





Welcome

CIT TRAINING

JUNE 26th - 30th, 2023



Opening Remarks

- Welcome
- Ground Rules
- Introductions – Person- Role-System Introductions
- Presentations
- Groups
- Evaluations
- Polling (Participants can vote at **slido.com** with **#2507601**)

Crisis Intervention Team (CIT) Overview & Co-Response

Hallie-Beth Hollister, M.Ed., Program Manager, BHN Crisis Services,
Carl Girouard, BHN Police Consultant, CIT-TTAC, BHN

June 26, 2023 - 8:30am-9:30am

What is CIT?

- The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.
- **Crisis Intervention Teams:** Local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises

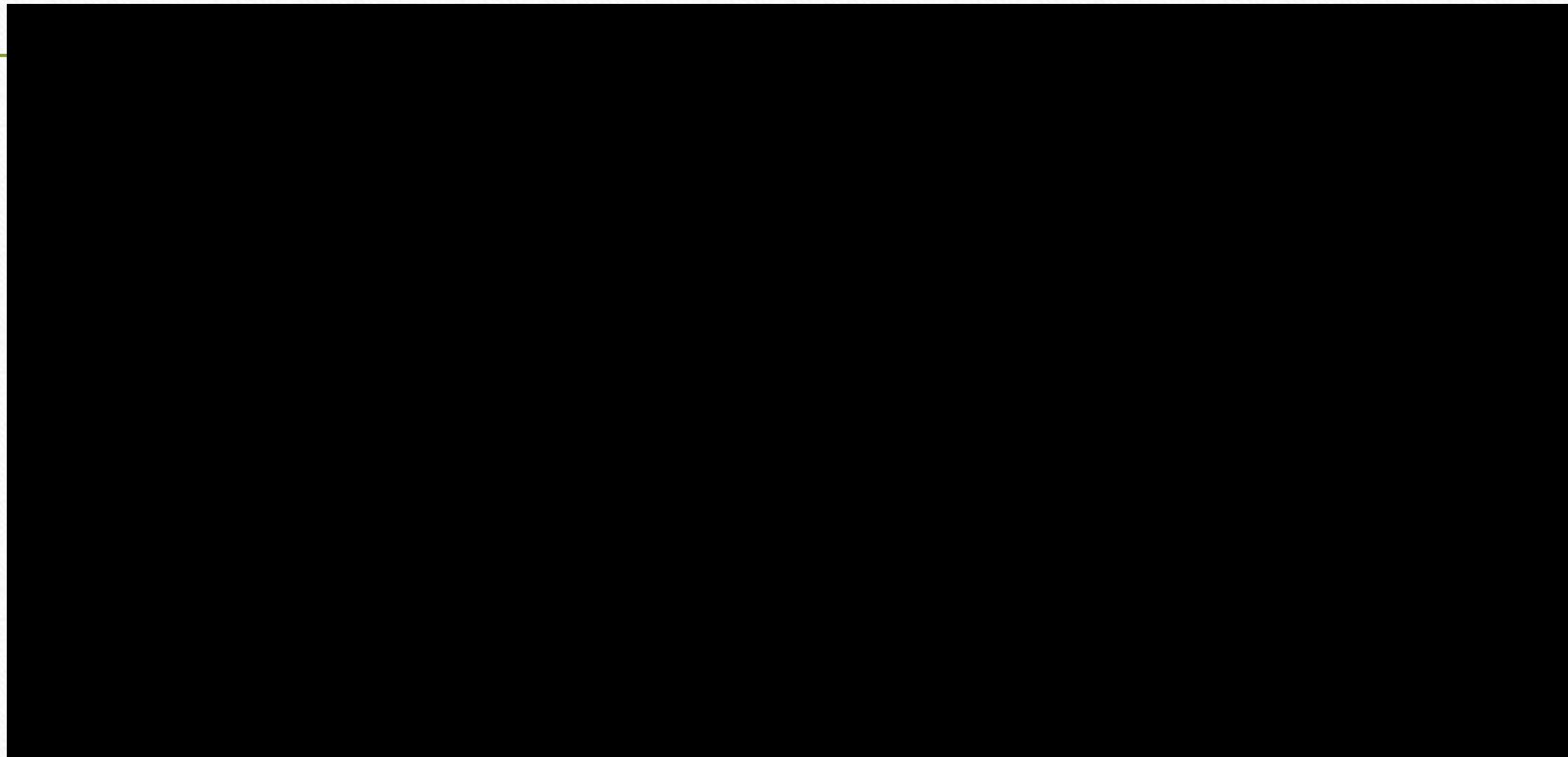
History of CIT

- First CIT program was established in Memphis in 1988.
- Established after the aftermath and public outcry of a 1987 incident when Memphis PD shot and killed a 27-year-old man with a mental illness.
- Memphis Police Department teamed up with NAMI, the city, MH consumers, MH Professionals, University of Memphis, and the University of Tennessee to develop.
- Often referred to as “The Memphis Model”
- Now utilized throughout the U.S. and internationally

Why collaborate?

- “Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers. Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them.” – *Police-Mental Health Collaborations : A Framework*. Bureau of Justice Assistance & Council of State Governments Justice Center

The Origins of CIT



- <https://www.youtube.com/watch?v=y99kODtyVhk&t=11s> 10:10

BHN Western Massachusetts CIT – Training & Technical Assistance Center (CIT-TTAC)

- Started in 2013 and funded through DMH Jail/Arrest Diversion grant.
- BHN provides 6 full 40 CIT hour training per year.
- Also provided are 8-hour CIT Dispatcher Training, 8-hour Youth Focused CIT, roll call training & Mental Health First Aid.
- Technical assistance to involved PDs which includes hot case reviews, consultation, collaborative programs, and assistance in starting and maintaining CIT Programs in their cities/towns.
- BHN CIT-TTAC team includes Assistant Program Director, Program Clinician, Police Consultants, Certified Peer Specialist, and Administrative Staff.
- 1067 officers trained in CIT, 86 in Youth-Focused CIT, 46 MHFA & 60 in CIT Dispatcher to date (06/25/2023)

What are the “Core Elements” of CIT?

- Partnerships:

 - Advocacy Community
 - Mental Health Community
 - NAMI
 - Stakeholders Meetings
 - Statewide conference
 - Law Enforcement Community

CIT Implementation

- Training and CIT Policy are first steps
- Training of Dispatch
- Having a skilled, trained first responder available to respond immediately
- Having a mentality of helping, with an awareness for safety.
- More than a training!
- A police department needs a CIT Coordinator, Mental Health Coordinator and team of officers.
- Working with community stakeholders and MH partners
- Stakeholder meetings and evaluation
- Continued collaboration

Why is CIT training necessary?

- Law enforcement, especially the dispatchers, are often the **first responders** for persons in mental health crises
- Available 24/7
- High response to an “Emotionally Disturbed Persons” call or “mental disturbance” call
- Decrease officer injury, increase safety
- Reduces stigma
- Redirect Individuals with Mental Illness from the Judicial System to the Behavioral Health Care System

BHN CIT-TTAC involved Law Enforcement Agencies

- BHN's Community Behavioral Health Center catchment area includes Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Indian Orchard, Longmeadow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, and Wilbraham.
- BHN/CIT-TTAC covers training for all Western Massachusetts Police Departments.

CO-RESPONSE

Consists of a clinician and their support staff that work directly with officers from the point of call to the point of conclusion.

OBJECTIVES:

- Objectives:
 1. What is Co-Response?
 2. Goals of Co-Response
 3. Co-Response Model being used in WM
 4. Police Departments with Co-Response
 5. Future of Co-Response.

GOALS OF CO-RESPONSE

1. To intervene with officers to a variety of mental health and substance abuse calls.
2. To evaluate individuals contacted in this way for safety and limiting the need for transports to the hospital.
3. To provide opportunities and choices that reduce the need for arrest through the addition of treatment and services.
4. To provide follow ups with community members to reduce recidivism

HOW CAN CO-RESPONSE HELP

1. Co-responders training helps calm community members experiencing acute Psychiatric symptoms.
2. Co-responders work to secure community support reducing the need for police responses to individuals over time.
3. Co-responders can work as a bridge between law enforcement, the courts and the jail systems to guide away from incarceration and towards treatment.
4. Providing alternative options in the moment that reduce conflict for the responding officers.

WHAT CAN CO-RESPONSE ACCOMPLISH.

Co-Response has been shown to reduce the need to engage physically with those with psychiatric illness. Which saves community member lives but also the lives of responding officers.

Close to a quarter of people killed by police officers in the United States had a known mental health condition, and a November 2016 study in the *American Journal of Preventive Medicine* estimated that 20% to 50% of law enforcement fatalities involved an individual with a mental illness.

<https://www.apa.org/monitor/2021/07/emergency-responses>

CO-RESPONSE MODEL TAKING SHAPE



-
- https://www.youtube.com/watch?v=anxhlthj_ZQ

Presentation # 2

9:30am -11:00am

Mental Health Disorders

Nicola Howe, MSW

Objectives

By the end of this presentation, participants will be able to:

- ❑ Understand the signs and symptoms of serious mental health disorders.
- ❑ Appreciate the role that stigma plays in preventing treatment, and that people do recover from mental illness.
- ❑ Understand how different types of disorders affect behaviors.
- ❑ Will understand what the CIT police officer's role is in encounters with people who have mental illnesses or are in crisis.
- ❑ Dissect myths about people with mental illnesses.
- ❑ Sensitized about concerns and types of victimization that individuals who have mental health and other conditions face.

Defining Mental Health and Mental Illness

Mental health refers to cognitive, behavioral, and emotional well-being. It is all about how people think, feel, and behave.



(Medical News Today, 2020)

Conversely, mental illnesses are health conditions involving changes in emotion, thinking, or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.

(Psychiatry.org, 2018).

Definitions of Mental Health

“Mental health influences how we think and feel about ourselves and others, and how we interpret events. It affects our capacity to learn, to communicate and to form, sustain and end relationships. It also influences our ability to cope with change, transition and life events, such as: having a baby, moving to a new house, experiencing bereavement”

Friedl, 2014

Signs and Symptoms of a serious Mental Health Disorder

What is a Sign? Clinician – Psychiatrist – Family member – Therapist – Medical Doctor

What is a Symptom? – Patient

The key difference between signs and symptoms is who observes the effect.

Symptoms can be remitting, chronic and relapsing.

Considerations when Working with Mental Health

Stigma

Presentations of diagnoses

Medical considerations

Using Person-Centered Language



Stigma - Exercise

What are some words we use to describe the symptoms of someone who is suffering from cancer?

What are some negative words we use to describe someone suffering with a mental health disorder?

Why are the two looked at differently?

Do you use these words? Regularly? Sometimes?

Do you think the stigma prevents someone from seeking help/treatment?

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**What are some negative words we use
to describe someone
suffering with a mental health disorder?**

ⓘ Start presenting to display the poll results on this slide.

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What are some words we use to describe someone who is suffering from cancer?

ⓘ Start presenting to display the poll results on this slide.

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Why are the two looked at differently?

ⓘ Start presenting to display the poll results on this slide.

Considerations When Working with Mental Health



slido



Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough.

ⓘ Start presenting to display the poll results on this slide.



Mental Health is too often ignored

- ❑ Currently:
- ❑ 1 in every 8 people in the world live with a mental disorder
- ❑ 1 in 5 people will experience mental health problems
- ❑ 1 in 6 workers are experiencing depression, anxiety or stress.
- ❑ 1 in 16 in General population have a serious mental illness

Myths vs Reality

Knowledge Check: Myths/Factual

Causes of Mental Health Disorders

- **Genetics**
- **Environment**
- **Childhood trauma**
- **Stressful events**
- **Negative thoughts**
- **Unhealthy habits**
- **Drugs and alcohol**
- **Brain chemistry / TBI**

M E N T A L



H E A L T H

Mood Disorders

Substance-Related Disorders

Psychotic Disorders

Neurocognitive Disorders

Anxiety Disorders

Autism Spectrum Disorders/Intellectual
Disabilities

Personality Disorders

Trauma/Stressor-related Disorders

Eating Disorders

Co-Occurring Disorders

Describe your mood?



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Mood Disorders:

General emotional state or mood is distorted or inconsistent with your circumstances and interferes with your ability to function. Can be extremely sad, empty or irritable (depressed), or have periods of depression alternating with being excessively happy (mania).

- **Major depressive disorder** — prolonged and persistent periods of extreme sadness
- **Bipolar disorder** — also called manic depression or bipolar affective disorder, depression that includes alternating times of depression and mania

Bipolar Disorder

Bipolar Disorders are groups of brain disorders that cause extreme fluctuation in a person's mood, energy, and ability to function.

An individual cannot be diagnosed with Bipolar Disorder until at least age 18

Bipolar I Disorder could include psychotic features and episodes of hypomania

Mania is defined as “a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently goal-directed behavior or energy, *lasting at least 1 week* and present most of the day, nearly every day”.

Hypomania is defined as “a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, *lasting at least 4 consecutive days* and present most of the day, nearly every day”.

Treatments for Bipolar Disorder



Types of Therapy:

- Cognitive Behavioral Therapy
- Family Therapy
- Psychoeducation
- Psychotherapy

Types of Medication:

- Anticonvulsants: Topiramate, Lamotrigine, Oxcarbazepine
- Antipsychotic: Risperidone, Haldol, Quetiapine
- SSRI -Fluoxetine

Depression

Depression is a mood disorder characterized by persistent sadness or loss of interest or pleasure in previously rewarding or enjoyable activities. The effects of depression can be long-lasting or recurrent and can dramatically affect a person's ability to function and live a rewarding life.

Included under depressive disorders:

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)

An individual must be experiencing five or more symptoms during the same two-week period to meet criteria for Major Depressive Disorder:

- [Psychom.net](https://www.psych.com), 2020

Black Dog/ Depression



Slowing the brain down?

Activity

Treatments for Depression



Types of therapy:

- Cognitive Behavioral Therapy (CBT)
- Behavioral Therapy
- Talk/psychotherapy

Types of medications:

- Selective Serotonin Reuptake Inhibitor (SSRI) –Sertraline, Fluoxetine, Escitalopram
- Antidepressant –Amitriptyline, Mirtazapine, Bupropion
- Antipsychotic –Aripiprazole

Medical Treatment:

- Electroconvulsive Therapy (ECT)

Psychotic Disorders:

A person's personality is severely confused, and that person loses touch with reality. When a psychotic episode occurs, a person becomes unsure about what is real and what isn't real and usually experiences hallucinations, delusions, off-the-wall behavior, chaotic speech, and incoherence.

Examples:

Schizophrenia - The most common psychotic disorder. Patients with this condition experience changes in behavior, delusions, and hallucinations that last longer than six months. Those diagnosed with this type of disorder often show a decline in social function, school, and work.

Schizoaffective Disorder

Patients with schizoaffective disorder have symptoms of both a mood disorder, such as depression and schizophrenia.

Psychotic Disorders:

Brief Psychotic Disorder

When a patient has only short, sudden episodes of psychotic behavior, the condition is diagnosed as brief psychotic disorder. These episodes are typically a response to a stressful situation and usually last less than a month.

Delusional Disorder

Patients that have false, fixed beliefs involving real-life situations that could be true, such as having a disease or being conspired against, are diagnosed with delusional disorder. These delusions persist for at least one month.

Treatments for Psychotic Disorders

Treatment is usually lifelong and often involves a combination of medication, therapy, and coordinated specialty care services.

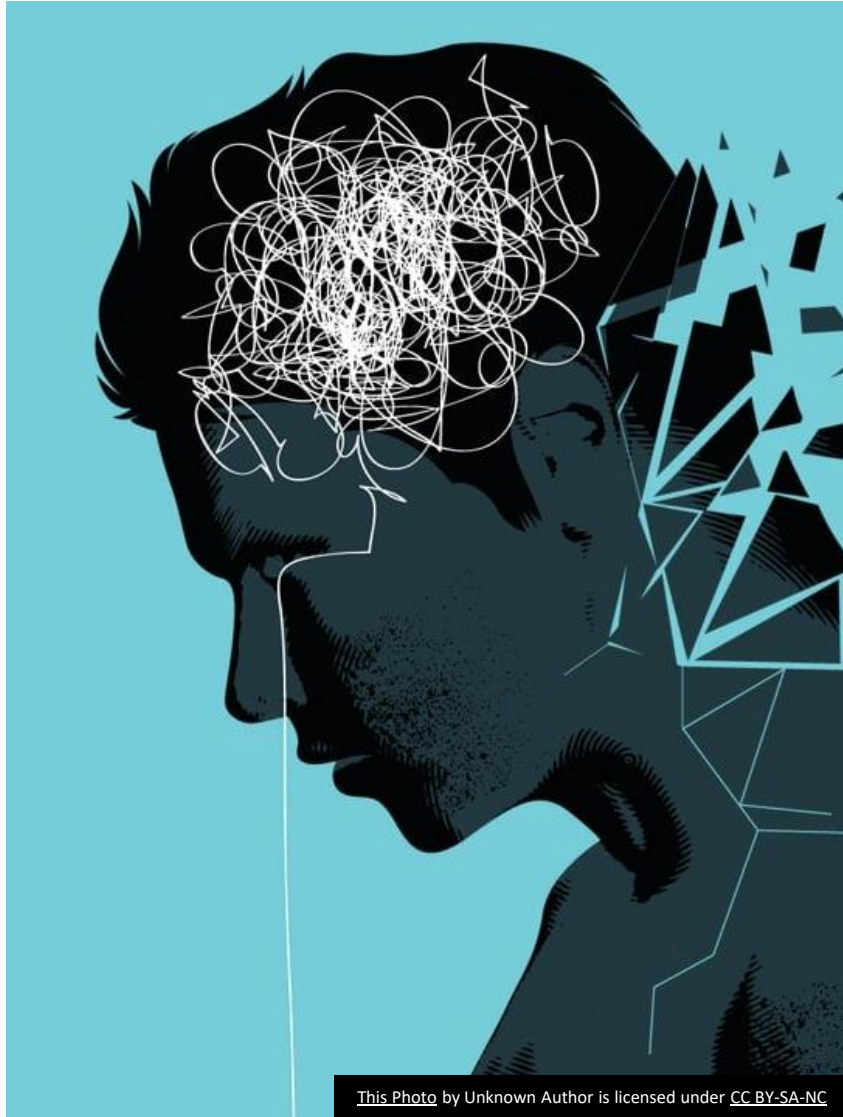
Types of Therapy:

- Support Groups
- Rehabilitation
- Cognitive Therapy
- Psychoeducation
- Family Therapy
- Behavior Therapy
- Group Psychotherapy

Types of Medications:

- Antipsychotic: Olanzapine, Risperidone, Haldol, Perphenazine, Clozapine
- Anti-tremor –Bentropine





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Anxiety

The term anxiety refers to feelings of worry, nervousness, apprehension, or fear commonly experienced by people when faced with something they view as challenging.

Anxiety Disorders

Classified when anxiety, fear, or nervousness does not go away and inhibits daily living activities.

Types of Anxiety Disorders:

- **Generalized Anxiety Disorder (GAD):** excessive anxiety or worry, most days for at least 6 months. Symptoms include feeling restless, easily fatigued, difficulty concentrating, forgetfulness, irritability, difficulty sleeping.
- **Panic Disorder:** Recurrent unexpected panic attacks; classified by periods of intense fear that come on quickly and can include heart palpitations, sweating, shaking, shortness of breath, feelings of impending doom, feeling of being out of control
- **Phobia-Related Disorders:** an intense fear or aversion to specific objects or situations
 - Common phobias: agoraphobia, social anxiety disorder, separation anxiety; “specific phobias” to things such as flying, blood, heights, etc.



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FEAR

Anxiety and adrenalin are connected to the feeling of fear. If we were not able to feel fear, we would be killed by a tiger when we were cavemen, but fear keeps us from doing dangerous things. Fear makes us think before we take action.

Fear is not reasonable when it keeps us from doing what we want or following our dreams. It gets in our way and stop us from taking action

The Psychology of Fear



Treatments for Anxiety

Self-care:

- Reduce caffeine intake
- Avoid alcohol and smoking
- Exercise and healthy diet
- Relaxation techniques

Types of therapy:

- Cognitive Behavioral Therapy (CBT)
- Meditation
- Psychotherapy

Types of medication:

- SSRI –Fluoxetine, Escitalopram, Sertraline, Citalopram, Paroxetine
- Anxiolytic –Diazepam, Buspirone
- Antidepressant –Imipramine, Duloxetine, Venlafaxine
- Sedative –Lorazepam, Clonazepam



Personality Disorder



Personality Disorders

Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

Changes in how a person feels and distorted beliefs about other people can lead to odd behavior, which can be distressing and may upset others.

Common features include:

- being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger
- avoiding other people and feeling empty and emotionally disconnected
- difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people
- odd behavior
- difficulty maintaining stable and close relationships, especially with partners, children and professional carers
- sometimes, periods of losing contact with reality

Personality Disorders

Cluster A : Paranoid personality disorder, Schizoid personality disorder; Schizotypal personality disorder

Cluster B: Antisocial personality disorder, Borderline personality disorder, Histrionic personality disorder, Narcissistic personality disorder

Cluster C: Avoidant personality disorder, Dependent personality disorder, Obsessive compulsive personality disorder

Treatments for Personality Disorders

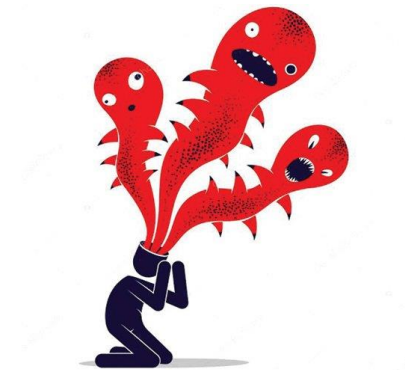
- ❑ Psychotherapy
- ❑ Cognitive Behavioral Therapy
- ❑ Medications: Antidepressants (citalopram, duloxetine) , Mood stabilizers (Olanzapine, Abilify, Latuda), Anti-Psychotic Medications (clozapine, Haldol, quetiapine), Anti-Anxiety (buspirone, Benzodiazepines, Hydroxyzine)
- ❑ Hospital and Residential Treatment programs
- ❑ Coping and support within family and community

Related Definitions

Delusions –fixed beliefs that are not amenable to change in light of conflicting evidence. May take on a variety of themes: persecutory, delusions of reference, erotomanic, grandiose, jealous, nihilistic, and somatic are the most common.

Hallucinations –perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control.

Catatonia –a marked psychomotor disturbance that may involve decreased motor activity, decreased engagement during interview or physical examination, or excessive or peculiar motor activity.



Other Commonly Encountered Diagnoses

Post-Traumatic Stress Disorder: classified by exposure to actual or threatened death, serious injury, or sexual violence by means of witnessing, directly experiencing, learning that it occurred to a friend or family member in a violent or accidental way, or extreme or repeated exposure to the aversive details of the event . Intrusion symptoms include distressing dreams, reactions, and dissociative reactions or physiological cues to internal or external cues that symbolize the event.

Neurocognitive Disorders: Commonly include delirium, dementia, or Alzheimer's Diagnoses, marked by behavioral disturbances, inability to verbally communicate, and are frequently degenerative.

Autism Spectrum Disorder: characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interactions; and skills in developing, maintaining, and understanding relationships.

- Presentations can range significantly in communication ability, behaviors, and independent functioning.

Commonly-Encountered Diagnoses (continued)

Attention-Deficit Hyperactivity Disorder (ADHD): A persistent pattern of inattention and/or hyperactivity that interferes with functioning or development. Examples of inattention include wandering off-task, lacking persistence, having difficulty sustaining focus, and being disorganized which is not due to defiance or lack of comprehension. ADHD begins in childhood and several symptoms must exist between the ages of 6 and 12 to meet the full criteria.

Substance-Related Disorders include ten different separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, and tobacco. Disorders are classified when substances produce such an intense activation of the reward system that normal activities may be neglected.

Co-Occurring Disorders

- This is any combination of two or more substance use disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
- No specific combinations of mental and substance use disorders are defined uniquely as co-occurring disorders.
- People with Substance Use Disorders are at particular risk for developing one or more primary conditions or chronic diseases. The coexistence of both a mental illness and a substance use disorder, known as a Co-Occurring Disorder, is common among people in medication-assisted treatment (MAT).
- People with mental illness are more likely to experience a substance use disorder than those not affected by a mental illness. According to SAMHSA's 2018 National Survey on Drug Use and Health, approximately 9.2 million adults in the United States have a co-occurring disorder.

Police Intercept with Mental Illness

- The police officer is not expected to be a clinician;
- Observation of behaviors (signs or symptoms reported to you)
- What is obviously different about the person's behavior?
- How are they dressed? What is the content of their thoughts (symptoms)?
- Are they talking about things that the officer cannot perceive or are nonsensical (delusions/hallucinations)?
- What is their mood like (signs – observe (affect) or symptoms)?
- Concern about suicide or violence?
- Substance use present?
- Are there cultural considerations?

What not to do.....



Presentation #3

Kathy Picard – Lived Experience

11am-12pm

Let's
RAISE
the
BAR...

AND
PROTECT
ALL OF OUR
CHILDREN FROM
SEXUAL ABUSE.



Kathy J. Picard



My Personal Story

With
help,
hope,
and the
necessary
tools
to heal. ♥



Advocacy and Beyond



The William Pynchon Award

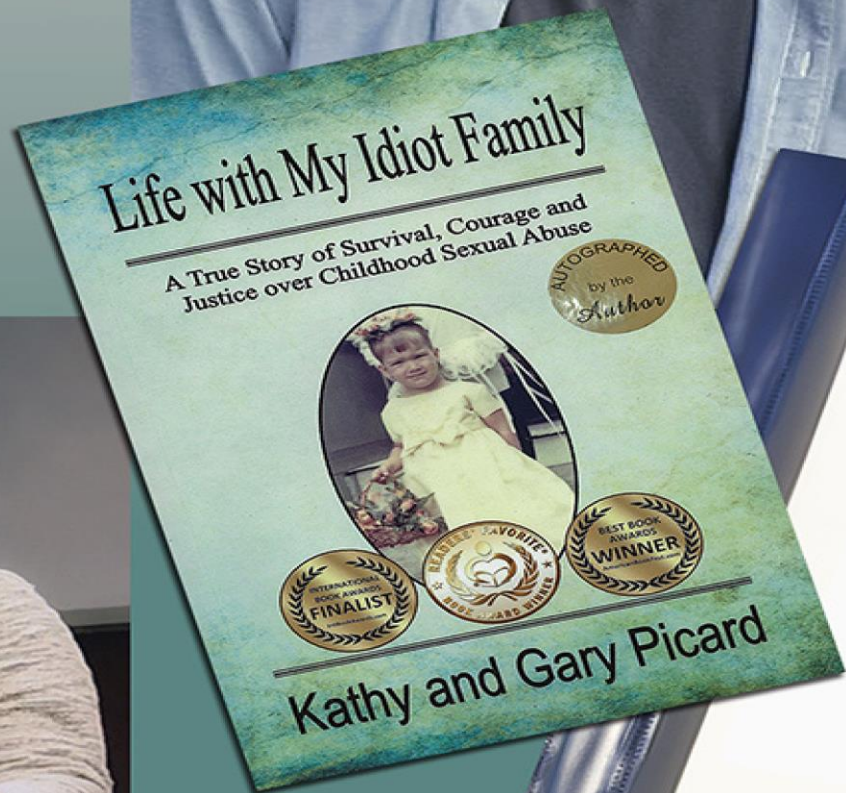
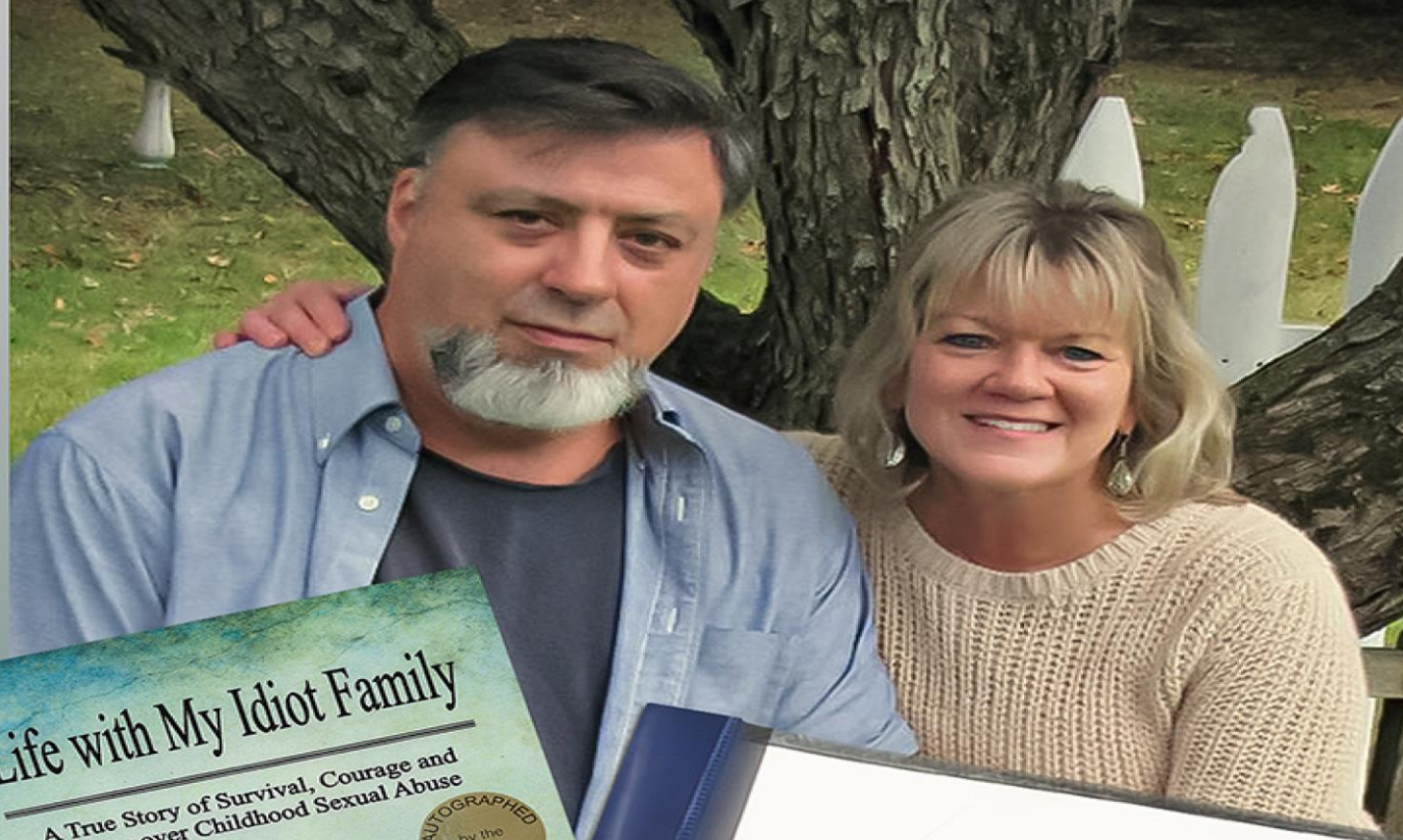


Childhelp®

A Fight for Justice



Finding My Voice



THE GIRL NEXT DOOR
Based on the Book, "Life With My Idiot Family"
by Kathy and Gary Picard

Screenplay by
GARY PICARD and VALERIE UTTON



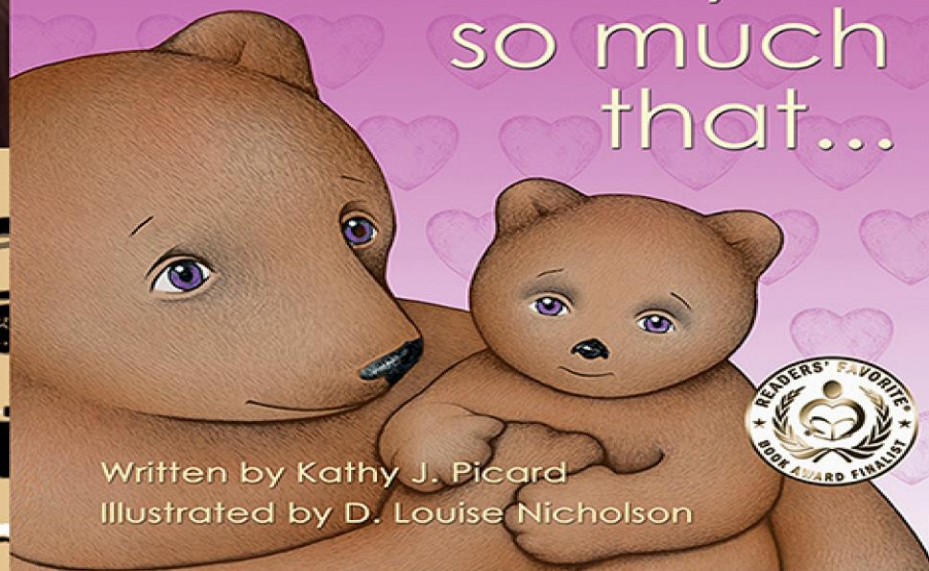


New Resources



♥ NEW EXPANDED SECOND EDITION ♥

I love you
so much
that...



Written by Kathy J. Picard
Illustrated by D. Louise Nicholson

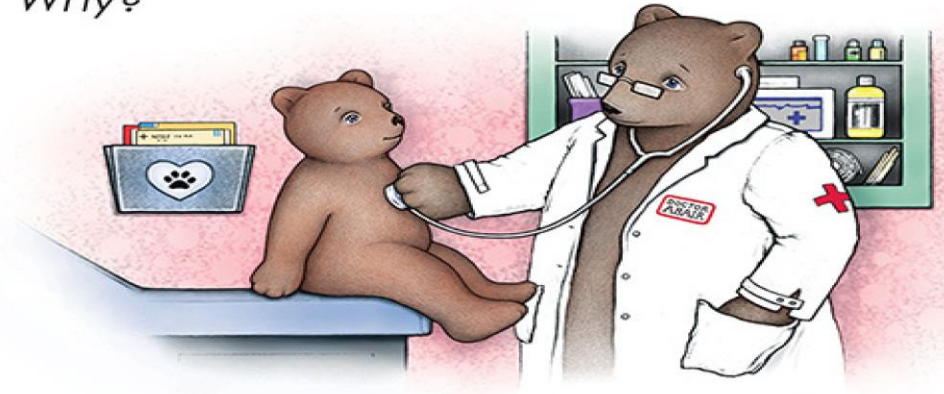


I love you and want you to be safe
so much that



I want you to
keep your private parts private.

Why?



*Because private means we don't show
or share them with other people.*

*Is there a time when it's okay for
someone to see your private parts?*

Early Prevention



This book was read with love
and belongs to:



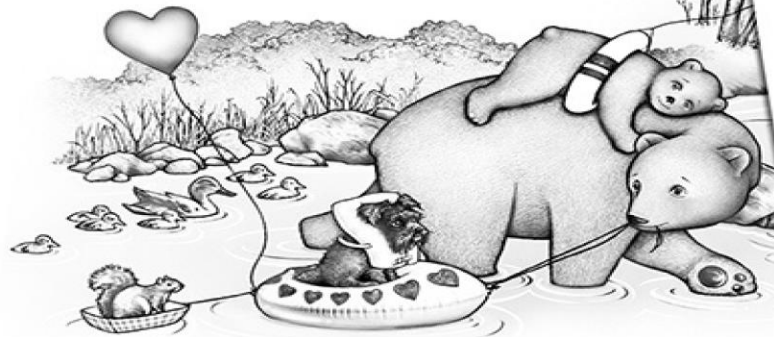
A Life Lesson

Who can you count on? Write down
three names...



What does being safe mean?

1. _____
2. _____
3. _____



Are they being safe in this picture? Why?

My Name is: _____



Kathy Picard read her book,
I love you so much that...
to me today!

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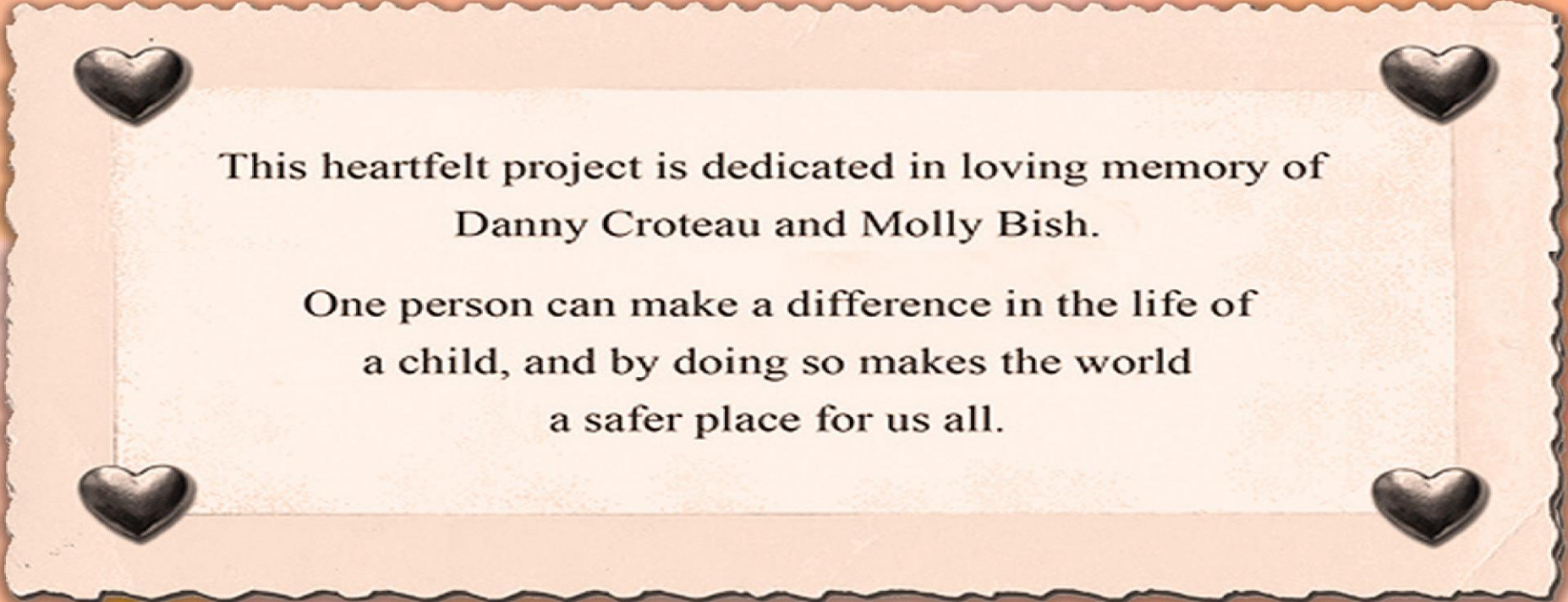
Child-Help – Speak Up

CHILDHELP
Speak Up Be Safe
PREVENTION THROUGH EDUCATION

OFFICIAL ATHLETES™
Athletes

Q & A:

All Questions Welcome!



This heartfelt project is dedicated in loving memory of
Danny Croteau and Molly Bish.

One person can make a difference in the life of
a child, and by doing so makes the world
a safer place for us all.

Thank you
on behalf
of children
everywhere



Kathy J. Picard

413.575.4674

♥ Kathychildadvocate@gmail.com ♥

Presentation # 4

1:00-2:00pm

The Family Perspective

Amanda Pappas, Care Coordinator, BHN Intensive Care Coordination
Program

Presentation # 5

2:00-3:00 pm

Special Consideration with a Veteran Population, Department of Veterans Affairs (VA Services)

Kate Nye, MSW, LICSW

Suicide Prevention Coordinator

VA Central Western Massachusetts Healthcare System

VA



U.S. Department
of Veterans Affairs

Special Considerations for the Veteran Population

Jeffrey McCarthy, PsyD

Program Manager CBOC Mental Health Services

VA Central Western Massachusetts Health Care System

Why We Are Here

First Responder Training



War may be hell...but home ain't exactly heaven,
either. When a Soldier comes home from war, he
finds it hard...

adapted from "A gentle reminder to keep your life in
perspective. "

CPT Alison L. Crane, RN, MS
Mental Health Nurse Observer-Trainer
7302nd Medical Training Support Battalion

VA



U.S. Department
of Veterans Affairs

...to listen to his son whine about being bored.



...to keep a straight face when people complain about potholes.



...to be tolerant of people who complain about the hassle of getting ready for work.



...to be understanding when a co-worker complains about a bad night's sleep.



...to control his panic when his wife tells him he needs to drive slower.



...to be silent when people pray to God for a new car.



...to be compassionate when a businessman expresses a fear of flying.



...to not laugh when anxious parents say they're afraid to send their kids off to summer camp.



...to not ridicule someone who complains about hot weather.



...to control his rage when a colleague gripes about his coffee being cold.



...to remain calm when his daughter complains about having to walk the dog.



...to be civil to people who complain about their jobs.



...to just walk away when someone says they only get two weeks of vacation a year.



...to be happy for a friend's new hot tub.

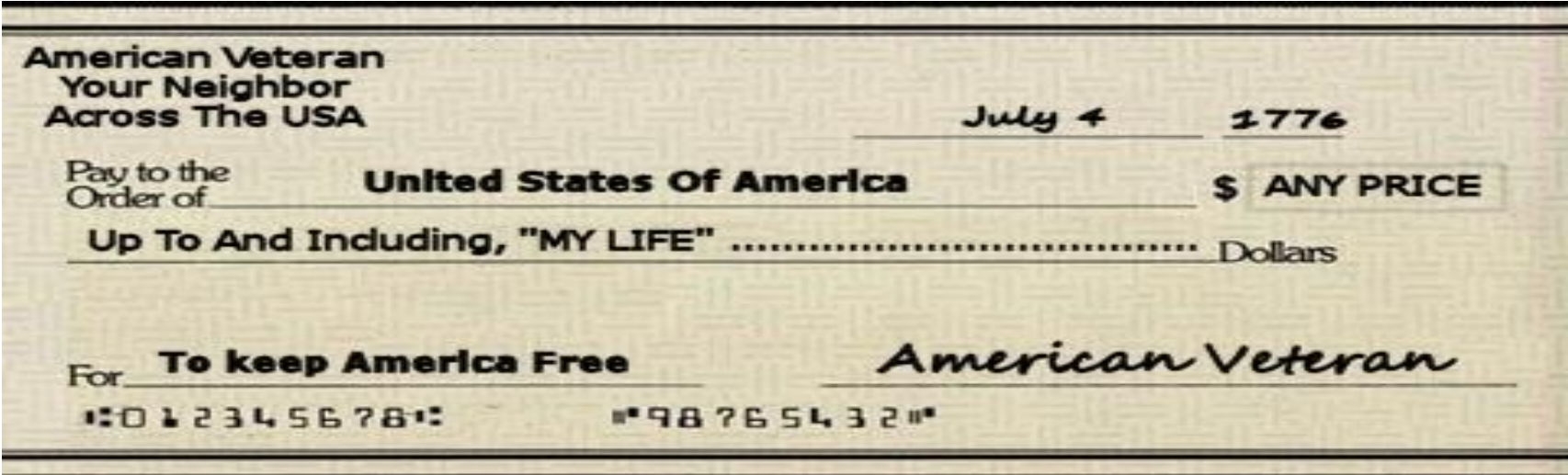


...to be forgiving when someone says how hard it is to have a new baby in the house.



What is a Veteran?

A Veteran is someone who, at one point in their life wrote a blank check made payable to the United States of America for an amount of up to and including their life.



RANK INSIGNIA OF THE U.S. ARMED FORCES

ENLISTED

E-1	E-2	E-3	E-4	E-5	E-6	E-7	E-8	E-9	SENIOR ENLISTED ADVISORS				
ARMY													
no insignia Private E-1 (PV1)	 Private E-2 (PV2)	 Private First Class (PFC)	 Corporal (CPL) Specialist (SPC)	 Sergeant (SGT)	 Staff Sergeant (SSG)	 Sergeant First Class (SFC)	 Master Sergeant (MSG)	 First Sergeant (1SG)	 Sergeant Major (SGM)	 Command Sergeant Major (CSM)	 Sergeant Major of the Army (SMA)		
MARINES													
no insignia Private (Pvt)	 Private First (PFC)	 Lance Corporal (LCpl)	 Corporal (Cpl)	 Sergeant (Sgt)	 Staff Sergeant (SSgt)	 Gunnery Sergeant (GySgt)	 Master Sergeant (MSgt)	 First Sergeant (1stSgt)	 Master Gunnery Sergeant (MGySgt)	 Sergeant Major (SgtMaj)	 Sergeant Major of the Marine Corps (SgtMajMC)		
AIR FORCE													
no insignia Airman Basic (AB)	 Airman (Amn)	 Airman First Class (A1C)	 Senior Airman (SrA)	 Staff Sergeant (SSgt)	 Technical Sergeant (TSgt)	 Master Sergeant (MSgt)	 First Sergeant (E-7)	 Senior Master Sergeant (SMSgt)	 First Sergeant (E-8)	 Chief Master Sergeant (CMSgt)	 First Sergeant (E-9)	 Command Chief Master Sergeant (CCM)	 Chief Master Sergeant of the Air Force (CMSAF)
NAVY													
no insignia Seaman Recruit (SR)	 Seaman Apprentice (SA)	 Seaman (SN)	 Petty Officer Third Class (PO3)	 Petty Officer Second Class (PO2)	 Petty Officer First Class (PO1)	 Chief Petty Officer (CPO)	 Senior Chief Petty Officer (SCPO)	 Master Chief Petty Officer (MCPO)	 Force or Fleet Command Master Chief Petty Officer (FORMC) (FLTMC)	 Master Chief Petty Officer of the Navy (MCPON)			
COAST GUARD													
 Seaman Recruit (SR)	 Seaman Apprentice (SA)	 Seaman (SN)	 Petty Officer Third Class (PO3)	 Petty Officer Second Class (PO2)	 Petty Officer First Class (PO1)	 Chief Petty Officer (CPO)	 Senior Chief Petty Officer (SCPO)	 Master Chief Petty Officer (MCPO)	 Command Master Chief (CMC)	 Master Chief Petty Officer of the Coast Guard (MCPO-CG)			

RANK INSIGNIA OF THE U.S. ARMED FORCES

OFFICERS

0-1	0-2	0-3	0-4	0-5	0-6	0-7	0-8	0-9	0-10	SPECIAL														
ARMY - AIR FORCE - MARINES																								
NAVY - COAST GUARD																								
W-1					W-2					W-3					W-4					W-5				
ARMY																								
NAVY - COAST GUARD																								
Warrant Officer 1 W-1 <small>* The grade of Warrant Officer W-1 is no longer in use.</small>										NO Chief Warrant Officer (CW05)														
MARINES																								
AIR FORCE																								
NO WARRANT		NO WARRANT		NO WARRANT		NO WARRANT		NO WARRANT		NO WARRANT														

HISTORY OF RECENT CONFLICTS

- World War II (1941-1945)
- Korean War (1950-1953)
- Vietnam (1961-1975)
- Grenada (1983)
- Panama (1989)
- First Gulf War/Desert Storm (1990-91)
- Somalia (1993)
- Bosnia(1993-1995)
- Kosovo (1998-1999)
- Operation Enduring Freedom/OEF (2001-present)
- Operation Iraqi Freedom (2003-2011)

War Environment

- **Climate, Gear, Technology, Accessibility to treatment, Type of Warfare, Environmental Exposure ...**



How to Spot a Veteran



OEF/OIF Facts

- 2.7 million military personnel have been deployed since the War in Afghanistan began in late 2001.
- 89 % are men, 11% are women
- 43% screened positive for PTSD, MDD, or Alcohol Use Disorder
- 2000 - 2017: > 379,000 suffer from some form of closed-head injury

Readjustment

Combat Zone



Home



Military vs. Civilian life

- Predictability vs. variation
- Following orders vs. making decisions
- Expectations of unit vs. expectations of family
- Mission orientation vs. every person for themselves
- Shared experience/camaraderie vs. no one understands

Adjustment

- The stresses and effects of combat on behavioral health are fairly well documented. PTSD, Traumatic Brain Injury, and general readjustment issues sometimes manifest themselves in Veterans as crisis encounters with law enforcement or first responders.
- The community's response to this crisis can have a major impact on the Veteran, the Veteran's family, and the community itself.

PTSD-Clinical Criteria

- Trauma-experiencing or witnessing life threatening event
- Symptoms lasting more than a few months and interfering in life:
 - Re-experiencing
 - Avoidance
 - Hypervigilance
 - Disconnection

Symptoms of PTSD

Re-experiencing the event

- nightmares
- flashbacks

Avoidance

- crowds
- people, places, things that remind you of the event
- thinking about or talking about event

Negative changes in beliefs and feelings

- difficulty connecting with others
- loss of interest in enjoyable activities
- difficulty recalling important parts of the traumatic event
- feelings of impending doom

Hyperarousal

- sleep challenges
- trouble concentrating
- easily startled
- hypervigilance/over interpret things as threats

PTSD Veteran Stats

- **Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF):** 11-20% who served in OIF or OEF have PTSD in a given year.
- **Gulf War (Desert Storm):** 12% have PTSD in a given year.
- **Vietnam War:** 15% (late 1980s study, estimated more likely to be 30%)

[Sounds of Trauma by David Lynch Foundation](#)

<https://www.youtube.com/watch?v=bgpRw92d1MA>

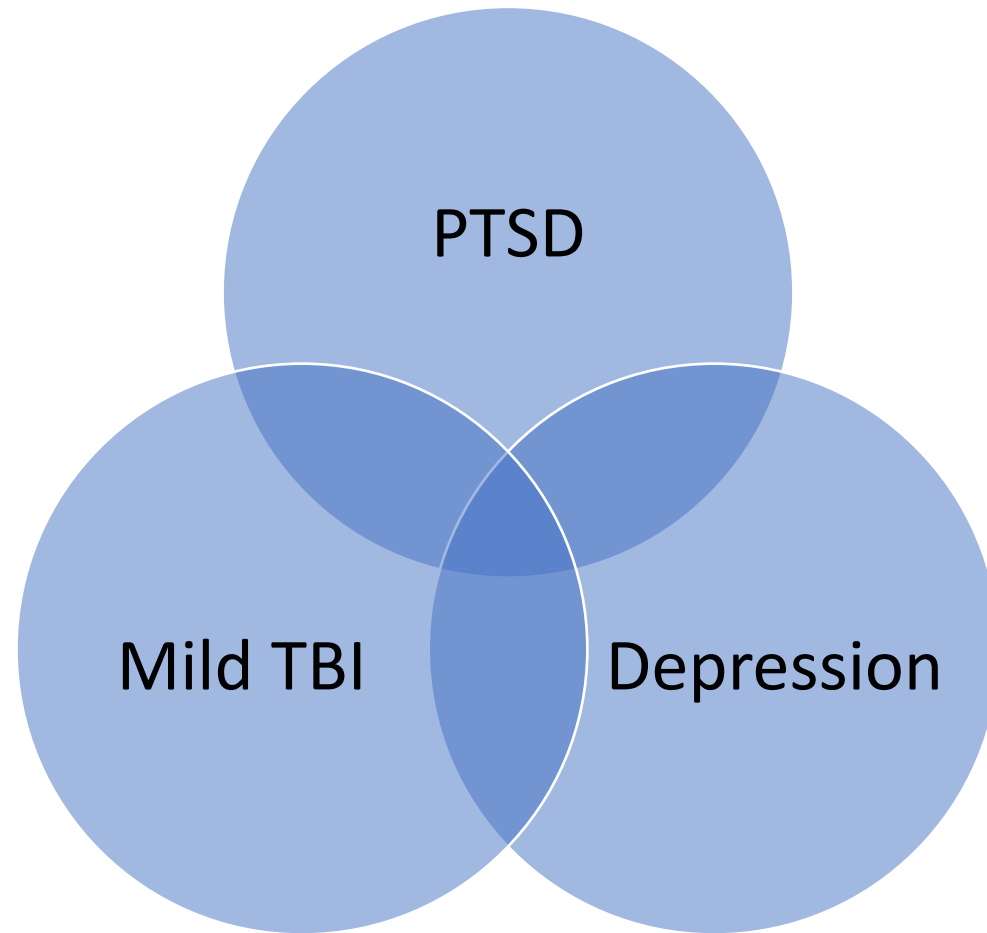


VA

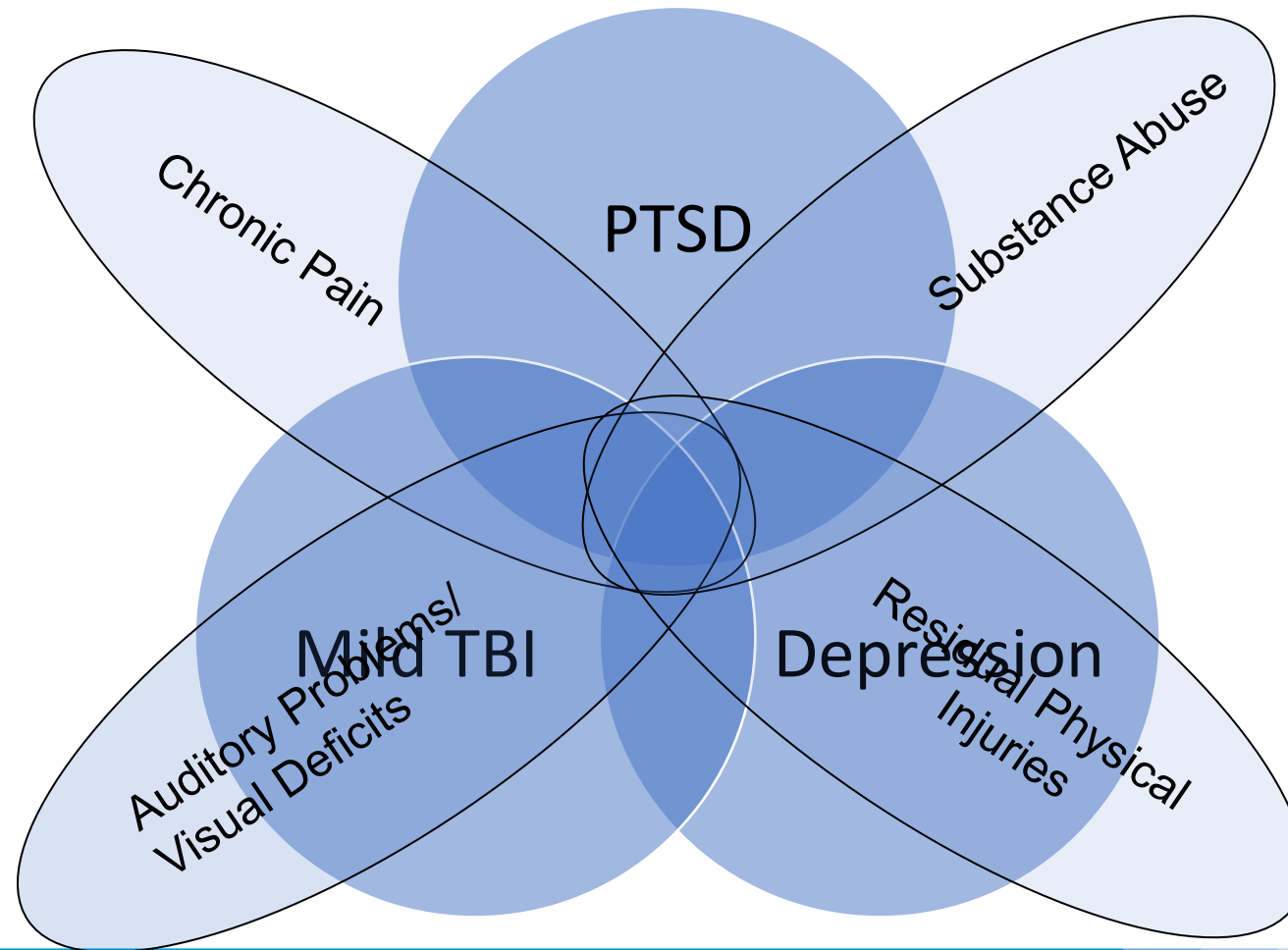


U.S. Department
of Veterans Affairs

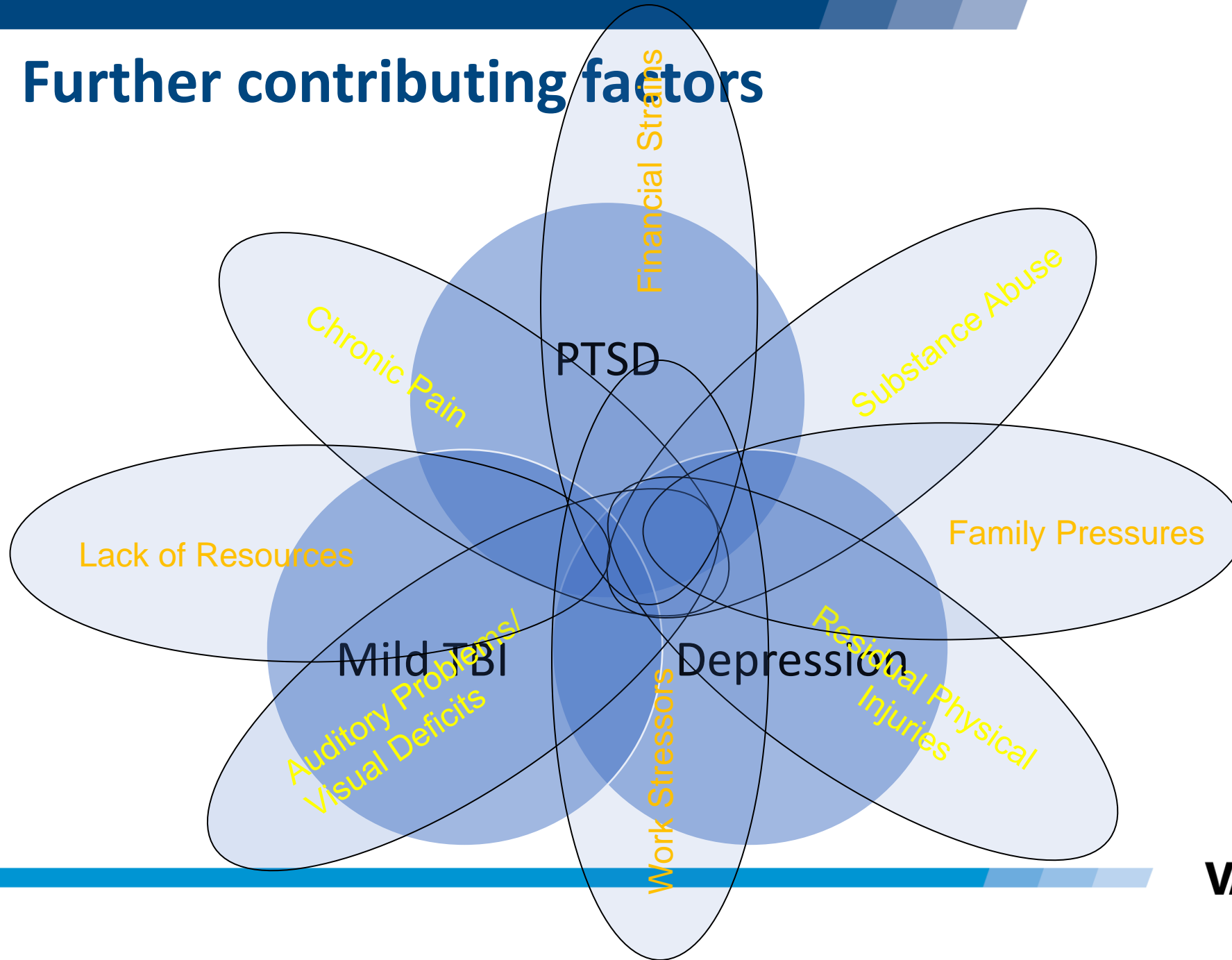
Difficulties with diagnoses and/or treatment



Further contributing factors



Further contributing factors



Behaviors We May See

- Risky behaviors to get the adrenaline rush
- Speeding/Erratic driving/road rage/avoidance driving/non-defensive driving
- Panic while in traffic
- Violent Behavior (**Rage**)/Domestic Violence/Child abuse
- Addictions (work, drugs, alcohol, food, adrenaline, sexual behavior)
 - Combat exposure increases the likelihood of substance use
- Withdrawal, isolation, intolerance of others
- Complain of headaches, chronic pain, forgetfulness
- Emotional dysregulation/Impulsive

Domestic Violence

- Higher rate of domestic violence in military compared to civilian counterpart
- There is generally a spike in DV upon return from deployment
- DV increases with subsequent deployments and with longer deployments
- DV increased by 33% from 2006-2011 in Army families
- June 2018: VA commits \$17 million to expand IPV assistance program

Combat Exposure and Substance Use

- Alcohol abuse doubles following combat deployment (Jacobson et al 2008)
- Greater combat exposure is associated with greater substance abuse
- Reserve & Guard personnel had higher rate of new onset alcohol abuse post deployment than active-duty personnel

Warning Signs of Suicide

- Hopelessness
- Rage, anger, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug abuse
- Withdrawing from friends, family, and society
- Anxiety, agitation, inability to sleep, or sleeping all the time
- Dramatic changes in mood
- Perceiving no reason for living, no sense of purpose in life

Facts about Veterans and Suicide

- Suicide was the **second** leading cause of death for Veterans ages 18-45
- Veterans are more likely than the general population to use **firearms** as a means for suicide
- On average, **16.8** Veterans die by suicide every day in the US. **6.7** of these Veterans are engaged in VHA care, **10.1** are not.
- **6,146** Veterans died by suicide in 2020, which is **343** fewer than in 2019

Veterans Crisis Line: Call, Chat, or Text



Share the new
Veterans Crisis Line number
with your Veteran loved ones.

Dial 988 then Press 1



VA



U.S. Department
of Veterans Affairs

What can we do?

De-escalation Techniques to employ

- When interacting with those who may be experiencing psychiatric symptoms and/or are conditioned to be impulsive, reactive, ready to defend, consider:
 - Non verbal awareness (eg. body posture)
 - Verbal cues (eg. tone of voice)
 - Personal Space
 - Environment (lower lights, radio)
- Reduce the intensity of the situation
- Goal is not only to maximize de-escalation, but also to PREVENT escalation or re-escalation
- Requires ongoing re-assessment of situation
- Speed up or slow down your response based on the situation

Techniques to employ (cont.)

- Other considerations:
 - Clarification (“good dentist technique”)
 - Simple 1-step instructions
 - Stay calm/supportive
 - Grounding ...*Get them in the here and now...(Where were you heading? Do you know what street you are on now?)*
 - Breathing
 - Walk together/Get to sit down
 - Avoid threats, intimidation, judgement
 - Active listening / Open-ended questioning

Actions to consider when responding to Veteran crisis

- Look for clues that your subject is a veteran
- Ask “Have you served in the US military?”
 - Respect veteran status
 - Express appreciation for their service
 - *Ask about military (“I see you have a veteran plate...thanks for your service! what branch were you in?”; IF you are a veteran and feel comfortable—disclose branch, etc).*

Actions to consider when responding to Veteran crisis

- Take extra safety precautions
- Establish a distance between the veteran and everyone around him/her
- Thank for service, try to be as respectful as possible. Do what you can to help him save face
- Minimize surprises

- Do things that will calm him
- If you have ties to military service mention it
- Let the veteran talk as long as it is helping him/her wind down
- ***Think of the veteran's behaviors as symptoms of an injury, not a mental illness***

Rapport Building

DON'TS:

- “Calm Down!”
- “Because I told you so!”
- “Get over here!”
- “It’s the law!”
- “I’m not going to tell you again!”

DO'S:

- “Can I speak with you a moment?”
- “I can see you are having some trouble. How can I help?”
- “I would appreciate the opportunity to explain why...”
- “Help me understand what I can do to help you.”

Communication Cautions

- Overreacting
- Power Struggles
- False promises
- Threats

Veteran status

- Ask the question (“Have you ever served in the US military?”)
- Once you’ve established Veteran status, ask if person is being seen at any VA
- If they are, ask if they have a safety plan and if they have someone they want to call from the plan

Justice Involved Veterans

- In 2018 – 180,000 incarcerated Veterans in MA
 - SUD was #1 factor for arrest
 - Symptoms of PTSD was #2 factor for arrest (anger/irritability)
- Veterans are more likely to be sentenced for violent offences

Veterans Justice Outreach Initiative

“The purpose of the VJO Initiative is to avoid unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible Veterans in contact with the criminal justice system have access to:

VHA mental health and substance abuse services when clinically indicated , and other VA services and benefits as appropriate.”

- Department of Veteran Affairs, April 30, 2009, Under Secretary for Health’s Information Letter

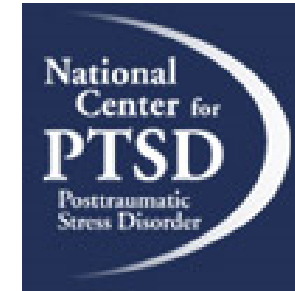
Also important to know about:

- Western Mass Veterans Treatment Court (for Vets with or without records who need intensive, long term probation. We are looking for high risk, high needs clients)



On-Line Resources

- National Center for Posttraumatic Stress Disorder (www.ncptsd.va.gov)
- Veterans Justice Outreach (www.va.gov/HOMELESS/VJO.asp)
- NcPTSD Police Officer Toolkit (<https://www.ptsd.va.gov/professional/toolkits/police/index.asp>)



Presentation # 6

3:00-4:00 pm

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

Vanessa Rossini , Intake Supervisor, DCF Springfield Area Office



DEPARTMENT OF CHILDREN AND FAMILIES

Guide to Protective Intake





OVERVIEW

- How do I file a report of child abuse or neglect?
- When should a 51A report involving domestic violence be filed?
- What will be asked when I file a report?
- What happens after I file a report?
- Additional information



DCF'S APPROACH TO ITS PROTECTIVE MANDATE

Vision

All children have the right to grow up in a nurturing home, free from abuse and neglect, with access to food, shelter, clothing, health care, and education.

Mission

Strive to protect children from abuse and neglect and, in partnership with families and communities, ensure children are able to grow and thrive in a safe and nurturing environment.

Values

Child Driven

Family Centered

Community Connected

Strengths-Based

Committed to Diversity & Cultural Competence

Committed to Continuous Learning & Improvement



SCOPE OF CHILD ABUSE & NEGLECT IN MASSACHUSETTS

- 91,494 reports of child abuse or neglect were filed in CY 2015, of which 62.2% of 51A reports were screened in for a response.
- 58.1% (45,657) of the 51A reports that were screened in were supported.
- As of December 31, 2015 DCF was serving 96,919 open consumers.
- As of April 30, 2016 DCF was serving 101,752 open consumers.



WHO IS A MANDATED REPORTER?

MGL Chapter 119, Section 21, lists the following professionals as Mandated Reporters:

- Physicians, medical interns, hospital personnel engaged in examination, care or treatment of persons, medical examiners;
- Emergency medical technicians, dentists, nurses, chiropractors, podiatrists, optometrists, osteopaths;
- Public or private school teachers, educational administrators, guidance or family counselors;
- Early education, preschool, child care or after school program staff, including any person paid to care for, or work with, a child in any public or private facility, home or program funded or licensed by the Commonwealth, which provides child care or residential services. This includes child care resource and referral agencies, family child care providers and child care food programs



WHO IS A MANDATED REPORTER? (CONTINUED)

MGL Chapter 119, Section 21, lists the following professionals as Mandated Reporters:

- School attendance officers;
- Allied mental health and licensed human services professionals licensed pursuant to MGL Chapter 112, Section 165;
- Psychiatrists, psychologists and clinical social workers, drug and alcoholism counselors;
- Persons in charge of a medical or other public or private institution, school or facility or any agent acting on behalf of such persons;
- Clergy members (including priests, rabbis and accredited Christian Science practitioners), who are ordained or licensed leaders of any church or religious body, persons performing official duties on behalf of a church or religious body, or persons employed by a church or religious body to supervise, educate, coach, train or counsel a child on a regular basis;
- The Child Advocate;
- Child care licensors, such as staff from the Department of Early Education and Care;
- Social workers, foster parents, probation officers, clerks magistrate of the district courts, and parole officers; and
- Firefighters and police officers.



REQUIREMENTS FOR MANDATED REPORTERS (MASS. GENERAL LAWS CHAPTER 119, SECTION 51A)

Mandated Reporters are required to report when, in their professional capacity, they have reasonable cause to believe that a child under age 18 years is suffering physical or emotional injury resulting from:

- **abuse** which causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse;
- **neglect**, including malnutrition;
- physical **dependence upon an addictive drug at birth**; or
- being a **sexually exploited child** or **human trafficking victim**.
Mandated Reporters are to report such conditions to DCF by:
 - **immediate** oral communication and
 - written report within 48 hours after the oral communication.

Requirements for Mandated Reporters



- **Penalty of \$1,000 for failure to report to DCF.** Penalty of \$1,000 for failure to report a death from such conditions to the District Attorney where the child died and the Office of the Chief Medical Examiner.
- **Penalty for willfully failing to report child abuse or neglect that resulted in serious bodily injury or death:** Can be punished by a fine of up to \$5,000 and up to 2½ years in jail, and be reported to the person's professional licensing authority (increase effective July 1, 2010).
- **Penalty for knowingly and willfully filing a frivolous report of child abuse or neglect:** Can be punished by a fine of up to \$2,000 for the first offense, up to 6 months in jail for a second offense, and up to 2½ years in jail for a third offense (increase effective July 1, 2010).
- **Mandated Reporters may notify local law enforcement or the Office of the Child Advocate** of any suspected child abuse or neglect, in addition to filing with the Department.
- **Mandated Reporters** who are professionally licensed in the Commonwealth **shall complete training** to recognize and report suspected child abuse or neglect (effective July 1, 2010).



Privileged Communication

- ***Any privilege*** established by MGL Chapter 112, Sections 135A and 135B, or by MGL Chapter 233, Sections 20A and 20B, relating to confidential communications, ***shall not prohibit the filing of a 51A report.***
- Notwithstanding MGL Chapter 233, Section 20A, a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body or accredited Christian Science practitioner ***shall report all cases of abuse and/or neglect, but need not report information solely gained in a confession or similarly confidential communication*** in other religious faiths.
- Notwithstanding any privilege or confidentiality created by statute or common law, a Mandated Reporter ***must answer questions and provide information posed by the DCF*** relating to any response conducted under MGL Chapter 119, Section 51B, whether or not the person filed the report.



Highlights of DCF's Protective Intake Policy

- Emphasizes child safety, the importance of obtaining and utilizing fullest possible family history and criminal history information, consistent practice expectations and group decision-making with managers at key junctures
- Unifies differential response tracks while maintaining broadened response outcome options enabling a decision that is better suited to each family's situation and is based on fuller information.
- Operationalizes statutory changes to MGL c. 119, §§ 51A and B that require DCF to receive and respond to reports of child sexual exploitation and human trafficking, including completing immediate referrals to the District Attorney.
- Provides for clinical reviews, involving a manager(s), when multiple reports are received during a 3 month or 12 month period.



AS A MANDATED REPORTER, WHAT DO I REPORT?



IMPORTANT DCF DEFINITIONS

Abuse

- (1) The non-accidental commission of any act by a caregiver which causes or creates a substantial risk of physical or emotional injury or sexual abuse of a child; or
- (2) The victimization of a child through sexual exploitation or human trafficking, regardless if the person responsible is a caregiver.

This definition is not dependent upon location. Abuse can occur while the child is in an out-of-home or in-home setting.

Neglect

- Failure *by a caregiver*, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care, including malnutrition or failure to thrive; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition.



IMPORTANT DCF DEFINITIONS (CONTINUED)

Caregiver

- A child’s parent, stepparent, guardian, or any household member entrusted with the responsibility for a child’s health or welfare; or
- Any other person entrusted with responsibility for a child’s welfare, whether in the child’s home, a relative’s home, a school setting, a child care setting (including babysitting), a foster home, a group care facility, or any other comparable setting. As such “caregiver” includes, but is not limited to:
 - School teachers,
 - Babysitters,
 - School bus drivers, and
 - Camp counselors.
- The “caregiver” definition should be construed broadly and inclusively to encompass any person who at the time in question is entrusted with a degree of responsibility for the child. This specifically includes a caregiver who is him/herself a child such as a babysitter under age 18.



IMPORTANT DCF DEFINITIONS (CONTINUED)

Physical Injury

Death; or fracture of a bone, a subdural hematoma, burns, impairment of any organ, and any other such nontrivial injury; or soft tissue swelling or skin bruising, depending upon such factors as the child's age, circumstances under which the injury occurred, and the number and location of bruises.

Emotional Injury

An impairment to or disorder of the intellectual or psychological capacity of a child as evidenced by an observable and substantial reduction the child's ability to function with a normal range of performance and behavior.

Sexual Abuse

Any non-accidental act by a caregiver upon a child that constitutes a sexual offense under the laws of the Commonwealth or any sexual contact between a caregiver and a child for whom the caregiver is responsible.

IMPORTANT DCF DEFINITIONS (CONTINUED)



- **Sexually Exploited Child** (as defined in MGL Chapter 119, Section 21)
 - Any person under the age of 18 who has been subjected to sexual exploitation because such person:
 - (1) is the victim of the crime of sexual servitude pursuant to section 50 of chapter 265, or is the victim of sex trafficking as defined in 22 United States Code 7105;
 - (2) engages, agrees to engage or offers to engage in sexual conduct with another person in exchange for a fee, in violation of subsection (a) of section 53A of chapter 272, or in exchange for food, shelter, clothing, education or care;
 - (3) is a victim of the crime of inducing a minor into prostitution under section 4A of chapter 272; or
 - (4) engages in common night walking or common streetwalking under section 53 of chapter 272.
- **Human Trafficking Victim** (based on MGL Chapter 233, Section 20M and MGL Chapter 265, Sections 50 and 51)
 - A person who is subjected to harboring, recruitment, transportation, provision, obtaining, patronizing, or soliciting for the purpose of:
 - (1) sex trafficking (i.e., inducement to perform a commercial sex act, forced sexual services and/or sexually explicit performance); and/or
 - (2) labor trafficking (i.e., forced services, involuntary servitude, peonage, debt bondage or slavery).



IMPORTANT DCF DEFINITIONS (CONTINUED)

- **Substance Exposed Newborn (SEN)**
 - A newborn who was exposed to alcohol or other drugs ingested by the mother in utero, whether or not this exposure is detected at birth through a drug screen or withdrawal symptoms. A SEN may also be experiencing Neonatal Abstinence Syndrome (NAS), which are symptoms and signs exhibited by a newborn due to drug withdrawal. NAS is a subset of SEN. Fetal Alcohol Syndrome (FAS) as diagnosed by a qualified licensed medical professional is also a subset of SEN.
- **Shaken Baby Syndrome (Abusive Head Trauma)**
 - Infants, babies or small children who suffer injuries or death from severe shaking, jerking, pushing or pulling may have been victims of Shaken Baby Syndrome. The act of shaking a baby is considered physical abuse, as spinal, head and neck injuries often result from violently shaking young children. It has been estimated that 50% of children who are victims of Shaken Baby Syndrome die from their injuries.

SIGNS OF PHYSICAL ABUSE



- Bruising, welts or burns that cannot be sufficiently explained, particularly bruises on the face, lips and mouth of infants or on several surface planes at the same time
- Unusual bruising patterns that reflect the shape of the instrument used to cause injury (e.g., belt, wire hanger, hairbrush, hand, human bite marks)
- Clusters of bruises, welts or burns, indicating repeated contact with a hand or instrument
- Injuries on the body where children usually do not get hurt (e.g., the torso, back, buttocks, thighs, neck)
- Burns that are insufficiently explained, e.g., cigarette burns or:
 - Immersion burns; marks indicating dunking in a hot liquid, including “stocking” and “glove” burns on feet and hands, or “donut-shaped” burns on buttocks and genitalia
 - Rope or restraint burns on the arms, hands, neck or legs
 - Dry burns caused by forced contact with a hot surface (e.g., a clothes iron, hair curler, heater or stove)
- Lacerations or abrasions to the lip, eye, or any part of a child’s face
- Tears in the tissue of the gums, possibly as a result of force-feeding
- Laceration or abrasion to external genitalia
- Absence of hair or hemorrhaging beneath the scalp due to vigorous hair pulling
- Withdrawn, fearful or extreme behavior

SIGNS OF POSSIBLE NEGLECT



Child/youth:

- Shows sudden changes in behavior or school performance
- Is frequently absent from school/child care
- Has not received help for physical/medical problems brought to caregiver's attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to
 - specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Begs or steals food or money
- Lacks adult supervision
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather



SIGNS OF POSSIBLE NEGLECT

Parent/caregiver:

- Denies the existence of, or blames the child for, problems in school
- Shows little concern for the child
- Is abusing alcohol or drugs
- Seems apathetic or depressed





SIGNS OF POSSIBLE SEXUAL ABUSE

Behavioral Signs of Sexual Abuse

- Withdrawal or chronic depression
- Inappropriate sex play or premature understanding of sex
- Feeling threatened by physical contact, closeness
- Promiscuity
- Running away from home
- Child is “parentified” or overly concerned for siblings
- Poor self-esteem, lack of confidence
- Peer problems, lack of involvement with friends
- Extreme weight change
- Suicide attempts or threats; especially with adolescents

SIGNS OF POSSIBLE SEXUAL ABUSE (CONTINUED)

- Extreme weight change
- Suicide attempts or threats; especially with adolescents
- Poor self-esteem, lack of confidence
- Peer problems, lack of involvement with friends
- Extreme weight change
- Suicide attempts or threats; especially with adolescents
- Hysteria, lack of emotional control
- Sudden school difficulties
- Unprovoked cruelty to animals.





SIGNS OF POSSIBLE SEXUAL ABUSE (CONTINUED)

Perceptible Signs of Sexual Abuse

- Difficulty walking or sitting
- Pain or itching in the genital area
- Torn, stained or bloody underclothing
- Bruises or bleeding in external genitalia
- Frequent complaints of stomachaches or headaches
- Venereal disease
- Frequent urinary or yeast infections
- Pregnancy



SIGNS OF POSSIBLE SEXUAL EXPLOITATION/ HUMAN TRAFFICKING



- **Instability in Life Functioning.** Youth lacks access to basic needs, including stable shelter, and is unable to engage in activities expected of her/his age.
- **Relationships.** Youth's relationships are concerning, placing him/her at risk or in danger.
- **Finances and Belongings.** Youth has money or material goods that are incongruent with her/his life circumstances.
- **Use of Technology.** Youth's use of internet, cell phone or social media involves social or sexual behavior that is atypical for his/her age.
- **Physical Health.** Youth has significant health problems related to sexual activity and lack of access to basic needs.



SIGNS OF POSSIBLE SEXUAL EXPLOITATION/ HUMAN TRAFFICKING (CONTINUED)



- **Risky Behaviors.** Youth engages in dangerous or risky behaviors, e.g., spending time with abusive partners or in locations where exploitation is known to occur, running away or staying away overnight, using substances).
- **Trauma Exposure/Signs.** Youth has been exposed to traumatic circumstances and/or exhibits signs and emotional symptoms of trauma exposure.
- **Coercion and Grooming.** Youth exhibits behaviors or otherwise indicates he/she is being controlled or coerced by another person.
- **Exploitation.** Youth has been exposed to sexual exploitation or victimization.



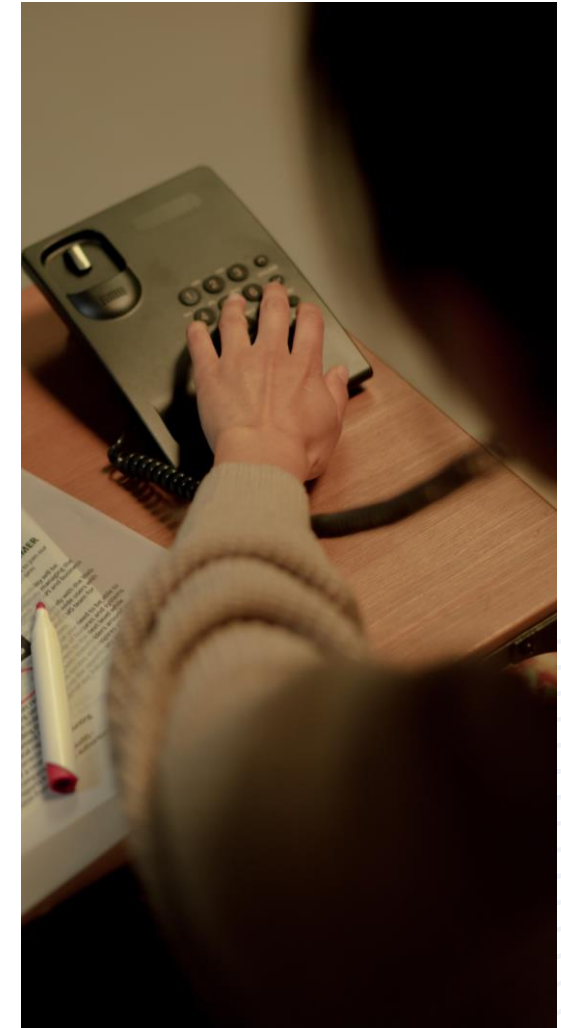
When Should a 51A Report Involving Domestic Violence Be Filed?

- Domestic violence is defined as a ***pattern of coercive controlling behaviors*** that one person exercises over another in an intimate relationship. Not every situation involving domestic violence merits DCF intervention.
- When considering ***whether or not to file a 51A report***, Mandated Reporters are encouraged to:
 - Carefully review the family's situation and identify the ***specific impact on the child(ren)***.
 - ***Assess carefully the caregiver's and child(ren)'s conditions*** and evaluate whether community services and support will strengthen the caregiver's resolve and ability to safeguard the child(ren). Connecting the family to social services, school, counseling services, faith organizations, battered women's programs or concerned family and/or friends may provide the support and encouragement needed to assist the victim and keep the child(ren) safe.
 - If possible, discuss the filing of a report with the caregiver first and ***address the potential need for safety planning***.
- ***For more information***, review the DCF brochure on *Promising Approaches: Working with Families, Child Welfare and Domestic Violence* for more information on when to file a report. This brochure is available at:
www.mass.gov/eohhs/docs/dcf/promising_approaches_publication.pdf



How Do I File a Report of Child Abuse or Neglect?

- When you suspect that a child is being abused or neglected, immediately telephone the DCF Area Office serving the child's residence and ask for the Protective Screening Unit. Visit: www.state.ma.us/dcf
 - ***Regular Office hours are 8:45 am – 5:00 pm, Monday through Friday.***
- To make a report at any other time, including after 5 p.m. and on weekends and holidays, please call the Child-At-Risk Hotline at: **1-800-792-5200.**





What Will I be Asked When I File a Report?

The DCF Screener will ask you to provide the following information:

- Your name, relationship (if any) to the child(ren), address and phone number.
- Names, ages of the child(ren) about whom you have a concern and emergency contact information for them, language(s) spoken.
- Names, addresses, contact information, ages, language(s) spoken of parents/guardians of the child(ren).
- Names and ages of other children in the family.
- Details about your concern – “What are your worries?”
 - The nature and extent of the suspected abuse or neglect, including any evidence or knowledge of prior injury, abuse, neglect or exploitation.
- Circumstances under which you became aware of injuries, abuse, or neglect.
- Dates and/or timeframes in which the maltreatment may have occurred.



What Will I be Asked When I File a Report? (continued)

The DCF Screener will ask you to provide the following information:

- Action(s) taken thus far to treat, shelter, or otherwise assist the child(ren).
- The identity of the person(s) you believe may be responsible for the abuse/neglect (if known).
- Any other information you believe might be helpful in establishing the cause of the injury and/or person(s) responsible, or for making safe contact with the family.
- Any other information you believe would be helpful to ensuring the child(ren)'s safety and/or supporting the family to address the abuse and/or neglect concerns.
- The extent to which the child(ren) is visible in the community.
- Any information about the protective capacities of the caregiver(s) to ensure the safety of the child(ren).
- Any information about the situation which could place a social worker in danger.



DCF's Screening of 51A Reports

Upon receiving a report, *DCF immediately begins to “screen” the report.* Screening activities include:

- gathering information from the reporter;
- reviewing any history the child or family may have with DCF or another state's child protection agency;
- conducting an identity query (if needed);
- conducting CORI and SORI checks;
- requesting information from local law enforcement;
- contacting other collaterals who may know the family;
- seeking clinical consultation (especially when multiple reports on separate incidents have been filed on any children in a family); and
- searching online and social media sources (if needed).



DCF's Screening of 51A Reports (continued)

- **DCF will determine if there is an immediate concern for child safety; and if a “reportable condition” exists** (i.e., there is information that a child may have been abused and/or neglected by a caregiver, or that a child may have been or may be at risk of sexual exploitation or human trafficking).
 - Reports that do not meet DCF's criteria of suspected abuse or neglect are *Screened-Out*. DCF will send you written notification.
 - Reports that meet the criteria are *Screened-In*.
- During screening, **DCF also determines if an emergency or non-emergency response is needed.**
 - **Emergency responses** begin ASAP and child is visited within 2 hours.
 - **Non-emergency responses** begin ASAP and child is visited within 3 business days.
- DCF completes screening of ***non-emergencies in one business day*** (of the total 15), but may extend screening one additional day in limited circumstances.



Screening Decision Making

There are 3 possible outcomes of a screening decision:

Screen In – Emergency Response

- This is a determination that the report involves a situation where the failure to take immediate action would pose a substantial risk of death, serious emotional or physical injury, or sexual abuse to a child.
- The Screener must consult with the Supervisor when there is any indication that the reported situation may be an emergency. If the Screener and the Supervisor determine that the situation does constitute an emergency, the Supervisor must immediately arrange for the report to be assigned for an emergency response and shall inform the manager responsible for intake that the emergency response has been initiated.
- During non-business hours, when a Hotline Screener receives a report that may warrant an emergency response, the Screener consults with the On Call Supervisor (OCS). If the OCS determines an emergency response is necessary, the OCS assigns an Emergency Response Worker (ERW).



Screening Decision Making (continued)

Screen In – Non-Emergency Response

- This is a determination that a child(ren) may have been abused and/or neglected or may be at risk of being abused and/or neglected by a caregiver, or that a child has been or may be at risk of sexual exploitation or human trafficking, AND that the situation as reported *does NOT* pose a substantial risk of death, serious emotional or physical injury, or sexual abuse to a child.



Screening Decision Making (continued)

Screen Out

- This is a determination that the report does not involve a child or the allegations are not within the Department's mandate concerning child abuse and neglect (Invalid Allegation); and/or
- there is no indication that a child(ren) has been or may have been abused or neglected or may be at risk of being abused and/or neglected by a caregiver; and/or
- the alleged perpetrator has been identified and was not a caregiver, and the child(ren)'s caregiver is safely protecting the child(ren) from the alleged perpetrator, unless the allegations involve sexual exploitation or human trafficking; and/or
- the specific injury or specific situation being reported is so old that it has no bearing on the current risk to the reported or other child(ren); and/or
- there are NO other protective concerns, and the only issue is maternal use of appropriately prescribed medication resulting in a SEN(s), AND the only substance affecting the newborn(s) was appropriately prescribed medication, AND the mother was using the medication(s) as prescribed which can be verified by a qualified medical or other provider.



When DCF Completes a Referral to the District Attorney and Local Law Enforcement

DCF must *immediately* notify the District Attorney and local law enforcement of cases of serious abuse or neglect. MGL Chapter 119, sec. 51B requires DCF to immediately notify the District Attorney and local law enforcement when a 51A report alleges one or more of the following:

- a child has died, been sexually assaulted, been sexually exploited or been the victim of human trafficking;
- a child has suffered brain damage, loss or substantial impairment of bodily function or organ, or substantial disfigurement;
- a child has suffered serious physical abuse or injury such as:
 - a fracture of any bone or a severe burn,
 - an injury requiring the child to be placed on life support systems; or
- a child has been the victim of physical abuse or sexual assault and there is a risk that physical evidence of the assault may be destroyed if the allegation is not promptly investigated by law enforcement.



DCF 51B Response Timelines

- **Emergency Response** – DCF will assess child safety within 2 hours, will visit and interview family within 24 hours and may take up to 5 business days to complete other response activities and the report.
- **Non-Emergency Response** – DCF will assess child safety within 3 business days may take up to 15 business days to complete the response and report.



DCF's 51B Response (continued)

The DCF Response Worker will:

- ***Determine if child can safely remain in the home***, considering child vulnerabilities and danger indicators.
- ***Conduct the response***, i.e., contact the reporter and the parent/caregiver, may request police accompaniment, establish the safety and well-being of reported and non-reported child(ren) in the home through visits/interviews, visit the home and determine action when access is prevented, conduct collateral contacts, seek clinical consultation (as needed), conduct identity queries (if needed) and CORI and SORI checks (including a national criminal history check) if not completed during screening, request local law enforcement response information, search online and social media information sources, and interview the person(s) alleged responsible.
- ***Assess parental/caregiver capacities*** to safely parent using the Protective Factors Framework.
- ***Determine risk to the children***, using DCF's designated tool.
- ***Determine response outcome*** and notify family and Mandated Reporter.



Possible 51B Response Outcomes

“Support” finding means:

- **Allegation(s):**
 - Reasonable cause to believe a child(ren) was abused and/or neglected; and
 - Actions/inactions of parent(s)/caregiver(s) place child in danger or pose substantial risk to child’s safety or well-being, or person(s) was responsible for child being a victim of child of sexual exploitation or human trafficking.
- **Person(s) responsible:**
 - Is named to DCF’s Central Registry, when known, and to the Registry of Alleged Perpetrators if there is substantial evidence the person was responsible and the report was referred to the District Attorney.
- **DCF Intervention:**
 - Open a case for Family Assessment and Action Planning, or
 - When case is already open, currently assigned Social Worker and Supervisor review risk level and update Family Assessment Service (Action) Plan, as warranted, and may change existing interventions/services; or
 - Determine intervention is not necessary, with manager approval.



Possible 51B Response Outcomes (continued)

“Substantiated Concern” finding means:

- **Allegation(s):**
 - Reasonable cause to believe a child(ren) was neglected; and
 - Actions/inactions of parent(s)/caregiver(s) create potential for abuse or neglect but there is no immediate danger to child’s safety or well-being.
- **Person(s) responsible:**
 - An alleged perpetrator is NOT named to DCF’s Central Registry (or Registry of Alleged Perpetrators even when report was referred to the District Attorney).
- **DCF Intervention:**
 - Open a case for Family Assessment and Action Planning, or
 - When case is already open, currently assigned Social Worker and Supervisor review risk level and update Family Assessment and Service (Action) Plan, as warranted, and may change existing interventions/services.



Possible 51B Response Outcomes (continued)

“Unsupport” finding means:

- **Allegation(s) & person(s) responsible:**
 - Not reasonable cause to believe a child(ren) was abused and/or neglected; or
 - Person believed to be responsible for the abuse or neglect was not a caregiver;
- **DCF intervention is not needed** to safeguard child(ren)’s safety and well-being.
 - DCF does not open a new case but family may apply for DCF voluntary services, or DCF may refer family to community services.
 - When case is already open, currently assigned Social Worker and Supervisor review risk level, update Family Assessment and Service (Action) Plan, as warranted, and may change existing interventions/services.



Other DCF Case Practice Features

- **Use of standardized decision support tools**
- **Enhanced community engagement through:**
 - DCF Area Boards
 - Citizen Advisory Panels (Youth Advisory Board and Family Advisory Committee)
 - Collaboration with community, e.g., Community Connections
 - Family Resource Centers

ADDITIONAL SOURCES OF INFORMATION

- www.mass.gov/dcf for general information or to find a DCF Area Office
- Child-At-Risk-Hotline: 1-800-792-5200
- DCF Ombudsman: 617-748-2444 (9-5pm, weekdays) for inquiries about agency programs, policies or service delivery

