g. Veteran Justice Outreach Coordinators). It is a companion document for the The Police Officer PTSD Online Toolkit.

The principal authors are: Robyn Walser, Ph.D., Christopher Weaver, Ph.D., Joel Rosenthal, Ph. D., Katherine Juhasz, M.S., Patricia Watson, Ph.D., Jessica Hamblen, Ph.D., and Rebecca Matteo, Ph.D.

Overview

A. Tips and Information

Thank you for choosing to share *PTSD and Military Veterans: Police Officer Training* slides. This trainer manual and slide deck were developed in conjunction with the *Police Officer Toolkit: PTSD and Military Veterans.*

We ask that you recognize NCPTSD as the content source and keep the NCPTSD template intact during your presentation. However, the individual slides may be amended (e.g. add or remove slides) to best serve your audience. For example, consider length of time available for your presentation, local resources to include, and be sure to add your contact information for attendees.

Notes are included for most slides. Feel free to revise the notes – these are offered as a guide to included slides.

Be sure to amend the title slide with your presenter information and include a final slide that offers contact information for those attending to follow up if necessary.

B. Enabling Objectives

Upon completion of this presentation, participants will be able to:

1. **Describe** PTSD issues among Veterans.
2. **Differentiate** the percentages of Veterans with PTSD and those without PTSD.
3. **Recognize** how to interact with Veterans in crisis.
4. **Describe** different types of situations in which it would be appropriate to recommended toolkit actions.
5. **Explain** why it is important to recognize the strengths of Veterans.
6. **Describe** similarities between military and law enforcement culture.
7. **Explain** the goals of using the recommended actions with Veterans in crisis.
8. **Describe** the spectrum of both verbal and non-verbal techniques.
9. **Describe** the methods for performing de-escalation techniques with Veterans in crisis, and the different ways of mobilizing resources for Veterans.
10. **Describe** the methods for providing peer support for police officers in crisis.

C. Training Materials Required

1. Attendance Form
2. Course Evaluation Form
3. PowerPoint Slides

D. Presentation Notes

To improve the presentation of this material:

1. Present real stories to illustrate the recommended actions.
2. Ask trainees to share relevant stories and situations.
3. Encourage trainees to participate, ask questions, role-play and discuss cases in small groups.
4. Encourage trainees to read the Online PTSD and Veterans: A Toolkit for Police Officers, and draw attention to the relevant portions during the presentation.
5. Show short clips from documentaries, television shows and movies that display situations illustrating a need for the recommended actions or use scenarios in which recommended actions are being performed. Afterwards, ask trainees to report back on what they saw, and how the scene or scenario relates to actual or potential actions.
6. Challenge trainees to apply the skills to the actual local cases.

E. Supplemental Module

At the end of the slide deck, there are a series of slides in a Supplemental Module. This content is not intended to be presented at the end of your presentation, but to be integrated at an earlier point of the discussion if you feel more detail is warranted.

For example, the Supplemental Module includes more detailed information about traumatic experiences, PTSD symptoms, effective treatments, and co-occurring conditions. This information may be useful to include depending on your time constraints and audience.

If you'd like to include more basic information about PTSD and effective treatments, we recommend our PTSD 101: *PTSD Overview* course. You are welcome to use screen shots of *PTSD Overview* or other NCPTSD courses or materials to amend the PPT.

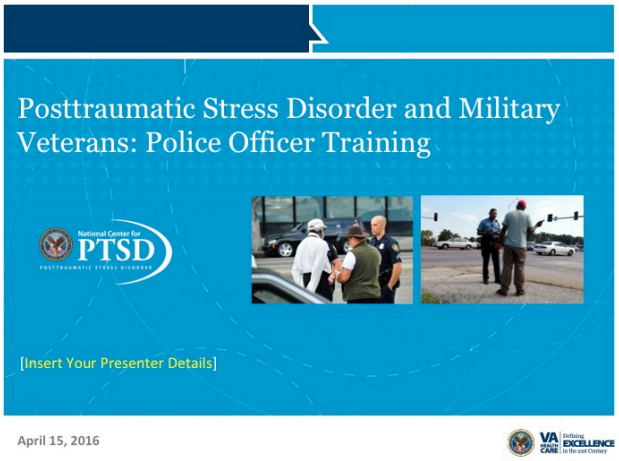
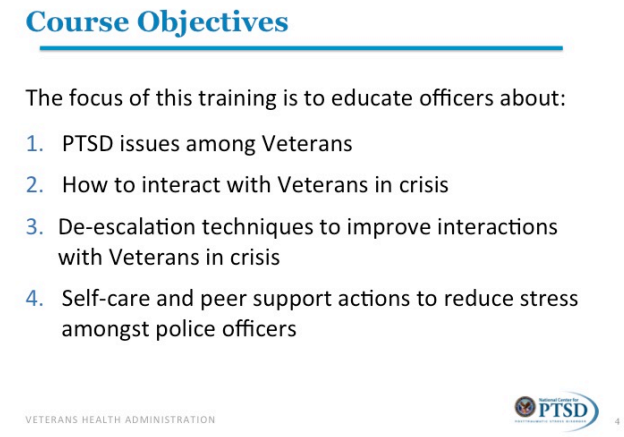
F. Additional Content

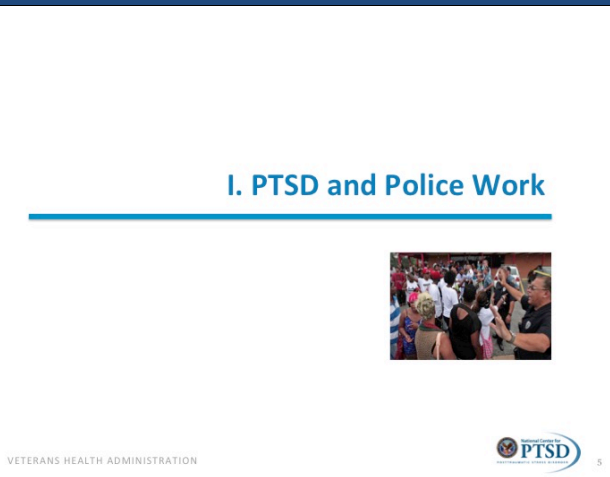
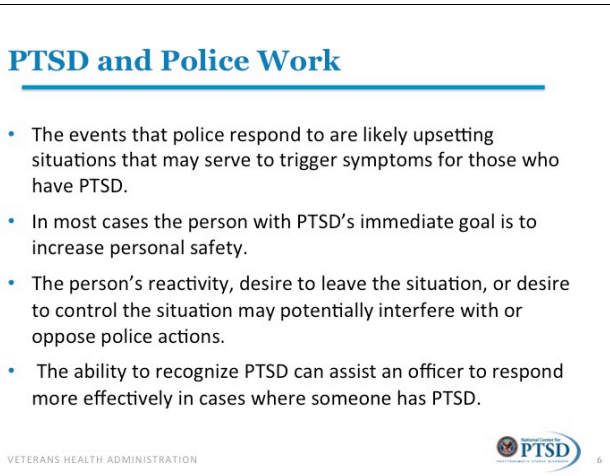
You might consider adding multimedia content to the PPT, which we did not do to maintain file size of this PPT. In particular:

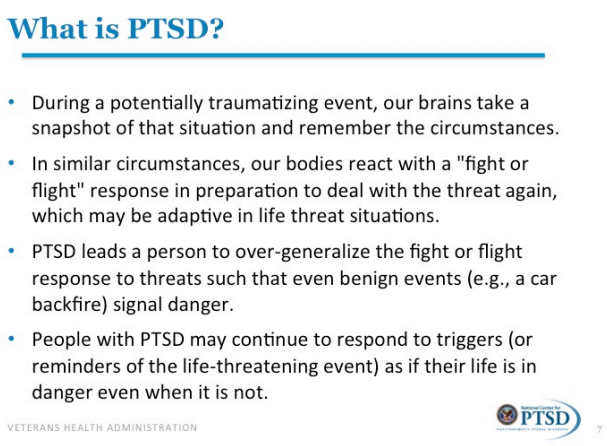
- Download AboutFace Previews: compilation of Veteran responses to key questions which overview symptoms and treatment experiences
- Download Whiteboard Videos (Public): series of 5 animated whiteboard videos on PTSD and effective treatments

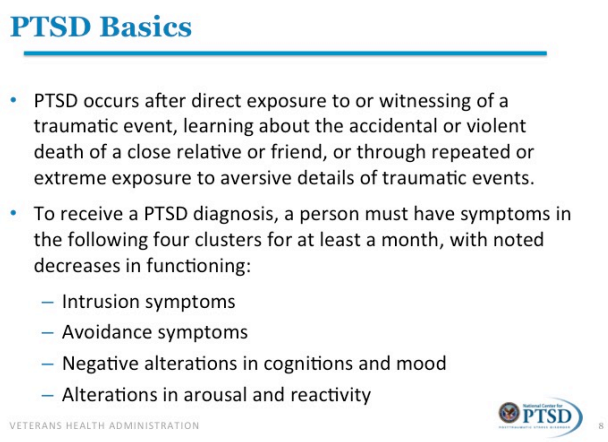
If you have questions or need more in-depth information for your presentation, contact: ncptsd@va.gov

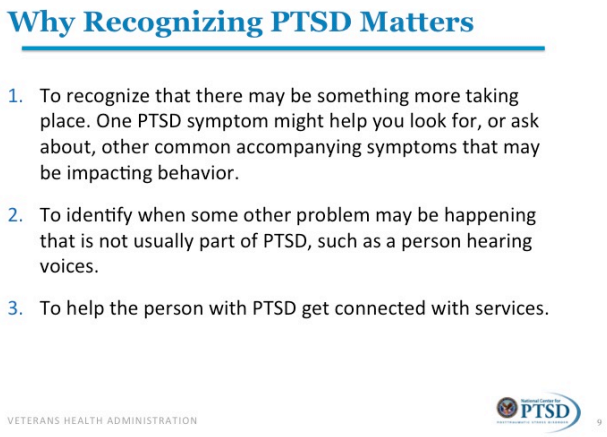
Slides and Discussion Points

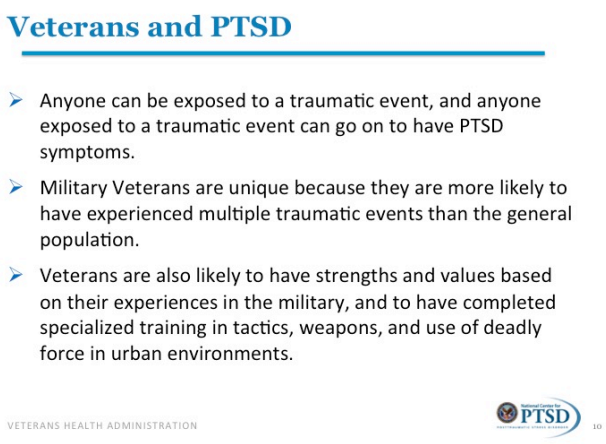
#	Discussion Points	Slide
1	**Introduction** Welcome participants to the PTSD and Military Veterans: Training Toolkit for Police Officers Training. **Logistics/Ground Rules** Introduce yourself and the topic. Inform participants of any additional requirements, rules, location of restrooms, approximate length of class and anything else pertinent for successful module delivery. Inform participants that as an instructor, you appreciate their input during class.	 ***BE SURE TO INSERT YOUR OWN PRESENTER INFORMATION ON THE TITLE SLIDE.*** ***CHANGE THE PRESENTATION DATE IF APPROPRIATE.***
2	**Course Objectives** This is a training designed to prepare police officers to work with Veterans in crisis, and to apply peer support actions to help each other when experiencing significant stress. After taking this course, police officers should be able to understand more about: 1. PTSD issues among Veterans 2. How to interact with Veterans in crisis 3. De-escalation techniques to improve interactions with Veterans in crisis 4. Self-care and peer support actions to reduce stress amongst police officers	

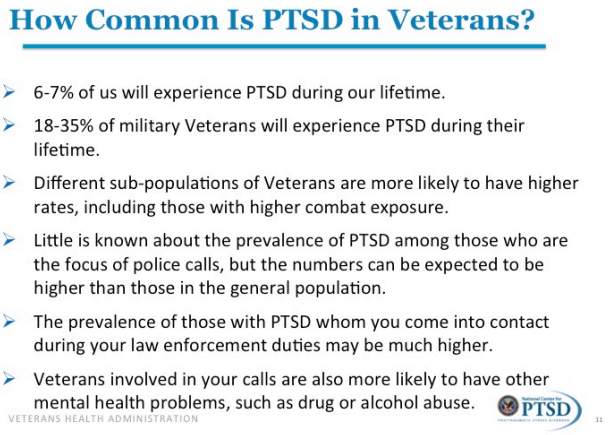
#	Discussion Points	Slide
3	**PTSD and Police Work** This module gives information about: • Why you have an important role to play in dealing with those affected by PTSD • PTSD Basics • Veterans and PTSD • Military Training	
4	**PTSD and Police Work** The events that police respond to are likely upsetting situations that may serve to trigger symptoms for those who have PTSD. This can be challenging, so it is helpful if police can recognize that PTSD may be impacting the way a person is responding to the situation. In most cases the person with PTSD's immediate goal is to increase personal safety, a goal actually shared by police officers. However, if not recognized, the person's reactivity, desire to leave the situation, or desire to control the situation may potentially interfere with or oppose police actions. The ability to recognize PTSD can assist an officer to respond more effectively in cases where someone has PTSD.	

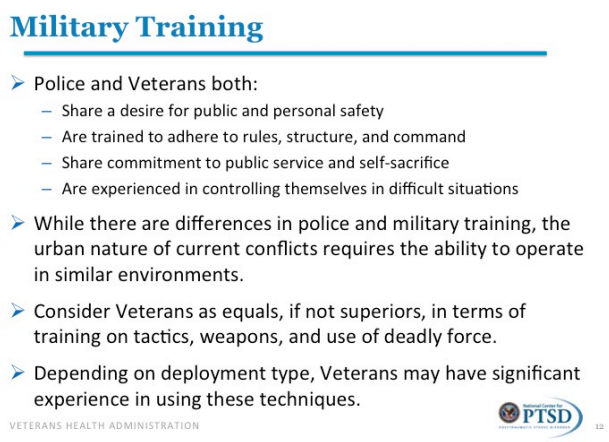
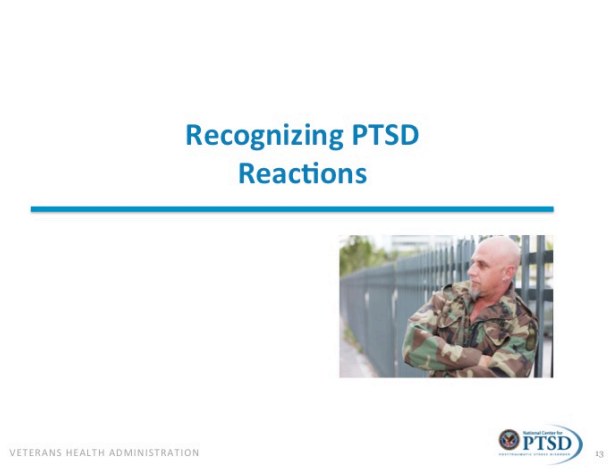
#	Discussion Points	Slide
5	**What is PTSD?** • Those with PTSD tend to experience it's effects in a cyclical manner • You may be seeing Veterans or others with PTSD when they have been triggered by something that increases PTSD symptoms • Your knowledge of the nature of PTSD and the ways to work with Veterans could have a profound affect on the course of their life as well as their recovery from PTSD • Using the techniques described in this toolkit will increase the likelihood that Veterans with PTSD can gain control of their behavior and be less likely to act out when they are triggered	

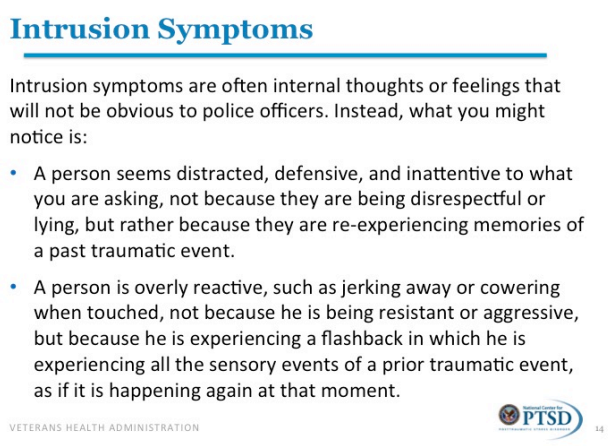
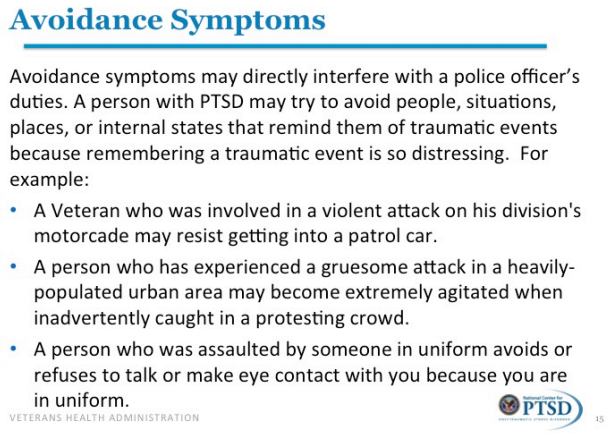
#	Discussion Points	Slide
6	**PTSD Basics** PTSD most commonly occurs after direct exposure to a traumatic event, but can also occur by being a witness to traumatic events, learning of the accidental or violent death of a close relative or friend, or through repeated or extreme exposure to aversive details of traumatic events, usually in the course of professional duties. To receive a PTSD diagnosis, a person must have symptoms in the following four clusters for at least a month, with noted decreases in functioning: **Intrusion symptoms.** Intrusive memories of traumatic events can come back at any time via any number of reminders or "triggers" (e.g., sounds, smells, visual cues). These reminders commonly cause emotional (e.g., fear, anger) and/or physical (e.g., racing heartbeat) reactions. In extreme situations, "flashbacks" of the event can occur where the person feels as though they are actually back at the time and place of the traumatic event. **Avoidance symptoms.** Because remembering a traumatic event is so distressing, those with PTSD may try to avoid people, places, thoughts, actions, and things that remind them of the trauma.	 **Negative alterations in cognitions and mood.** These changes can take the form of emotional numbing or having difficulty feeling, forgetting, estrangement from others, or negative views of themselves and the world. For instance, a person may find it hard to express emotions or may detach from their emotions, or they may use substances or activities to numb themselves. They may find it difficult to remember pieces of the trauma or the entire event, whether they want to remember or not. The person may stop feeling excitement or interest in activities or things for which they used to have interest. **Alterations in arousal and reactivity.** A person with PTSD may respond by frequently being overly alert, "keyed up" or jittery, paranoid about danger, or quick to get agitated or react aggressively to others. Anger may be their response to feeling threatened even when they are not really in danger.

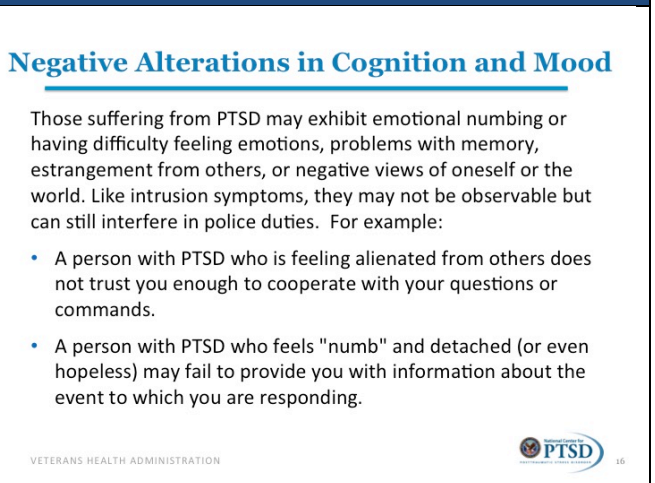
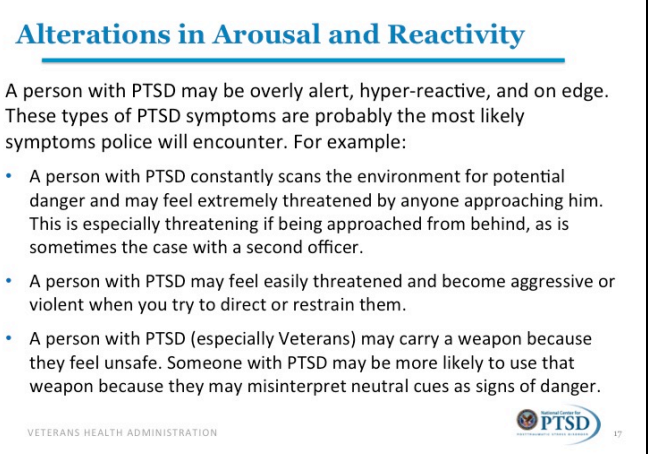
#	Discussion Points	Slide
7	**Why Recognizing PTSD Matters** There are several reasons why it is helpful to be able to recognize PTSD symptoms. 1. Having an overall understanding of the disorder can help you to recognize that there may be something more taking place. For instance, if you see one PTSD symptom (e.g., exaggerated startle response) in a person at the scene, it might help you look for, or ask about, other symptoms that may be impacting behavior (e.g., extreme lack of sleep). Additionally, keep in mind that over three-quarters of men and women with PTSD have co-occurring diagnoses, most commonly substance abuse and depression[1]. 2. Knowing the symptoms of PTSD can help you identify when some other problem may be happening. For example, auditory hallucinations (or "hearing things") that are not connected to a traumatic event are not usually part of PTSD. If a person in crisis appears to be hearing voices and is not having a flashback to the traumatic event, then this symptom might indicate a thought disorder. 3. You may be in a unique position to assist Veterans (or anyone) with PTSD. If you recognize symptoms as potentially being indicative of PTSD, you may be able to help Veterans get connected with services using a crisis line, Veterans' programs, or treatment resources[2,3]. Treatments for PTSD (psychotherapy and medication) are among the most effective available for any of the mental health problems.	 ***Teaching rationale and techniques*** *— Simply stating the symptoms of PTSD may not be very helpful. This section is designed to set a more useful context for understanding the PTSD criteria as a foundation of the remainder of the training. Make an attempt to relate anecdotes about salient symptoms to improve the appeal of this section of the training.* 1. *Breslau, N. (2012). Epidemiology of posttraumatic stress disorder in adults. Oxford Handbooks Online. Retrieved 10 Apr. 2016, from http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780195399066.001.0001/oxfordhb-9780195399066-e-7.* 2. *Glynn, L. H., Kendra, M. S., Timko, C., Finlay, A. K., Blodgett, J. C., Maisel, N. C., Midboe, A. M., McGuire, J. F., & Blonigen, D. M. (2014). Facilitating treatment access and engagement for justice-involved Veterans with substance use disorders. Criminal Justice Policy Review, 27, 138-163. doi: 10.1177/0887403414560884.* 3. *Finlay, A. K., Smelson, D., Sawh, L., McGuire, J., Rosenthal, J., Blue-Howells, J., Timko, C., Binswanger, I., Frayne, S. M., Blodgett, J. C., Bowe, T., Clark, S. C., & Harris, A. H. S. (2016). U. S. Department of Veterans Affairs Veterans Justice Outreach Program Connecting justice-involved Veterans with mental health and substance use disorder treatment. Criminal Justice Policy Review, 27, 203-222. doi: 10.1177/-887403414562601*

#	Discussion Points	Slide
8	**Veterans and PTSD** • Anyone can be exposed to a traumatic event, and anyone exposed to a traumatic event can go on to have PTSD symptoms. • Military Veterans are unique because they are more likely to have experienced multiple traumatic events than the general population. • Veterans are also likely to have strengths and values based on their experiences in the military, and to have completed specialized training in tactics, weapons, and use of deadly force in urban environments. If police have awareness of these factors, they may be more prepared and effective when encountering Veterans with PTSD.	

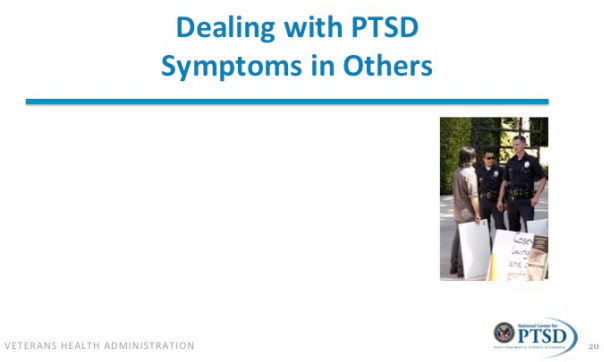
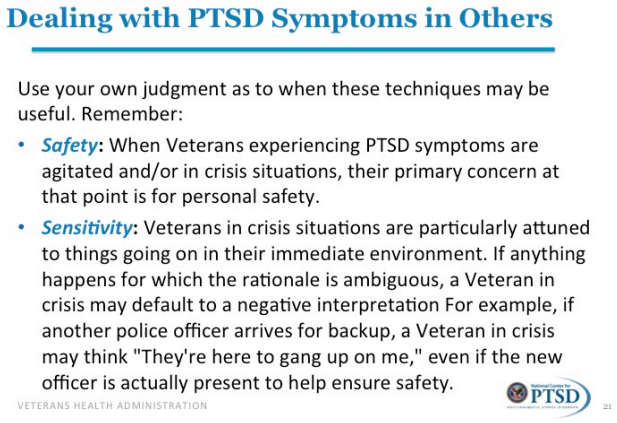
#	Discussion Points	Slide
9	**How Common is PTSD in Veterans?** The best estimates for the rates of PTSD in the general population indicate around 6-7% of us will experience PTSD at some point during our lifetime[1]. Military Veterans show higher rates; about 8-35% of Veterans will experience PTSD. Different sub-populations of Veterans are more likely to have higher rates, including those with higher combat exposure[2]. It is important to note that despite higher rates of PTSD among Veterans in comparison to the general population, most Veterans will never experience PTSD. However, little is known about the prevalence of PTSD specifically among those who are the focus of police calls. The rates of PTSD among these Veterans can be expected to be higher than among Veterans in general or the general population, given that the rates of combat-related PTSD have been reported at 37% in incarcerated Iraq and Afghanistan (OIF/OEF/OND) Veterans[3]. Veterans involved in your calls are also more likely to have other mental health problems, such as drug or alcohol abuse[4]. ***Teaching rationale and techniques*** — *The point to be made here and throughout this section is that officers should not make assumptions about which Veterans may or may not have PTSD symptoms. While certain things indeed increase the likelihood (e.g., firefights), it would be an error to assume the absence of PTSD in the absence of such factors.*	 1. Breslau, N. (2012). Epidemiology of posttraumatic stress disorder in adults. *Oxford Handbooks Online.* Retrieved 10 Apr. 2016, from http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780195399066.001.0001/oxfordhb-9780195399066-e-7. 2. Wisco, B. E., Marx, B. P., Wolf, E. J., Miller, M. W., Southwick, S. M., & Pietrzak, R. H. (2014). Posttraumatic stress disorder in the US Veteran population: Results from the National Health and Resilience in Veterans Study. *The Journal of Clinical Psychiatry*, *75*, 1338-1346. doi: 10.4088/JCP.14m09328 3. Tsai, J., Rosenheck, R. A., Kasprow, W. J., & McGuire, J. F. (2013). Risk of incarceration and other characteristics of Iraq and Afghanistan era Veterans in state and federal prisons. *Psychiatric Services*, *64,* 36-43. doi: 10.1176/appi.ps.201200188 4. Kelsall, H. L., Wijesinghe, M. S. D., Creamer, M. C., McKenzie, D. P., Forbes, A. B., Page, M. J., & Sim, M. R. (2015). Alcohol use and substance use disorders in Gulf War, Afghanistan, and Iraq War Veterans compared with nondeployed military personnel. *Epidemiologic Reviews, 37*, 38-54. doi: 10/1093/epirev/mxu014

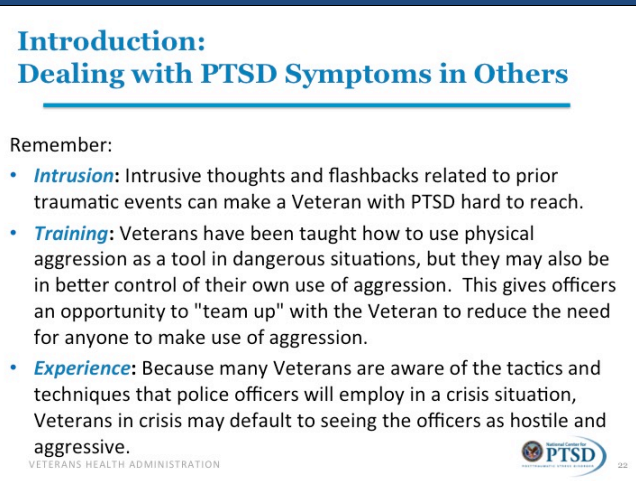
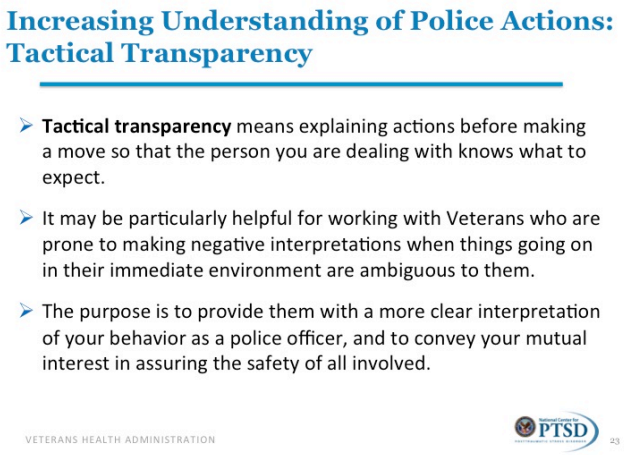
#	Discussion Points	Slide
10	**Military Training** While Veterans you encounter in your work are more likely to have experienced traumatic events, their training may serve their ability to connect with you. For example, Veterans generally: share a desire for public and personal safety; are trained to adhere to rules, structure, and command; and, share commitment to public service and self-sacrifice. Although there are differences in police and military training, Veterans are experienced in controlling themselves in difficult situations. In addition, the urban nature of current military conflicts requires the ability to operate in similar environments as you. Police officers are encouraged to consider Veterans as their equals, if not superiors, in terms of training on tactics, weapons, and use of deadly force. Depending upon deployment type, Veterans may also have significant experience in using these techniques. For these and other reasons, Veterans often make strong candidates for police work.	 ***Teaching rationale and techniques*** *— The point being made here is to try to get officers to recognize that they:* a) *Can connect with Veterans around similar values and skills* b) *May not be the best trained or most experienced individual when encountering a Veteran in crisis. Many police officers maintain that they can keep control of a crisis situation in part by being the only ones privy to tactical decisions being made by the officers. Police tactics can actually be recognized by Veterans with similar training.*
11	**Recognizing PTSD Reactions** This section gives more specific examples of ways PTSD reactions might show up in Veterans' encounters with police.	

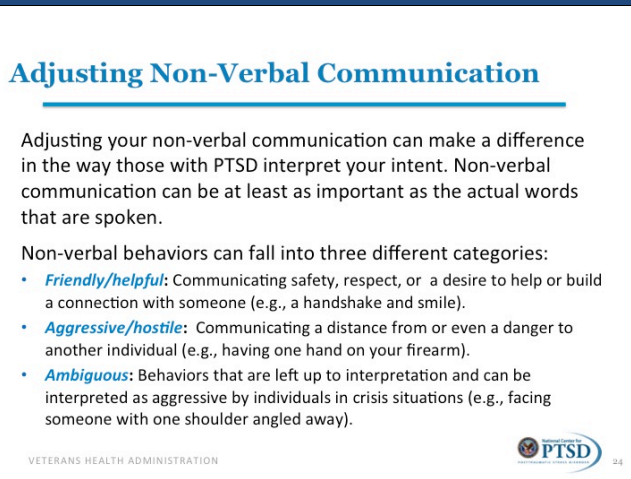
#	Discussion Points	Slide
12	**Intrusion Symptoms** Intrusion symptoms are often internal thoughts or feelings that will not be obvious to police officers. Instead, what you might notice is: • A person seems distracted, defensive, and inattentive to what you are asking, not because they are being disrespectful or lying, but rather because they are re-experiencing memories of a past traumatic event. • A person is overly reactive, such as jerking away or cowering when touched, not because he is being resistant or aggressive, but because he is experiencing a flashback in which he is experiencing all the sensory events of a prior traumatic event, as if it is happening again at that moment.	
13	**Avoidance Symptoms** Avoidance symptoms may directly interfere with a police officer's duties. A person with PTSD may try to avoid people, situations, places, or internal states that remind them of traumatic events because remembering a traumatic event is so distressing. For example: • A Veteran who was involved in a violent attack on his division's motorcade may resist getting into a patrol car. • A person who has experienced a gruesome attack in a heavily-populated urban area may become extremely agitated when inadvertently caught in a protesting crowd. • A person who was assaulted by someone in uniform avoids or refuses to talk or make eye contact with you because you are in uniform.	 ***Teaching rationale and techniques*** *— The primary purpose of this section is to underscore the importance of the subtler "behind the scenes" symptoms. Setting these into context builds an appreciation that the experience of someone with PTSD is even more complicated than is immediately evident from the more obvious symptoms*

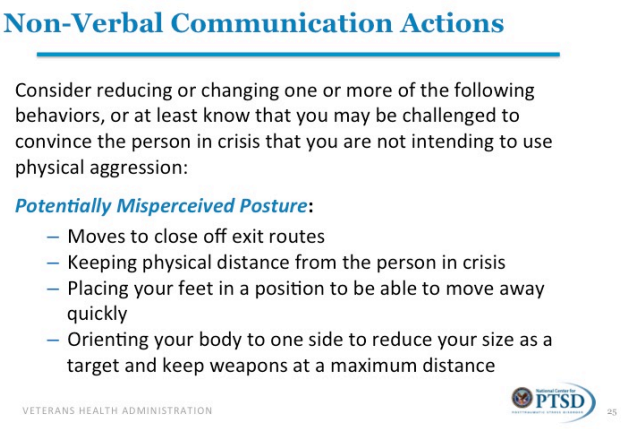
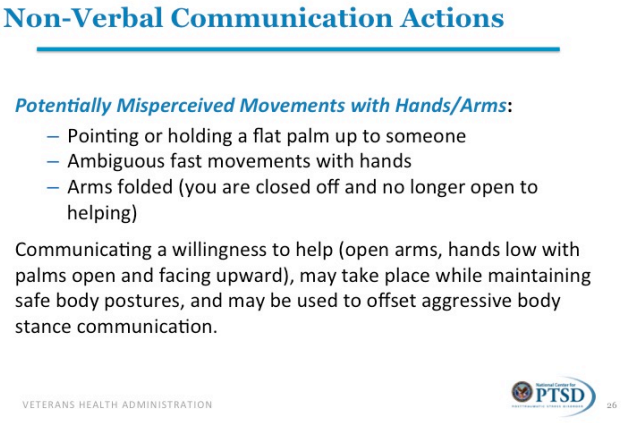
#	Discussion Points	Slide
14	**Negative Alterations in Cognition and Mood** Those suffering from PTSD may exhibit emotional numbing or having difficulty feeling emotions, problems with memory, estrangement from others, or negative views of oneself or the world. Like intrusion symptoms, they may not be observable but can still interfere in police duties. For example: • A person with PTSD who is feeling alienated from others does not trust you enough to cooperate with your questions or commands. • A person with PTSD who feels "numb" and detached (or even hopeless) may fail to provide you with information about the event to which you are responding.	
15	**Negative Alterations in Arousal and Reactivity** As a result of living through a traumatic event that was unpredicted, a person with PTSD may be overly alert, hyper-reactive, and on edge. These types of PTSD symptoms are probably the most likely symptoms police will encounter. For example: • A person with PTSD constantly scans the environment for potential danger and may feel extremely threatened by anyone approaching him. This is especially threatening if being approached from behind, as is sometimes the case with a second officer. • A person with PTSD may feel easily threatened and become aggressive or violent when you try to direct or restrain them. • A person with PTSD (especially Veterans) may carry a weapon because they feel unsafe. Someone with PTSD may be more likely to use that weapon because they may misinterpret neutral cues as signs of danger.	

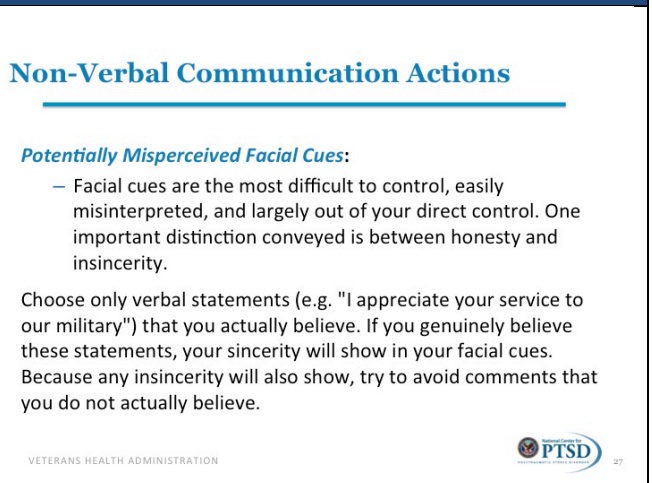
#	Discussion Points	Slide
16	**Negative Reactions May Not Mean PTSD** While all these examples are indicative of the potentially negative symptoms related to PTSD, keep in mind that PTSD may not always be the reason for these reactions. Veterans may have many of the symptoms of PTSD without a full diagnosis of PTSD, or may have similar reactions for different reasons, such as having difficulty sleeping because of chronic pain, or being angry because they feel civilians do not have that same service orientation as Servicemembers and Veterans. Any assumption on your part that they are only acting in a certain way because of PTSD may result in their feeling misunderstood or angry.	**Negative Reactions May Not Mean PTSD** • PTSD may not always be the reason for negative reactions. • Veterans may have many of the symptoms of PTSD without a full diagnosis of PTSD. • Veterans may have negative reactions for reasons other than PTSD, such as: – Having difficulty sleeping because of chronic pain – Being angry because they feel civilians do not have that same service orientation as Servicemembers and Veterans. • Any assumption on your part that a person is acting in a certain way because they have PTSD may result in the person feeling misunderstood or angry. VETERANS HEALTH ADMINISTRATION 18
17	**Managing PTSD** • You may be called upon to deal with PTSD reactions in both your encounters with Veterans, as well as in yourself and your fellow officers. • This section contains strategies for working with different types of PTSD symptoms you may encounter with Veterans, as well as peer and self-care strategies for dealing with PTSD symptoms in yourself.	**II. Managing PTSD**  VETERANS HEALTH ADMINISTRATION 19

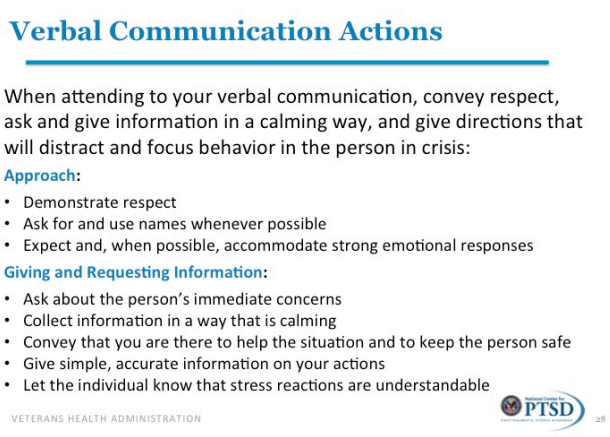
#	Discussion Points	Slide
18	**Dealing with PTSD Symptoms in Others** The techniques described in this section are tools that you may find helpful for dealing with many individuals who are reacting to stress, and particularly those who have PTSD. Each of these techniques is commonly used by mental health providers when working with people in crisis situations.	
19	**Dealing With PTSD Symptoms in Others** These suggestions may not be useful in all circumstances. You are encouraged to practice these skills and use your own judgment as to whether or not these techniques will be useful in a given situation. Keep the following in mind when making a decision about using these techniques: • ***Safety:*** When Veterans experiencing PTSD symptoms are agitated and/or in crisis situations, they are experiencing heightened activation of their natural "fight or flight" responses. Their primary concern at that point is for personal safety, a goal they likely share with responding police officers.	 • ***Sensitivity:*** Because it helps their "fight or flight" response, Veterans in crisis situations are particularly attuned to things going on in their immediate environment. If anything happens that is ambiguous, a Veteran in crisis may default to a negative interpretation. For example, if another police officer arrives for backup, a Veteran in crisis may think "They're here to gang up on me," even if the new officer is actually present to help ensure safety.

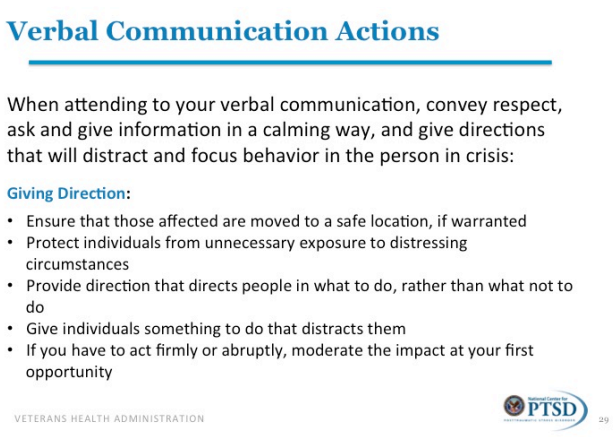
#	Discussion Points	Slide
20	**Dealing with PTSD Symptoms in Others** Keep the following in mind when making a decision about using these techniques: • ***Intrusion:*** Intrusive thoughts and flashbacks related to prior traumatic events can make a Veteran with PTSD hard to reach. • ***Training:*** As part of their military training, Veterans have been taught how to use physical aggression as a tool in dangerous situations. However, because of this training and experience, Veterans may also be in better control of their own use of aggression. This gives officers an opportunity to "team up" with the Veteran to reduce the need for anyone to make use of aggression.	 ***Experience:*** Veterans with tactical military training are aware of most, if not all, of the tactics and techniques that police officers will employ in a crisis situation. When left to make their own interpretation of police officer behavior, Veterans in crisis may default to seeing the officers as hostile and aggressive.
21	**Increasing Understanding of Police Actions: Tactical Transparency** • Tactical transparency means explaining actions before making a move so that the person you are dealing with knows what to expect. • Tactical transparency may be particularly helpful for working with Veterans who are prone to making negative interpretations when things going on in their immediate environment are ambiguous to them. • The purpose of these tactical actions is to provide them with a more clear interpretation of your behavior as a police officer, and to convey your mutual interest in assuring the safety of all involved.	

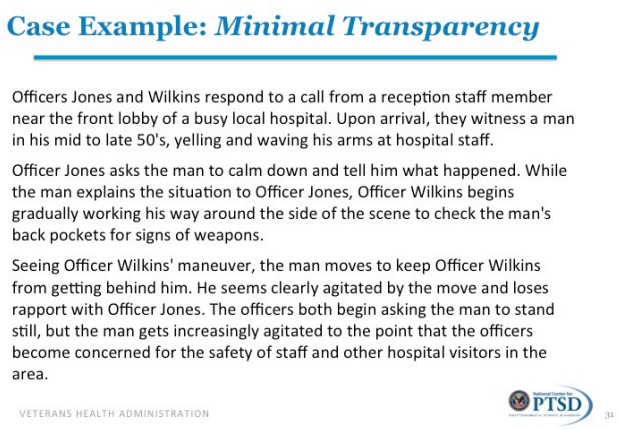
#	Discussion Points	Slide
22	**Adjusting Non-Verbal Communication** Adjusting your non-verbal communication can make a difference in the way Veterans with PTSD interpret your intent. Most experts agree that non-verbal communication is at least as important as the actual words that are spoken, and most would agree that non-verbal cues can be much more important than spoken words. It may be helpful to think of these behaviors as falling into three different categories: • **Friendly/helpful:** These are behaviors that clearly communicate safety, respect, a desire to help, or other attitudes that build a connection with someone (e.g., a handshake and smile). • **Aggressive/hostile**: These are behaviors that communicate a distance from or even a danger to another individual (e.g., having one hand on your firearm). • **Ambiguous:** These are behaviors that are left up to interpretation and may have a wide range of meanings (e.g., facing someone with one shoulder angled away). They are often interpreted as aggressive by individuals in crisis situations.	

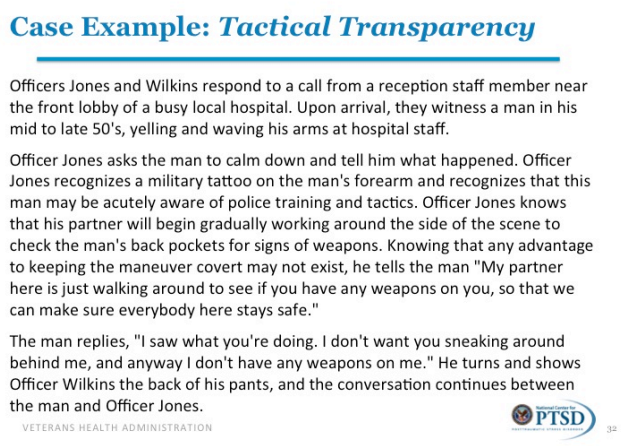
#	Discussion Points	Slide
23	**Non-Verbal Communication Actions** When attending to your non-verbal communication, take care to note the following body language: • Posture: Crisis situations often require you to be physically prepared for aggressive behavior. This may take the form of keeping physical distance from the person in crisis, placing your feet in a position to be able to move away quickly, and orienting your body to one side to reduce your size as a target and keep weapons at a maximum distance. For better or worse, all of these behaviors clearly communicate a readiness to be aggressive, especially to Veterans who have combat training. Consider changing one or more of these behaviors to reduce your communication of aggression, or at least know that you may be fighting an uphill battle to convince the Veteran that you are not intending to use physical aggression. Any moves by you to close off exit routes will also be perceived in a negative manner.	 ***Teaching rationale and techniques*** *— Police officers typically receive some training on the recognition and use of non-verbal communication. This section is meant to make them recall that basic training and to reinforce their consideration of their nonverbal behaviors in a crisis situation.*
24	**Non-Verbal Communication Actions** When attending to your non-verbal communication, take care to note the following body language: • Hands: Some hand behaviors, such as pointing or holding a flat palm up to someone, can be interpreted as directly aggressive. Ambiguous fast movements with hands may also be interpreted as aggressive. Hands may easily communicate a willingness to help (open arms, hands low with palms open and facing upward), or that you are closed off and no longer open to helping (arms folded). Communicating different messages with hands may take place while maintaining safe body postures and may be used to offset aggressive body stance communication.	 ***Teaching rationale and techniques*** *— Police officers typically receive some training on the recognition and use of non-verbal communication. This section is meant to make them recall that basic training and to reinforce their consideration of their nonverbal behaviors in a crisis situation.*

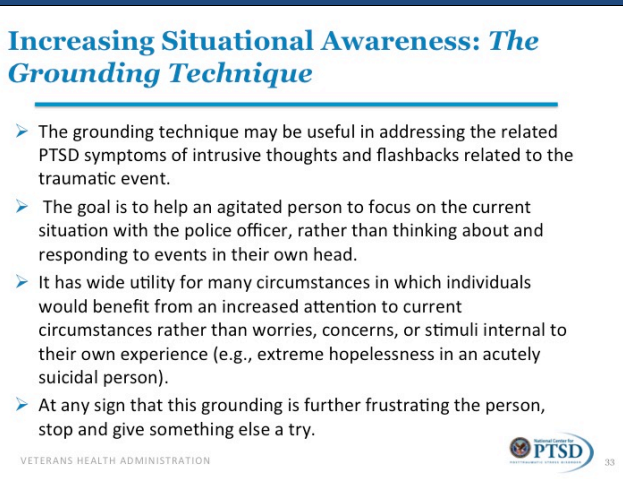
#	Discussion Points	Slide
25	**Non-Verbal Communication Actions** When attending to your non-verbal communication, take care to note the following body language: • Face: Facial cues represent the biggest challenge in nonverbal communication. They are the most difficult to alter, easily misinterpreted, and largely out of our direct control. Perhaps the most important distinction that can be given away by facial cues is that between honesty and insincerity. Choose only verbal statements (e.g. "I appreciate your service to our military") that you actually believe. If you genuinely believe these statements, your sincerity will show in your facial cues.	 ***Teaching rationale and techniques*** *— Police officers typically receive some training on the recognition and use of non-verbal communication. This section is meant to make them recall that basic training and to reinforce their consideration of their nonverbal behaviors in a crisis situation.*

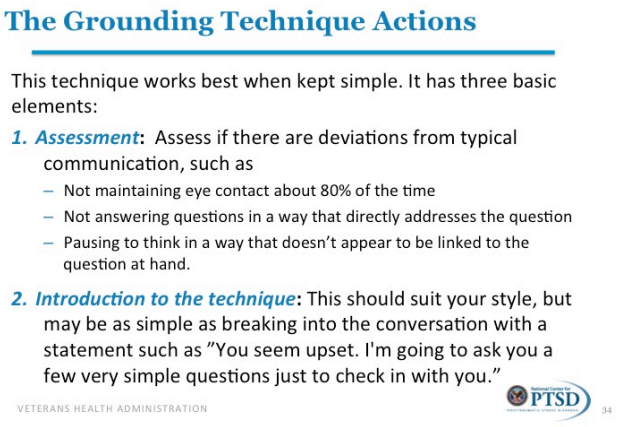
#	Discussion Points	Slide
26	**Verbal Communication Actions** When attending to your verbal communication, first and foremost, make every effort to verbally describe and explain what you are about to do before you do it or as you are doing it. If not possible, make every effort to convey respect, ask and give information in a calming way, and give directions that will distract and focus behavior in the person: **Approach:** • Ask for and use the person's name whenever possible. • Expect and, when possible, accommodate rather than react to strong emotional responses. **Giving and Requesting Information:** • Ask about the person's immediate concerns. • Collect information in a way that is calming, for example: • Encourage the person to answer a series of simple and direct questions to help focus attention. • Ask questions about the order of what happened in a structured way to help organize a person's thinking. • If talking about the situation increases distress in the person, ask unrelated questions to distract the person from their reactions. • Use reflective, clarifying or summarizing statements to let the person know that you understand the person correctly. • Convey that you are there to help the situation and to keep the person safe. • Let the person know that in these circumstances, stress reactions, while they may be alarming, are understandable.	 ***Teaching rationale and techniques*** *— Police officers typically receive some training on the recognition and use of verbal communication. This section is meant to give a framework, make them recall that basic training, and to reinforce their consideration of their verbal behaviors in a crisis situation.*

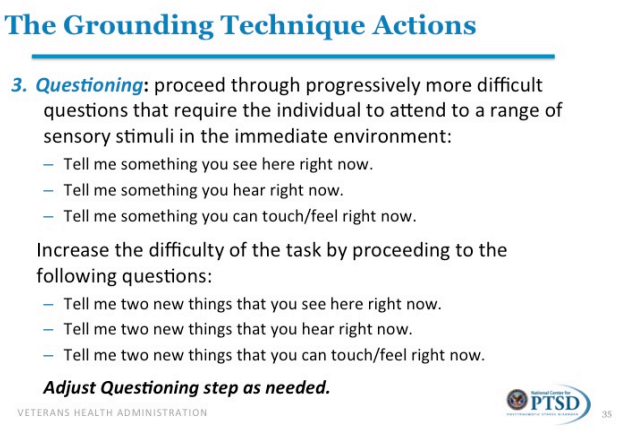
#	Discussion Points	Slide
27	**Verbal Communication Actions** When attending to your verbal communication, first and foremost, make every effort to verbally describe and explain what you are about to do before you do it or as you are doing it. If not possible, make every effort to convey respect, ask and give information in a calming way, and give directions that will distract and focus behavior in the person: **Giving Direction:** • Ensure that the person is moved to a safe location, if warranted. • Whenever possible, protect the person from unnecessary exposure to additional circumstances that could cause additional distress (e.g. disturbing sensory input, media, curious onlookers or other involved individuals who are distressed or angry). • Provide direction that is clear and positive, oriented towards directing the person in what to do, rather than what not to do. For example, instead of yelling "Get out of the way," try "I need you to move over here so you don't get hurt." • Give the person something to do that distracts them. • If you have to act firmly or abruptly, moderate the impact at your first opportunity by returning to a calm tone, explaining the importance of compliance with your instructions and emphasizing that the person's safety and protection is your foremost concern. • Reinforce compliance by promptly and positively acknowledging actions that follow your instructions.	 ***Teaching rationale and techniques*** *— Police officers typically receive some training on the recognition and use of verbal communication. This section is meant to give a framework, make them recall that basic training, and to reinforce their consideration of their verbal behaviors in a crisis situation.*

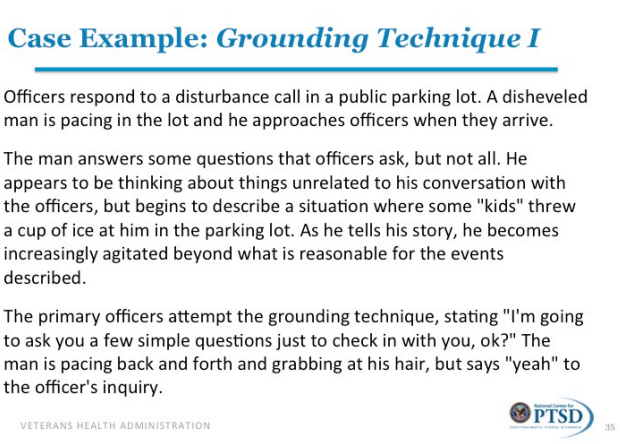
#	Discussion Points	Slide
28	**Case Example: Disturbance Call at Local Hospital – Minimal Transparency** The following is a description of a hypothetical encounter between a police officer and a Veteran. While hypothetical, it is based on tactics and situations described to us by police officers during our police training efforts at the National Center for PTSD. Officers Jones and Wilkins respond to a call from a reception staff member near the front lobby of a busy local hospital. Upon arrival, they witness a man in his mid to late 50's, yelling and waving his arms at hospital staff. Officer Jones asks the man to calm down and tell him what happened. While the man explains the situation to Officer Jones, Officer Wilkins begins gradually working his way around the side of the scene to check the man's back pockets for signs of weapons. Seeing Officer Wilkins' maneuver, the man moves to keep Officer Wilkins from getting behind him. He seems clearly agitated by the move and loses rapport with Officer Jones. The officers both begin asking the man to stand still, but the man gets increasingly agitated to the point that the officers become concerned for the safety of staff and other hospital visitors in the area.	 ***Teaching rationale and techniques*** *— This case is meant to demonstrate how minimal transparency can affect a situation with a Veteran with PTSD. One purpose of these stories is to set some of the symptoms of PTSD into a context relevant to the police officers. The hope is that officers can have a greater appreciation for the impact of their behaviors on a crisis situation.* *Because it may increase the quality of the training, presenters are encouraged to include their own anecdotes when describing how specific actions may affect Veterans with PTSD in a crisis situation.*

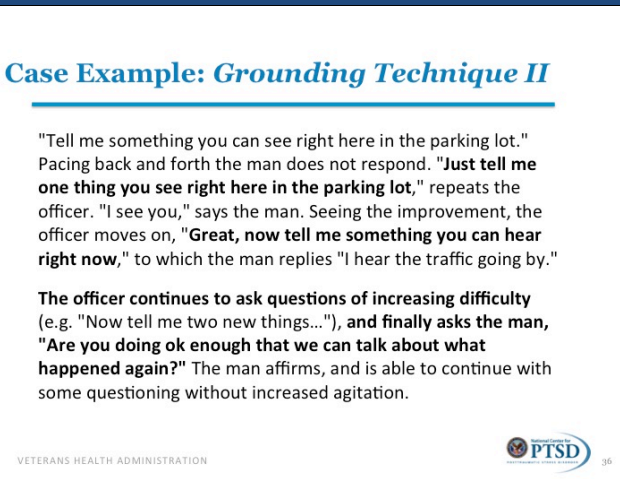
#	Discussion Points	Slide
29	**Case Example: Disturbance Call at Local Hospital – Tactical Transparency** The following is the same hypothetical encounter between a police officer and a Veteran, with tactical transparency used by police instead of minimal transparency. Officers Jones and Wilkins respond to a call from a reception staff member near the front lobby of a busy local hospital. Upon arrival, they witness a man in his mid to late 50's, yelling and waving his arms at hospital staff. Officer Jones asks the man to calm down and tell him what happened. Officer Jones recognizes a military tattoo on the man's forearm and recognizes that this man may be acutely aware of police training and tactics. Officer Jones knows that his partner will begin gradually working around the side of the scene to check the man's back pockets for signs of weapons. Knowing that any advantage to keeping the maneuver covert may not exist, he tells the man "My partner here is just walking around to see if you have any weapons on you, so that we can make sure everybody here stays safe." The man replies, "I saw what you're doing. I don't want you sneaking around behind me, and anyway I don't have any weapons on me." He turns and shows Officer Wilkins the back of his pants, and the conversation continues between the man and Officer Jones.	 ***Teaching rationale and techniques*** *— This is a place where you may want to take some time to elaborate, it is always a matter of some discussion at trainings.* *The point requires different levels of explanation for different officers to understand, hence the breakdown all the way to the simplified vignettes above.* *Police officers who are themselves Veterans will often join the conversation, sometimes even describing how they see this point (i.e., Veteran recognition of tactical maneuvers) as a significant concern for police officer safety.* *It is important to defer to individual police departments, and even individual officers as to how best to address (or ignore) this topic, but it should be explored given its significance.*

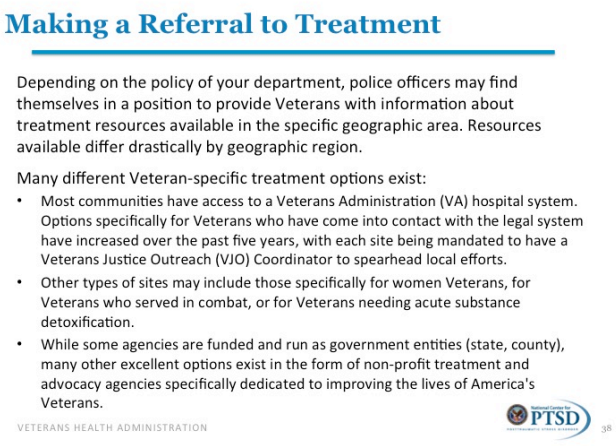
#	Discussion Points	Slide
30	**Increasing Situational Awareness: The Grounding Technique** The grounding technique may be useful in addressing intrusive thoughts and flashbacks related to the traumatic event. The purpose of this technique is to help an agitated person to focus on the current situation with the police officer, rather than thinking about and responding to events in their own head. While useful with Veterans experiencing PTSD symptoms, this technique has wide utility for many circumstances in which individuals would benefit from an increased attention to current circumstances rather than worries, concerns, or stimuli internal to their own experience (e.g., extreme hopelessness in an acutely suicidal person). As with any technique, this one could also be counterproductive. At any sign that this grounding is further frustrating the person, stop and give something else a try.	

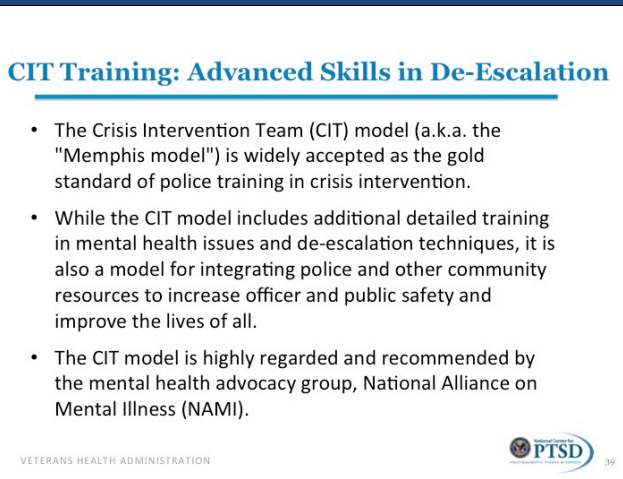
#	Discussion Points	Slide
31	**The Grounding Technique Actions** This technique works best when kept simple. It is described in full below, and illustrated with examples afterward to demonstrate how it may actually be employed in the field. The technique has three basic elements: assessment, introduction and questioning. **Assessment** This technique may be useful when a person is responding to things, such as a flashback, that are not actually present in the immediate environment. In typical communication, people maintain eye contact about 80% of the time, respond to questions with answers that make sense, and pauses appear to be used to think about the immediate question at hand. If a person's ability to carry on a conversation appears to be impaired or if they don't appear to know what is going on around them, grounding may be appropriate.	 **Introduction to the Technique** Begin grounding by breaking into the conversation with a statement such as "I'm going to ask you a few very simple questions, just to check in with you." A more elaborate script follows, but individuals are encouraged to adopt an introduction that suits their own personal style: "I've noticed that you're upset. I'm going to ask you some questions just to see that you're with me, and then we are going to address your concerns."

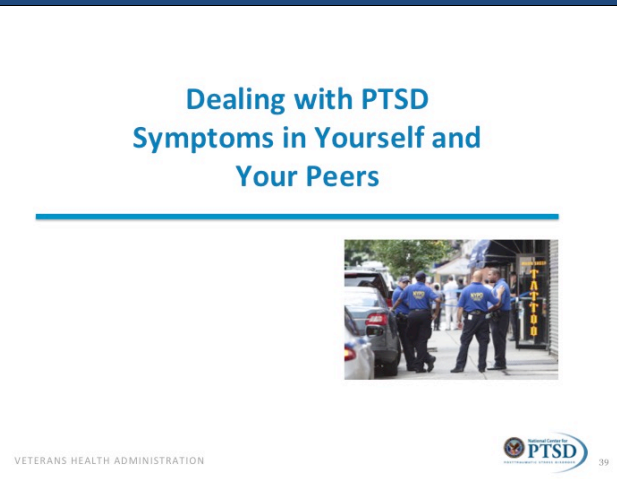
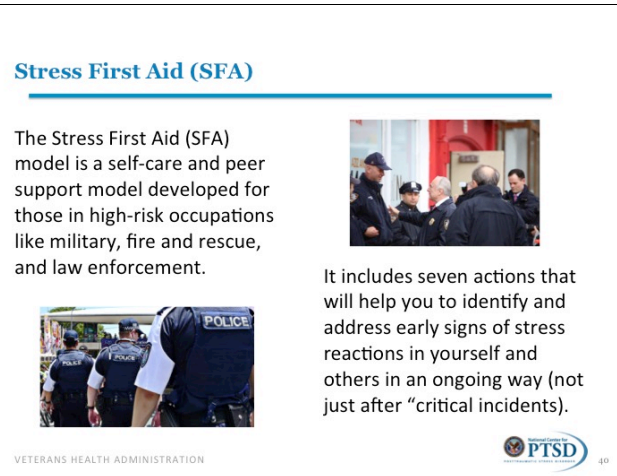
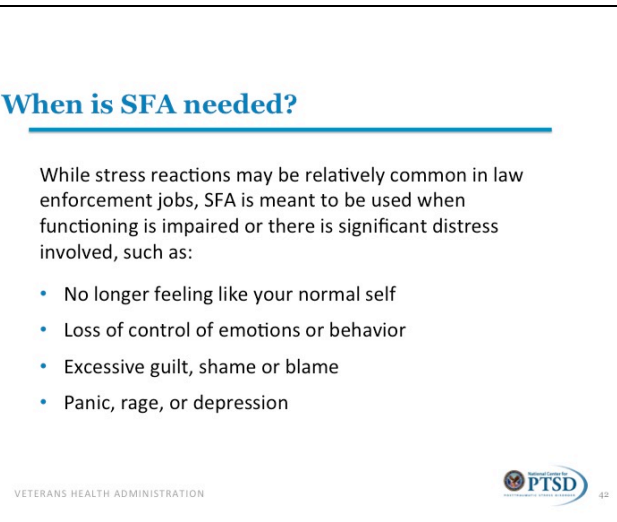
#	Discussion Points	Slide
32	**The Grounding Technique Actions** This technique works best when kept simple. It is described in full below, and illustrated with examples afterward to demonstrate how it may actually be employed in the field. The technique has three basic elements: assessment, introduction and questioning. **Questioning** In this stage, you will proceed through progressively more difficult questions that require the individual to attend to sensory stimuli in the immediate environment: **Phase I:** Start here. This is the simplest form of question and any answer requires attention to the immediate environment. The questions are: • Tell me something you see here right now. • Tell me something you hear right now. • Tell me something you can touch/feel right now. **Phase II**: If the questions in Phase I appear to be helping, but you are uncertain that the person is sufficiently oriented to the present, you can increase the difficulty of the task by proceeding to the following questions: • Tell me two new things that you see here right now. • Tell me two new things that you hear right now. • Tell me two new things that you can touch/feel right now.	 **Adjust as Needed:** The Questioning step can be adjusted as needed. It is critical to ask questions over a range of sensory modalities (visual, auditory, tactile) as the internal stimuli that you are trying to override may come in any form. It may be obvious after your very first question that the person is now alert, oriented and responding to the current situation. It may be that you need to go farther into the question list to get someone to attend to you and to the situation at hand. Grounding should help the person be able to focus on the here and now. If your attempt at this technique yields no improvement or a worsening of symptoms, then you may abandon this technique for the current situation or you may make another attempt later.

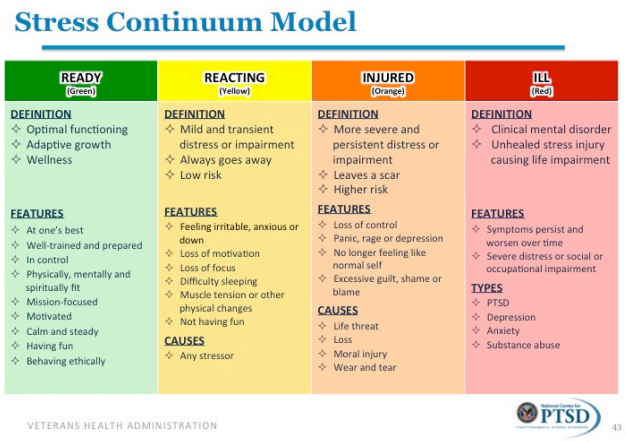
#	Discussion Points	Slide
33	**Case Example: Grounding Technique Part 1** • Officers respond to a disturbance call in a public parking lot. A disheveled man is pacing in the lot and he approaches officers when they arrive. • The man answers some questions that officers ask, but not all. He appears to be thinking about things unrelated to his conversation with the officers, but begins to describe a situation where some "kids" threw a cup of ice at him in the parking lot. As he tells his story, he becomes increasingly agitated beyond what is reasonable for the events described. • The primary officers attempt the grounding technique, stating "I'm going to ask you a few simple questions just to check in with you, ok?" The man is pacing back and forth and grabbing at his hair, but says "yeah" to the officer's inquiry.	 ***Teaching rationale and techniques*** *— There are two primary challenges to teaching this technique. First, it is difficult for some officers to believe that something so simple can actually be useful. Reassure them that this technique does sometimes work, in fact because of its simplicity. Second, because it seems so simple, it is easy to underestimate the awkwardness of employing this technique. Time permitting, behavioral practice is recommended. Spend some time teaching this technique – actually conduct the grounding technique after showing the audience a brief emotionally evocative video (we use a short clip of the 9/11 news footage). Following the grounding technique, debrief the experience, asking "Was anything going on for you when you watched the video?" and "What changed when I started asking the grounding questions?" Due to the possibility that some audience members may have served in combat, and may even have had PTSD symptoms at some point, it is NOT recommended to use a video of combat or other police-related event for the induction part of the procedure.*

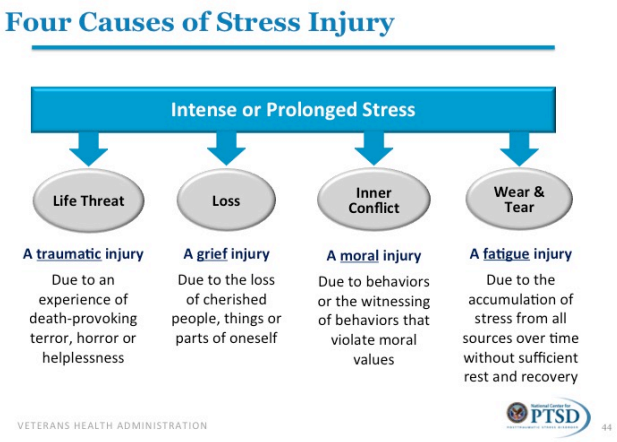
#	Discussion Points	Slide
34	**Case Example: Grounding Technique Part 2** • "Tell me something you can see right here in the parking lot." Pacing back and forth the man does not respond. "Just tell me one thing you see right here in the parking lot," repeats the officer. "I see you," says the man. Seeing the improvement, the officer moves on, "Great, now tell me something you can hear right now," to which the man replies "I hear the traffic going by." • The officer continues to ask questions of increasing difficulty (e.g. "Now tell me two new things…"), and finally asks the man, "Are you doing ok enough that we can talk about what happened again?" The man affirms, and is able to continue with some questioning without increased agitation.	 ***Teaching rationale and techniques*** *— There are two primary challenges to teaching this technique. First, it is difficult for some officers to believe that something so simple can actually be useful. Reassure them that this technique does sometimes work, in fact because of its simplicity. Second, because it seems so simple, it is easy to underestimate the awkwardness of employing this technique. Time permitting, behavioral practice is recommended. Spend some time teaching this technique – actually conduct thegrounding technique after showing the audience a brief emotionally evocative video (we use a short clip of the 9/11 news footage). Following the grounding technique, debrief the experience, asking "Was anything going on for you when you watched the video?" and "What changed when I started asking the grounding questions?" Due to the possibility that some audience members may have served in combat, and may even have had PTSD symptoms at some point, it is NOT recommended to use a video of combat or other police-related event for the induction part of the procedure.*

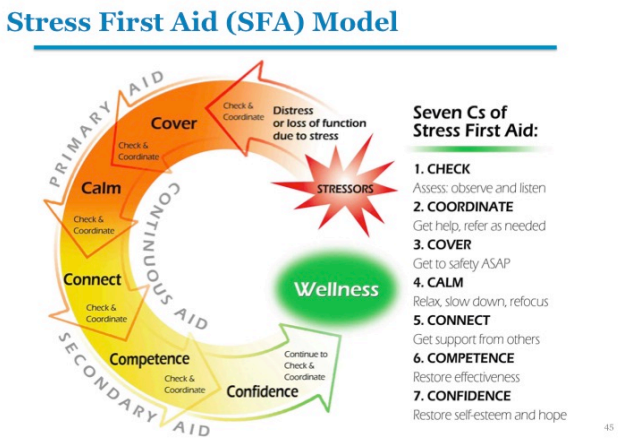
#	Discussion Points	Slide
35	**Making a Referral to Treatment** Depending on the policy of your department, you may be able to provide Veterans with information about hotlines, treatment options, and other resources available in the local area. Some departments allow or even encourage officers to transport Veterans directly to a site. Resources available differ by geographic region. Some areas may have a single point of contact for Veterans to seek treatment (e.g. a local clinic), while others may have an overwhelming array of options. **Types of Sites** Many different Veteran-specific treatment options exist: • Most communities have access to a Veterans Administration (VA) hospital system. Options specifically for Veterans who have come into contact with the legal system have increased over the past five years, with each site being mandated to have a Veterans Justice Outreach (VJO) Coordinator to spearhead local efforts. • Other types of sites may include those specifically for women Veterans, for Veterans who served in combat, or for Veterans needing acute substance detoxification. • While some agencies are funded and run as government entities (state, county), many other excellent options exist in the form of non-profit treatment and advocacy agencies specifically dedicated to improving the lives of America's Veterans.	 ***Teaching rationale and techniques*** *— The goal of this section is to introduce officers to the option of giving Veterans a referral to treatment. Additional resources for doing this are included elsewhere in this toolkit in the form of the referral card. An ongoing difficulty with encouraging officers to make treatment referrals is that the process for doing so is unique for individual sites and these sites differ by geographic region. Giving standard instructions in this section is thus not possible and trainers will need to focus significant effort on developing a training module specific to your geographic area.*

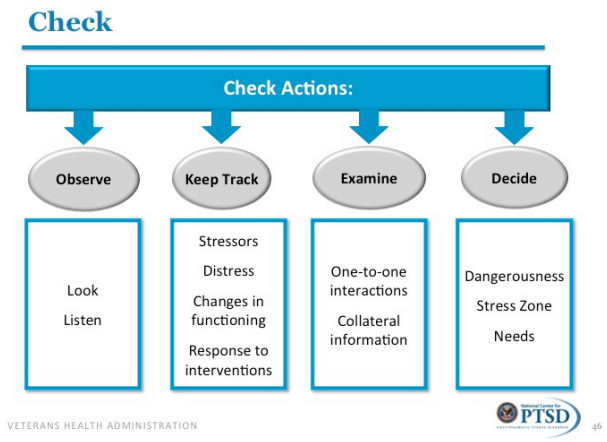
#	Discussion Points	Slide
36	**CIT Training: Advanced Skills in De-Escalation** Depending on the policy of your department, you may be able to provide Veterans with information about hotlines, treatment options, and other resources available in the local area. Some departments allow or even encourage officers to transport Veterans directly to a site. Resources available differ by geographic region. Some areas may have a single point of contact for Veterans to seek treatment (e.g. a local clinic), while others may have an overwhelming array of options. **Types of Sites** Many different Veteran-specific treatment options exist: • Most communities have access to a Veterans Administration (VA) hospital system. Options specifically for Veterans who have come into contact with the legal system have increased over the past five years, with each site being mandated to have a Veterans Justice Outreach (VJO) Coordinator to spearhead local efforts. The VA Veterans Justice Outreach (VJO) Program is a prevention-focused component of VA's Homeless Programs Office (HPO). VHO provide outreach and linkage to other VA and/or community services for justice-involved Veterans in various settings, including jails and courts. They connect Veteran defendants with needed VA services and provide valuable information on their progress in treatment.	 • Other types of sites may include those specifically for women Veterans, for Veterans who served in combat, or for Veterans needing acute substance detoxification. • While some agencies are funded and run as government entities (state, county), many other excellent options exist in the form of non-profit treatment and advocacy agencies specifically dedicated to improving the lives of America's Veterans. ***Teaching rationale and techniques*** *— We have tried to make it explicit that the information in this toolkit is only a modest introduction to what is available for training in crisis management relevant to Veterans with PTSD. Our experience is also that, even for departments who push very hard to have minimal training at the outset, getting some training in Veteran mental health issues and PTSD often makes departments ask for additional training. Orienting them to the optimal training model, CIT, lets them know what one eventual goal for their departments may be.*

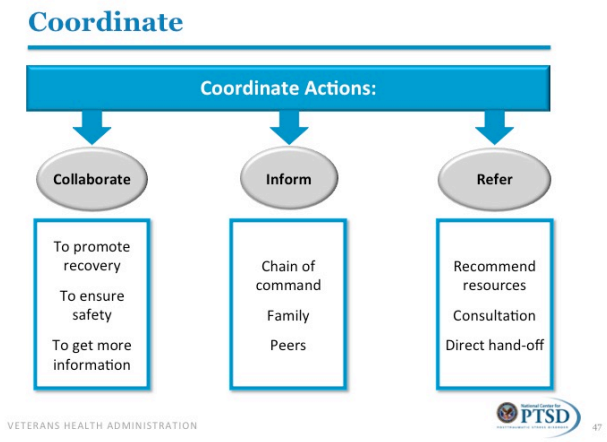
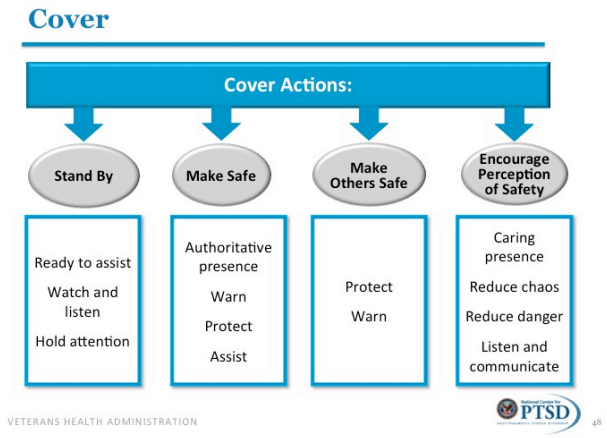
#	Discussion Points	Slide
37	**Dealing with PTSD Symptoms in Yourself and Your Peers** This section gives information on the Stress First Aid Model (SFA), an evidence-informed peer support model developed for those in high-risk occupations like military, fire and rescue, and law enforcement. It includes seven actions to take to identify and address early signs of stress reactions in yourself and others.	
38	**Stress First Aid** The Stress First Aid (SFA) model is a self-care and peer support model developed for those in high-risk occupations like military, fire and rescue, and law enforcement. It includes seven actions that will help you to identify and address early signs of stress reactions in yourself and others in an ongoing way (not just after "critical incidents").	
39	**When is SFA Needed?** While stress reactions may be relatively common in law enforcement jobs, SFA is meant to be used when functioning is impaired or there is significant distress involved, such as: • No longer feeling like your normal self • Loss of control of emotions or behavior • Excessive guilt, shame or blame • Panic, rage, or depression	

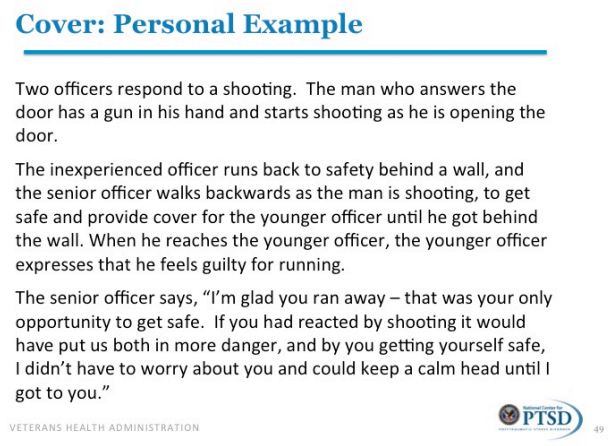
#	Discussion Points	Slide
40	**The Stress Continuum Model** The Stress Continuum Model is a foundational part of the SFA model. It was developed as a way to assess the level of your own and other's stress responses. It was first developed for by Navy/Marine Corps service members a way to acknowledge that stress reactions occur on a continuum, and that early awareness and response could bring a person back into a less severe zone before they had the need for more formal intervention. The crux of the stress continuum model is that stress responses lie along a spectrum of severity. Everyone will react when faced with severe enough or extended enough stress, and many factors can affect how they respond and how they recover. A person's reactions can range relatively rapidly from Green to Yellow to Orange to Red zone, and back again. The stigma associated with reacting to stress can result in someone trying to conceal stress reactions from peers and those up the chain of command, to avoid perceived judgment, employment consequences, and/or medical or psychological intervention. However, when a person recognizes the signs of orange zone stress in themselves or others around them, it can often make a difference to be more disciplined about self-care for a period of time, or to support a coworker or get them connected with a trusted support. This may help prevent stress reactions from progressing into the Red Zone.	

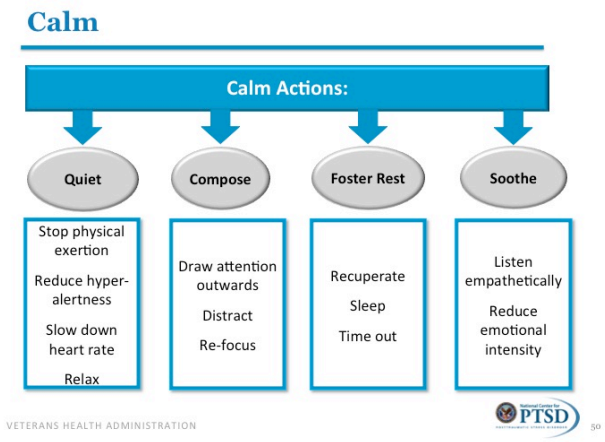
#	Discussion Points	Slide
41	**Four Causes of Stress Injury** Four types of stress are most likely to move someone into the orange zone. Generally, entering the orange or red zones are the result of a combination of the four following types of stressors: • **Life Threat:** life-threatening or other situations that provoke terror, horror or helplessness. This type of injury can include experiencing a near-miss or close call • **Loss:** grief due to the loss of close comrades, leaders, family members or other cared-for individuals. This can also include loss of role, functioning, relationships, and values. • **Inner Conflict:** a sense of inner turmoil due to conflict between one's moral/ethical beliefs and current experiences. Inner conflict can result from acting outside of internal, self-imposed morals or values, or the perception of contributing to or being unable to prevent harm to others. Indications for inner conflict include the words: "could've," "should've," "ought to have," or "if only." • **Wear and Tear:** the result of fatigue and accumulation of prolonged stress, including from non-operational sources, without sufficient sleep, rest and restoration.	

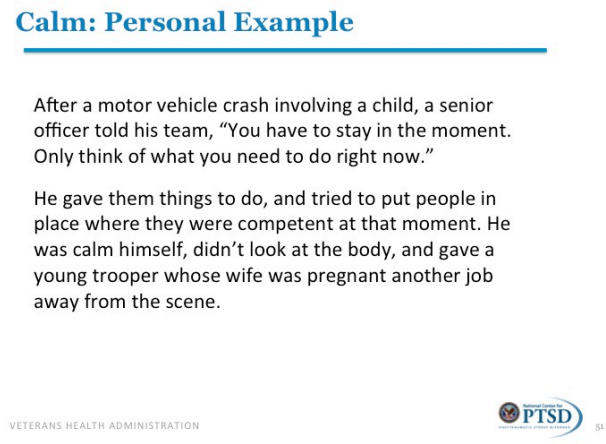
#	Discussion Points	Slide
42	**Stress First Aid Model** SFA is based on a set of five elements that have been linked to better functioning after stress and adversity across a number of settings. These elements are: (1) ***Cover:*** Regaining a sense of safety, or cover (2) ***Calm:*** Restoring calm, to reduce intense physiological arousal and negative emotions (3) ***Connect:*** Feeling connected to sources of social support (4) ***Competence:*** Increasing the sense of self-efficacy, which means feeling competent to handle the situations that create stress, or ones own reactions to the stress (5) ***Confidence:*** Experiencing hope, or confidence, in ones self and the world.	 The SFA model includes two additional actions, Check and Coordinate, which are considered *continuous* actions because they should be performed in an ongoing way to monitor and recruit assistance any time a person is showing persistent Orange Zone reactions. In contrast, the other five SFA actions are used only *as needed.*

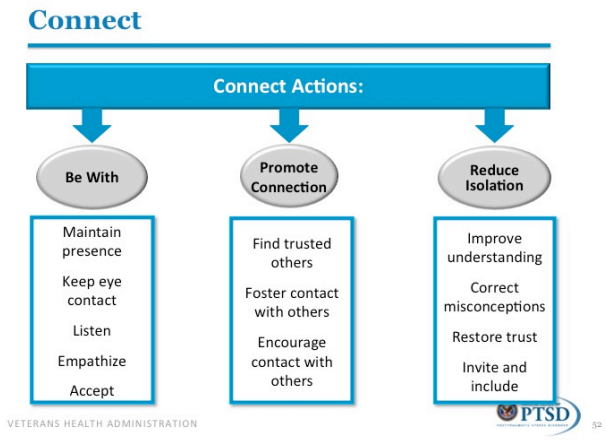
#	Discussion Points	Slide
43	**The Check Action** The Check action in SFA involves increased situation awareness about stress reactions in yourself and your coworkers in an ongoing way, whether stressors at work or at home cause them. The components of Check involve: • *Observing* what is going on by noting how you or your coworker is being affected, and by what. This is not meant to be an intrusive process, but one of awareness and caring. • *Keeping track of* the key indicators of the Stress Zones. Pay special attention to stressor events (both at work and on the home front) and the internal distress and changes in functioning that these events (or their accumulation over time) may have provoked. If SFA actions have already been used, you will also keep track of whether they have been effective. • *Examining* all the information gathered from your observations over time, as well as from other sources, such as peers and supervisors. • *Deciding* on what stress zone is involved, whether anyone is in danger, and what potential next steps and/or SFA actions need to be taken, based on the information you gather.	 The Check action often begins with awareness that an individual has been exposed to specific stressors. However, exposure to stressors is not enough to warrant SFA. *Most people who experience even intense stressors don't need help*. What triggers the sequence of Checks that initiate SFA are not the events themselves but *indications* that someone who has been exposed to these events is functioning in the Orange or Red Zone.

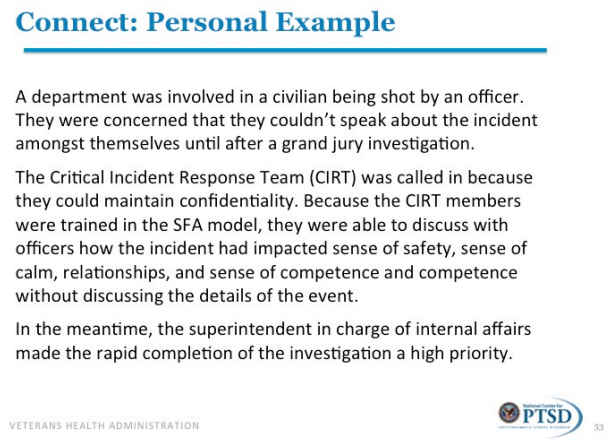
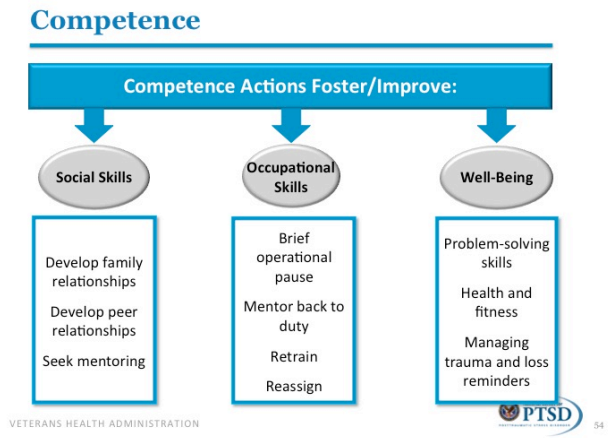
#	Discussion Points	Slide
44	**The Coordinate Action** The Coordinate action in SFA involves getting any additional information and assistance that might be needed. This could involve consulting with and collaborating with others, or informing those who need to know. The key components of the Coordinate action involve: • *Collaborating* with everyone who has a stake in the well being of the stressed individual. • *Getting assistance* from others at any step in the process, especially when help is needed to care for those in the Orange Zone. • *Informing* the chain of command to the extent that they need to know. • *Referring* the stress-affected person to others who can help, either via a direct hand-off to formal treatment, or through a more gradual mentoring process that results in them eventually getting the care they need.	 Confidentiality may be challenging when using the Coordinate action, so you may need to ask for advice from those in your organization as to the most appropriate ways to refer for care or inform others in your setting.
45	**Cover** This slide shows the primary components of the next SFA action, Cover. To provide Cover means to ensure ongoing safety, usually performed more for others more than yourself. The components of Cover involve: • *Standing by* a fellow officer and remaining available and ready to assist as needed. • *Making the person safe* in any way you can. When necessary, Cover also encompasses *making others safe* from the officer if he/she is not functioning well because of stress reactions. • *Encouraging a perception of safety* for both affected officers and their families via a greater commitment to organizational safety and order.	

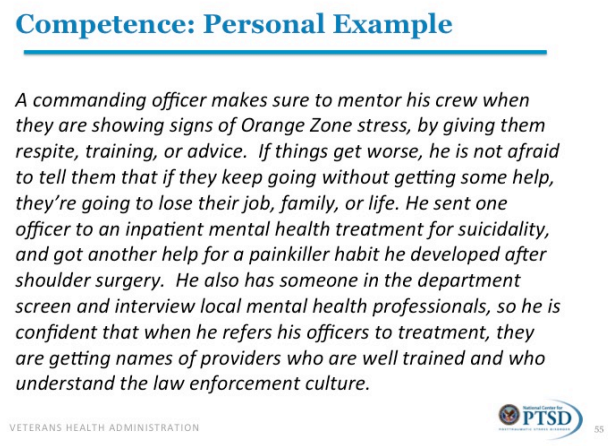
#	Discussion Points	Slide
46	**Cover Personal Example** Facilitate a discussion where this example prompts participants to give their own examples of Cover. Two officers responded to a shooting. The man who answers the door has a gun in his hand and starts shooting as he is opening the door. The inexperienced officer runs back to safety behind a wall, and the senior officer walks backwards as the man is shooting, to get safe and provide cover for the younger officer until he got behind the wall. When he reaches the younger officer, the younger officer expresses that he feels guilty for running. The senior officer says, "I'm glad you ran away – that was your only opportunity to get safe. If you had reacted by shooting it would have put us both in more danger, and by you getting yourself safe, I didn't have to worry about you and could keep a calm head until I got to you."	 ***Teaching rationale and techniques*** *- The goals are to have the participants start to connect their own experiences with the concept of cover and identify behaviors that would be consistent with a stress injury that need a cover intervention.*

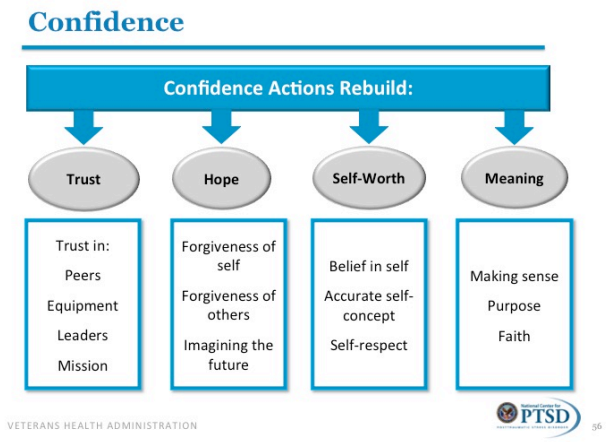
#	Discussion Points	Slide
47	**Calm** This slide shows the major components of the next SFA action, Calm. The goal of the Calm action in SFA is to reduce the intensity of physiological, emotional and behavioral stress. There is overlap between the actions of Cover and Calm, but the difference is that the primary goal of Cover is safety, and Calm actions may have no direct connection with safety. Calm actions for yourself or others involve: • *Stopping, quieting oneself, and ceasing physical exertion* if possible, such as by sitting down or walking away, with the goal of slowing heart rate. • *Regaining composure* to move into a more orderly and coherent way of thinking and reacting. For instance, you can help an officer compose him or herself by drawing attention away from chaotic inner thoughts and feelings, and refocusing him her on another task that is less stressful. • *Resting or sleeping* for as long as is necessary, which is sometimes the only thing that will restore a person to more effective functioning. • *Soothing,* which means to provide a calm physical presence and/or listen in a caring way.	

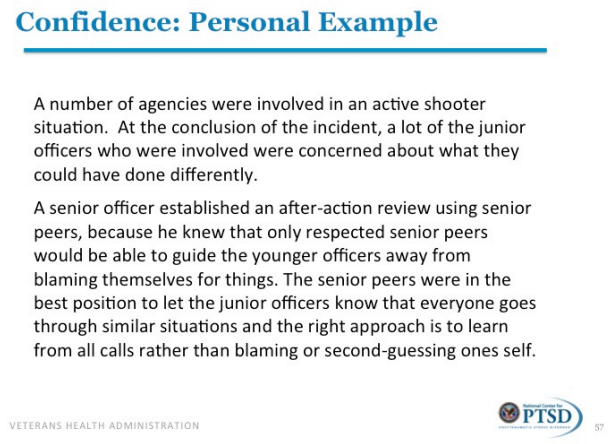
#	Discussion Points	Slide
48	**Calm Personal Example** Facilitate a discussion where this example prompts participants to give their own examples of Calm. After a motor vehicle crash involving a child, a senior officer told his team, "You have to stay in the moment. Only think of what you need to do right now." He gave them things to do, and tried to put people in place where they were competent at that moment. He was calm himself, didn't look at the body, and gave a young trooper whose wife was pregnant another job away from the scene.	 ***Teaching rationale and techniques*** *- The goals are to have the participants start to connect their own experiences with the concept of Calm and identify behaviors that would be consistent with a stress injury that need a Calm intervention.*

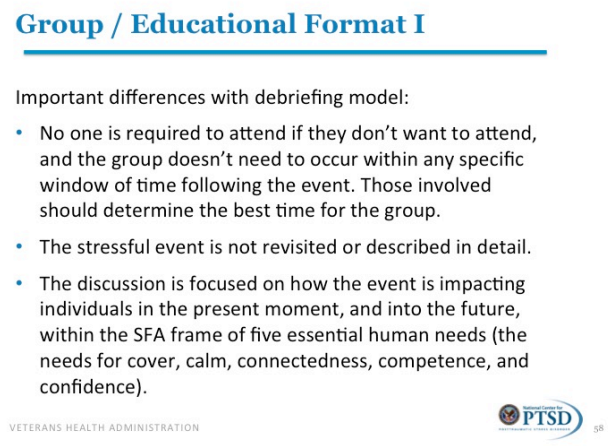
#	Discussion Points	Slide
49	**Connect** The Connect action of SFA involves restoring or increasing social support, such as asking for or providing support when you see Orange Zone stress in yourself or others. The elements of the Connect action involve: • *Being with* the person who is experiencing Orange zone stress, when they need support. This means being present, showing support, listening and/or mentoring and empathizing. • *Promoting connection*, which may involve including the person in an activity, problem-solving obstacles that are getting in their way to receiving social support, or giving help and information in strictly practical way. • *Reducing the person's sense of isolation,* which can often occur when Orange Zone stress reactions make the person want to be alone. This may involve improving the person's understanding of the situation or his or her stress reactions. Often, you can help the person to see that stress reactions are understandable and acceptable, or that they are not alone in their experience of stress reactions.	

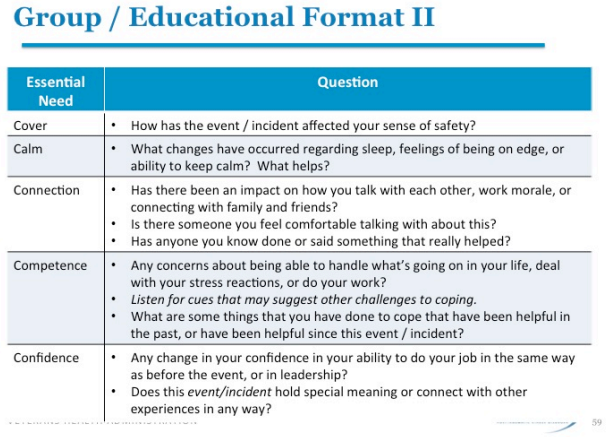
#	Discussion Points	Slide
50	**Connect Personal Example** Facilitate a discussion where this example prompts participants to give their own examples of Connect. A department was involved in a civilian being shot by an officer. They were concerned that they couldn't speak about the incident amongst themselves until after a grand jury investigation. The Critical Incident Response Team (CIRT) was called in because they could maintain confidentiality. Because the CIRT members were trained in the SFA model, they were able to discuss with officers how the incident had impacted sense of safety, sense of calm, relationships, and sense of competence and competence without discussing the details of the event. In the meantime, the superintendent in charge of internal affairs made the rapid completion of the investigation a high priority.	 ***Teaching rationale and techniques*** *- The goals are to have the participants start to connect their own experiences with the concept of Connect and identify behaviors that would be consistent with a stress injury that need a Connect intervention.*
51	**Competence** The Competence action of SFA focuses on fostering and restoring a stress-affected person's capacity to function in all his or her important life roles, including occupational, personal, and social domains. Competence elements involve: • *Improving social skills* that have been damaged by stress, which can negatively affect a person's ability to function with others at home and on the job. • *Improving occupational skills* that have either contributed to stress reactions, or may have been damaged by stress reactions. This may require mentoring, respite, and retraining. • *Fostering the development of coping skills* that can help improve one's abilities to deal with stress reactions.	

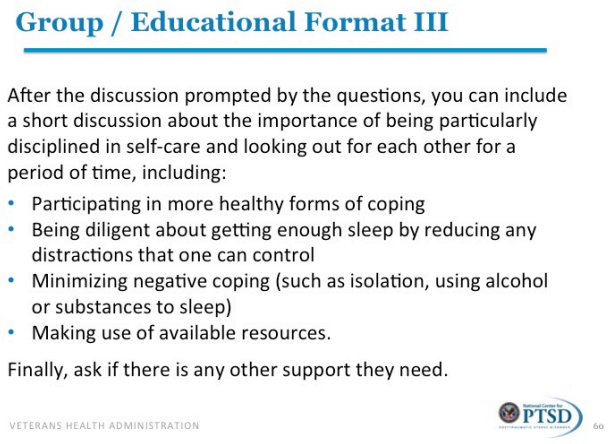
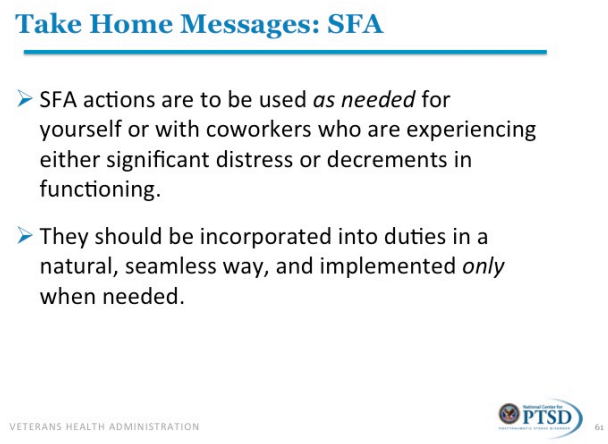
#	Discussion Points	Slide
52	**Competence Personal Example** Facilitate a discussion where this focus group example prompts participants to give their own examples of Competence. A commanding officer makes sure to mentor his crew when they are showing signs of Orange Zone stress, by giving them respite, training, or advice. If things get worse, he is not afraid to tell them that if they keep going without getting some help, they're going to lose their job, family, or life. He sent one officer to an inpatient mental health treatment for suicidality, and got another help for a painkiller habit he developed after shoulder surgery. He also has someone in the department screen and interview local mental health professionals, so he is confident that when he refers his officers to treatment, they are getting names of providers who are well trained and who understand the law enforcement culture.	 ***Teaching rationale and techniques*** *- Facilitate a discussion with the participants. The goals are to have the participants start to describe their own experiences with the concept of Competence and identify behaviors that would be consistent with a stress injury that need a Competence intervention.*

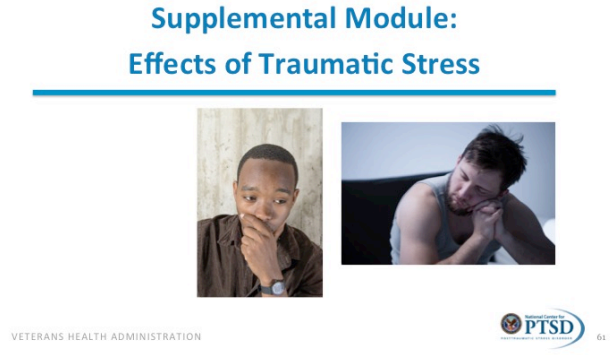
#	Discussion Points	Slide
53	**Confidence** The final SFA action is Confidence, originally derived from the literature on "hope." The Confidence action of SFA may be a more challenging action to implement than the rest of the SFA actions, but it may also have the greatest impact for someone who has lost confidence in themselves or others. The Confidence action involves promoting realistic hope and building self-esteem that may have been damaged or lost as a result of stress, promoting confidence in core values and beliefs, or bolstering pride and commitment. The components of Confidence involve: • *Fostering trust,* which can be trust in many things, such as peers, equipment, leaders, self or mission. • *Increasing hope*, which is often the result of forgiving self or others, or being able to imagine the future in a positive way. • *Improving self-worth*, which includes improving belief in self, accurate self-image, self-respect, and the awareness of and motivation to take the steps necessary to achieve one's life goals • *Fostering meaning*, which includes making sense of the events on one's life, having a sense of purpose, holding a spiritual or philosophical perspective related to the human condition, or having a belief in others that gets one through difficult times.	

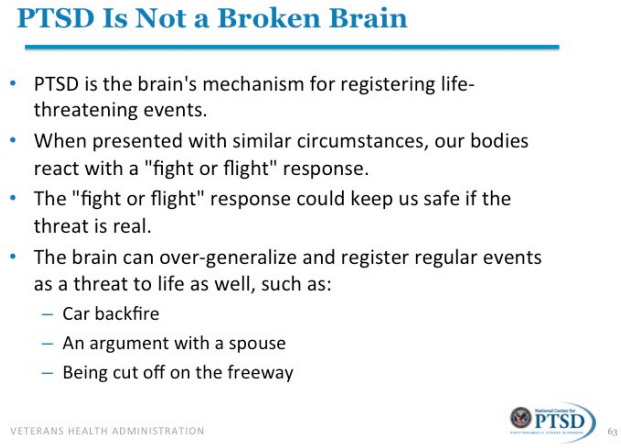
#	Discussion Points	Slide
54	**Confidence Personal Example** Facilitate a discussion where this focus group example prompts participants to give their own examples of Confidence. A number of agencies were involved in an active shooter situation. At the conclusion of the incident, a lot of the junior officers who were involved were concerned about what they could have done differently. A senior officer established an after-action review using senior peers, because he knew that only respected senior peers would be able to guide the younger officers away from blaming themselves for things. The senior peers were in the best position to let the junior officers know that everyone goes through similar situations and the right approach is to learn from all calls rather than blaming or second-guessing ones self.	 ***Teaching rationale and techniques*** *- Facilitate a discussion with the participants. The goals are to have the participants start to describe their own experiences with the concept of Confidence and identify behaviors that would be consistent with a stress injury that need a Confidence intervention.*

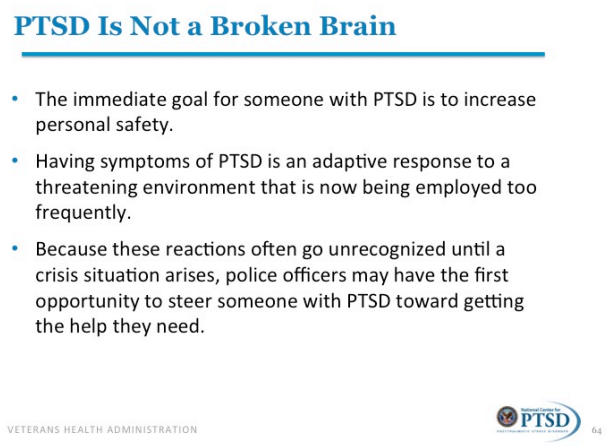
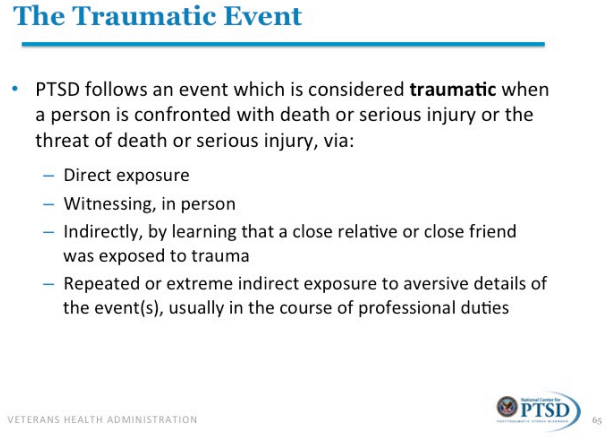
#	Discussion Points	Slide
55	**Group Educational Format I** The SFA model is primarily a one-on-one model, so that it can be more effectively tailored for the needs and priorities of the individual involved. However, in certain circumstances, SFA actions can also be used to structure a group following a stressful event. This use may look similar to a debriefing model in that it systematically uses all the five core SFA actions to lead a discussion, but there are some important differences: • No one is required to attend if they don't want to attend, and the group doesn't need to occur within any specific window of time following the event. Those involved should determine the best time for the group. • The stressful event is not revisited or described in detail. • The discussion is focused on how the event is impacting individuals in the present moment, and into the future, within the SFA frame of five essential human needs (the needs for cover, calm, connectedness, competence, and confidence).	

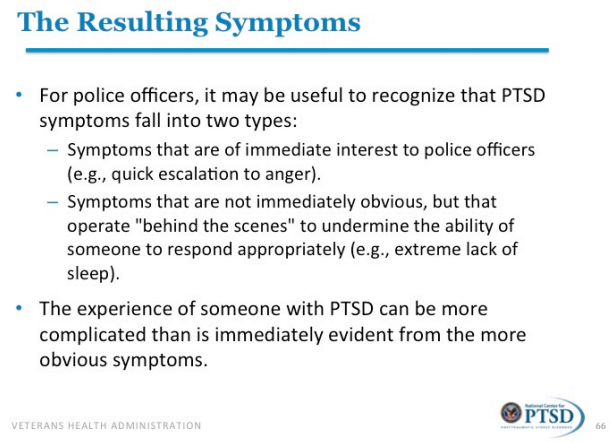
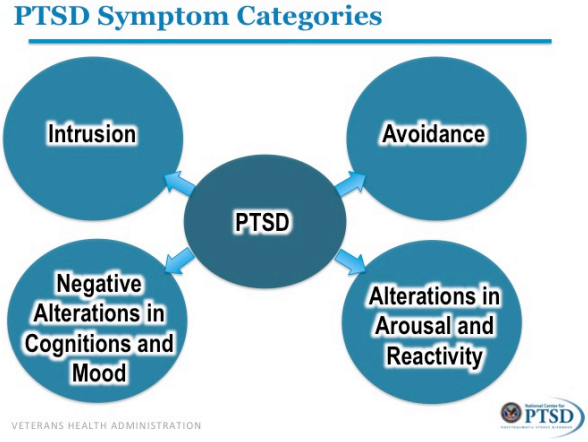
#	Discussion Points	Slide
56	**Group / Educational Format II** These are some *sample* questions to address the impact of an event on the five essential needs. They are not mandatory, and you may pick and choose the questions that best fit the context, and change them as needed to fit the situation and your style of interacting. • *Cover:* How has the incident affected your sense of safety? • *Calm:* What changes have occurred regarding sleep, feelings of being on edge, or ability to keep calm? What helps? • *Connection:* Has there been an impact on how you talk with each other, work morale, or connecting with family and friends? Is there someone you feel comfortable talking with about this? Has anyone you know done or said something that really helped? Does anyone here feel the need for any practical support right now? • *Competence:* Do you have any concerns about being able to handle what's going on in your life, deal with your stress reactions, or do your work? What are some things that you have done to cope that have been helpful in the past, or have been helpful since this incident? • *Confidence:* Have you noticed any change in your confidence in your ability to do your job in the same way as before the event, or your confidence in leadership? Are you feeling guilty or wish you had done something differently? Does this incident hold special meaning or connect with other experiences in any way? What can we learn from this event?	

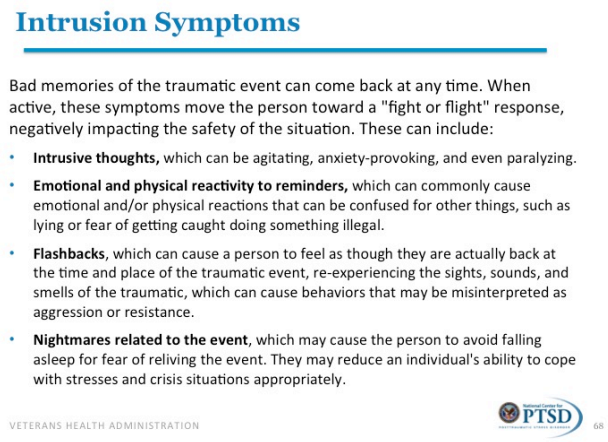
#	Discussion Points	Slide
57	**Group Educational Format III** After the discussion prompted by the questions, you can include a short discussion about the importance of being particularly disciplined in self-care and looking out for each other for a period of time, including: 1. Participating in more healthy forms of coping 2. Being diligent about getting enough sleep by reducing any distractions that one can control 3. Minimizing negative coping (such as isolation, using alcohol or substances to sleep) 4. Making use of available resources. Finally, ask if there is any other support they need.	
58	**Take Home Messages: SFA** • SFA actions are to be used *as needed* for yourself or with coworkers who are experiencing either significant distress or decrements in functioning. • They should be incorporated into duties in a natural, seamless way, and implemented *only* when needed. **ASK:** ***Does anyone have any closing comments and questions?***	

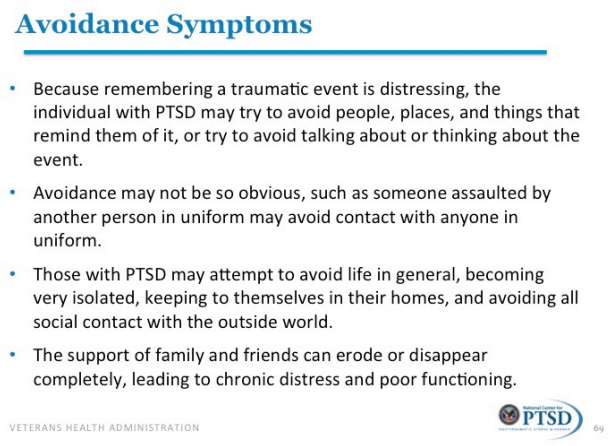
#	Discussion Points	Slide
59	**Supplemental Module: Effects of Traumatic Stress** This optional supplemental module gives more information about the effects of traumatic stress, including: • The nature of PTSD and traumatic events • The PTSD symptom categories • The course of PTSD symptoms and triggers • Conditions commonly co-occurring with PTSD	

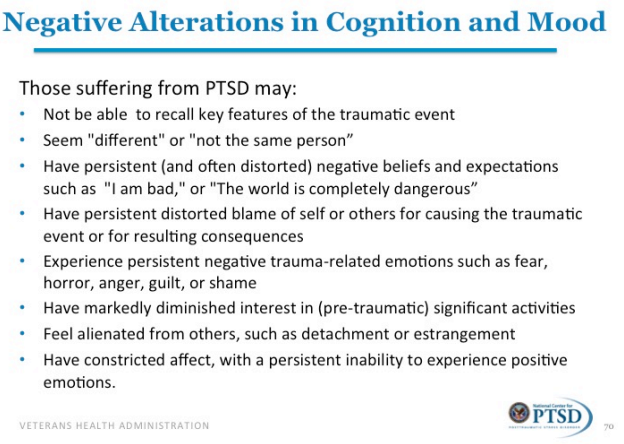
#	Discussion Points	Slide
60	**PTSD Is Not a Broken Brain** It is useful to recognize the potential utility of the symptoms that we know as Posttraumatic Stress Disorder when they become maladaptive. PTSD is the brain's mechanism for registering life-threatening events and activating a fight/flight response in similar future situations. When faced with a traumatizing event, our brains are quite adept at taking a snapshot of that situation and remembering the circumstances under which we were confronted with death or serious harm. When we are again presented with similar circumstances, our bodies react in preparation to deal with the threat again. This is commonly known as our "fight or flight" response. When this "fight or flight" response remains connected to events that truly are life-threatening, the utility of the response is evident. It could indeed keep us safe if the threat is real. It is important to recognize how the symptoms of Posttraumatic Stress Disorder may once have been quite useful. That is, they were appropriate responses to threat. However, if they continue for a period of time beyond the threat, they can become maladaptive. Fairly commonly, the brain will connect the previous threat with too many new circumstances. It over-generalizes the connections, and may register even regular events (e.g., a car backfire) as a threat to life. Ambiguous situations, such as an argument with a spouse or being cut off on the freeway, may also register as life-threatening.	 ***Teaching rationale and techniques*** *— The main goal here is to try to start changing perceptions that PTSD is a weakness. This helps officers to recognize that help is needed to deal with the symptoms of PTSD, and that they may be the first people who can help a Veteran. It also serves the purpose of normalizing and decreasing shame about their own symptoms of PTSD if they are themselves experiencing them.*

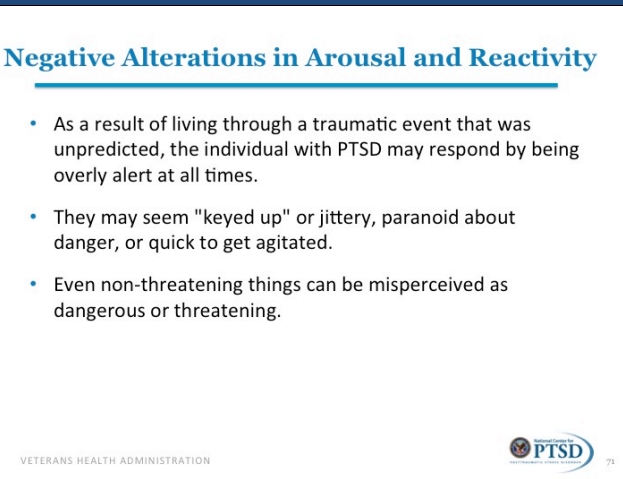
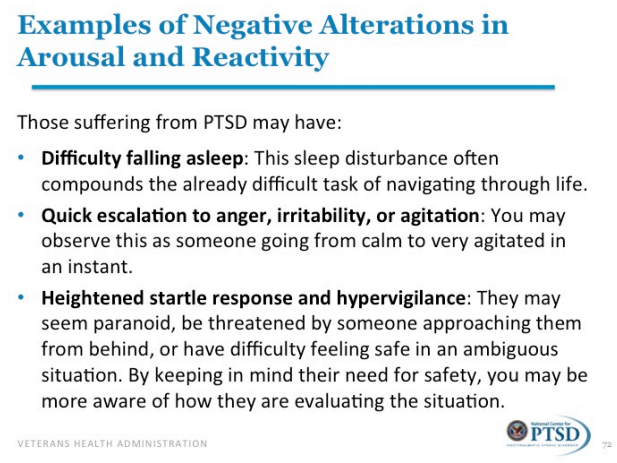
#	Discussion Points	Slide
61	**PTSD Is Not a Broken Brain** Individuals may appear to outside observers to overreact, but internally, they are literally (if erroneously) trying to save their own lives. Herein lies the most significant opportunity when working in crisis situations with Veterans experiencing PTSD: The Veteran's immediate goal is to increase personal safety, a goal actually shared by police officers. Having symptoms of PTSD therefore does not result from a weakness or a lack of toughness. Rather, it is an adaptive response to a threatening environment that is now being employed too frequently or in inappropriate situations. Because these problems often go unrecognized until a crisis situation arises, police officers may have the first opportunity to steer a Veteran toward getting the help needed to alleviate the problematic elements of PTSD.	 ***Teaching rationale and techniques*** *— The main goal here is to try to start changing perceptions that PTSD is a weakness. This helps officers to recognize that help is needed to deal with the symptoms of PTSD, and that they may be the first people who can help a Veteran. It also serves the purpose of normalizing and decreasing shame about their own symptoms of PTSD if they are themselves experiencing them.*
62	**The Traumatic Event** The first step toward experiencing symptoms of PTSD is, of course, being exposed to a traumatic event. Experts' understanding of just what constitutes a traumatic event is evolving. Generally speaking, the person must be confronted with death or serious injury or the threat of death or serious injury. A traumatic event occurs when a person is confronted with death or serious injury or the threat of death or serious injury, via: • Direct exposure • Witnessing, in person • Indirectly, by learning that a close relative or close friend was exposed to trauma • Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties	 This does not include indirect non-professional exposure through electronic media, television, movies, or pictures. Some situations (e.g., combat, rape) obviously meet these criteria. Others (e.g., divorce) may be experienced as "traumatic," but probably do not meet current criteria for PTSD. Still other extremely distressing events, such as receiving notification of the combat death of a loved one, are more ambiguous and less well understood by even the experts.

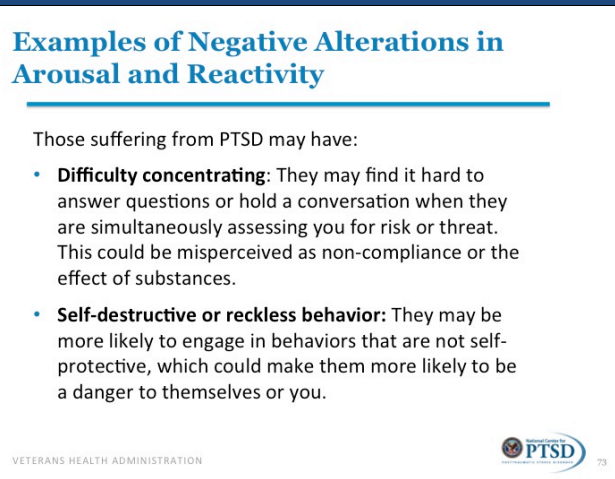
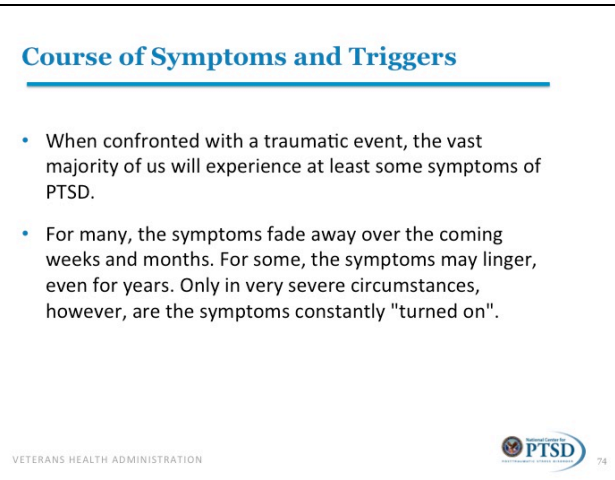
#	Discussion Points	Slide
63	**The Resulting Symptoms** Following the exposure to a traumatic event comes the onset of specific symptoms detailed. For police officers, it may be useful to recognize that these symptoms fall into two types: • Symptoms that are of immediate interest to police officers (e.g., quick escalation to anger), and • Symptoms that are not immediately obvious, but that operate "behind the scenes" to undermine the ability of someone to respond appropriately (e.g., extreme lack of sleep).	 ***Teaching rationale and techniques*** *— The primary purpose of this section is to underscore the importance of the subtler "behind the scenes" symptoms. Setting these into context builds an appreciation that the experience of someone with PTSD is even more complicated than is immediately evident from the more obvious symptoms*
64	**PTSD Symptom Categories** Diagnostic criteria for PTSD include a history of exposure to a traumatic event and symptoms from each of four symptom clusters: • Intrusion symptoms • Avoidance symptoms • Negative alterations in cognitions and mood • Alterations in arousal and reactivity Symptoms must be evident for at least a month and decrements in functioning must be noted in order to make a diagnosis, and symptoms must not be attributable to a substance or co-occurring medical condition. When the full diagnostic criteria for PTSD are met, two specifications can additionally be made, including delayed expression and a dissociative subtype.	

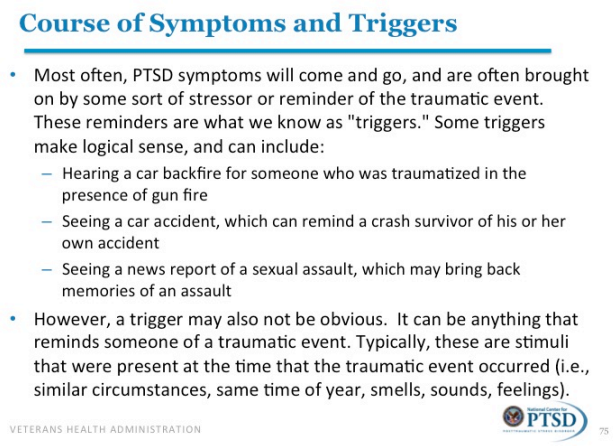
#	Discussion Points	Slide
65	**Intrusion Symptoms** Bad memories of the traumatic event can come back at any time. When active, these symptoms move the person toward a "fight or flight" response, negatively impacting the safety of the situation. These symptoms can come in the following forms: • **Intrusive thoughts** — The person may be tormented by unwelcome and distressing thoughts about the traumatic event and may find it nearly impossible to get these thoughts and images of the trauma out of their head. These thoughts can be agitating, anxiety-provoking, and even paralyzing. • **Emotional and physical reactivity to reminders** — Almost anything can remind someone with PTSD of the traumatic events that they have experienced. In fact, they may not even realize this when it happens. Such reminders commonly cause emotional (e.g. fear) and/or physical (e.g. racing heartbeat) reactions that can be confused for other things, such as lying or fear of getting caught doing something illegal.	 • **Flashbacks** — In extreme situations, flashbacks of the event can occur where the person feels as though they are actually back at the time and place of the traumatic event. When this happens, people may incorrectly report the current time and date. Their entire sensory experience may be distorted, meaning they are actually re-experiencing the sights, sounds, and smells of the traumatic event as if they are happening right there and then. In crisis situations, even simple things (e.g. a police officer touching someone on the shoulder or grabbing his arm), may induce a flashback. A person's reaction during a flashback (e.g. jerking away from the officer) can easily be misinterpreted as aggression or resistance to the officer. • **Nightmares relating to the event** — The person may relive the trauma in their dreams and may even try to avoid falling asleep for fear of reliving the event. While officers may not typically witness this directly, nightmares may contribute to a lack of general well-being that reduces an individual's ability to cope with stresses and crisis situations appropriately.

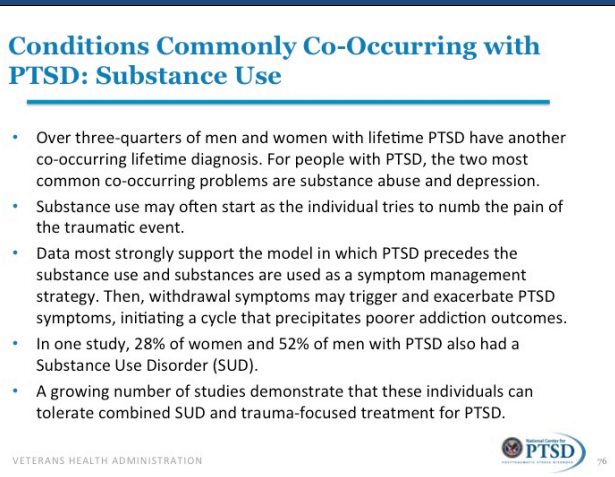
#	Discussion Points	Slide
66	**Avoidance Symptoms** Because remembering the event is so distressing, the individual may try to avoid people, places, and things that remind them of it. For example, they may try to avoid talking about or thinking about the event. Avoidance may not be so obvious, such as someone assaulted by another person in uniform may avoid contact with anyone in uniform. Those with PTSD may attempt to avoid life in general, becoming very isolated, keeping to themselves in their homes, and avoiding all social contact with the outside world. Through this avoidance, the support of family and friends can erode or disappear completely, leading to chronic distress and poor functioning.	

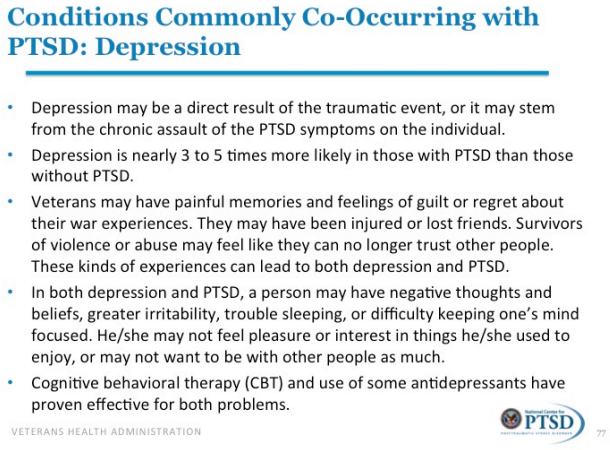
#	Discussion Points	Slide
67	**Negative Alterations in Cognitions and Mood** Those suffering from PTSD may exhibit: 1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs). 2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous"). 3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences. 4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame). 5. Markedly diminished interest in (pre-traumatic) significant activities. The person may stop feeling excitement or interest in activities or things they used to have interest in. This is not necessarily permanent, but a reflection of the detachment they have made from their emotions, and can further decrease the ability to cope with daily stress. This again is a symptom that degrades the general well-being of an individual, reducing their ability to cope with crises when they occur. 6. Feeling alienated from others (e.g., detachment or estrangement). The person may feel as if they are no longer on "the same page" as everyone else. The person may find it difficult to relate to others and because of the change in this person's demeanor, others may find it difficult to relate to him or her as well. This often results in diminished resources to cope with stress, leading to increased frequency and severity of crisis situations.	 7. Constricted affect, such as persistent inability to experience positive emotions. The person may report feeling "numb", "blank", or like they aren't themselves anymore. Responding officers may get the impression that a Veteran in crisis does not appreciate the gravity of a situation, or even that the Veteran is acting cold or callous in the middle of what should be an emotional event (e.g. an argument with a spouse). 8. Substance use. Some find alcohol and/or drugs to be an effective tool to emotionally numb themselves. PTSD and substance use are two mental health disorders that are often found together. In fact, 60%-80% of Vietnam Veterans seeking treatment for PTSD also have problems with alcohol. Because it is so common a combination, specific treatments exist to deal with PTSD and substance use when they occur together. When officers observe that a Veteran has been abusing substances, it actually increases the likelihood that PTSD is also present for that individual.

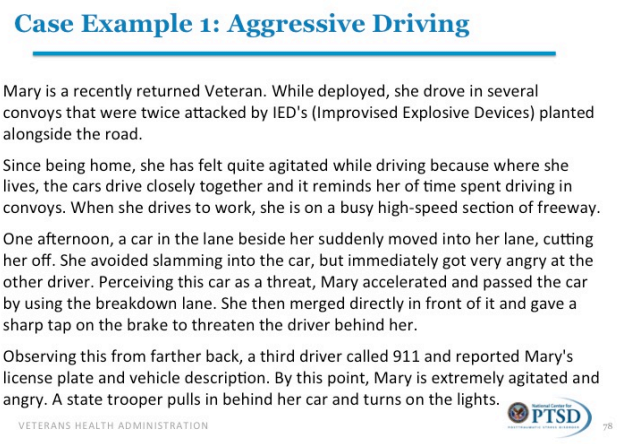
#	Discussion Points	Slide
68	**Negative Alterations in Arousal and Reactivity** As a result of living through a traumatic event that was unpredicted, the individual with PTSD may respond by being overly alert at all times. The person may seem "keyed up" or jittery, paranoid about danger, or quick to get agitated. Keep in mind that PTSD is related to the body's "fight or flight" response in preparation for perceived danger. Because of this, even non-threatening things can be misperceived as dangerous. When in this state, a person with PTSD symptoms may interpret ambiguous situations as threatening.	
69	**Examples of Negative Alterations in Arousal and Reactivity** Those suffering from PTSD may have: • **Difficulty falling asleep** — It's hard to be alert to the potential dangers around you when you are asleep, but it's also hard to fall asleep when you're keyed up or if you're having constant nightmares about a traumatic event. Individuals with PTSD may find it hard to allow themselves to relax enough to fall asleep and this sleep disturbance often compounds the already difficult task of navigating everyday life after such a traumatic event. • **Quick escalation to anger, irritability, or agitation** — People with PTSD symptoms may seem oversensitive to minor irritations and may react aggressively to others. Anger may be the only emotion they seem to be able to experience, when what is actually happening is that they feel threatened when they are not really in danger. Officers may observe this as someone going from calm to very agitated in an instant. • **Heightened startle response and hypervigilance** — We all startle when caught off guard, such as being startled when someone sneaks up on you. Having been caught off guard by a traumatic event may leave a person more on guard for future danger. In their constant assessment of potential danger, these individuals may seem extremely paranoid. They may feel safer sitting or standing with their backs to a wall and with a clear exit path. Therefore, they may feel extremely threatened by someone approaching them from behind (i.e., a second officer coming to aid in the questioning of the Veteran).	

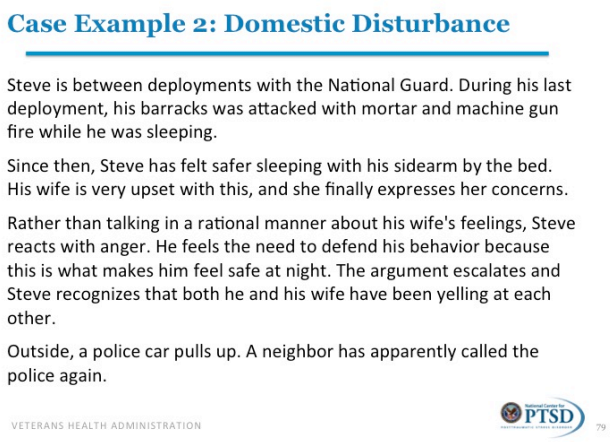
#	Discussion Points	Slide
70	**Examples of Negative Alterations in Arousal and Reactivity** Those suffering from PTSD may have: • Difficulty concentrating — Because the individual is so concerned about potential dangers (a top priority they have been trained to be concerned with), it may be difficult for them to maintain focus on other tasks. They may find it hard to answer questions or hold a conversation when they are simultaneously assessing you for risk or threat. Again, this could easily be misperceived as non-compliance or even the effect of substances. • Self-destructive or reckless behavior: The person may be more likely to engage in behaviors that are not self-protective, which could make them more likely to be a danger to themselves or you.	
71	**Course of Symptoms and Triggers** When confronted with a traumatic event, the vast majority of us will experience at least some symptoms of PTSD. For many, the symptoms fade away over the coming weeks and months. For some, the symptoms may linger, even for years. Only in very severe circumstances, however, are the symptoms constantly "turned on." Most often, the symptoms will come and go throughout a day or week, and are often brought on by some sort of stressor or reminder of the traumatic event. ***Teaching rationale and techniques*** *— There are at least two important points to make about triggers: 1) PTSD symptoms may not be present but could come back at any time in the presence of a trigger, and 2) Some triggers may be obvious, but many may not be.*	

#	Discussion Points	Slide
72	**Course of Symptoms and Triggers** • Most often, PTSD symptoms will come and go, and are often brought on by some sort of stressor or reminder of the traumatic event. These reminders are what we know as "triggers." Some triggers make logical sense, and can include: ○ Hearing a car backfire for someone who was traumatized in the presence of gun fire (e.g. combat). ○ Seeing a car accident, which can remind a crash survivor of his or her own accident. ○ Seeing a news report of a sexual assault, which may bring back memories of assault for a man or woman who was raped. • However, a trigger can be anything that reminds (even subconsciously) someone of a traumatic event. Typically, these are stimuli that were present at the time that the traumatic event occurred. For example, if a soldier was near children playing soccer when a bomb exploded nearby, then the sound of children playing could later become a trigger for that soldier, or it could be other similar circumstances, the same time of year, or similar smells, sounds, feelings.	 ***Teaching rationale and techniques*** *— There are at least two important points to make about triggers: 1) PTSD symptoms may not be present but could come back at any time in the presence of a trigger, and 2) Some triggers may be obvious, but many may not be.*

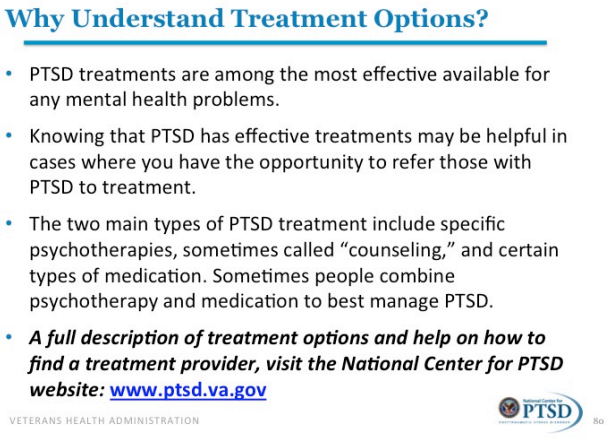
#	Discussion Points	Slide
73	**Conditions Commonly Co-Occurring With PTSD: Substance Use** Over three-quarters of men and women with lifetime PTSD have another comorbid lifetime diagnosis. For people with PTSD, the two most common co-occurring problems are substance abuse and depression (1). Substance use may often start as the individual tries to numb the pain of the traumatic event. Data most strongly support the model in which PTSD precedes the substance use and substances are used as a symptom management strategy. Then, withdrawal symptoms may trigger and exacerbate PTSD symptoms, initiating a cycle that precipitates poorer addiction outcomes (2). In one study, 28% of women and 52% of men with PTSD also had SUD (3). A growing number of studies demonstrate that these patients can tolerate trauma-focused treatment indicating that providers have a range of options to help improve the lives of patients with the co-occurring disorders (4).	 1. *Kessler, R. C., Sonnega, A., Bromet, E. J., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. Archives of General Psychiatry, 52, 1048-1060.* 2. *Berenz, E. C., & Coffey, S. F. (2012). Treatment of co-occurring posttraumatic stress disorder and substance use disorder. Current Psychiatry Reports, 14, 469-477.* 3. *Kessler, R. C., Sonnega, A., Bromet, E. J., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. Archives of General Psychiatry, 52, 1048-1060.* 4. *Mills, K. L., Teesson, M., Back, S. E., Brady, K. T., Baker, A. L., Hopwood, S., Sannibale, C., Barrett, E. L., Merz, S., Rosenfeld, J., & Ewer, P. L. (2012) Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. Journal of the American Medical Association, 308, 690-699.*

#	Discussion Points	Slide
74	**Conditions Commonly Co-Occurring With PTSD: Depression** • Depression may be a direct result of the traumatic event, or it may stem from the chronic assault of the PTSD symptoms on the individual. • Depression is nearly 3 to 5 times more likely in those with PTSD than those without PTSD. • Veterans may have painful memories and feelings of guilt or regret about their war experiences. They may have been injured or lost friends. Survivors of violence or abuse may feel like they can no longer trust other people. These kinds of experiences can lead to both depression and PTSD. • In both depression and PTSD, a person may have negative thoughts and beliefs, greater irritability, trouble sleeping, or difficulty keeping one's mind focused. He/she may not feel pleasure or interest in things he/she used to enjoy, or may not want to be with other people as much. • Cognitive behavioral therapy (CBT) and use of SSRIs have proven effective for both problems.	

#	Discussion Points	Slide
75	**Case Example 1: Aggressive Driving** This case is a description of actual events as described by patients experiencing symptoms of PTSD: Mary is a recently returned Veteran. While deployed, she drove in several convoys that were twice attacked by IED's (Improvised Explosive Devices) planted alongside the road. Since being home, she has felt quite agitated while driving because where she lives, the cars drive closely together and it reminds her of time spent driving in convoys. When she drives to work, she is on a busy high-speed section of freeway. One afternoon, a car in the lane beside her suddenly moved into her lane, cutting her off. She avoided slamming into the car, but immediately got very angry at the other driver. Perceiving this car as a threat, Mary accelerated and passed the car by using the breakdown lane. She then merged directly in front of it and gave a sharp tap on the brake to threaten the driver behind her. Observing this from farther back, a third driver called 911 and reported Mary's license plate and vehicle description. By this point, Mary is extremely agitated and angry. A state trooper pulls in behind her car and turns on the lights.	 ***Teaching rationale and techniques*** *— Cases like this are meant to demonstrate how some of the stresses related to traumatic events can affect a situation before the police arrive. One purpose of these stories is to set some of the symptoms of PTSD into a context relevant to the police officers. The hope is that officers can have a greater appreciation for the impact of these symptoms on a situation, even if they do not directly observe any symptoms while they are on scene.* *Because it may increase the quality of a training, presenters are encouraged to include their own anecdotes when describing how specific symptoms may become of interest to police officers responding to a crisis situation involving a Veteran who is experiencing symptoms of PTSD.*

#	Discussion Points	Slide
76	**Case Example 2: Domestic Disturbance** This case is a description of actual events as described by patients experiencing symptoms of PTSD: Steve is between deployments with the National Guard. During his last deployment, his barracks was attacked with mortar and machine gun fire while he was sleeping. Since then, Steve has felt safer sleeping with his sidearm by the bed. His wife is very upset with this, and she finally expresses her concerns. Rather than talking in a rational manner about his wife's feelings, Steve reacts with anger. He feels the need to defend his behavior because this is what makes him feel safe at night. The argument escalates and Steve recognizes that both he and his wife have been yelling at each other. Outside, a police car pulls up. A neighbor has apparently called the police again.	 ***Teaching rationale and techniques*** *— Cases like this are meant to demonstrate how some of the stresses related to traumatic events can affect a situation before the police arrive. One purpose of these stories is to set some of the symptoms of PTSD into a context relevant to the police officers. The hope is that officers can have a greater appreciation for the impact of these symptoms on a situation, even if they do not directly observe any symptoms while they are on scene.* *Because it may increase the quality of a training, presenters are encouraged to include their own anecdotes when describing how specific symptoms may become of interest to police officers responding to a crisis situation involving a Veteran who is experiencing symptoms of PTSD.*

#	Discussion Points	Slide

77	**Why Understand Treatment Options?**
	
	Why Understand Treatment Options?
	• By knowing that treatments for PTSD are among the most effective available for mental health problems, you may be able to refer those with PTSD to treatment.
	• The two main types are psychotherapy, sometimes called "counseling," and medication. Sometimes people combine psychotherapy and medication. The VA does not offer medical marijuana/cannabis treatment for PTSD because it has not yet shown a level of evidence that offsets the problems with addiction among those with PTSD. However in some states it may be prescribed by a community provider to reduce hyperarousal, anxiety, and sleep problems.
	• The following treatments for PTSD have evidence showing that they work:
	  ○ Cognitive Behavioral Therapy (CBT)
	  ○ Prolonged Exposure Therapy (PE)
	  ○ Eye Movement Desensitization and Reprocessing (EMDR)
	  ○ Medications called Selective Serotonin Reuptake Inhibitors (SSRIs)
	• Psychotherapy often involves active components such as:
	  ○ Learning ways to reduce distress when triggered or anxious, and practicing with guidance
	  ○ Becoming aware of thoughts and feelings, and learning skills to challenge them
	  ○ Talking through the trauma to get control of thoughts and feelings about it
	
	Encourage anyone experiencing any of the symptoms of PTSD to contact a service provider.
	
	A full description of treatment options, help on how to find a treatment provider, as well as more general information about PTSD, is available at the National Center for PTSD website.
		
		
		Why Know PTSD Treatment Facts?
		
		• By knowing PTSD treatment facts, you will be able to let Veterans know that PTSD treatment is:
		• *Active* – the patient and therapist work together developing skills towards shared goals
		• *Time-limited* – usually 5-12 sessions
		• *Focused* - geared towards helping the person understand and get more control over thoughts and feelings
		• *Effective* – much more so than trying to get better on one's own if PTSD has been present for a year or more
		• *Safe and controlled* – the patient is encouraged to only go into memories as far as they feel safe, and they learn coping skills to help manage anxiety
		• *Potent* - providers with and without their own trauma histories can effectively deliver PTSD treatments with good training and experience
		• *Necessary* – while social support and interpersonal connection are important, there's little evidence that they help the PTSD symptoms themselves.
		
		Teaching rationale and techniques *— This section is kept brief in this toolkit so as to encourage interested individuals to look to the established NCPTSD website. Available resources vary tremendously by geographic area. If conducting training, be prepared with information on local treatment providers. Not only may such information prove helpful should a police officer have an opportunity to refer or take someone to get treatment, but often officers are personally interested as they may recognize themselves as having experienced some of the symptoms of PTSD.*

Appendix 1: Relevant Article Summaries

Below is a sample of article summaries relevant to the training of police officers in mental health topics.

Implementing a Crisis Intervention Program for Police Officers: What's the Difference?

This study found that CIT-trained officers were more likely than non-CIT-trained officers to react to mental health calls by transporting individuals to mental health and non-mental health facilities, or to jail. They were also more likely to gain consent to transport individuals to these facilities, while non-CIT trained officers responded by not transporting individuals anywhere. The department who received the CIT training had no significant change in the rate of arrests even while noting an increase in calls relating to mental illness, and consumers reported that they were more comfortable with calling the trained police for help with a mentally-ill loved one, themselves, or a peer.

Reference

Teller, J.L.S., Munetz, M.R., Gil, K.M., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services, 57*(2).

After the CIT-Training Program: Do Officers Retain the Knowledge?

In this study, CIT-trained police officers' knowledge of CIT material decreased significantly in the months following the completion of the training program, with less experienced officers retaining less knowledge over time than officers with 15 or more years of experience, but the study was not able to determine what level of knowledge an officer must have to be an effective CIT-trained officer. Factors such as age, gender, and education had no bearing on officers' performance, and performance stayed the same from 6 months post-training to 2 years post-training. The authors highlighted the need for ongoing education and noted that experienced officers may benefit more from the training.

Reference

Compton, M.T. & Chien, V.H. (2008). Factors related to knowledge retention after crisis intervention team training for police officers. *Psychiatric Services, 59*(9).

Are Police Departments Equipped to Handle Mental Health Crisis Calls?

In this survey of metropolitan police departments, more than half (55%) had no specialized program for mental health crisis calls. Of those that did have special programs, there were three different approaches: 1) using police officers who are trained to respond to mental health crisis calls; 2) using mental health professionals available for police officer consultation, and; 3) using mobile crisis teams with mental health professionals who partner with police departments. Despite the fact that more than half of the departments did not have a specialized response for mental health calls, over two thirds rated themselves as moderately to very effective at dealing with mental health crisis,. Departments utilizing a crisis drop-off center were significantly more confident in their effectiveness to deal with mental health crisis calls.

Reference

Williams-Deane, M., Steadman, H.J., Borum, R., Veysey, B.M., & Morrissey, J.P. (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services, 50*(1).

Creating Integrated Service Systems for Offenders With Multiple Mental Health Issues

This article highlighted the need to divert offenders with mental health and substance use disorders away from the criminal justice system and into treatment programs. It describes a CIT training program for a Seattle-based department which offered training to officers and integrated services across several public service areas. The departments shared resources in order to move away from the "treat and release" model (which often results in repeat offenders), and towards a model of "assess, intervene, and link to needed services."

Reference

Wertheimer, D.M. (2004). Creating integrated service systems for people with co-occurring disorders diverted from the criminal justice system: The King County (Seattle) experience (program pamphlet).

What Has CIT Done for You?

This is an interview with Dr. Munetz, one of the creators of the Akron CIT training program, and Justice Evelun Lundberg Stratton of the Supreme Court of Ohio, which touches on their reasons for creating the CIT program, the basics of a CIT program, and changes observed since the implementation of the program.

Reference

Munetz, M.R. (2002). What is a CIT? Why do you need one in your community? *For the Record, 1.*

A Comparison of Program Characteristics: What Makes it Work?

This article describes a comparison of 3 police programs designed to address mental health crisis calls, and the strengths and weaknesses of each model. A department using a mobile crisis unit noted limitations related to the response time of the far-reaching mobile units, which resulted in first responders having to handle the situation without the help of those specially trained for such situations, usually resulting in transport to a treatment location or referral for treatment. A department using community Service Members as mental health responders noted limitations related to the low numbers of available individuals at the time of crisis calls. However, even with this limitation, this department tended to resolve the situation at the scene with no transport. A department using a no-refusal crisis drop-off center reported being able to respond to 95% of mental health crisis calls with specialized response (as compared to the 28% response rate or 40% response rate of the other sites). This department most often responded to mental health calls with a transport to a treatment location.

Reference

Steadman, H.J., Williams Deane, M., Borum, R., & Morrissey, J.P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services, 51*(5).

Key Characteristics of a Successful Jail Diversion Programs for Mentally-Ill Offenders

In this article, key characteristics, core features, and operation procedures of three successful jail diversion programs are described. Some of the elements of a successful program are a no-refusal policy, a highly visible program, a single point of entry into the program, streamlined intake procedures for police officers, and the ability to link clients to necessary resources.

Reference

Steadman, H.J., Stainbrook, K.A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services, 52*(2).

Who Are We Serving?

This article describes a comparison of individuals brought into emergency psychiatric services by CIT-trained police officers and mental inquest warrants versus by non-CIT means. CIT-trained officers brought in significantly more individuals suffering from schizophrenia than non-CIT officers, but rates of hospitalization were roughly equal between subjects brought in by CIT officers and those self-referred for emergency services. Patient demographics are examined across disposition types and possible reasons for the results are discussed.

Strauss, G., Glenn, M., Reddi, P., Afaq, I., Podolskaya, A., Rybakova, T., Saeed, O., Shah, V., Singh, B., Skinner, A., & El-Mallakh. (2005). Psychiatric disposition of patients brought in by crisis intervention team police officers. Community Mental Health Journal, 41(2).

What are the Consequences of this Work?

This article contains detailed statistics regarding police officer and offender deaths, injuries, and various other crime characteristics in total and by state/region.

Reference

Mumola, C.J. (2007). Arrest-related deaths in the United States, 2003-2005. Bureau of Justice Statistics: Special Report, NCJ 219534.