

# DAY 4 – CIT TRAINING



**8:00-9:00am**

**Psychological Trauma** – Amber Robinson-Green, PsyD, DFP (Designated Forensic Psychologist), Adult Court Clinic

**9:00-10:30am**

**Forensics Services Overview, John Barber, LICSW  
DMH**

**10:30am- 12:00pm**

**ALEC – Autism and law Enforcement Education  
Coalition** – Det.Lt. V. Caputo

# Psychological Trauma



**AMBER ROBINSON GREEN, PSY.D, DFP**

**LICENSED PSYCHOLOGIST  
DESIGNATED FORENSIC PSYCHOLOGIST**

# The Basics - We know this!



- Trauma –damage to the mind - an emotional response – to a distressing event or events. Trauma is person specific and can occur when stress level exceeds person’s ability to cope and integrate the emotions associated with traumatic event. Sense of helplessness in the face of one’s emotional and physical safety/wellbeing.

*i.e. - witnessing a terrible event, being the victim of interpersonal violence, natural disasters, car accidents and injury, loss of a loved one, public humiliation.....other ideas ???*

**Studies have shown that interpersonal trauma can be more damaging than natural disasters etc. WHY???**

# Prevalence of trauma



Who here has experienced an event that they consider to be traumatic?

The majority of Americans – 70% - of people experience an event or events that would be considered traumatic.

Risk factors – men, youth, history of prior trauma (sexual trauma), occupation (military, police), history of childhood conduct disorder, familial psychiatric history, personal characteristics such as extroversion, high crime neighborhoods

# Police Work is Dangerous



# Complex Trauma



Complex Trauma describes children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect.

- Needs are not fulfilled, attachments are not formed
- Life is seen as unpredictable
- World is not a safe place – survival, me vs. the world
- Early attachment pioneers / Bowlby and Ainsworth – It's basically the mother's fault!!!

\* handout - New Yorker article

# Adverse Childhood Experiences


Adverse Childhood Experiences (ACE) Study - decade-long and ongoing study designed to examine the childhood origins leading to health and social problems.

Key concept underlying the Study is that stressful or traumatic childhood experiences (abuse, neglect, witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, or crime in the home) lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality.

\* Handout – ACES

# How Does Trauma Affect You?





The more categories of trauma experienced in childhood, the more likely one experiences the following.....

- adolescent health
- teen pregnancy
- smoking
- alcohol abuse
- illicit drug abuse
- problem sexual behavior
- mental health problems
- risk of revictimization
- lack of stability of relationships
- poor performance in the workforce



These behaviors lead to increased risk for heart disease, Chronic Lung disease, Liver disease, Suicide, Injuries-HIV and STDs  
Diabetes

# Are you allowed to feel the pain?

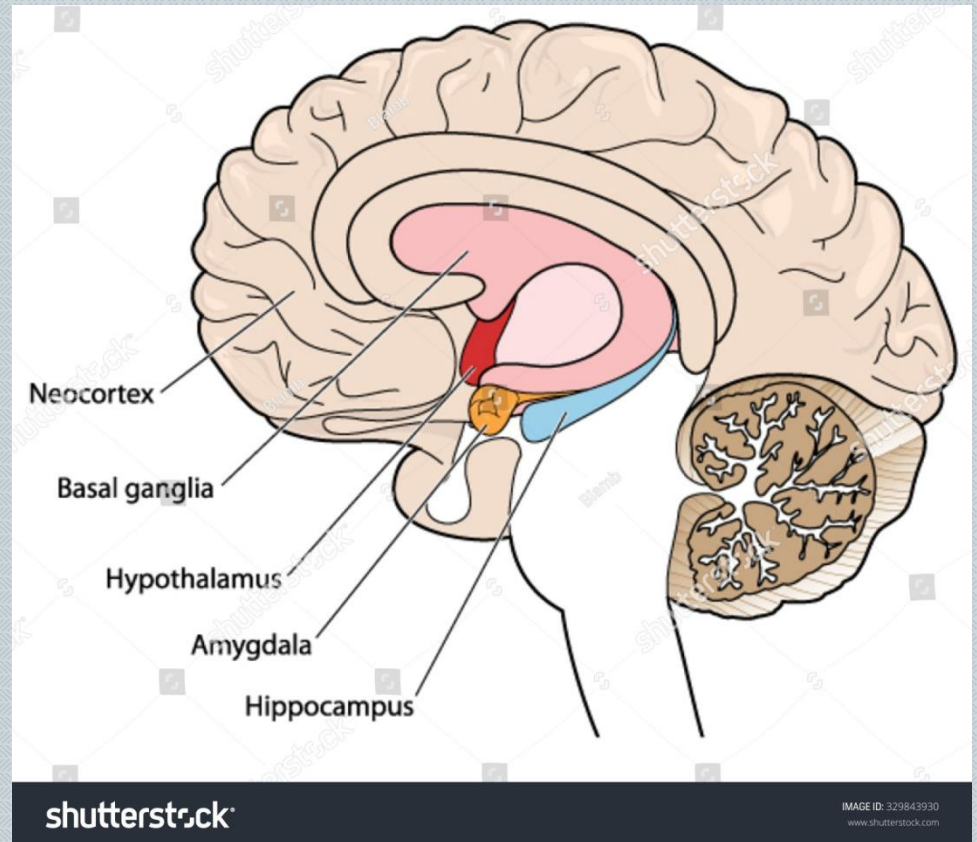


# Neurological Response to Threat



Humans have an automatic response to threat that is common to all animals

Threat is processed in the lower, primitive part of the brain – amygdala which is a part of limbic system



# Fight Flight Freeze



- When a threat occurs, the reptilian brain makes an immediate decision whether to fight, flee, or freeze.
- The reptilian brain learns from prior threats and over generalizes to keep you safe.
- ***Training and life experience can override these automatic impulses.***



# *Everybody is different*



Severity and type of trauma,  
interpersonal trauma vs.  
accidental – sense of betrayal

One time event or chronic  
underlying mental health  
condition

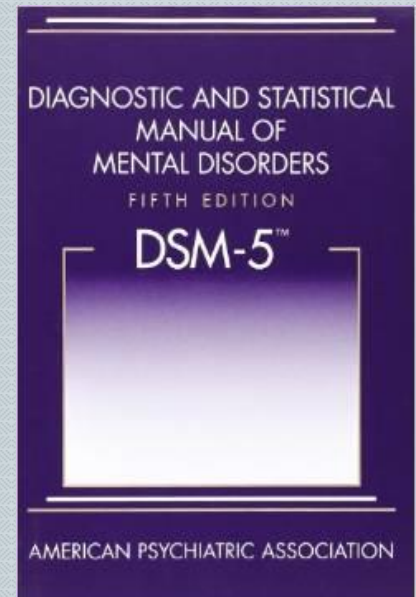
May not meet diagnostic  
classification for PTSD but....

Many other psychological  
problems can occur, depression,  
panic disorder, other anxiety  
disorders. Not just PTSD!

# A diagnosis



It is natural to feel afraid. Fear triggers a “fight-or-flight” response – a typical reaction meant to protect a person from harm. Most people recover from initial trauma symptoms naturally. Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened even when they are not in danger.



# PTSD criteria



## Intrusive Symptoms

- Re-experiencing
  - Nightmares
  - Dissociative reactions including flashbacks – sensory triggers
  - Intrusive thoughts
- Intense or prolonged distress after exposure to traumatic reminders
- Marked physiologic reactivity after exposure to trauma-related stimuli

## Avoidance - Persistent effortful avoidance of trauma-related stimulus

- Trauma-related thoughts or feelings
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

# PTSD Criteria



## Dissociation



**Depersonalization:** experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).

**Derealization:** experience of unreality, distance, or distortion (e.g., "things are not real").

# PTSD Criteria

## Negative alterations in cognitions and mood

- Inability to recall key features of the traumatic event
- Persistent negative belief about self and world
- Persistent distorted blame on self or others for trauma
- Persistent negative trauma related emotions (fear, guilt, sadness, shame, or confusion)
- Lack of interest in activities
- Feelings of alienation
- Inability to feel positive emotions

## Alterations in arousal and reactivity

- Central nervous system arousal
  - Trouble sleeping
  - Irritability
  - Reckless or self-destructive behavior
  - Exaggerated startle response
  - Poor concentration

# Biological Perspectives



*In PTSD multiple neurobiological systems are dysregulated and maladaptive*

Brain Regions (prefrontal cortex, amygdala, hippocampus, dorsal raphe nucleus, locus coeruleus) In child brain - disruption to actual cognitive development

Neurotransmitter/  
Neurohormonal System  
(Noradrenergic, Serotonergic,  
Hypothalamic-Pituitary-  
Adrenal axis (HPA axis))

# What have you seen in your work?



# Presentation # 2

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**9:30-11:00am**    **Department of Mental Health (DMH) Forensic Services**  
**Overview** – John Barber, LICSW, Western MA Area Director of DMH  
Forensic Services

# **DMH FORENSIC SERVICES OVERVIEW**

**PRESENTED BY:**

**JOHN C. BARBER, LICSW,**

**WESTERN MA AREA FORENSIC DIRECTOR, STATEWIDE  
COORDINATOR OF CIT-TTACS**

**EOHHS**

**DEPARTMENT OF MENTAL HEALTH**

**JUNE 6, 2022**

# **DMH FORENSIC SERVICES**

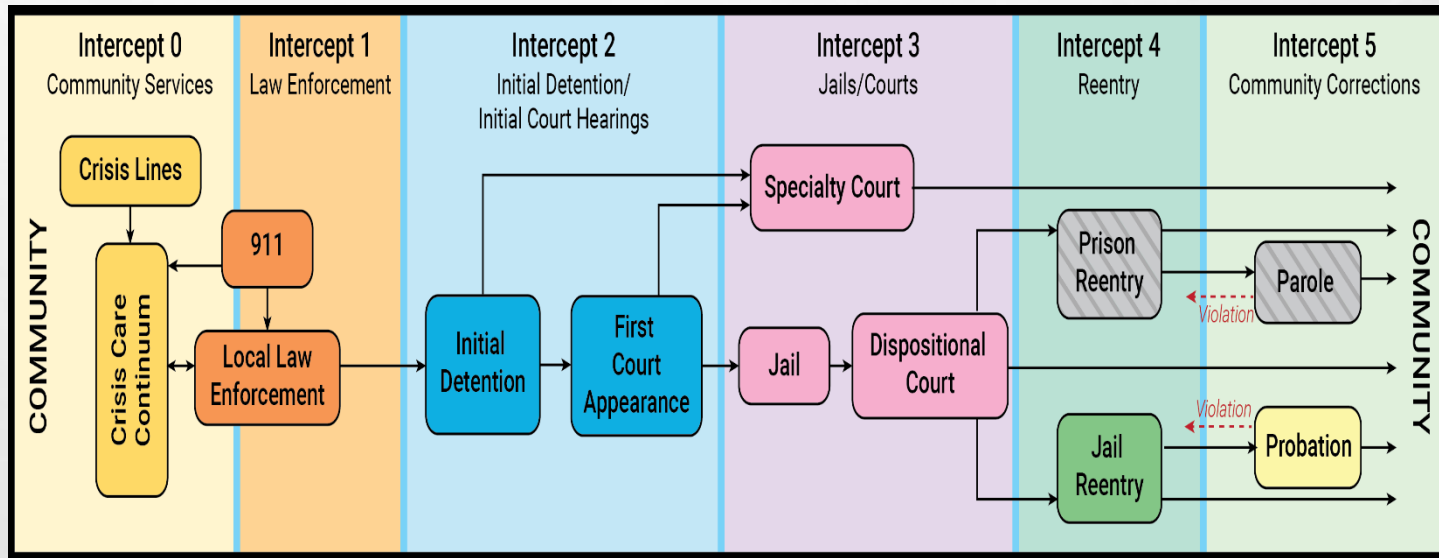
**DMH FORENSIC MENTAL HEALTH SERVICES  
(FORENSIC SERVICES)**

**IS INVOLVED AT THE INTERSECTION BETWEEN  
BEHAVIORAL HEALTH AND ACROSS  
MULTIPLE POINTS IN THE JUSTICE SYSTEM**

# DMH FORENSIC SERVICES OVERVIEW

- **JAIL/ARREST DIVERSION PROGRAMS (CIT/CO-RESPONDER)**
- **COURT CLINICS - BHN CONTRACTED ACC AND JCC IN WM**
- **INPATIENT FORENSIC EVALUATIONS\***
- **MI/PSB EVALUATIONS (MENTALLY ILL/PROBLEMATIC SEXUAL BEHAVIOR)\***
- **SPECIALTY COURT SERVICES**
- **FORENSIC TRANSITION TEAM (FTT)**
- **DFP CERTIFICATION AND TRAINING\***
- **INSPECTION OF CORRECTIONAL HEALTH SERVICES IN SEGREGATION UNITS\***

# MENTAL HEALTH AND SUBSTANCE ABUSE INTERCEPTS IN THE CRIMINAL JUSTICE PROCESS: A BROAD OVERVIEW



# POLICE-BASED JAIL DIVERSION

- **EARLY INTERCEPT FOCUS**
- **DMH FUNDING FOR POLICE-BASED DIVERSION BEGAN IN 2007**
- **DMH CURRENTLY FUNDS AROUND 70 JDP'S (JAIL DIVERSION PROGRAMS) IN MA, IMPACTING OVER 155 CITIES AND TOWNS**
- **EMERGENCY SERVICE PROGRAMS ARE KEY PARTNERS – \$12 MERRY-GO-ROUND VS. WARM HANDOFF?**
- **EXAMPLES**

# JAIL DIVERSION PROGRAM TYPES

- **POLICE DROP OFF CENTERS**
- **CRISIS INTERVENTION TEAM: COMMUNITY INITIATIVES THAT ARE LAW ENFORCEMENT LED**
- **POLICE-BASED CLINICIAN**
  - **CO-RESPONSES**
  - **FOLLOW UP RESPONSES**
- **TTACS: TRAINING AND TECHNICAL ASSISTANCE CENTERS**
  - **CRISIS INTERVENTION TEAM**
  - **CO-RESPONSE**

# WHY JAIL DIVERSION MATTERS

- **DISPROPORTIONATE PERCENTAGE OF PEOPLE WITH SMI (SERIOUS MENTAL ILLNESS) IN JAIL: ABOUT 14.5% OF MALES, 31% OF FEMALES**
- **1 IN 16 PEOPLE HAVE A SMI, BUT PEOPLE WITH SMI ARE 3-4X AS LIKELY TO BE IN JAIL**
- **OPPORTUNITY TO ENGAGE WITH TREATMENT THROUGH PROBATION AND SPECIALTY COURT SERVICES**
- **CASE EXAMPLE**

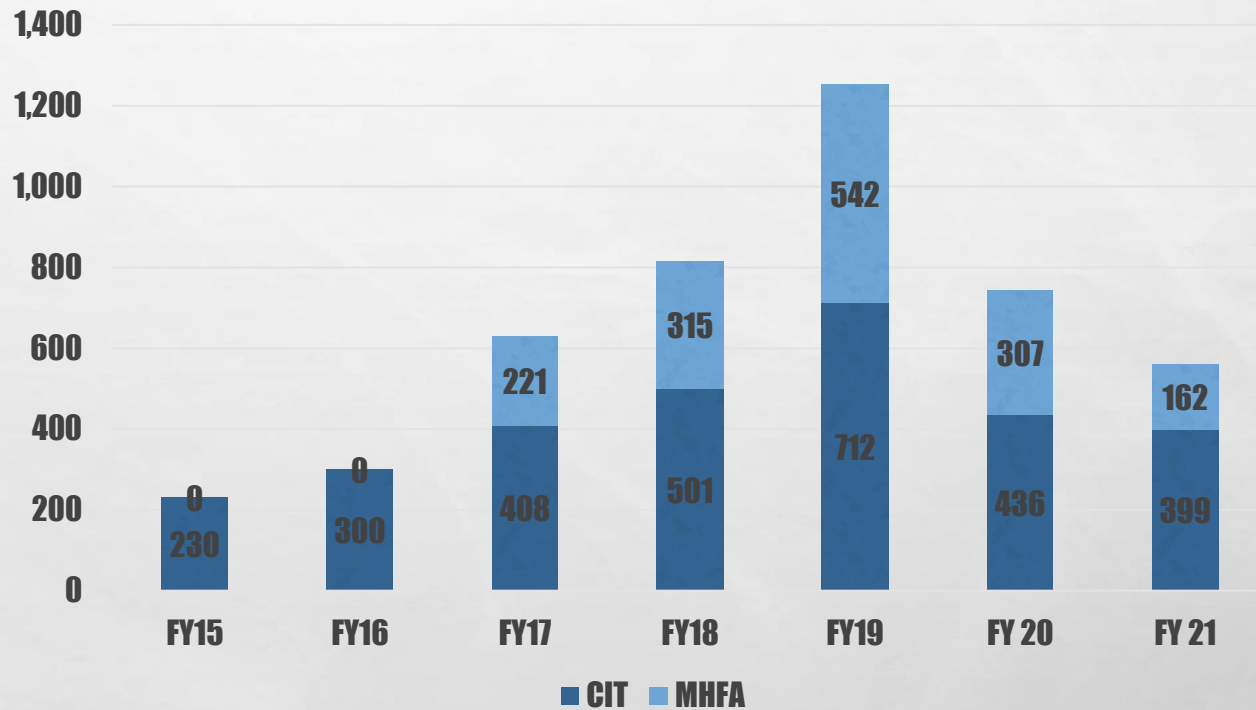
# CO-RESPONSE IMPACTS

- **USE OF POLICE-BASED CO-RESPONSE CLINICIANS RESULT IN:**
- **1) LESS USE OF ER'S**
- **2) PSYCHIATRIC SITUATIONS BEING RESOLVED AT THE SCENE**
- **3) LESS ARRESTS, MORE DIVERSIONS INTO TREATMENT APPROPRIATE SERVICES**
- **4) LESS TIME THAT OFFICERS NEED TO WAIT FOR CLINICIANS/MENTAL HEALTH RESPONSE.**

# PUBLIC SAFETY

- **PEOPLE WITH MI MUCH MORE LIKELY TO BE VICTIMS THAN PERPETRATORS OF VIOLENCE**
- **SKILLFUL INTERVENTION AND FINDING APPROPRIATE OPTIONS FOR TREATMENT MAY BE MORE EFFECTIVE AND REQUIRE LESS TIME**
- **LESS USE OF FORCE AND MORE FOCUS ON EFFECTIVE DE-ESCALATION TECHNIQUES AND APPROACHES THAT MANAGE, NOT INFLAME THE CRISIS**
- **PEOPLE WITH UNTREATED MENTAL ILLNESS ARE 16X MORE LIKELY TO BE FATALLY SHOT BY LAW ENFORCEMENT DURING AN ENCOUNTER**

# DMH GRANT SUPPORTED POLICE OFFICER TRAINING FY 16-22



# CIT TRAINING RESULTS

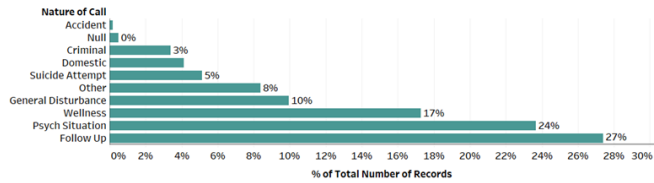
- **STUDIES INDICATE THAT CIT TRAINING DEVELOPS POSITIVE PERCEPTIONS AND INCREASED CONFIDENCE AMONG POLICE OFFICERS.**<sup>1,2</sup>
- **ADDITIONALLY, CIT OFFICERS HAVE VERY EFFICIENT CRISIS RESPONSE TIMES**
- **INCREASED DIVERSIONS FROM ARREST AND INCARCERATION AMONG THOSE WITH MENTAL ILLNESS**
- **IMPROVES THE LIKELIHOOD OF TREATMENT CONTINUITY WHILE SIGNIFICANTLY DECREASING POLICE OFFICER INJURY RATES**

1. **COMPTON ET AL. "A COMPREHENSIVE REVIEW OF EXTANT RESEARCH ON CRISIS INTERVENTION TEAM (CIT) PROGRAMS" J AM ACADEMY PSYCHIATRY LAW 36:1:47-55 (MARCH 2008)**

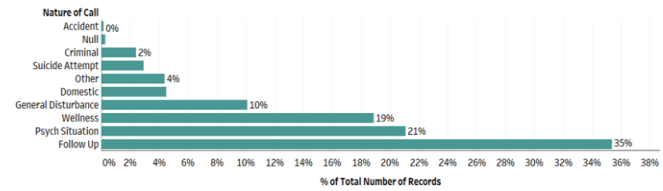
2. **[HTTP://WWW.CITINTERNATIONAL.ORG/TRAINING-OVERVIEW/163-MEMPHIS-MODEL.HTML](http://www.citinternational.org/training-overview/163-memphis-model.html)**

# JDP Call Types

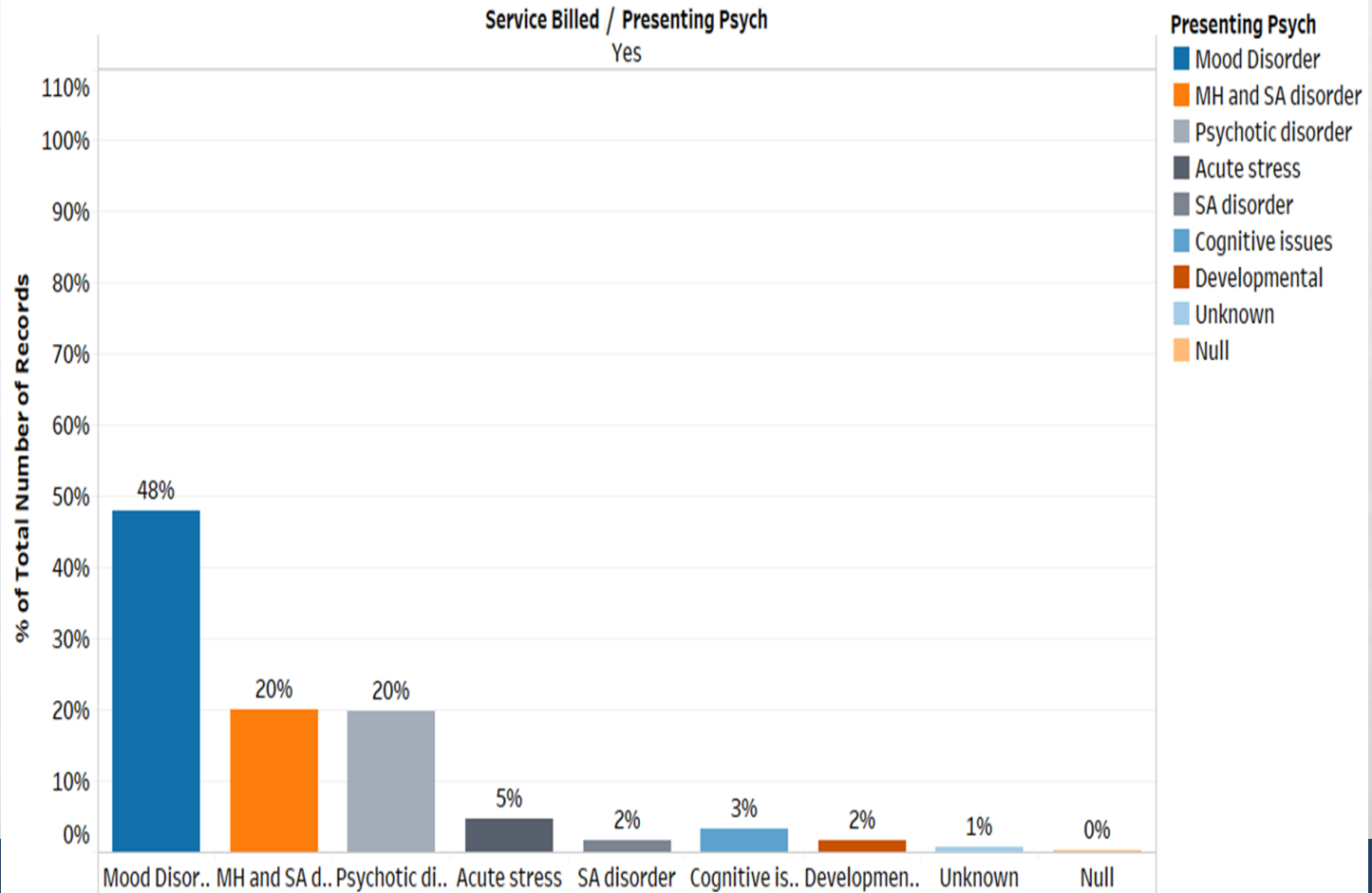
JDP Call Types, statewide (FY14 to FY21)



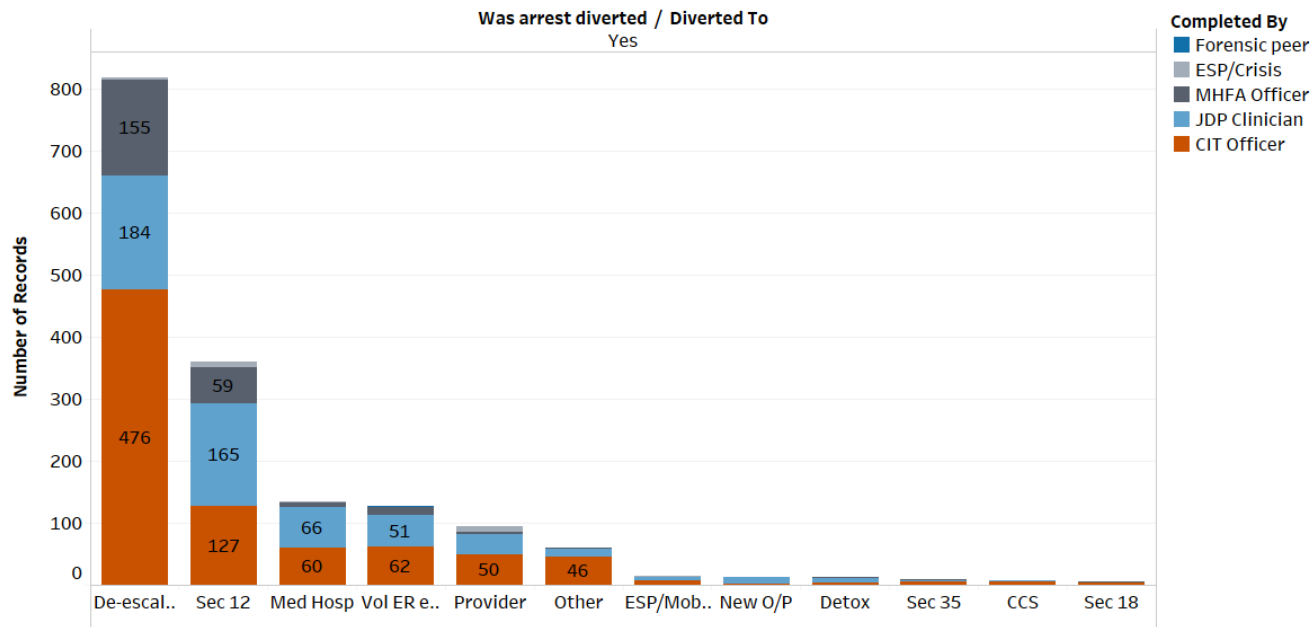
FY21 JDP Call Types, statewide



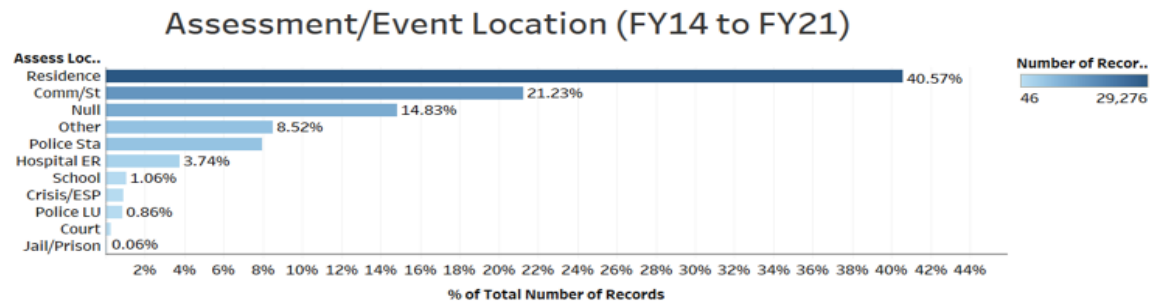
# Primary Behavioral Health Issue



# Diverted to by Model (FY21)



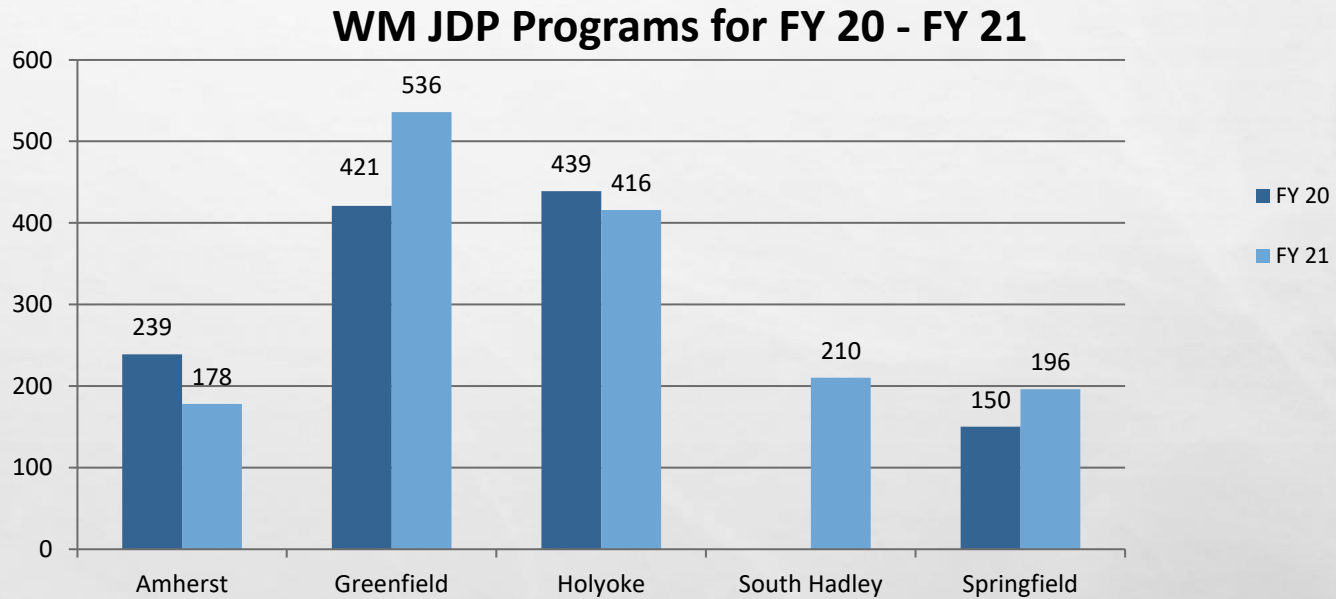
# JDP Assessment/Event Locations



## **WM DMH JDP GRANTEES**

- **BHN CIT-TTAC (CIT TRAINING & TECHNICAL ASSISTANCE CENTER)**
- **BHN: POLICE DROP OFF CENTER (SPRINGFIELD), CSO: FRANKLIN AND HAMPSHIRE COUNTIES**
- **CURRENT POLICE DEPARTMENT AWARDEES: AMHERST, BELCHERTOWN, CHICOPEE, EASTHAMPTON/HADLEY, GRANBY, GREENFIELD REGIONAL, HOLYOKE, LONGMEADOW, NORTHAMPTON, SOUTH HADLEY, SPRINGFIELD, WARE, WILBRAHAM**
- **OTHER WM COMMUNITIES INVOLVED WITH CIT TRAINING: DEERFIELD, EASTHAMPTON, E. LONGMEADOW, GREAT BARRINGTON, HAMPSHIRE COUNTY SHERIFF DEPT, HATFIELD, MONTAGUE, W. SPRINGFIELD, AND...**
- **PAST WM GRANTEES INCLUDE: BELCHERTOWN, EGREMONT, AND WESTFIELD**

# WM JDP DATABASE INPUTS



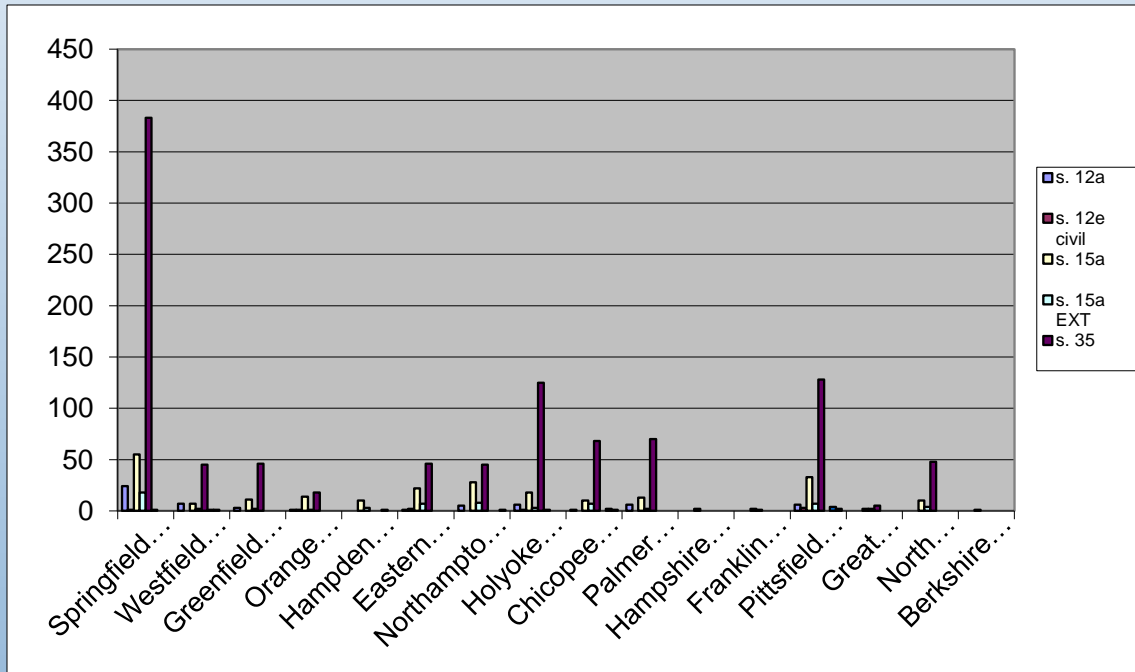
# **OTHER DMH POLICE TRAINING EFFORTS**

- **ANNUAL MENTAL HEALTH AND LAW ENFORCEMENT CONFERENCE (JUNE)**
- **OTHER SPECIALIZED TRAININGS (EX: MHFA FOR PUBLIC SAFETY, ADVANCED CIT, BLUE COURAGE, DISPATCH, ETC.)**
- **LOCAL MH-LE COLLABORATIVE MEETINGS**
- **WORKING WITH THE MPTC ON MENTAL HEALTH TRAINING**

# COURT CLINIC EVALUATIONS

- **BEHAVIORAL HEALTH NETWORK (BHN, INC.) IS DMH PROVIDER FOR COURT CLINIC EVALUATIONS (ADULT AND JUVENILE) IN WESTERN MA\***
- **REFERRALS AND CONSULTATION SERVICES CAN PROVIDE INFORMAL DIVERSION INTO TREATMENT**
- **§12E'S ROUTINELY TURN INTO §12A'S**

# TYPES OF WM COURT ORDERED EVALUATIONS COMPLETED, FY 21



# MGL CHAPTER 123, §15A AND §15B

- **§15A SCREENING– OUTPATIENT COMPETENCY TO STAND TRIAL (CST) OR CRIMINAL RESPONSIBILITY (CR) EVALUATIONS**
- **§15B – INPATIENT COMMITMENT FOR EVALUATION PURPOSES (CST AND/OR CR) – 20 TO 40 DAYS**

# LEGAL BASIS FOR COMPETENCY TO STAND TRIAL

- **IN MASSACHUSETTS A DEFENDANT IS FOUND COMPETENT TO STAND TRIAL IF HE HAS "SUFFICIENT PRESENT ABILITY TO CONSULT WITH HIS LAWYER WITH A REASONABLE DEGREE OF RATIONAL UNDERSTANDING, AND IF HE HAS A RATIONAL AS WELL AS FACTUAL UNDERSTANDING OF THE PROCEEDINGS AGAINST HIM"**

***(COMMONWEALTH V. VAILES, 1971)***

# WHY DOES COMPETENCY MATTER?

- **CASE EXAMPLES**
- **WHAT HAPPENS IF SOMEONE IS FOUND INCOMPETENT?**
- **WHAT IF THE DEFENDANT REMAINS INCOMPETENT?**

# CST AND CR TIMELINES

- **COMPETENCY REPORTS LOOK AT WHETHER THE ACCUSED INDIVIDUAL IS COMPETENT *NOW* (ONE CAN BE FOUND INCOMPETENT TO STAND TRIAL AND THEN LATER FOUND CST)**
- **CRIMINAL RESPONSIBILITY LOOKS AT THE MENTAL STATUS AT THE TIME OF THE CRIME**
- **EXAMPLE OF CR CASE**

# NGI: NOT GUILTY BY REASON OF INSANITY

- **WHAT PERCENTAGE OF CASES USE NGI DEFENSE?**
- ***LESS THAN 0.1% AND ONLY 25% SUCCEED***
- **WHAT HAPPENS WHEN SOMEONE IS FOUND NGI?  
WHERE DO THEY GO?**
- **WHY ARE THERE SO FEW NGI'S?**
- **PUBLIC PERCEPTION VS. REALITY**

# NGI CRITERIA

## **MASSACHUSETTS LEGAL CRITERIA FOR BEING FOUND NOT CRIMINALLY RESPONSIBLE:**

- **INABILITY TO APPRECIATE WRONGFULNESS DUE TO MENTAL ILLNESS OR MENTAL DEFECT AT THE TIME OF THE CRIME**
- **INABILITY TO CONFORM CONDUCT DUE TO MENTAL ILLNESS OR MENTAL DEFECT AT THE TIME OF THE CRIME**

# FORENSIC HOSPITALIZATION

- **WHERE DO PEOPLE GO WHEN THEY ARE FORENSICALLY HOSPITALIZED?**
- **HOW LONG ARE THEY HOSPITALIZED FOR?**
- **WHERE DO THEY GO WHEN THEY COMPLETE A FORENSIC HOSPITALIZATION?**
- **WHY ARE SOME MI PEOPLE HOSPITALIZED AFTER A CRIME, AND SOME ARE NOT? DOES THAT OCCUR BEFORE OR AFTER SENTENCING?**

# DMH INPATIENT UNITS

- **SOLOMON CARTER FULLER (SCF), BOSTON**
- **WORCESTER RECOVERY CENTER AND HOSPITAL (WRCH)**
- **HAWTHORNE MENTAL HEALTH UNITS, TEWKSBURY STATE HOSPITAL**
- **METRO BOSTON MENTAL HEALTH UNITS AT LEMUEL SHATTUCK HOSPITAL (LSH)**
- **VIBRA WM UNIT (SPRINGFIELD)\***
- **TAUNTON STATE HOSPITAL\*\***

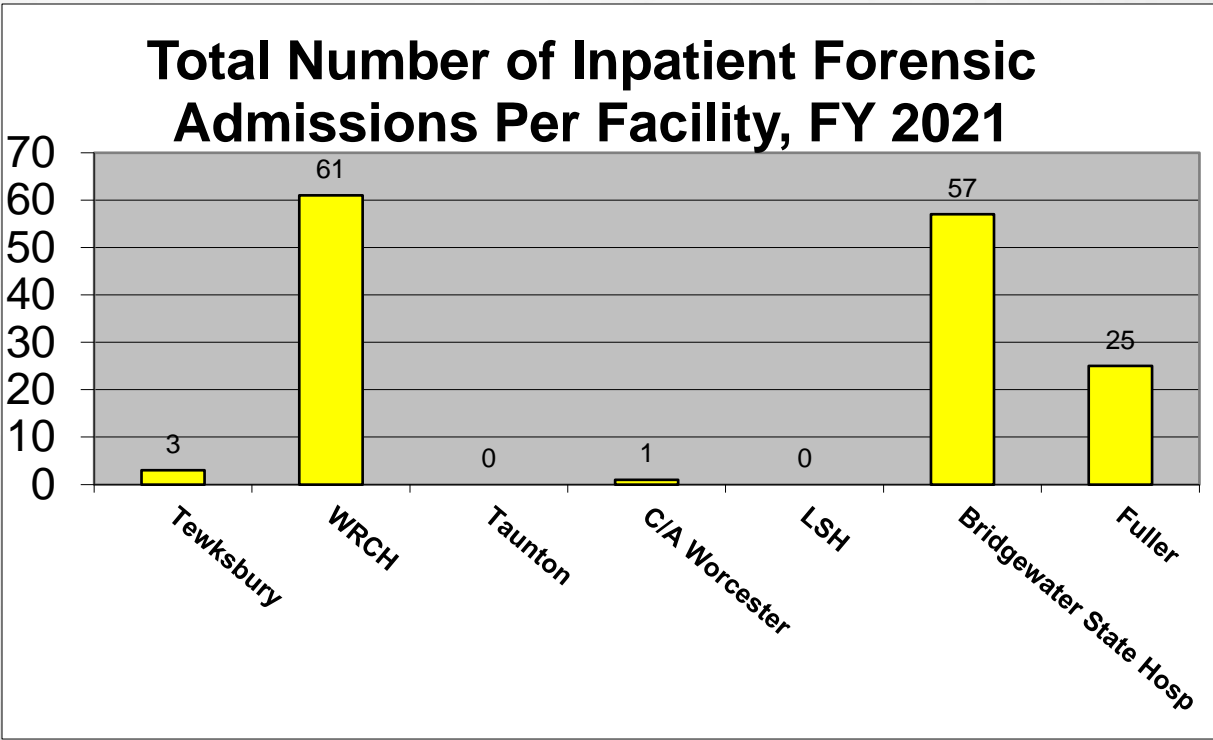
# DMH ADULT INPATIENT

- **AGE 19 AND OVER**
- **EVALUATION AND COMMITMENT FOR TREATMENT**
- **FORENSIC CASES COMPRISE OVER 50% OF ALL ADMISSIONS**
- **CIVIL AND VOLUNTARY PATIENTS**
- **PRE-ARRAIGNED PRISONERS IN POLICE CUSTODY VIA SEC.18(A)**

# DMH ADOLESCENT INPATIENT

- **UNDER AGE 19, OCCURS AT WRCH'S ADOLESCENT UNIT**
- **EVALUATION AND COMMITMENT FOR TREATMENT**
- **FORENSIC CASES COMPRISE ONLY A SMALL FRACTION OF ADMISSIONS, BUT LENGTH OF STAY MAY BE LONGER**
- **CASES COME FROM ADULT AND JUVENILE COURT SETTINGS**

# WM FORENSIC HOSPITALIZATIONS AND PLACEMENTS, FY 21



## **§15E: “AID IN SENTENCING”**

- **EVALUATION CONDUCTED AFTER FINDING OF GUILT**
- **EXAMINES NEED FOR HOSPITALIZATION AND OTHER TREATMENT NEEDS**
- **EXAMINES MENTAL HEALTH FACTORS RELATED TO CRIMINAL CONDUCT**
- **WHY ARE 15E’S ORDERED?**

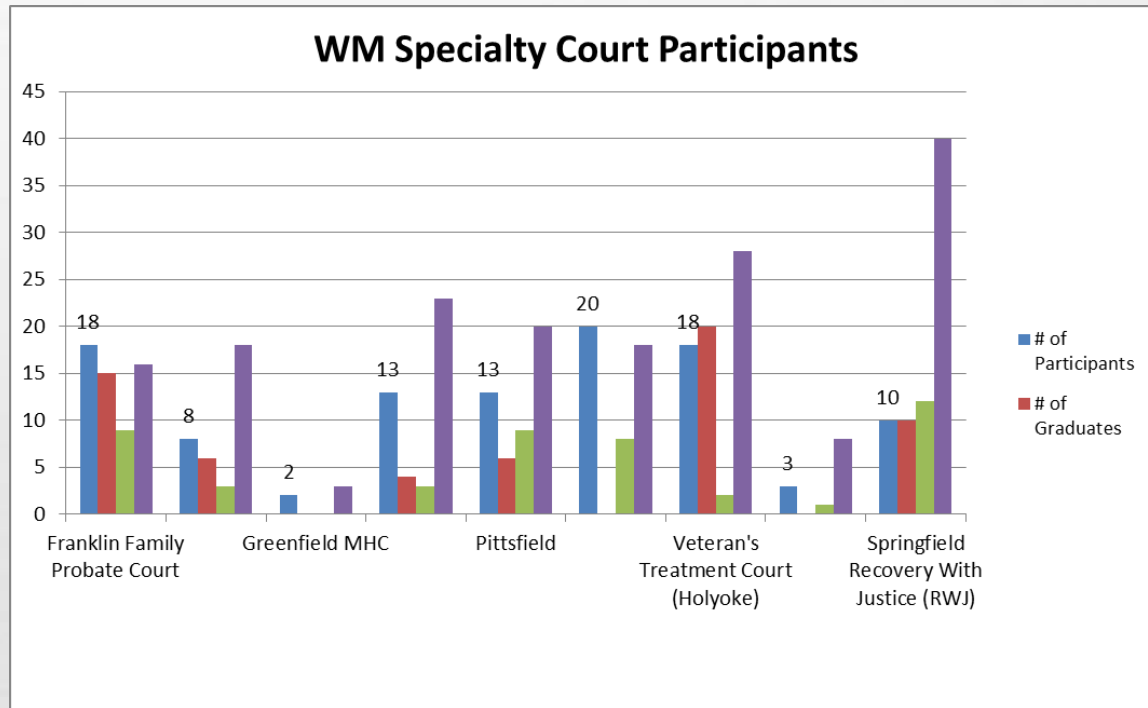
# SECTION 16'S

- **§16 (A): COURT ORDERED INPATIENT EVALUATION OF A CRIMINAL DEFENDANT AFTER A FINDING OF INCOMPETENCE TO STAND TRIAL (IST) OR NOT GUILTY BY REASON OF INSANITY**
- **§16(B) AND §16(C): COURT ORDERED COMMITMENT FOR CONTINUED TREATMENT OF A PERSON WHO HAS PREVIOUSLY BEEN FOUND EITHER IST OR NGI. NEED TO BE DEEMED A RISK TO SELF OR OTHERS**
- **§16(B) COMMITMENT – UP TO 6 MONTHS; §16(C) COMMITMENT– UP TO 1 YEAR**
- **PERIODIC COMPETENCY RE-EVALUATIONS (§17A)**

# **WESTERN MA SPECIALTY COURTS**

- **SPRINGFIELD MENTAL HEALTH COURT – RECOVERY WITH JUSTICE; GREENFIELD HAS A SMALL MENTAL HEALTH COURT**
- **GREENFIELD, FRANKLIN FAMILY PROBATE, ORANGE, NORTHAMPTON, HAMPSHIRE PROBATE AND FAMILY, PITTSFIELD, AND SPRINGFIELD DRUG COURTS (BHN VENDOR)**
- **VETERANS SPECIALTY COURT (SERVING HAMPDEN, HAMPSHIRE, AND FRANKLIN COUNTIES) AT HOLYOKE DISTRICT COURT**
- **VETERANS TREATMENT COURT: SOLDIER ON IS DMH-CONTRACTED PROVIDER**
- **HOW DO SPECIALTY COURTS WORK?**

# WM SPECIALTY COURT DATA – FY 21



# §18A TRANSFER

## **§18: TRANSFER OF PRISONERS IN NEED OF HOSPITALIZATION BY REASON OF MENTAL ILLNESS:**

- **COURT-ORDERED INPATIENT EVALUATION OR COMMITMENT OF A PRISONER IN NEED OF TREATMENT**
- **MOST GO TO BSH AND REQUIRE STRICT SECURITY AS THEY ARE INCARCERATED**
- ***WOMEN PRISONERS COME TO DMH FACILITIES***

# CIVIL COMMITMENT §35'S

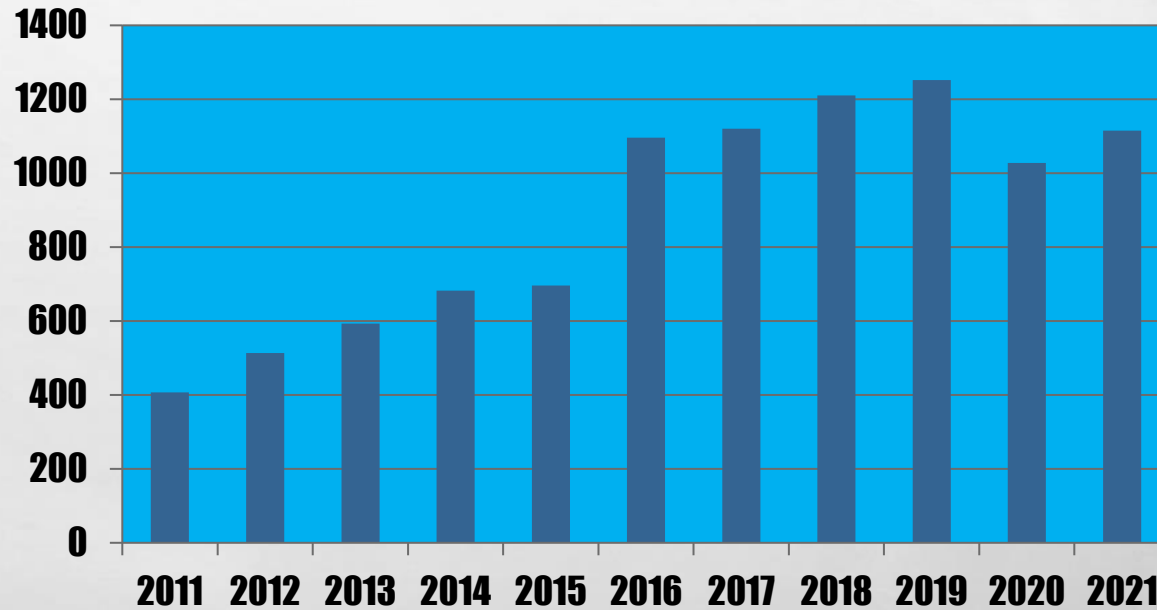
- **CIVIL COMMITMENT OF SUBSTANCE ABUSER FOR UP TO 90 DAYS, BECAUSE OF IMMINENT SERIOUS RISK TO SELF OR TO OTHERS BECAUSE OF ALCOHOL OR DRUG USE.**
- **WHO CAN PETITION? SPOUSE, BLOOD RELATIVE, GUARDIAN, POLICE OFFICER, PHYSICIAN OR COURT OFFICIAL**
- **CAN BE EITHER AN ADVERSARIAL PROCESS OR “UNCONTESTED”**
- **AVERAGE LOS VARIES**
- **CASE EXAMPLE**

## **§ 35 TREATMENT FACILITIES**

- **WOMEN ON CIVIL §35'S GO TO WATC (WOMEN'S ADDICTION TREATMENT CENTER) IN NEW BEDFORD OR OR TO DMH'S RAP (RECOVERY FROM ADDICTION PROGRAM) IN TAUNTON**
- **BHN OPENING A PROGRAM TBD**
- **WOMEN ON "DUAL STATUS" MAY BE SENT TO MCI-FRAMINGHAM**
- **MEN ON CIVIL §35'S CAN GO TO MATC (MEN'S ADDICTION TREATMENT CENTER) IN BROCKTON OR DMH RAP PROGRAM**
- **MEN COMMITTED UNDER S.35 CAN ALSO BE SENT TO STONYBROOK STABILIZATION AND TREATMENT CENTER AT HAMPDEN COUNTY SHERIFF OR TO MASAC/PLYMOUTH**

# WM §35 TRENDS

**WM Court Ordered s.35 evals**



# SPOTLIGHT ON S. 35'S AND OPIATE EPIDEMIC

- **OPIOID EPIDEMIC IS PERSISTENT**
- **NEW §35 FACILITIES OPENING**
- **LOCAL OPIOID TASK FORCES ASSIST WITH IDENTIFYING SUPPORT FOR RECOVERY, TREATMENT OPTIONS, AND COMMUNITY COALITIONS**
- **POLICE WORKING MORE AND MORE WITH TREATMENT PROVIDERS AND RECOVERY COACHES TO RESPOND AND OFFER LINKAGE TO TREATMENT TO PREVENT FUTURE OVERDOSE**
- **FOCUS IS ON EDUCATION, DE-STIGMATIZATION, TREATMENT, MAT AND NARCAN AVAILABILITY**

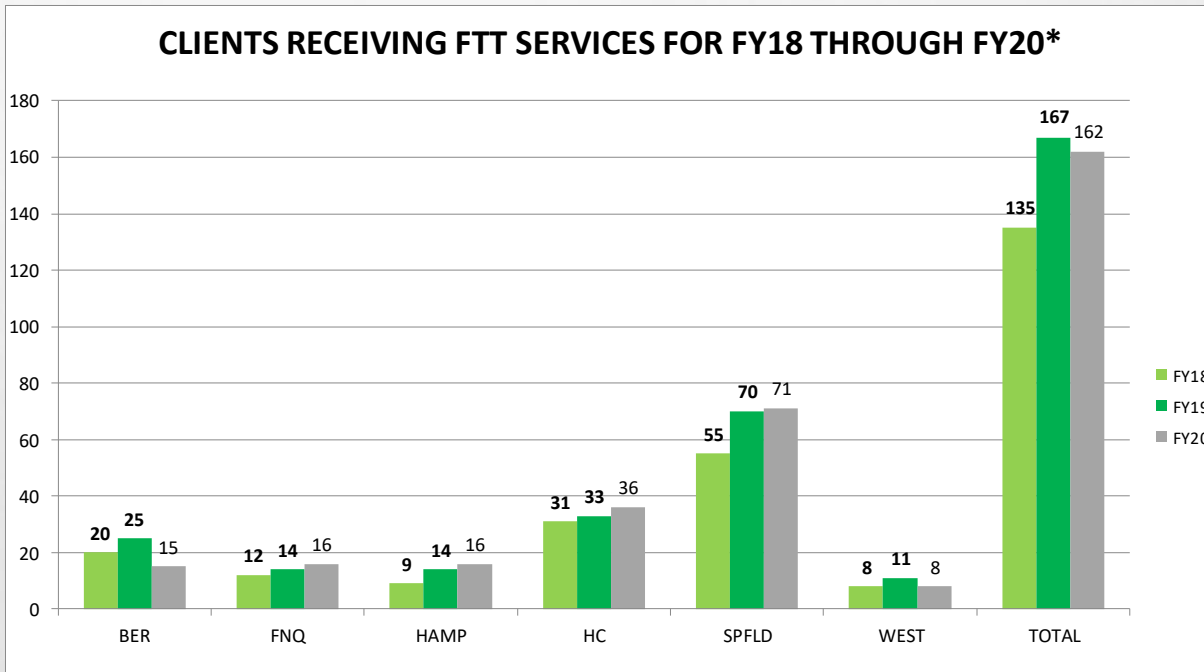
## **BRIDGEWATER STATE HOSPITAL**

- **SOME STATUTORY OBLIGATIONS ARE SHARED WITH BRIDGEWATER (§15B'S, §16'S, AND §18'S THAT REQUIRE STRICT SECURITY).**
- **CONCEPT OF “STRICT SECURITY” – LEGAL TERMINOLOGY, NOT DEFINED –HOW DO OUR ACC STAFF VIEW IT?**
- **BSH, A DOC STATE HOSPITAL: MINIMUM, MAXIMUM, ITU, MED WEST/INFIRMARY**
- **BSH CHANGES UNDER NEW VENDOR: WELLPATH 60 – 80 ADMISSIONS A MONTH AT BSH, MOSTLY 18A'S (60%)**

## **FORENSIC TRANSITION TEAM (FTT)**

- **DMH ESTABLISHED THE FTT IN 1998**
- **FTT IS A BOUNDARY SPANNING, STATEWIDE SERVICE OF DMH FORENSIC SERVICES THAT ENSURES AN EFFECTIVE REENTRY PLAN FOR DMH-SERVICE AUTHORIZED INDIVIDUALS FROM STATE PRISONS AND COUNTY HOUSES OF CORRECTION**
- **ALL HOC'S/DOC FACILITIES HAVE AN ASSIGNED FTT STAFF**

# FTT IMPACT IN WESTERN MASS



# QUESTIONS AND EVALUATIONS

## CONTACT INFORMATION:

**JOHN BARBER**

**(413) 587-6244**

**[JOHN.BARBER@MASS.GOV](mailto:JOHN.BARBER@MASS.GOV)**

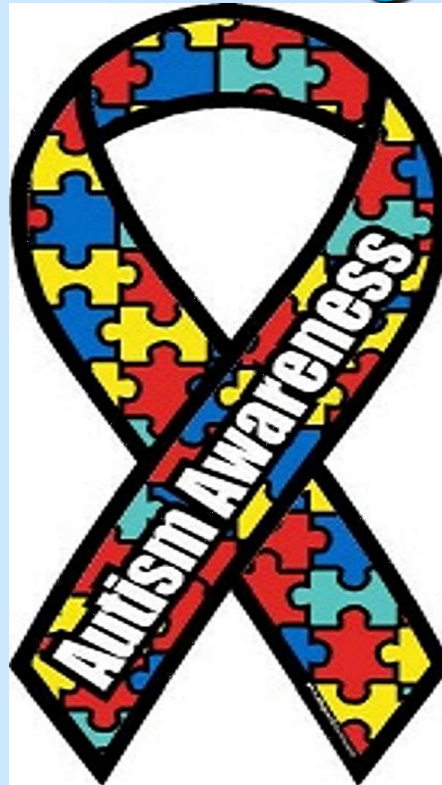
# PRESENTATION # 3

**10:30am- 12:00pm**

**ALEC – Autism and law Enforcement  
Education Coalition**

Det. Lt. Victor Caputo,  
Northampton Police Department

# Law Enforcement Autism Training

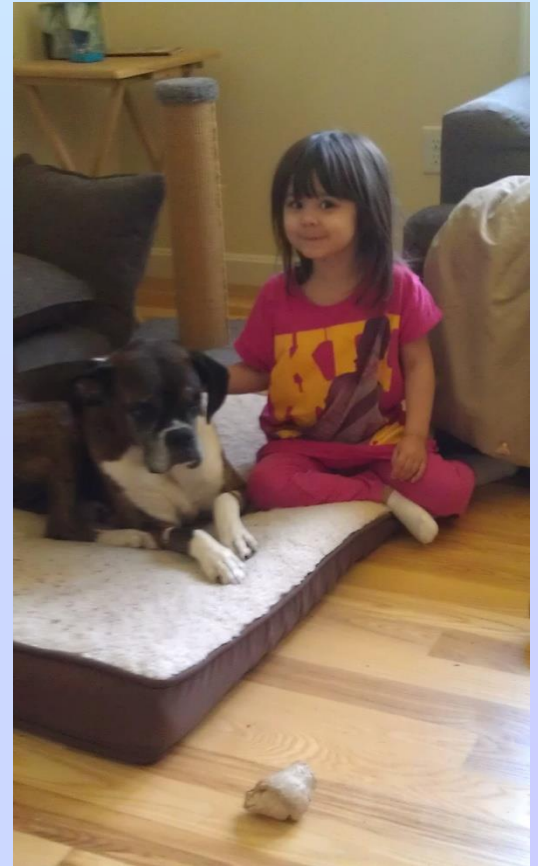


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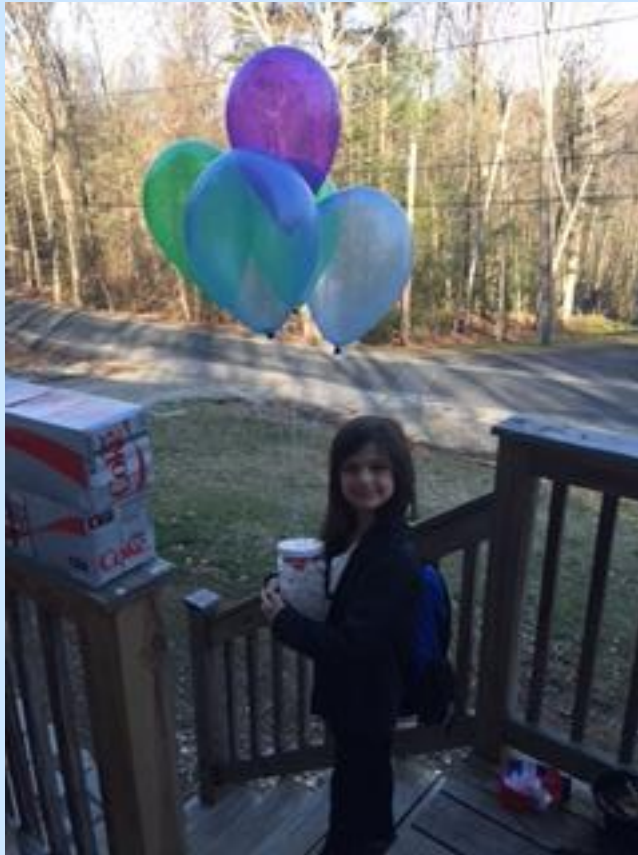
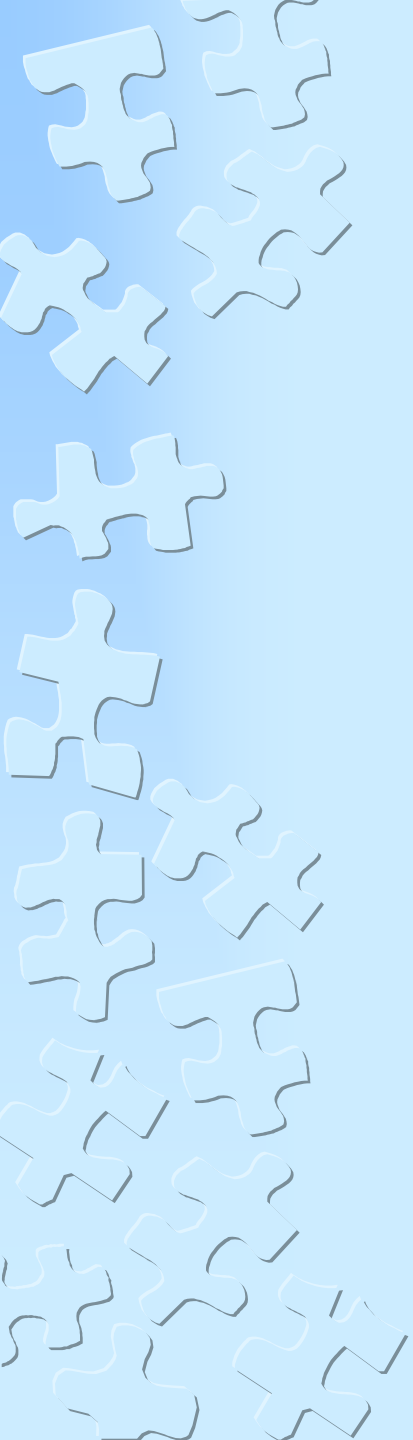


# **What Is Autism?**











# What is Autism?

- Autism Spectrum Disorder (ASD) is a developmental disability that usually appears during the first three years of life
- Asperger's can be diagnosed as late as early adult-hood



# What is Autism

Autism is a neurological disorder that impacts:

- Social interactions
- Communication and language skills
- Behavior



# Autism is a spectrum disorder with varying levels of functioning

- Low functioning
- Middle functioning
- High functioning



# The 5 Categories of Autism

## 1) Autism

Language and communication deficits with challenging behavioral traits

## 2) Childhood Disintegrative Disorder

Complete loss of language at age 2 with little subsequent improvement

## 3) Retts Syndrome

90% affected are female who are multiply and severely disabled

## 4) Asperger Syndrome

Typically high intellect and verbal abilities, but still lack common social skills

## 5) PDD-Pervasive Developmental Disorder or PDD-NOS (Not otherwise specified)



# **Autism Facts**



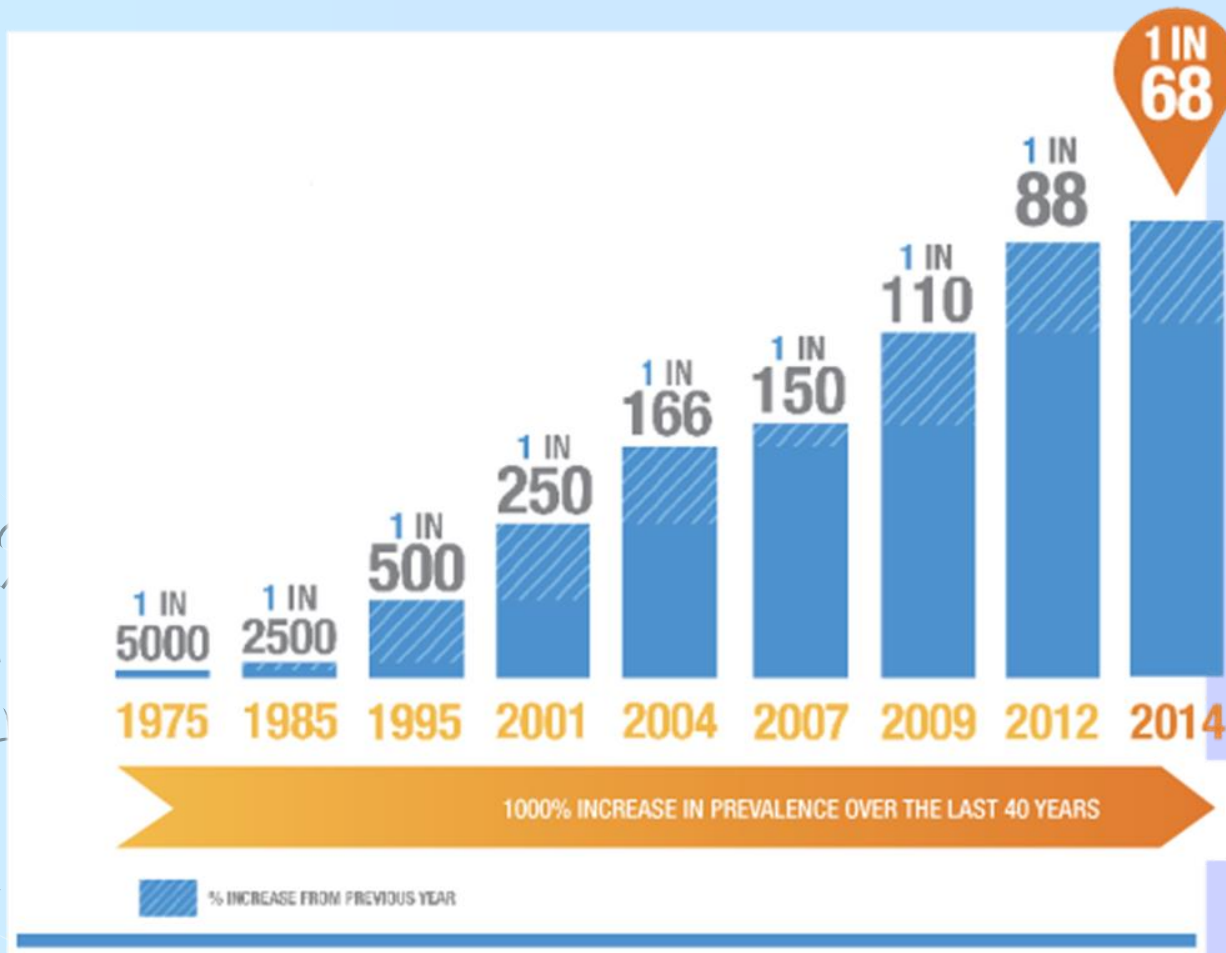
- More than 3 million people live with ASD in the United States


- 1 in 50 people are born today have ASD


- ASD is growing at a rate of about 10-17% per year

- A new case of autism is diagnosed every 20 minutes.

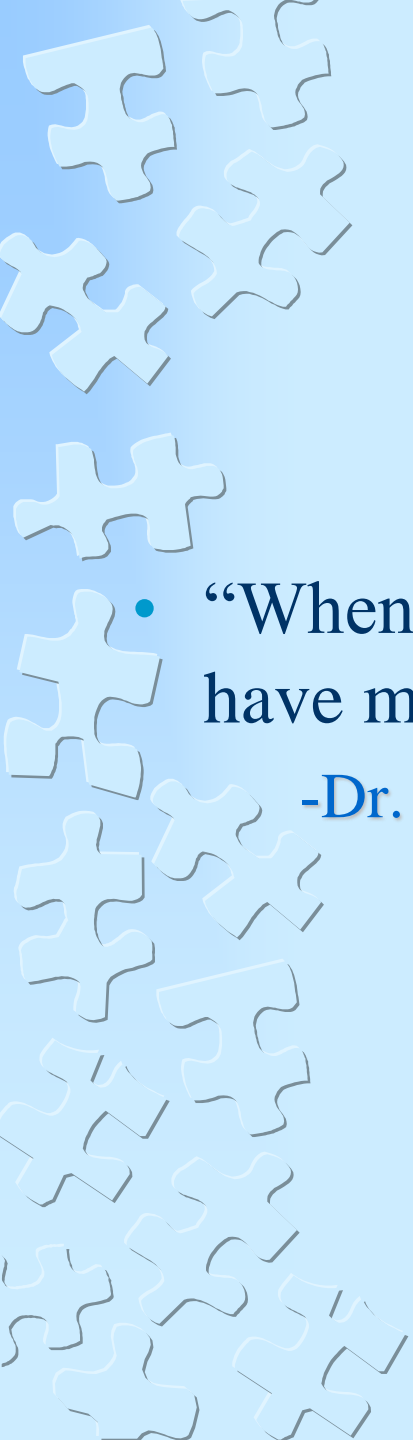
# PREVALENCE STATISTICS



- 
- Autism knows no racial, ethnic, or socio-economic boundaries.
  - It is four times as prevalent in males as in females.

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There are no known causes of autism; however, it is generally thought to be triggered by abnormalities of brain structure or function.

- 
- “When you have met an individual with autism, you have met **one** individual with autism.”

-Dr. Stephen Shore, a professor with Asperger Syndrome



# Most Common Theories for Cause of Autism

- Genetic Vulnerability
- Environmental triggers (chemicals, toxins)
- Vaccine Injury (immunizations, thimerosal)



**Simple answer**

**We Don't Know The Cause**



# How Autism is Diagnosed

- No medical or blood test available to detect ASD
- Diagnosis based on observation of communication, behavior, and developmental levels



# Who Makes an ASD Diagnosis

Generally, a multidisciplinary diagnostic team, which may include:

- Neurologist
- Psychologist
- Developmental pediatrician
- Speech Therapist
- Occupational Therapist

# AUTISM SPECTRUM DISORDER

**CLASSIC  
AUTISM**

**PDD-NOS**

**ASPERGER  
SYNDROME**

**Severe**

**Moderate**

**Mild**

*“Low Functioning”*

*“High Functioning”*



# **A Few Common Characteristics**

# Temple Grandin PHD




- Love of Animals
- Designed Curved Loading Chutes and the Center-Track Restrainer System.
- Design within 1/2 Inch

# Stephen Wiltshire

- London Born
- Photographic Memory
- 20 Minute Helicopter Ride around NYC
- Recreated NYC Skyline from memory, to scale.



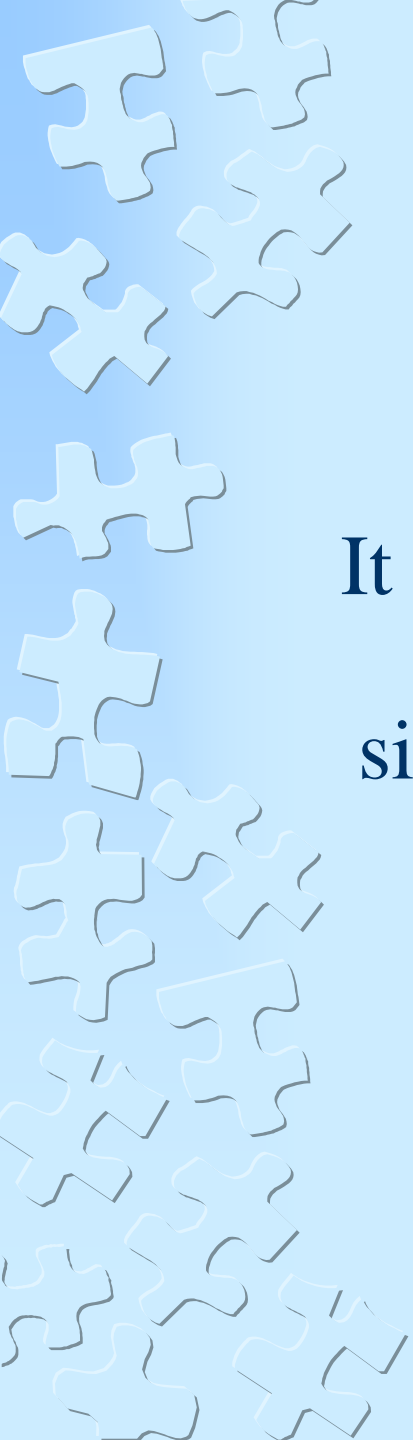
A decorative graphic on the left side of the slide consists of several white puzzle pieces of various shapes and sizes, arranged in a vertical column. The background is a light blue gradient.

It is essential to remember that every person on the spectrum is affected by autism in a different way though certain similarities do exist.



Loud noises and other sensory stimuli may overwhelm the person and cause sensory overload



A decorative graphic on the left side of the slide consists of several white puzzle pieces of various shapes and sizes, arranged in a vertical column. The background is a light blue gradient.

It is common for people with ASD to have seemingly inappropriate reactions to situations, commands and body language.



# **How to Recognize Someone with ASD**

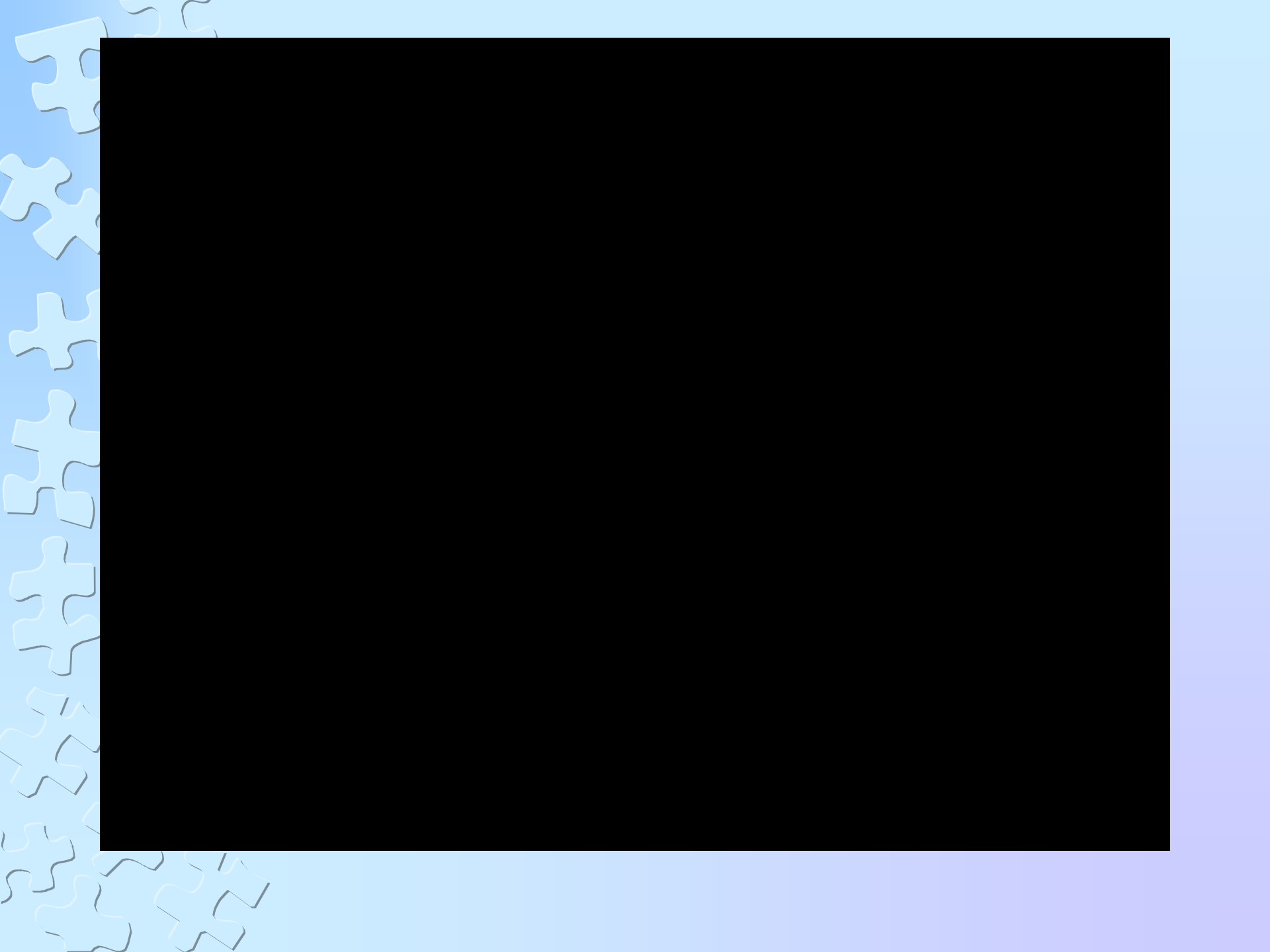


# Common Speech Patterns

- Many people with ASD will simply repeat words that have been spoken to them (known as echolalia)
- Many people with ASD will repeat phrases that they have learned in the past (known as scripting)
- The above should not be confused as comprehension of your words or commands

# Speech

- Many people with ASD are non-verbal
- People with ASD who are verbal may have limited speech and struggle to express themselves, especially in stressful situations
- People with Asperger's Syndrome may appear to be more verbally sophisticated but still lack comprehension capabilities





# Body Language

- Appear to be poor listeners
- Little or no eye contact
- Flat facial affect
- May have an inappropriate reaction to the situation (laughing when afraid)



# Body Movements

May have the following:

- Unusual walking pattern or balance
- Prone to repetitive actions, including spinning of objects, rocking self back and forth, flapping of hands, and pacing or constant movement
- Tend to wander without reacting to surroundings







# Sensory Impairment

## Hypersensitive/Hyposensitive

- Sights
- Hearing
- Smell
- Touch
- Taste





# Little Sense Of:

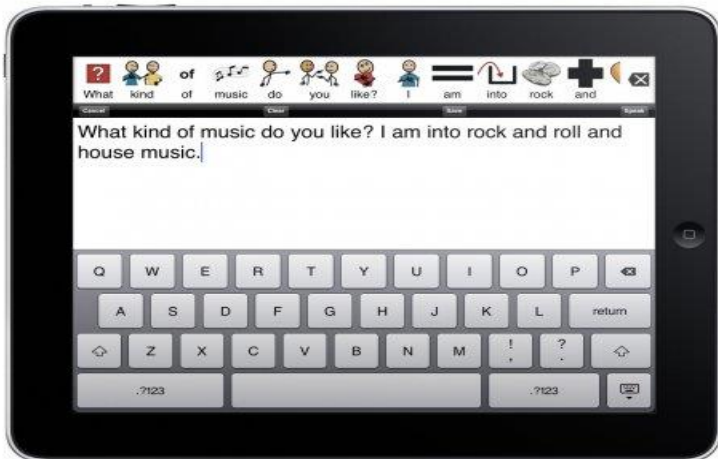
- Pain
- Fear
- Danger
- Safety





# **How to Best Approach a Person with ASD**

Try to utilize communication cards to communicate, though not all people with ASD are familiar with them





- Use calm, simple language
- Be literal and specific
- Avoid slang words



“Go Fly A Kite”



# Speak in short clear phrases

- Sit down
- Get in
- Wait here
- Stop

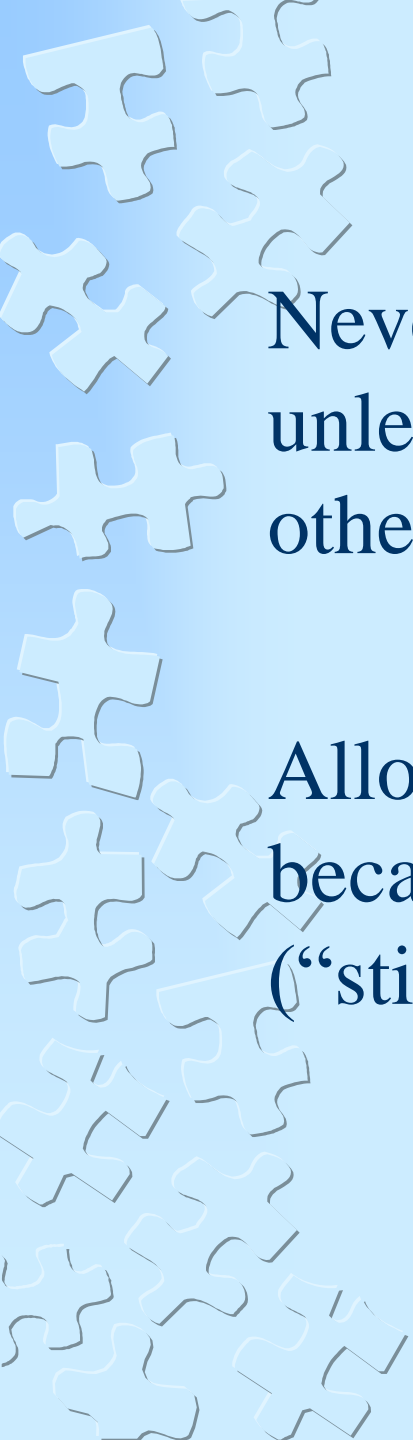
Some non-verbal  
people with ASD  
communicate with  
sign language instead  
of or in addition to  
using the PECS  
picture cards





# Repetitive Behavior

- Stimming (Stereotypy)
- Compulsive behavior
- Sameness-resistance to change
- Ritualistic behavior-activities the same way each time.
- Restrictive behavior-limited in focus, interest, or activity
- Self Injury-30% of children with ASD



Never try to stop a repetitive behavior unless it is self-injurious or dangerous to others.

Allow the person to finish the behavior because this self-stimulating behavior (“stimming”) can be self-soothing.


- Avoid touching or standing behind the person.
- Always be aware of the possibility of bolting: people with ASD are very prone to running away.




May invade personal space of others



Close Talker



It is important to remember that stressful or upsetting situations overwhelm people with ASD and can adversely affect them. They may struggle with tasks they could normally perform (regression)



# **Avoiding Unfortunate Situations**



**Every year, numerous people with ASD suffer psychological trauma, physical injury, or even death as a result of a lack of understanding.**



- Be Patient and Calm.

- Get correct information

(speak with a parent or caregiver, check 911, biographical information forms,

etc).




# Roll Call DVD

Dennis Debbaudt

[autismriskmanagement.com](http://autismriskmanagement.com)

# Police Response



- 
- A decorative graphic in the top-left corner of the slide consists of several white puzzle pieces of various shapes and sizes, arranged in a cluster. The background of the slide is a light blue gradient.
- No one expects a responding officer to be able to diagnose a child or adult's autism in the field.
  - Disclosure or discover will more likely come via a 911 call, from a parent, care provider, or neighbor on scene.

# Behaviors generating 911 calls

Escalated behaviors may be in the form of:

- Violent rocking often in a car seat
- Pacing
- Loud grunting
- Noisemaking
- Utterances
- Running into walls
- Head banging
- Hiding under mattresses or other large objects

These behaviors may be a form of self-stimulation or a sensory reaction to objects and influences in the environment or a change in their normal routine.



# Behaviors generating 911 calls

- Citizens or officers may interpret what they see as someone high on illegal drugs, as violent, suspicious or as a possible crime taking place.
- If verbal, the individual may talk to themselves or no one in particular.
- Parent or caregiver actions such as hugging or wrapping arms around a child or adult may be misinterpreted or appear as assault.

# Response

- Be as patient as the situation will safely allow. Autism field responses will require more time to resolve.



# Response

- Make sure person is unarmed
- Approach in a quiet, non-threatening manner



# Response

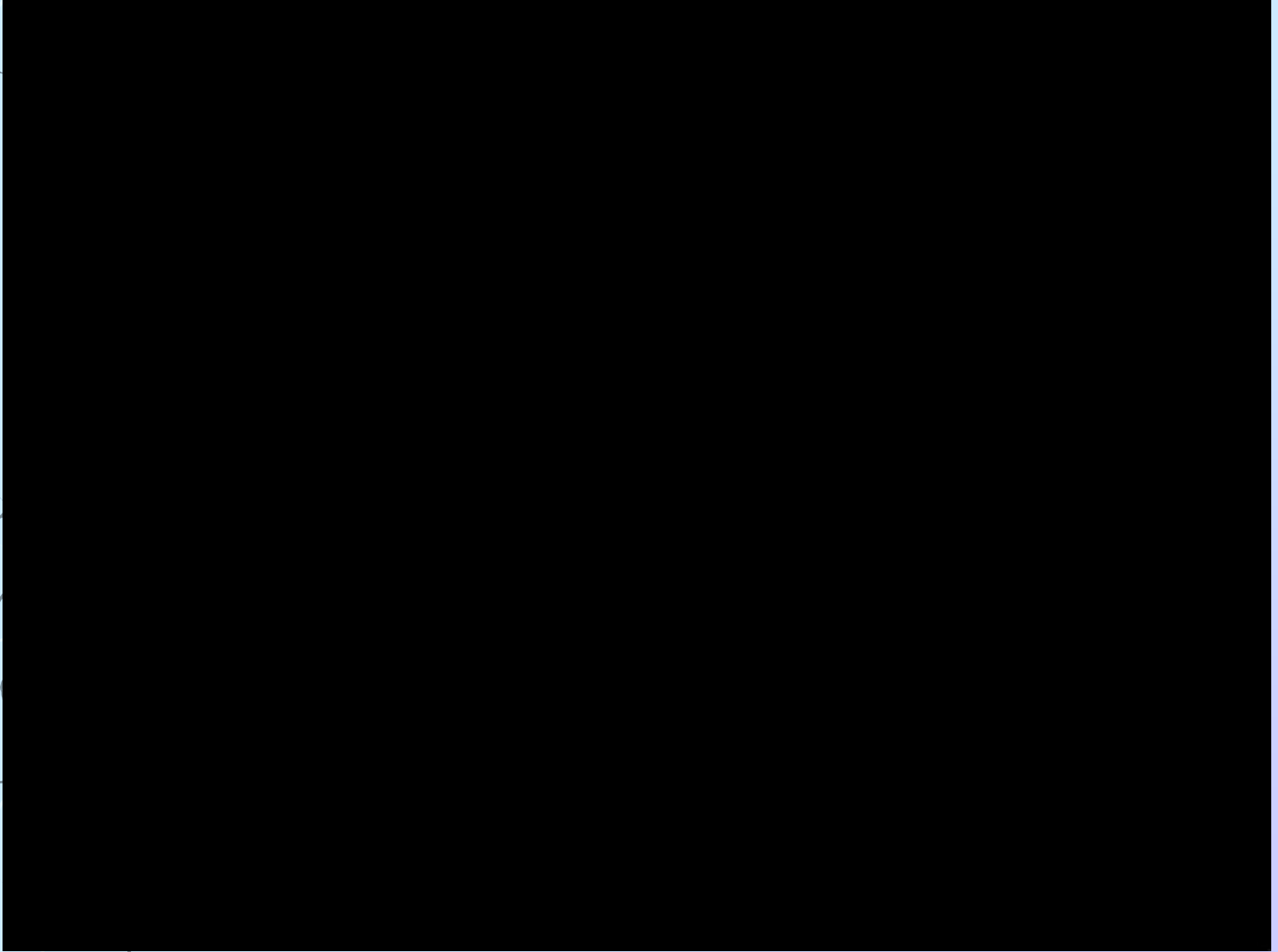
- Police dogs or mounted patrol may be present. Be aware that these animals may cause the person to quickly move towards or away from the animals.
- If possible, move the person away from crowds of strangers to a quiet place or make the scene as quiet as possible.



# Stimming Behavior

- If the individual is holding and appears to be fascinated with an inanimate object, consider allowing him or her to hold the item for the calming effect (if officer safety is not jeopardized by doing so).
- Be aware that these behaviors can be severe, for example a person slapping, pinching or even biting themselves.

# Self Injurious Behavior





# De-escalation of Behavior

Anyone can become upset and display anger, frustration and aggressive behavior.

Remember that calm creates calm.

After the discovery of the person's autism at the scene, consider the use of geography, space, positioning and available time.



# De-escalation of Behavior

## Personal Space

If safe to do so, take a step or two back from the person's space. You are not retreating and are still a buffer to escape.

Explain in a calm voice that you are there to help, not hurt. Let the person know that they can take all the time they need to calm down. Explain this in simple terms.



# De-escalation of Behavior

## Positioning & Time

Use your discretion. If the person's behavior escalates, use geographic containment and maintain a safe distance until any inappropriate behaviors lessens. Use time to allow the person to deescalate themselves without your intervention.



# De-escalation on the Scene

Explain the rules beforehand even when the person doesn't appear to be listening to your commands. Verbalize everything before you do it.

If the person has to wear handcuffs in order to leave, tell them what will happen before it happens. Give them time to process the information.

Remain alert to the possibility of sudden invasion of your personal space, outbursts or impulsive acts such as bolting into traffic.



# Hypotonia

- Be aware of hypotonia-people with ASD may have under developed trunk muscles and may be unable to support their airway when lying flat on their chest
- If individual has to be restrained, if situation allows sit the individual upright or roll the individual to his/her side, monitor breathing to avoid positional asphyxiation .



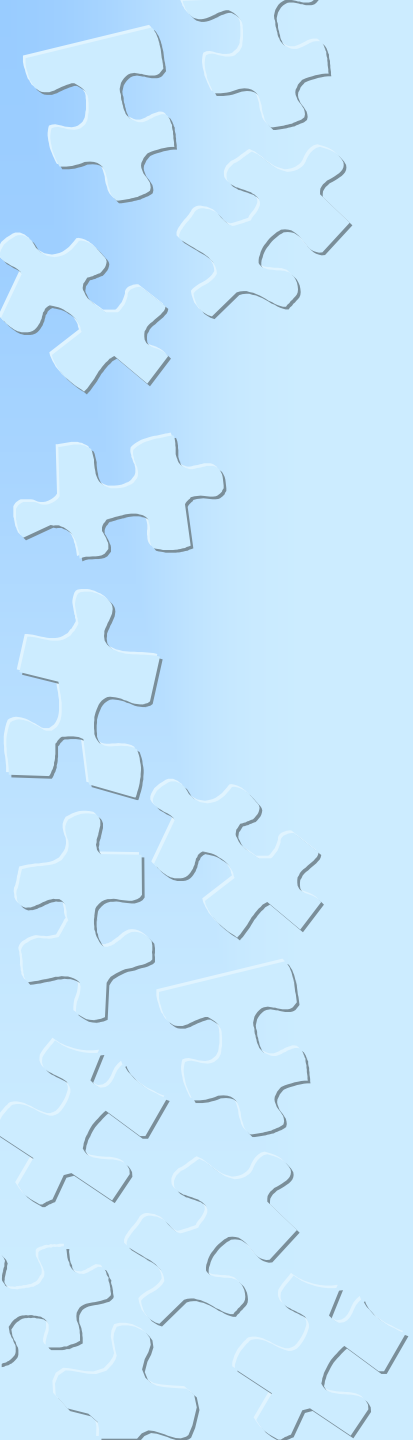
# Custody

Alert supervisors of your discovery of the person's autism.

Consider a medical evaluation for seizure disorder.

The person may have medication requirements or special dietary needs.

Seek information from care providers that will assist jail, lock-up or mental health facility authorities.



# Interview



# Why ASD is tricky

- Concrete answers
- Inability to grasp abstract concepts
- Inability to make or maintain eye contact
- Sensory overload
- Apparent inattentiveness
- Little to no understanding of non-verbal communication
- Insistence on changing the subject or controlling the conversation



# Why you need to know

- Standard interrogation techniques can
  - Confuse the concrete thinker
  - Lead to unexplainable anxiety responses like giggling or uncontrollable laughing
  - Inaccurate answers or misleading statements
    - Based on leading questions by interviewer or
    - The individuals desire to please the interviewer or
    - Overwhelming need to escape a stressful and confusing situation



# Conducting an Interview

- Use his name at the start of each sentence so they know you are addressing them
- Explain how long the interview is going to last, and what will happen at the end
- Allow for frequent breaks
- Maintain a calm environment; minimize distractions e.g., sensory
- Use clear concise and simple language
- 1 question at a time
- Increase allowed processing time



# Typical Police and Autism Offender Interactions

- Stalking or making threats in person, via the internet, postal service or telephone
- Intentional or unintentional shoplifting or peeping tom
- Inappropriate sexual advances
- Downloading child pornography



# Typical Police and Autism Offender Interactions

- Accomplice crime with false friends
- Physical outbursts at school or in the community
- Other violent crimes such as assault and homicide



# Wandering-Elopement

- Many Individuals with ASD wander; it may even be the call first responders get most often



# THE CHALLENGE OF WANDERING

- **49%** of children with ASD wander/elope
- More than **1/3** of children with ASD cannot communicate their name, address or phone #
- Drowning accounts for **91%** of autism wandering deaths  
- *AWAARE*
- Wandering occurs across all settings, by people with ASD of **all ages**, under every type of adult supervision
- Risks increase with autism severity
- Drowning, Exposure, Dehydration, Hypothermia, Traffic Injuries, Falls, Physical Restraint, Encounters with Strangers, Encounters with Law Enforcement



## **Remember that the first responder should check attractive hazards:**

- Water (pools, lakes, rivers, etc.)
- Construction sites
- Drainage areas
- Train and Traffic

# Missing Children Strategies

- **Team Adam will deploy on cases of missing children with special needs**
  - **Specialized Team Adam search personnel may also deploy**



Parents or caregiver to develop and carry a handout.



# Emergency Biographical Information Form

## Emergency Biographical Information

A registry to assist persons-at-risk

Complete form, affix photograph and return to: SNCARC 789 Clapboardtree St., Westwood, Ma 02090

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

### Personal Description:

Date of Birth: \_\_\_\_\_

Race & Sex: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Hair Color: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Scars or Birthmarks: \_\_\_\_\_

Glasses: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Affix Recent Photo Here

### Important Address Information:

Home: \_\_\_\_\_

Phone: \_\_\_\_\_

School: \_\_\_\_\_

Phone: \_\_\_\_\_

### Emergency Contacts

At Home: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

At School: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number \_\_\_\_\_

Others: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number \_\_\_\_\_

## Additional Information

### Current Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Verbal \_\_\_\_\_ Non Verbal \_\_\_\_\_

If non-Verbal, preferable mode of communication (e.g. Sign, Pictures, word approximations):  
\_\_\_\_\_  
\_\_\_\_\_

Describe medical alert ID or other identifying information carried or worn:  
\_\_\_\_\_  
\_\_\_\_\_

Describe favored places your child might wander to:  
\_\_\_\_\_  
\_\_\_\_\_

Will your child respond to his/her name? \_\_\_\_\_

Does your child/family use a password? \_\_\_\_\_ If so, What: \_\_\_\_\_

Important information that will help identify the risk or assist personnel to communicate, understand, care for and maintain the safety of this person.  
If necessary, attach a separate page.

Note: SNCARC can not guarantee the availability nor the utilization of this information by all emergency service systems.

### Release

I, \_\_\_\_\_ give my permission to the town of \_\_\_\_\_ to retain and distribute this information to first response personnel for the sole purpose of identification and assistance to the person-at-risk.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If there is any additional information needed, please contact Family Support Services @ South Norfolk County Association for Retarded Citizens @ 781-762-4001

**Emergency Biographical Information**

A registry to assist persons-at-risk

Complete form, affix photograph and return to: Att: Veronica Kane  
SNCARC 789 Clapboardtree St., Westwood, Ma 02090

Last Name: \_\_\_\_\_ First Name: "TED"  
EDWARD

**Personal Description:**

Date of Birth: \_\_\_\_\_  
Race & Sex: W \_\_\_\_\_ M  
Height: 5' 2 1/2"  
Weight: 100  
Hair Color: BROWN  
Eye Color: BLUE  
Scars or Birthmarks: \_\_\_\_\_  
Glasses: NO



Diagnosis: ALTISM +  
RECEPTIVE/EXPRESSIVE LANGUAGE  
DISORDER

**Important Address Information:**

Home: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Day Program: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Emergency Contacts**

At Home: Name \_\_\_\_\_ Relationship PARENTS  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

At Day Program: Name \_\_\_\_\_ Relationship \_\_\_\_\_  
TEACHER  
Address: \_\_\_\_\_  
Phone Number \_\_\_\_\_

Others: Name \_\_\_\_\_ Relationship GRANDPARENTS  
Address: \_\_\_\_\_  
Phone Number \_\_\_\_\_

**Please complete back side of form**



# HANDOUT INFORMATION

- Emergency contact numbers
- Name, address, phone & photo, physical description
- ID jewelry and clothing tags
- Medical/medication requirements, dietary needs, any sensory issues
- Favorite places to go
- Best way to communicate: verbal, PECS, ASL, computer

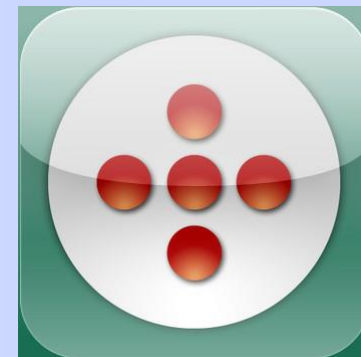
# Emergency Contact Temporary Tattoos



# ICE



# Phone Apps



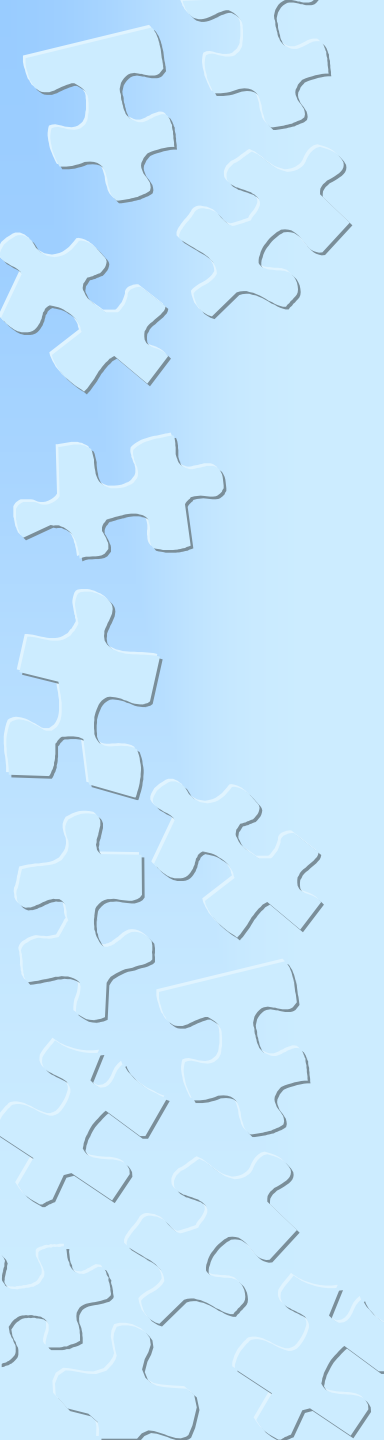


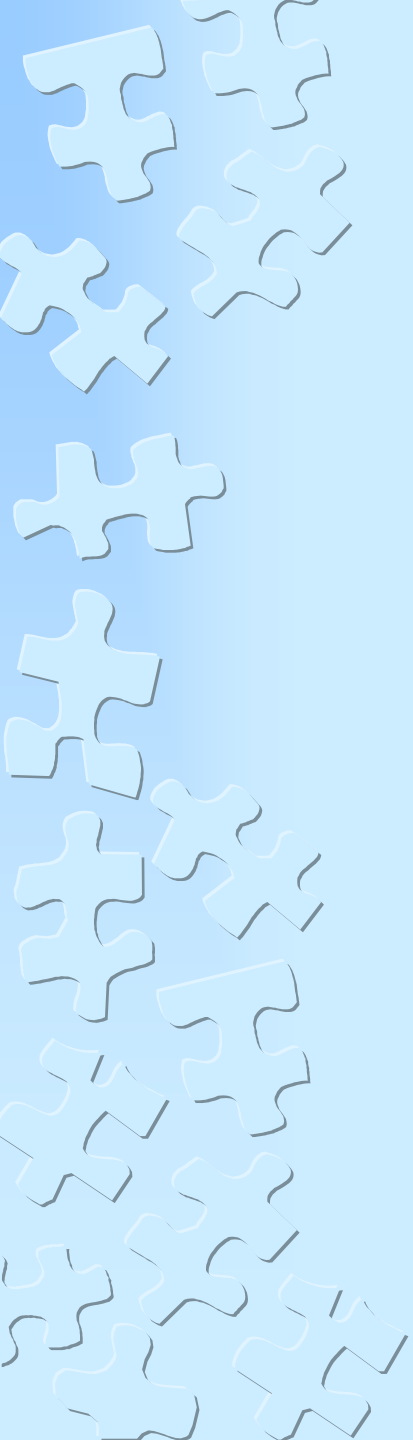




# Rescue from Heights

- Extreme caution should be used with any rescue from heights. A fire department aerial tower or platform would be the easiest way to remove an individual with ASD. This person may aggress towards a rescuer during this operation. Always make sure you are secured before you attempt to rescue the individual







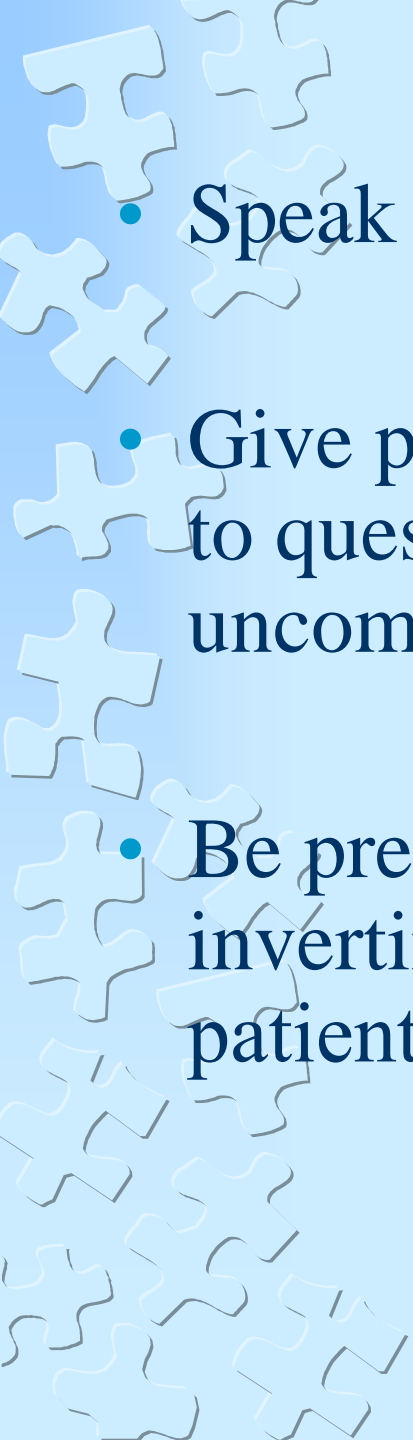
# Bolt Risk


- People with ASD are a bolt risk after rescue. A first responder must stay with the person

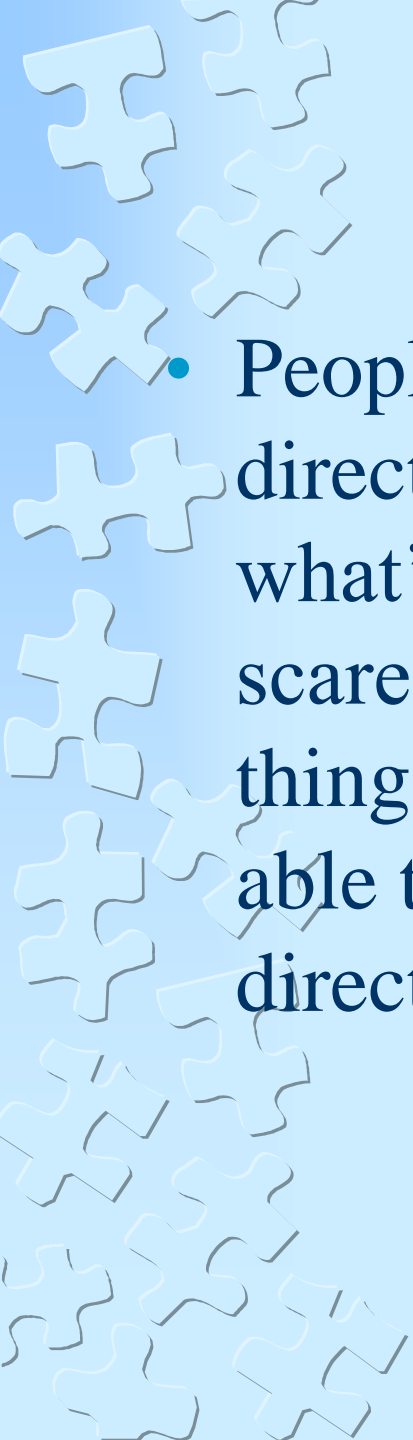


# Routines

- People with ASD often prefer a routine, and adjusting the routine even slightly may result in disruptive behavior.
- Remember, a 911 call is not in this person's routine!

- 
- Speak simply using a calm voice
  - Give plenty of time for the person to respond to questions. A 3-10 second delay is not uncommon
  - Be prepared to repeat your question. Also, try inverting your questions to validate the patient's response

- 
- Provide paper and a pen or a laptop for the best chance of getting the information required from the person
  - Use established communication systems if available

- 
- People with ASD may not respond to directives because they do not understand what's being asked of them or because they are scared. The fact that they're scared is the only thing they will be aware of-they may not be able to process language or understand the directive when fearful





# MVA's

- The parent/caregiver will be your best asset
- Beware of answering yes to all questions
- C-Spines will be difficult
- Befriend the patient
- BOLT RISK even into traffic



# Sensory Issues

- Because of sensory issues, scene noise such as breaking glass, equipment, and vibrations during an extrication may cause a negative reaction from a person with ASD

# Reactions

- Aggression
- Regression
- Sensory Overload



# Super Strong



- They may fixate on an object in a room or on your body such as a badge, earrings.

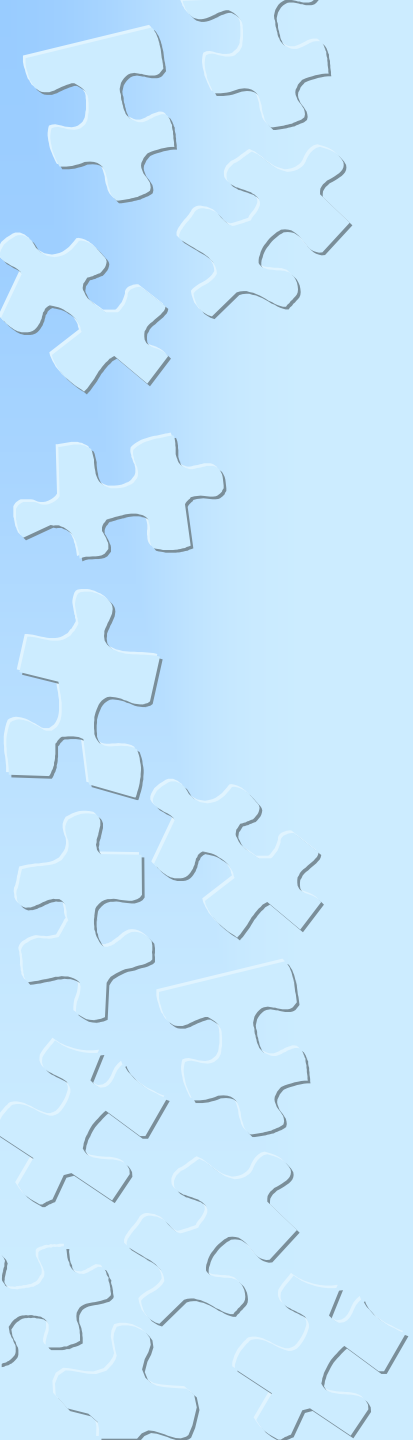


- They may also fixate on your personal gear such as a hat, radio, cuffs and flashlight.

# Community Day




# Community Day



# Community Day



- 
- The goal of these trainings is to provide additional tools to use in assessing the risk of a situation in order to complement but not replace your previous training

# Credits

- Autism and Law Enforcement Education Coalition (ALEC) [www.sncarc.org/alec.htm](http://www.sncarc.org/alec.htm)
- Autism Society-[www.autism-society.org](http://www.autism-society.org)
- Bill Cannata, [www.firerescueautism.com](http://www.firerescueautism.com)
- Dennis Debbaudt-Autism Risk Safety  
[www.autismriskmanagement.com](http://www.autismriskmanagement.com)



# **PRESENTATION #4**

**1:00-2:00pm**

## **Mental Health in Elders**

**Jenny Cox, Director – Behavioral  
Health, Baystate Medical Center**

# Mental Health Issues in Older Adults



JENNIFER COX, LICSW  
BAYSTATE HEALTH

# Mental Illness vs. Cognitive Impairment



- After about age 70 (sometimes earlier) what looks like mental illness is often really a neurological problem with psychiatric symptoms
- Older adults are more likely than other populations to experience psychiatric symptoms related to
  - Delirium
  - Medication interactions
  - Confusion or agitation related to infection or medical condition
  - Dementia (many different types, some with hallucinations and delusions)
  - Increased anxiety and fear due to confusion or memory problems

# Living with cognitive impairment



- Dementia is not just a “memory problem”. Domains that are affected
  - Sensory/motor input
  - Problem solving, sequencing and sorting
  - Wayfinding and navigation
  - Facial recognition
  - Incorrect (delusional) beliefs about themselves or their situation
  - Errors in judgement
  - Ability to predict consequences of actions or solve multi-step problems

# It's all in your approach



- Never contradict or “reorient” a confused older adult
- Ask for permission to enter personal space
- Use a supportive stance with room
- Join with and validate the older adult’s experience
- Engage in emotional mirroring even when it doesn’t make sense
- Try and reach a collaborative solution
- “therapeutic fibbing” is fine
- Utilize the hand-over-hand technique when possible

# Communication strategies



- Ensure you engage eye contact first, using the person's name
- Speak slowly and eliminate unnecessary words and phrases – pause longer between words and sentences than you think you need to
- Ask failure-free questions, and provide information when you can. Don't use open ended questions or ask someone to explain a situation
- Try and use a gentle tone of voice, even when a person is extremely agitated. Keep in mind that most aggressive behavior in older adults is rooted in fear.



**THANK YOU**

# Presentation # 5

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2:00-3:00pm

## **Department of Children & Families (DCF) Intersections with Law Enforcement**

Michael Collins, MS, Criminal Justice, Area Clinical Manager, DCF Springfield  
Area Office

# PRESENTATION # 6



**3:00-4:00pm**

## **Co-Response**

William Witherspoon, MA

Kristin Cianciolo, MA

Richard Winning, MSW, LICSW

Behavioral Health Network