

DAY 4 – CIT TRAINING



8:00-9:00am

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

9:00-10:00am

Mental Health in Elders – Jenny Cox, Director – Behavioral Health, Baystate Medical Center

10am- 10:30am

CIT Officer - IOOV

10:30am- 12:00pm

ALEC – Autism and law Enforcement Education Coalition – Captain V. Caputo

Psychological Trauma



AMBER ROBINSON GREEN, PSYD, 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

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 – Blame the mother

* handout - New Yorker article

Racial Trauma



- Racial trauma or race-based traumatic stress, is the cumulative effects of racism on an individual's mental and physical health.
- Racial discrimination and race-based violence, can cause anxiety, avoidance, depression, suicidal ideation and PTSD, whether
 - overt (assaults, threats, slurs),
 - covert (crossing the street when a young Black male is walking towards you) or
 - institutional (difficulty accessing benefits like housing or education).
This is true whether there is one incident or ongoing discrimination.
- Racial trauma can compound stress reactions to other forms of trauma
- Racial differences exist in rates of trauma exposure

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!

How Does Trauma Affect You?



Adverse Childhood Experiences


BRFSS Adverse Childhood Experience (ACE) Module

Prologue: I'd like to ask you some questions about events that happened during your childhood. This information will allow us to better understand problems that may occur early in life, and may help others in the future. This is a sensitive topic and some people may feel uncomfortable with these questions. At the end of this section, I will give you a phone number for an organization that can provide information and referral for these issues. Please keep in mind that you can ask me to skip any question you do not want to answer. All questions refer to the time period before you were 18 years of age. Now, looking back before you were 18 years of age---

- 1) Did you live with anyone who was depressed, mentally ill, or suicidal?
- 2) Did you live with anyone who was a problem drinker or alcoholic?
- 3) Did you live with anyone who used illegal street drugs or who abused prescription medications?
- 4) Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?
- 5) Were your parents separated or divorced?
- 6) How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?
- 7) Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking. Would you say—
- 8) How often did a parent or adult in your home ever swear at you, insult you, or put you down?
- 9) How often did anyone at least 5 years older than you or an adult, ever touch you sexually?
- 10) How often did anyone at least 5 years older than you or an adult, try to make you touch sexually?
- 11) How often did anyone at least 5 years older than you or an adult, force you to have sex?

Key concept underlying the study is that stressful or traumatic childhood experiences lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality.

* Handout – ACES



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**

Law Enforcement Work is Dangerous



Are you allowed to feel the pain?



Vicarious trauma



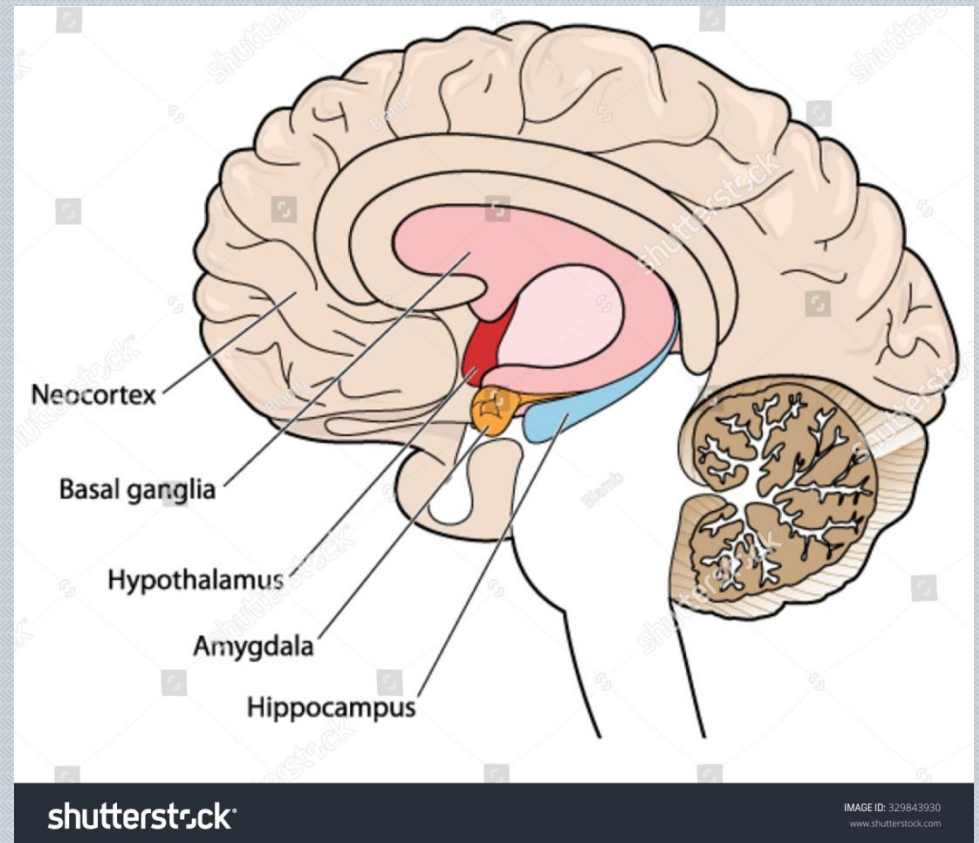
- **Work-related trauma exposure following:**
 - listening to individual clients recount their victimization
 - looking at videos or images of exploitation and abuse
 - reviewing case files
 - hearing about or responding to the aftermath of violence and other traumatic events day after day
 - responding to mass violence incidents
- Ongoing vicarious trauma can change a person's worldview
- Secondary traumatic stress (STS): behaviors and emotions that often result from knowing about another's trauma and the stress resulting from helping, or wanting to help.

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.***



Biological Perspectives



In PTSD multiple neurobiological systems are dysregulated and maladaptive

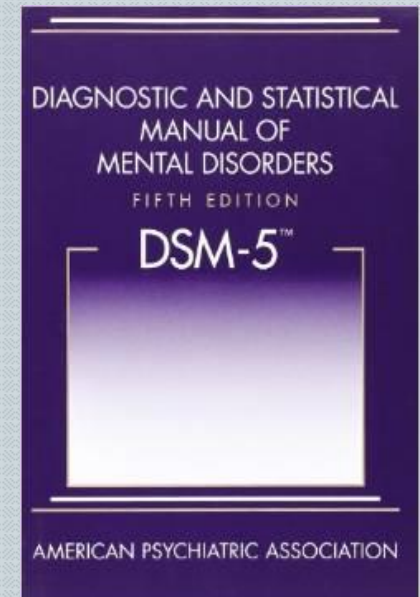
Brain Regions (prefrontal cortex, amygdala, hippocampus, dorsal raphe nucleus, locus coeruleus) In child brain - disruption to actual cognitive development

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

A diagnosis but



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.



...so while the criteria may not be fully met, trauma lies at the root of much of what we see in the criminal justice system

PTSD symptoms/criteria



- **Stressor/s**
- **Intrusive symptoms**
(Nightmares, flashbacks, thoughts, intense or prolonged distress after exposure to traumatic reminders, physiologic reactivity after exposure to trauma-related stimuli)
- **Avoidance - Persistent effortful avoidance of trauma-related stimulus**
- **Dissociation**
(Depersonalization - experience of being an outside observer of or detached from oneself and Derealization - experience of unreality, distance, or distortion)
- **Negative alterations in cognitions and mood**
- **Alterations in arousal and reactivity**
(Trouble sleeping, Irritability, Reckless or self-destructive behavior Exaggerated startle response, Poor concentration)

What have you seen in your work?

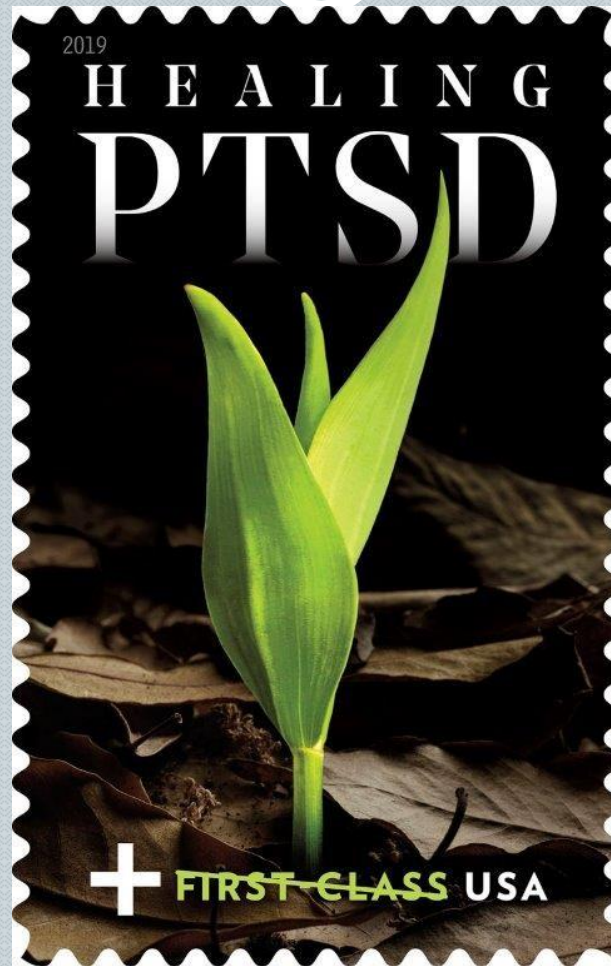


Resilience and hope



- Medications, therapy, meditation, exercise, hobbies and on and on
- If you believe a coworker might be experiencing negative reactions to trauma, consider—
 - reaching out and talking to them individually about the impact of the work;
 - helping them establish a consistent work-to-home transition that creates an important boundary and safe place outside the workplace;
 - encouraging them to attend to the basics—sleep, healthy eating, hygiene, and exercise;
 - supporting connections with family, friends, and coworkers;
 - referring them to organizational supports such as a peer support team, employee assistance program, or chaplain;

More awareness and dialogue



End of Presentation



- Question and Answers

PRESENTATION #2

9:00-10:00 am

Mental Health in Elders

Jenny Cox, Director – Behavioral
Health, Baystate Medical Center

Mental Health Issues in Older Adults



JENNIFER COX, LICSW

BAYSTATE HEALTH

EMAIL:

JENNIFER.COX@BAYSTATEHEALTH.ORG

TEL: 413-794-8308

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.

PRESENTATION #3

10:00-10:30 am

CIT Officer -IOOV

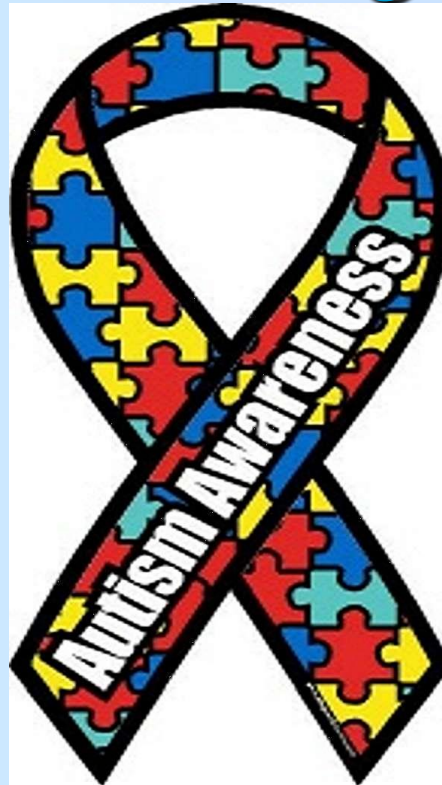
PRESENTATION # 3

10:30am- 12:00pm

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

Captain Victor Caputo,
Northampton Police Department

Law Enforcement Autism Training

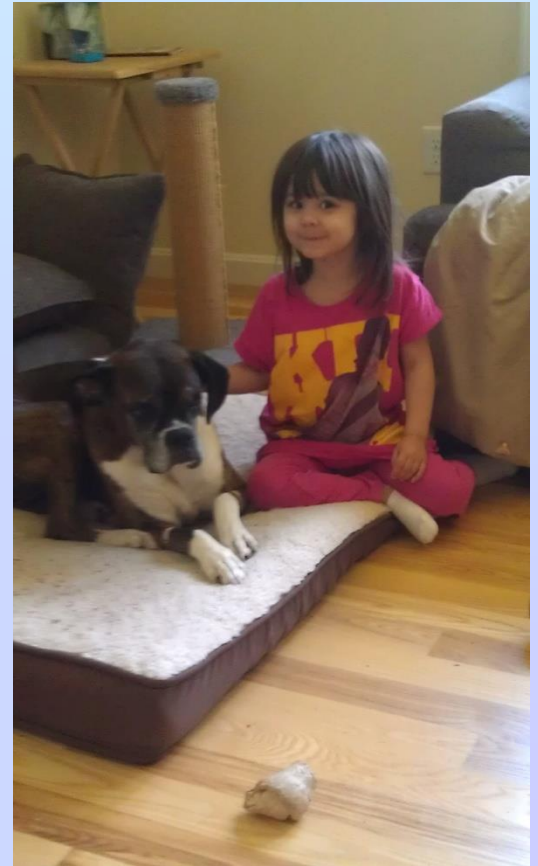


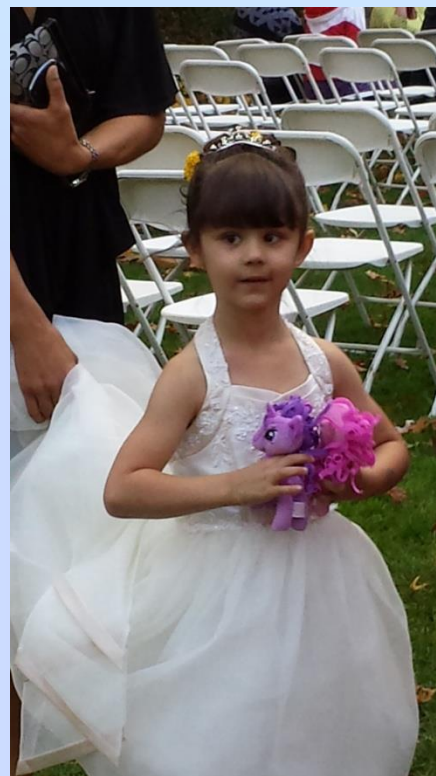
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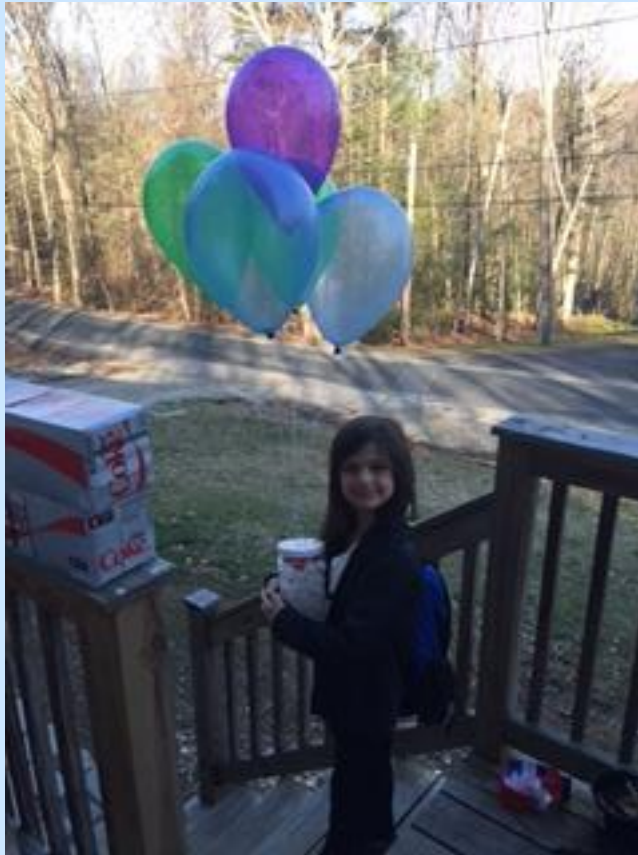
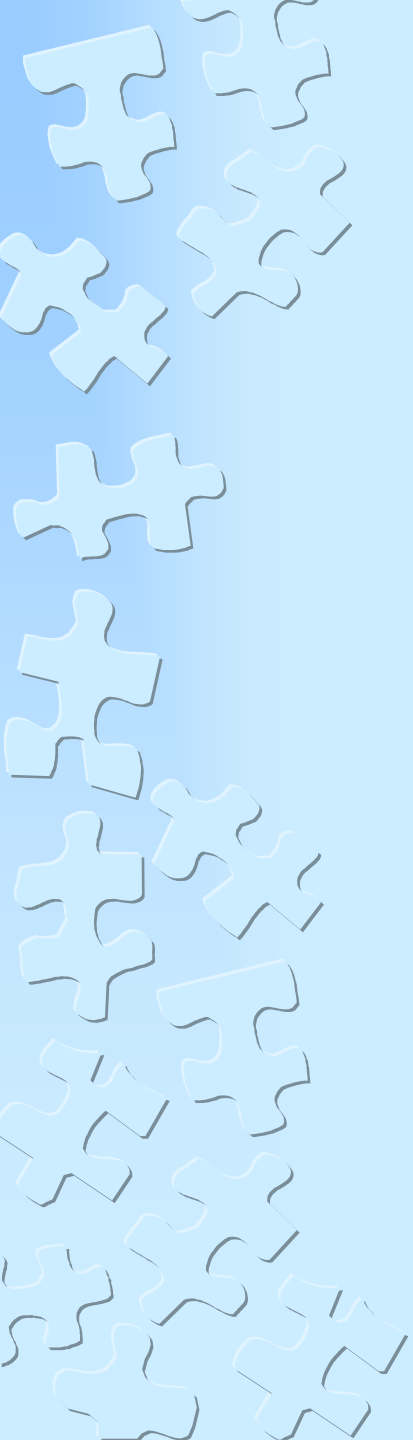


What Is Autism?











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



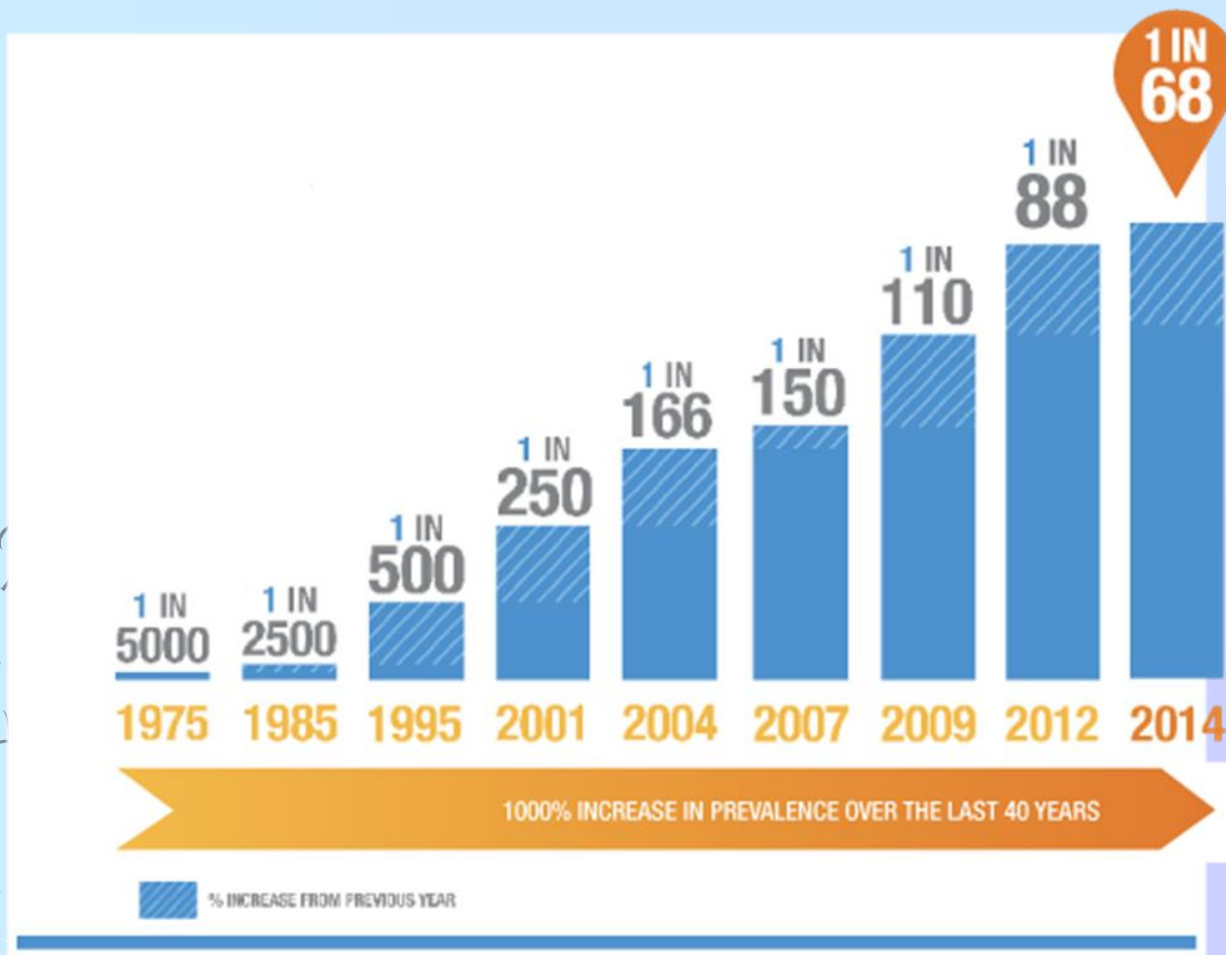
- More than 3 million people live with ASD in the United States


- 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.

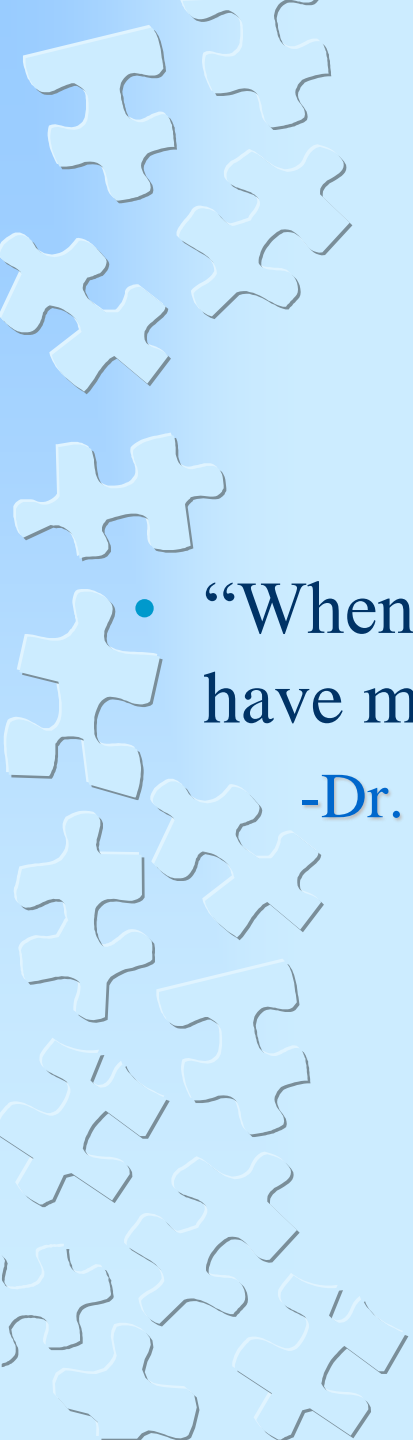
PREVALENCE STATISTICS



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

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.

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.



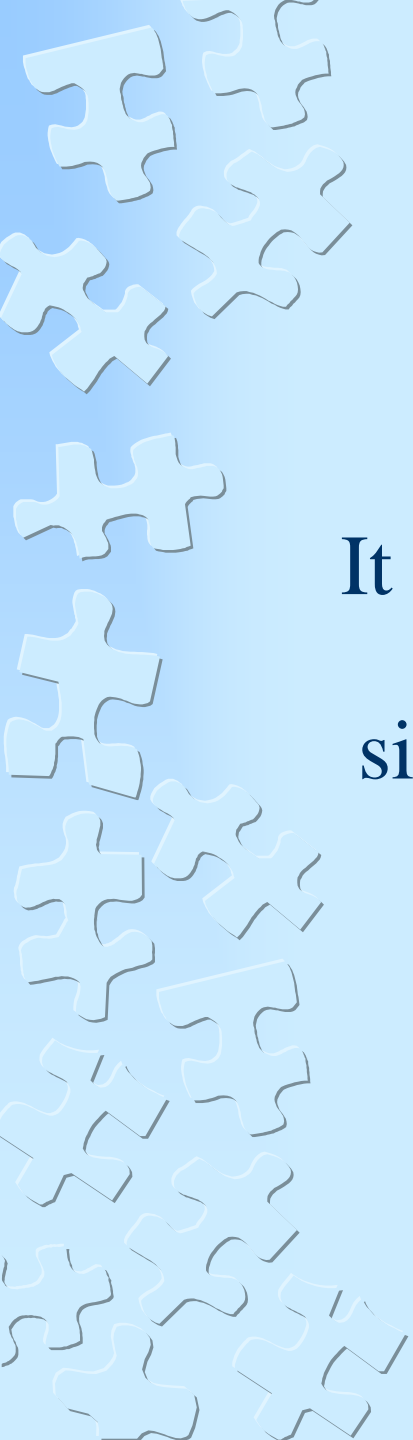
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It is essential to remember that every person on the spectrum is affected by autism in a different way though certain similarities do exist.



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



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



How to Recognize Someone with ASD

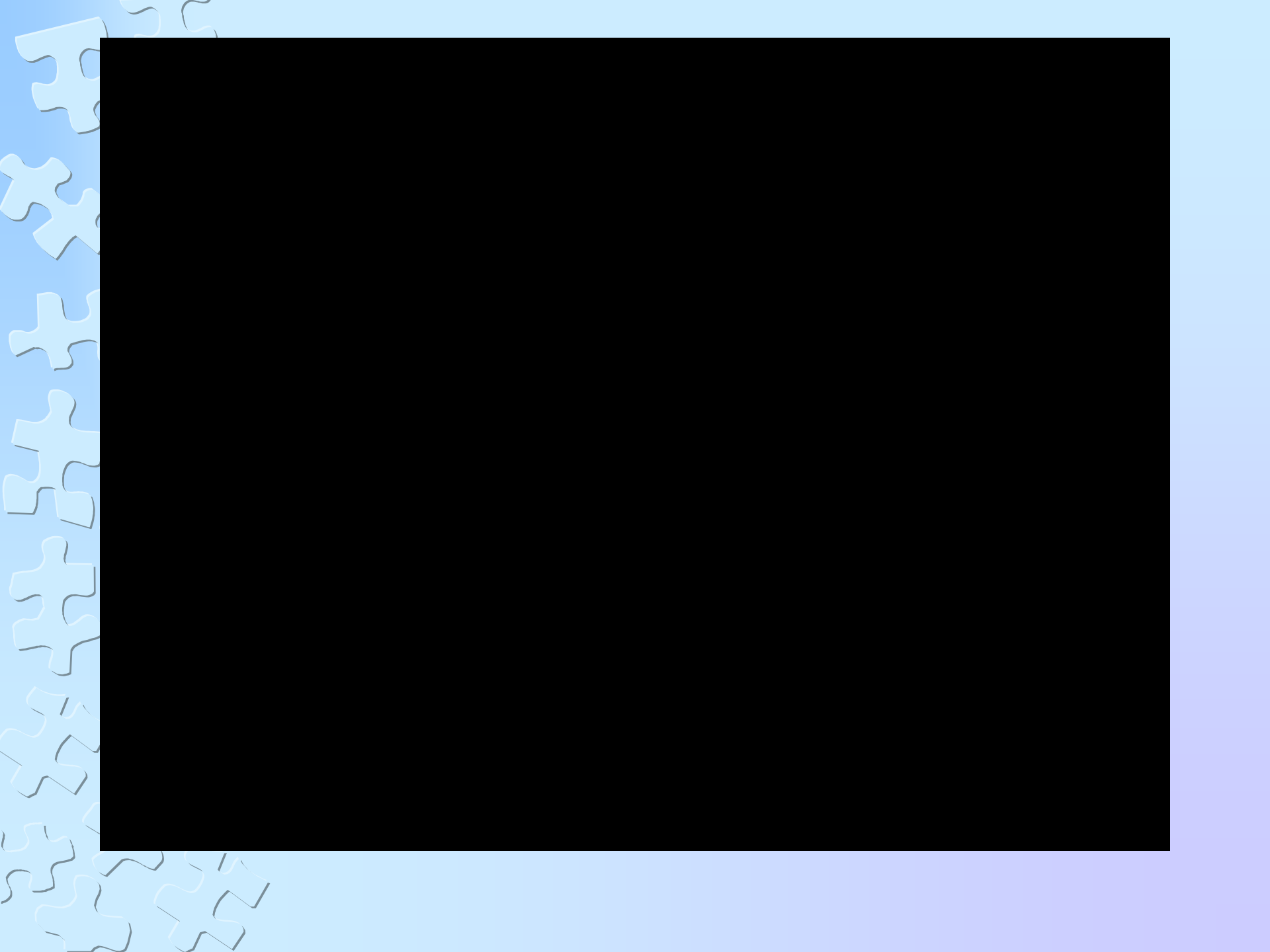


Common Speech Patterns

- 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:

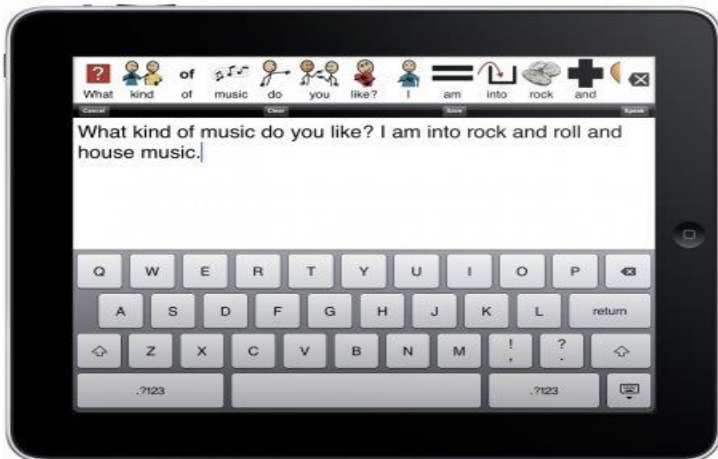
- Pain
- Fear
- Danger
- Safety





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

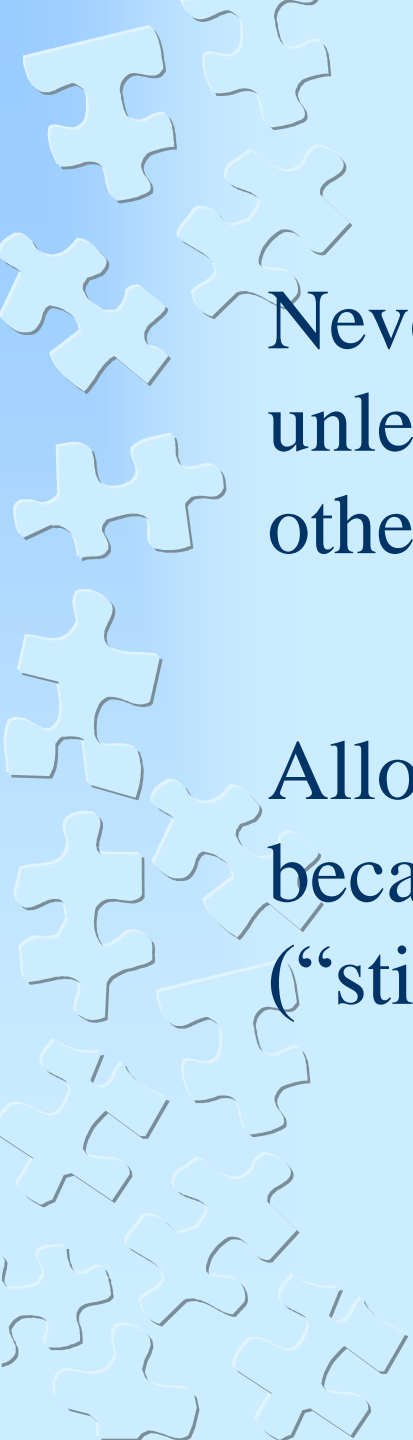
- Sit down
- Get in
- Wait here
- Stop

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

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

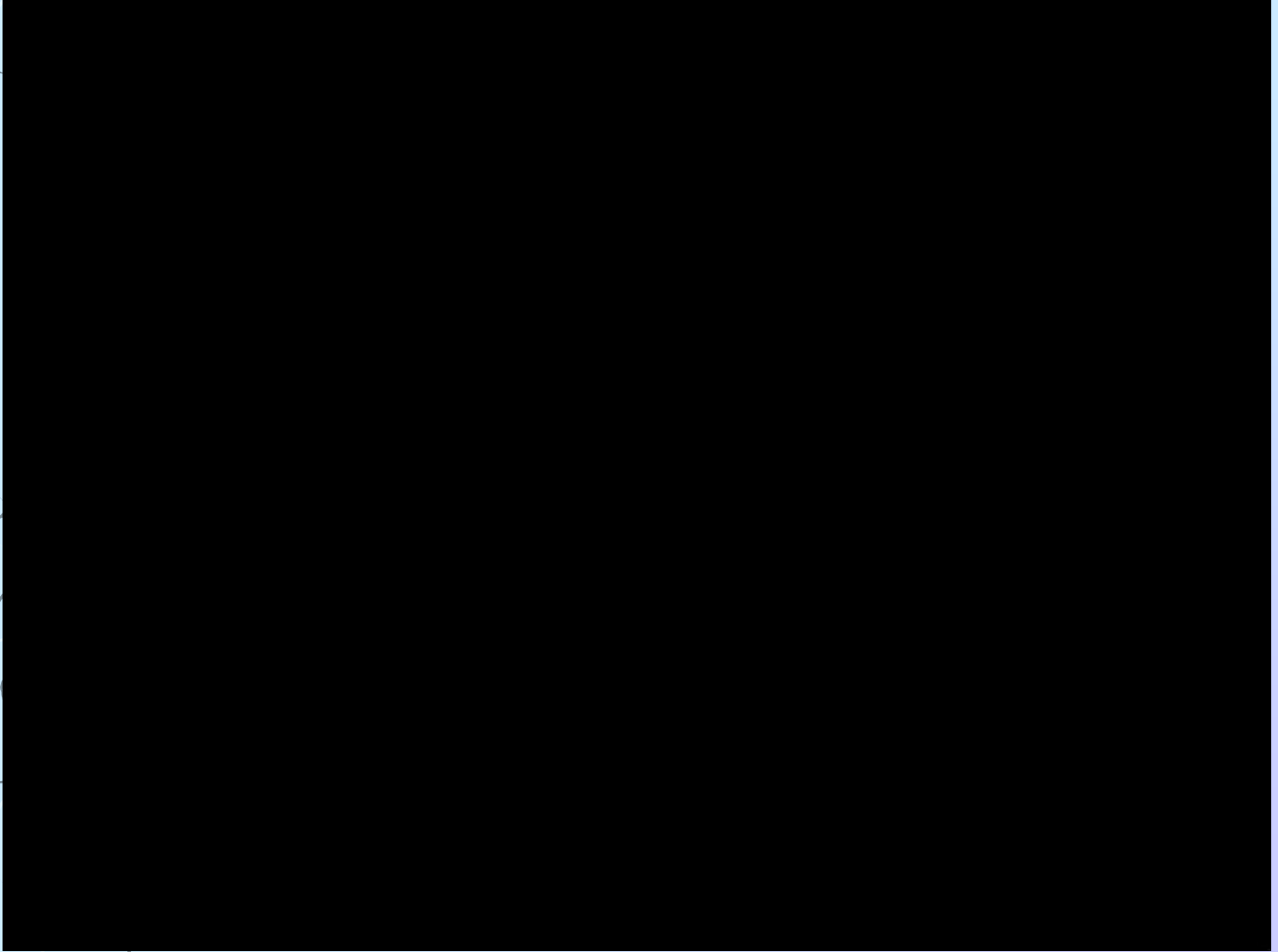
- Police dogs or mounted patrol may be present. Be aware that these animals may cause the person to quickly move towards or away from the animals.
- If possible, move the person away from crowds of strangers to a quiet place or make the scene as quiet as possible.



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 .



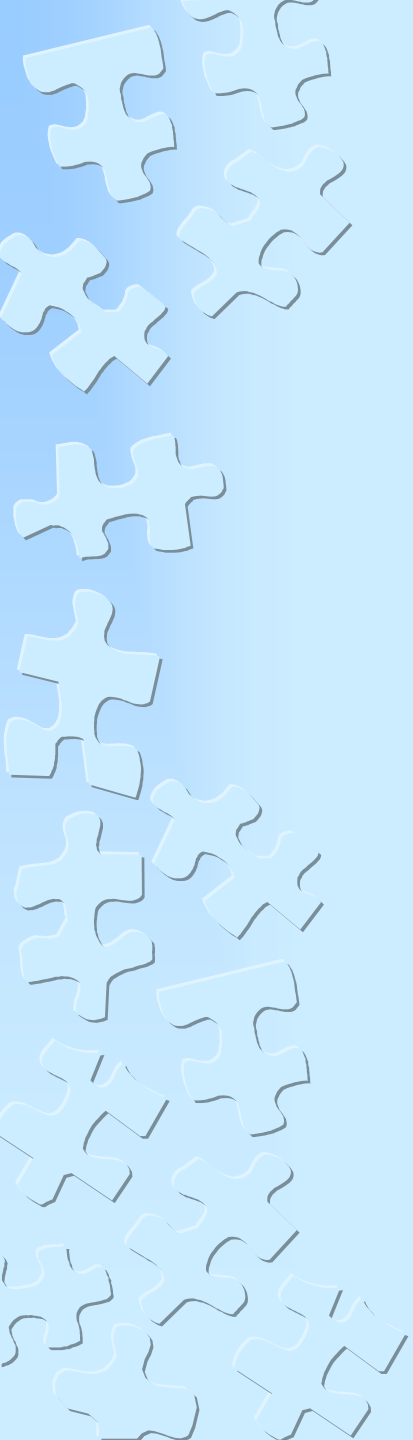
Custody

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: ALTIM +
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

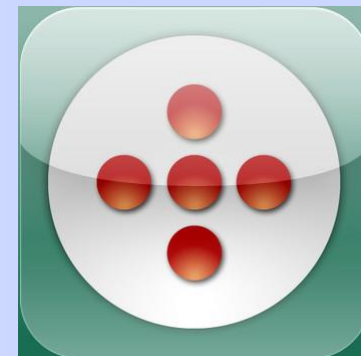
Emergency Contact Temporary Tattoos

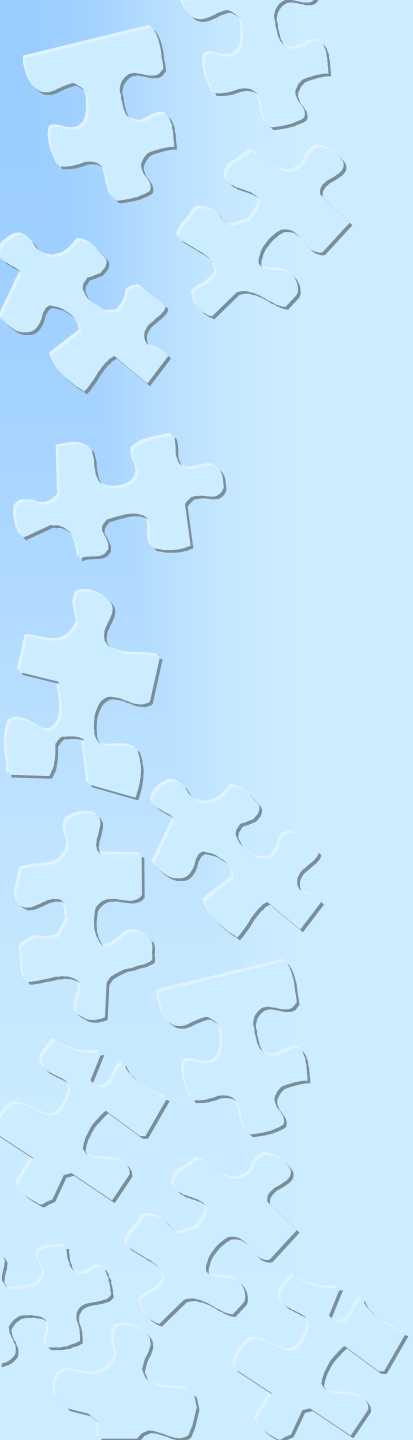


ICE



Phone Apps



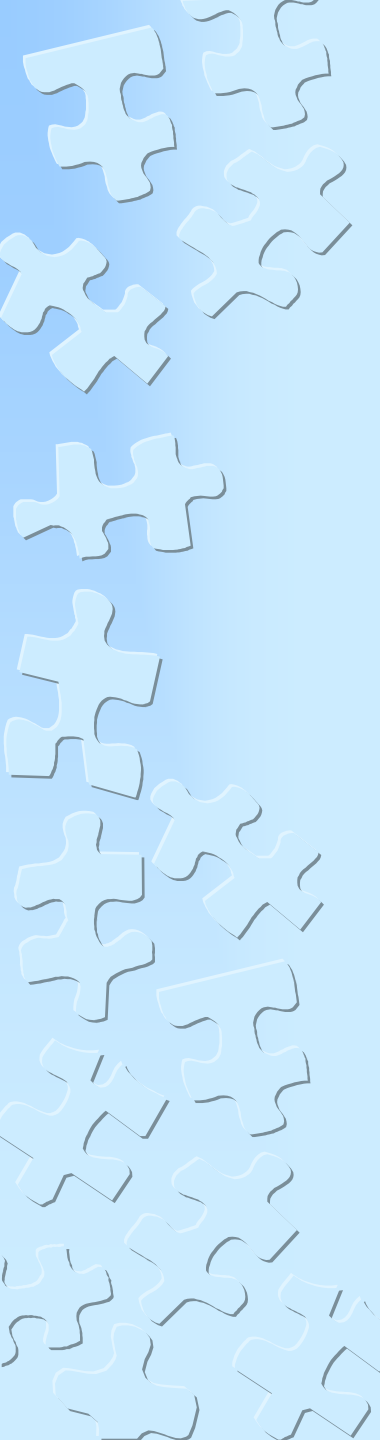


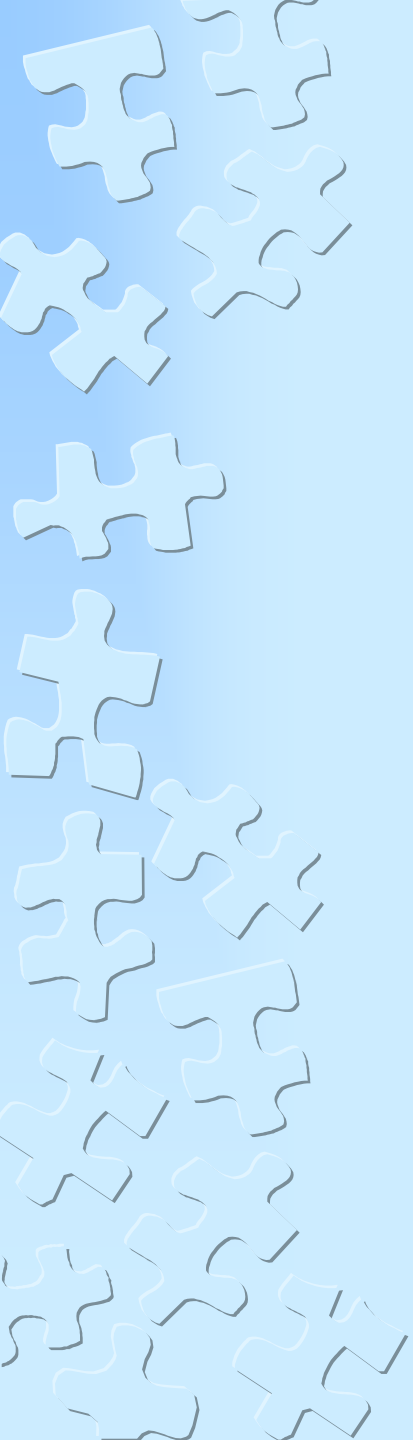




Rescue from Heights

- 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







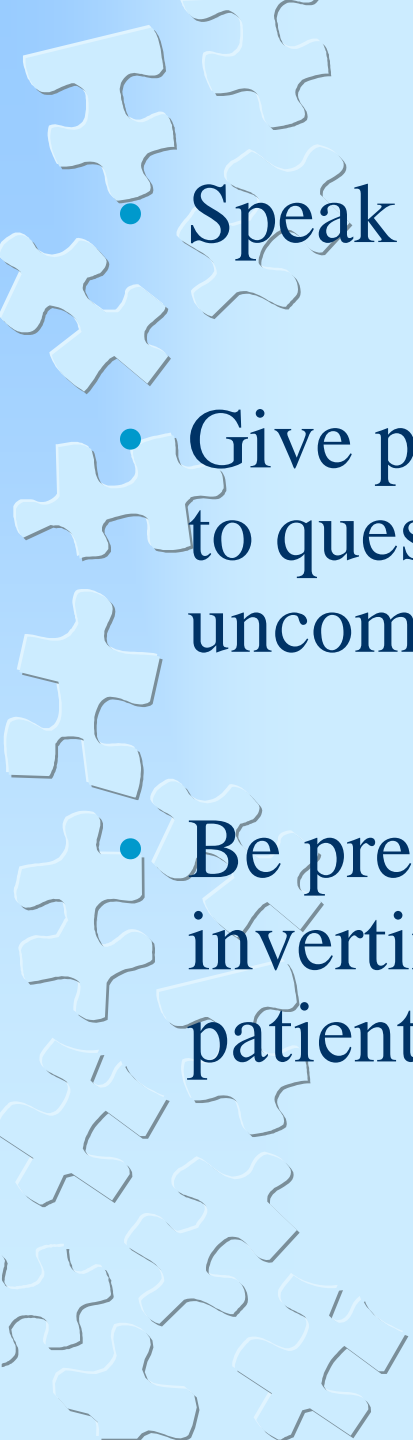
Bolt Risk


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

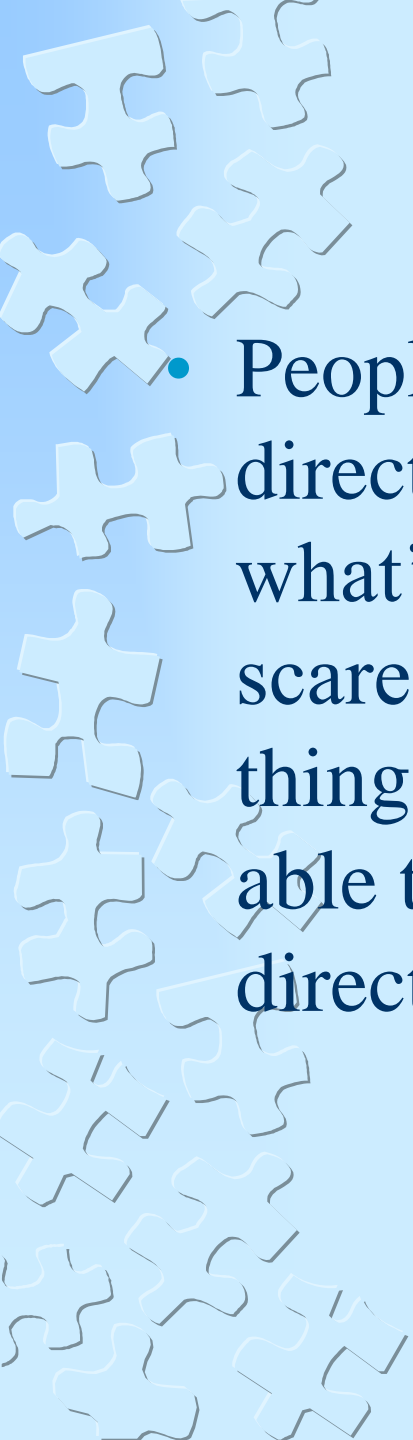


Routines

- 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.

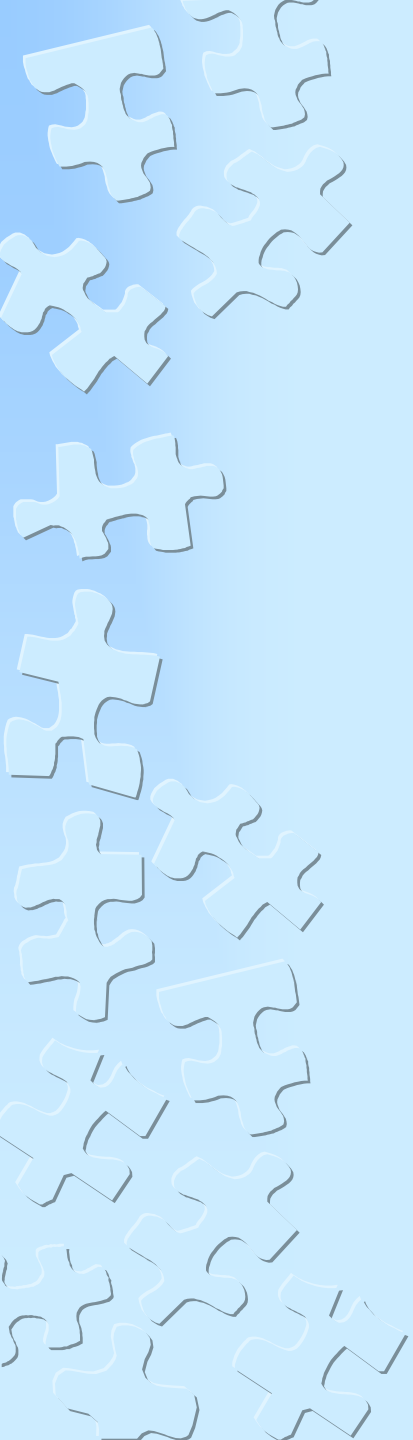


- They may also fixate on your personal gear such as a hat, radio, cuffs and flashlight.

Community Day




Community Day



Community Day



- 
- 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.
- 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
- Autism Society-www.autism-society.org
- Bill Cannata, www.firerescueautism.com
- Dennis Debbaudt-Autism Risk Safety
www.autismriskmanagement.com



CIT Training – Afternoon Session

12:30 – 1:30 PM – Mental Health in Elders

1:30: - 3:00 PM – DMH Overview – Forensic
Services

3:00 – 4:00PM – DDS Services/ Support

Presentation # 6

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
MAY 25, 2023**

DMH FORENSIC SERVICES

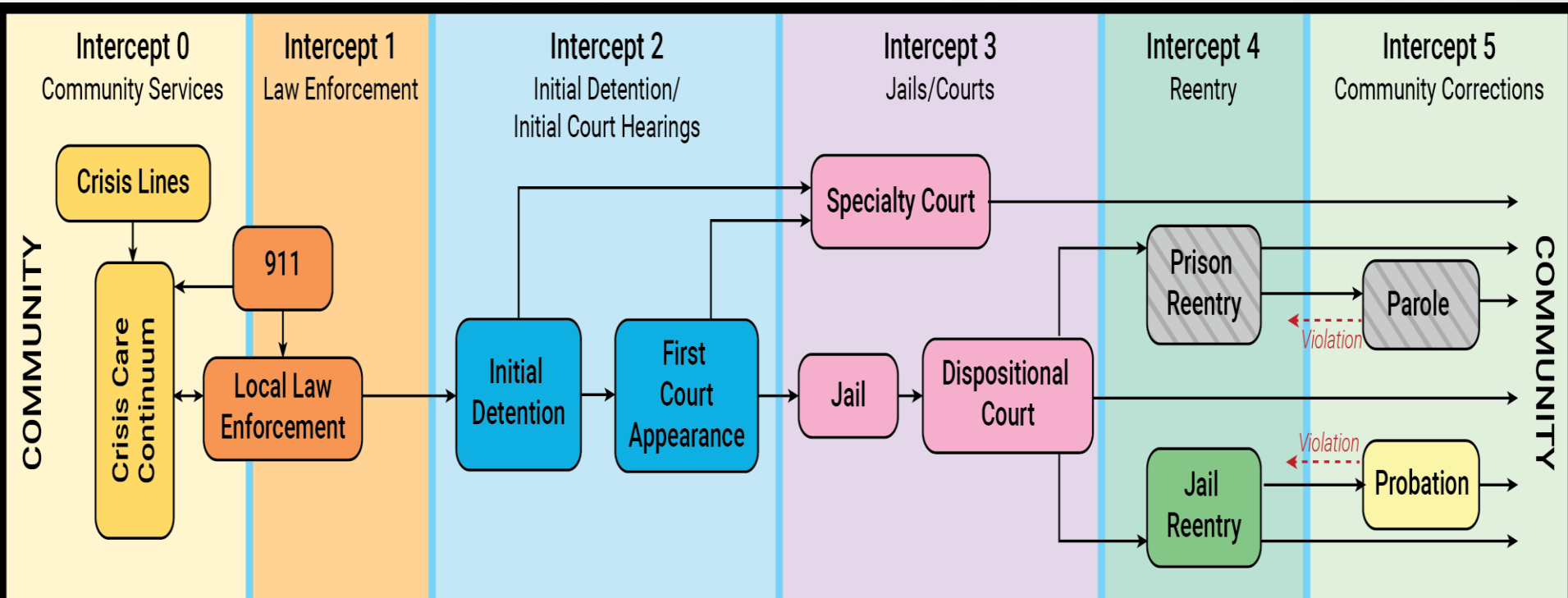
**DMH FORENSIC MENTAL HEALTH SERVICES
(FORENSIC SERVICES)**

**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 100 JDP'S (JAIL DIVERSION PROGRAMS) IN MA, IMPACTING OVER 170 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

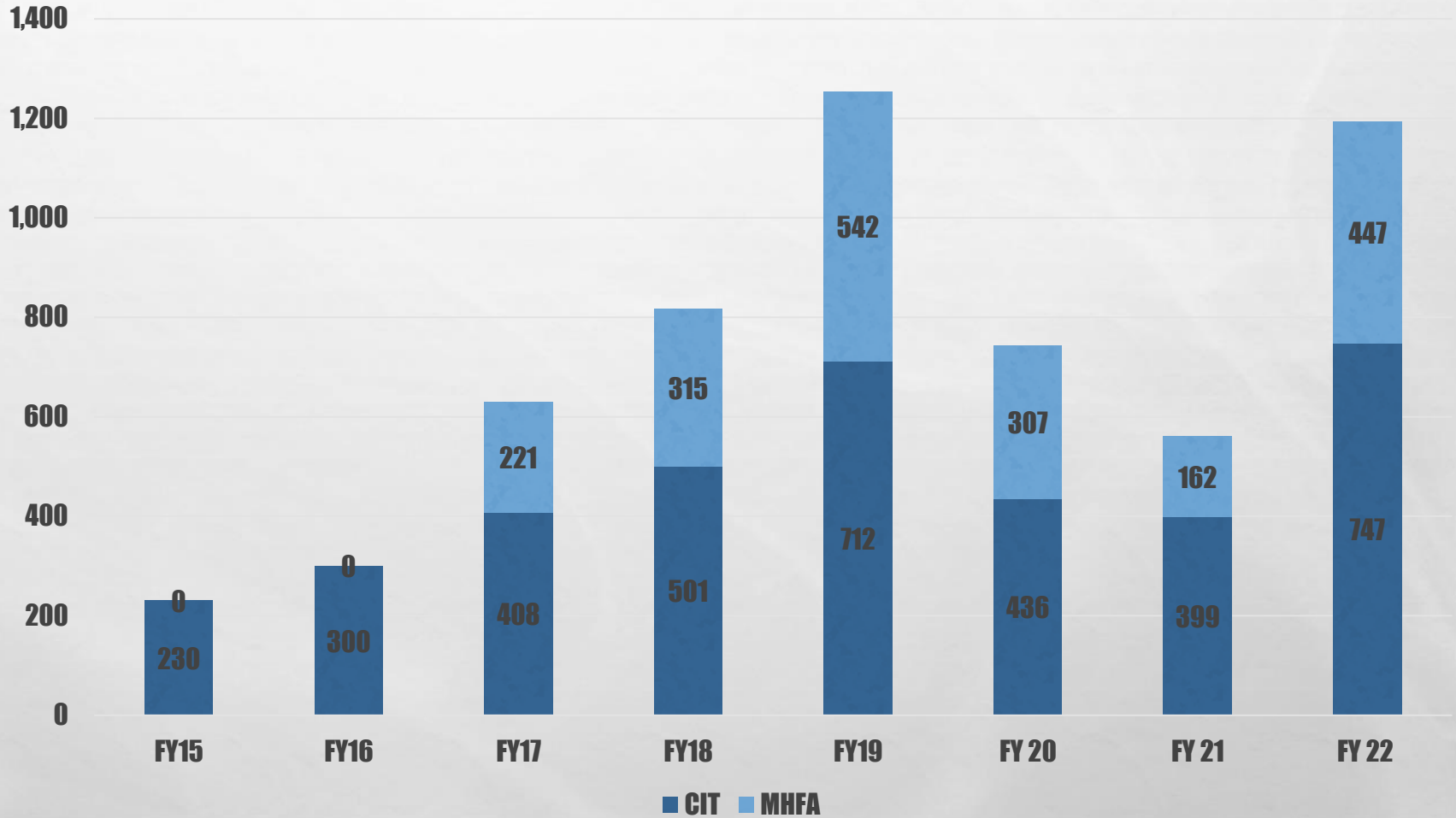
USE OF POLICE-BASED CO-RESPONSE CLINICIANS RESULT IN:

- **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

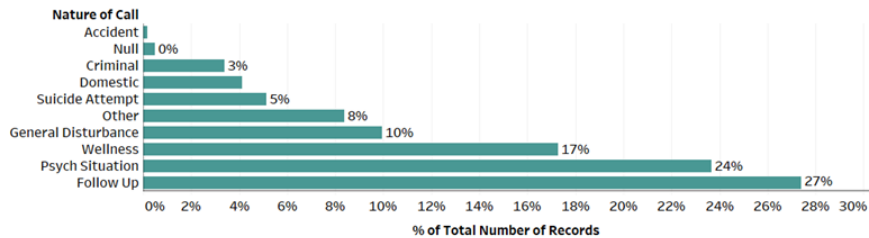
- **STUDIES INDICATE THAT CIT TRAINING DEVELOPS INCREASED CONFIDENCE AMONG POLICE OFFICERS^{1,2}**
- **CIT OFFICERS HAVE VERY EFFICIENT CRISIS RESPONSE TIMES**
- **INCREASED DIVERSIONS FROM ARREST AMONG THOSE WITH MENTAL ILLNESS**
- **IMPROVES TREATMENT CONTINUITY**
- **SIGNIFICANTLY DECREASES POLICE 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)

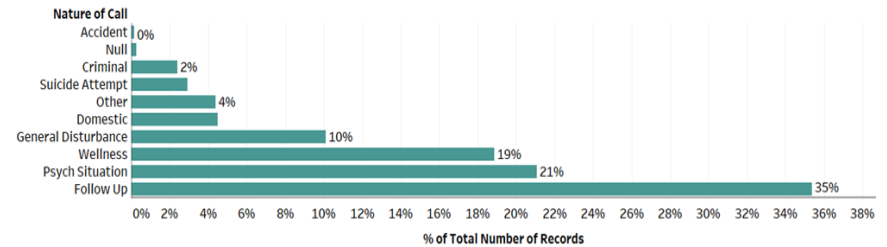
2. [HTTP://WWW.CITINTERNATIONAL.ORG/TRAINING-OVERVIEW/163-MEMPHIS-MODEL.HTML](http://www.citinternational.org/training-overview/163-memphis-model.html)

JDP Call Types

JDP Call Types, statewide (FY14 to FY21)



FY21 JDP Call Types, statewide



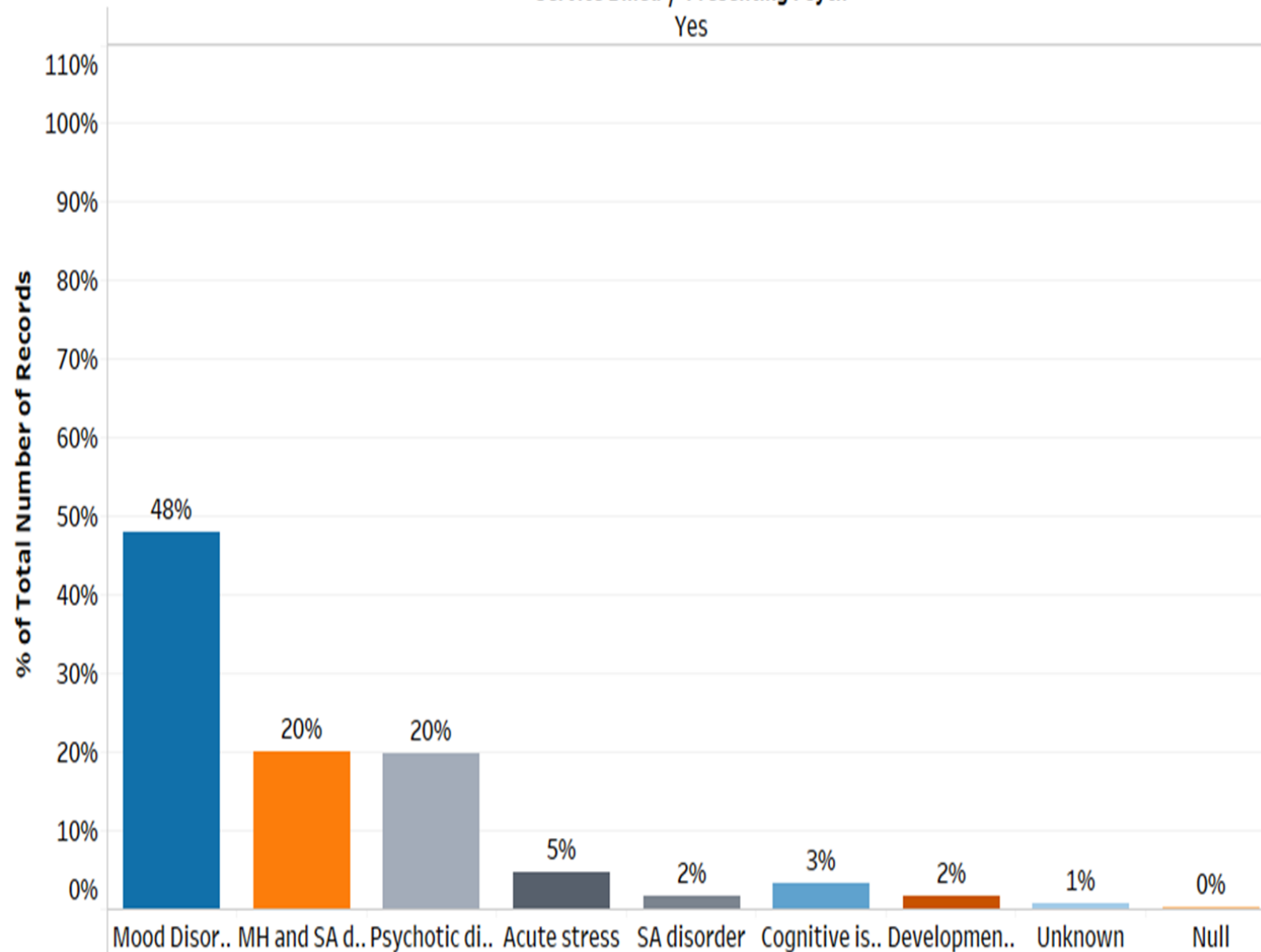
Primary Behavioral Health Issue

Service Billed / Presenting Psych

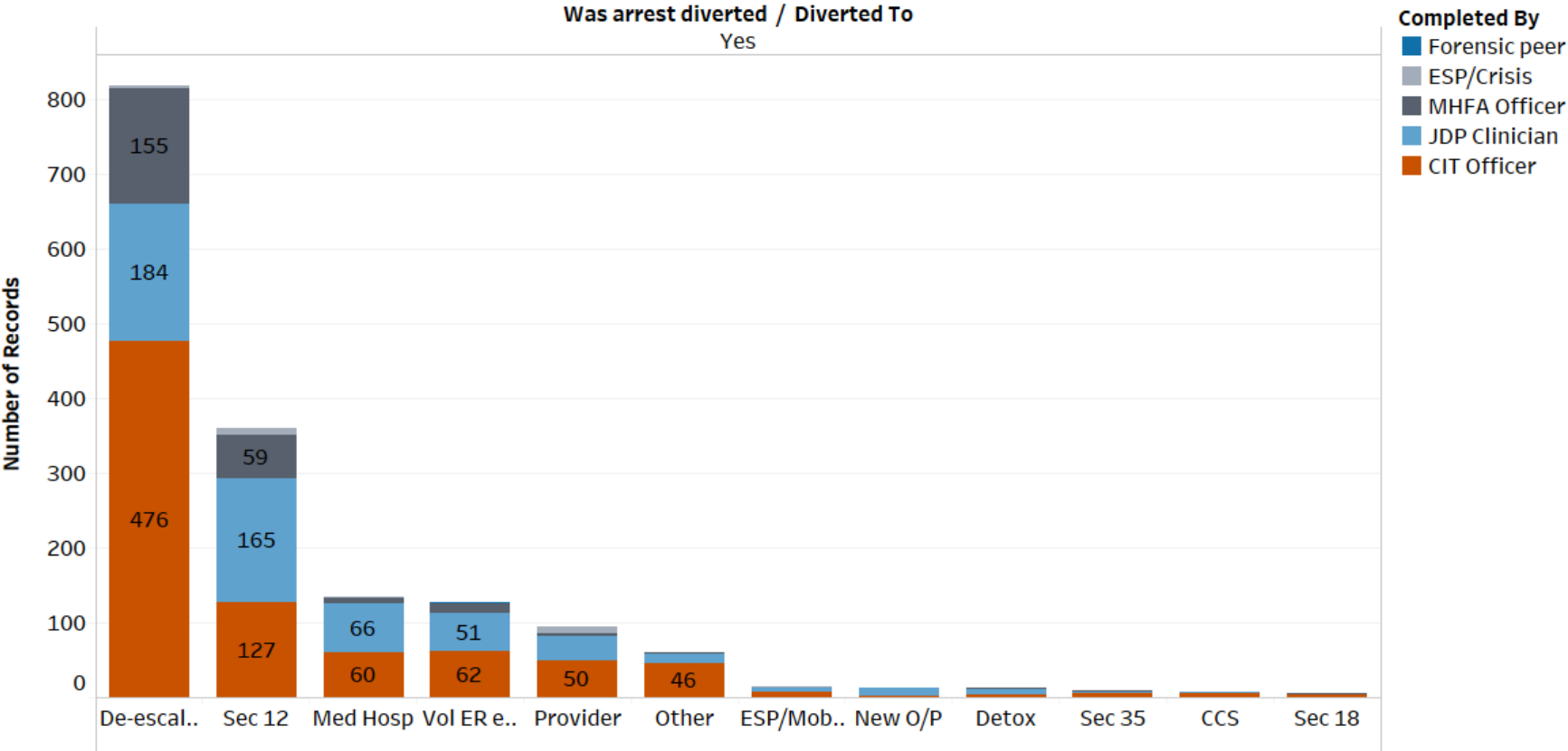
Yes

Presenting Psych

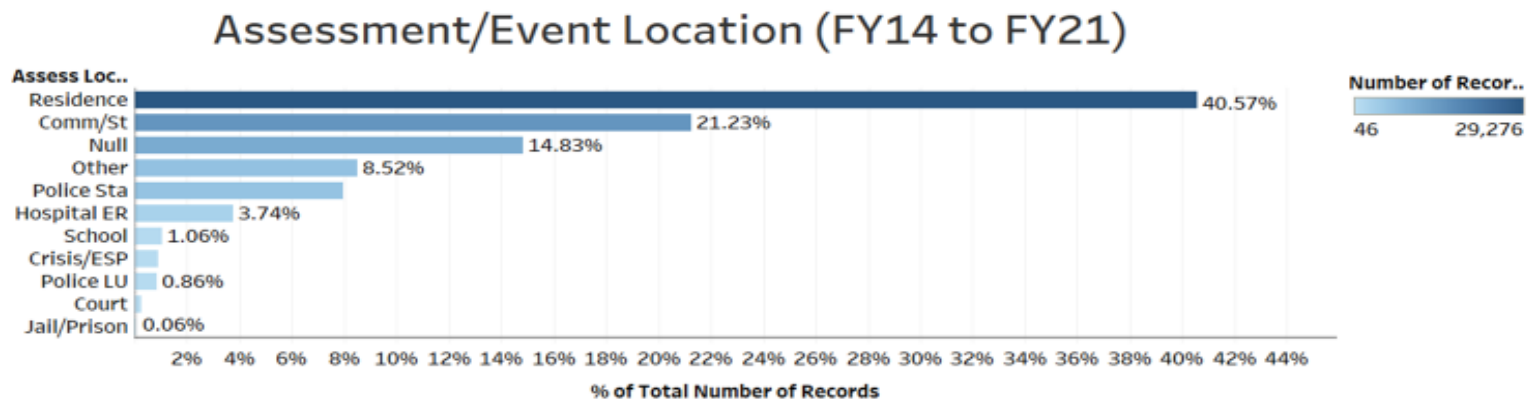
- Mood Disorder
- MH and SA disorder
- Psychotic disorder
- Acute stress
- SA disorder
- Cognitive issues
- Developmental
- Unknown
- Null



Diverted to by Model (FY21)



JDP Assessment/Event Locations

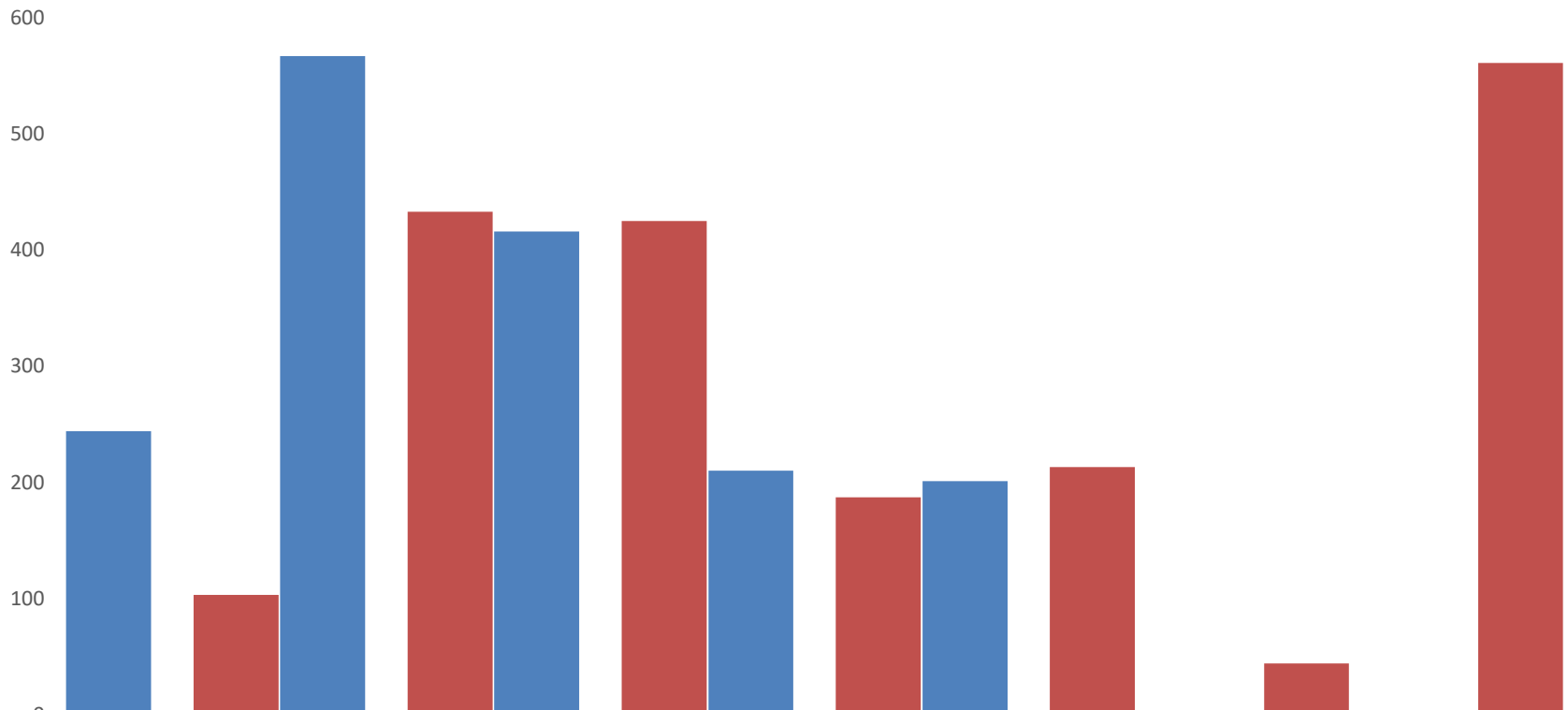


WM DMH JDP GRANTEES

- **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, DEERFIELD, EASTHAMPTON/HADLEY, GRANBY, GREENFIELD, GREENFIELD REGIONAL, HOLYOKE, LONGMEADOW, MONTAGUE, NORTHAMPTON, SOUTH HADLEY, SOUTH HADLEY REG, SPRINGFIELD, WARE, WILBRAHAM**
- **OTHER WM COMMUNITIES INVOLVED WITH CIT TRAINING: E. LONGMEADOW, GREAT BARRINGTON, HAMPSHIRE COUNTY SHERIFF DEPT, HATFIELD, UMASS, WESTFIELD, W. SPRINGFIELD, AND...**
- **PAST WM GRANTEES INCLUDE: EGREMONT, AND WESTFIELD**

WM JDP DATABASE INPUTS

WM JDP Programs for FY21-FY22



	Amherst	Greenfield	Holyoke	South Hadley	Springfield	Easthampton	Northampton
FY21	244	567	416	210	201	0	3
FY22	103	433	425	187	213	44	561

■ FY21 ■ FY22

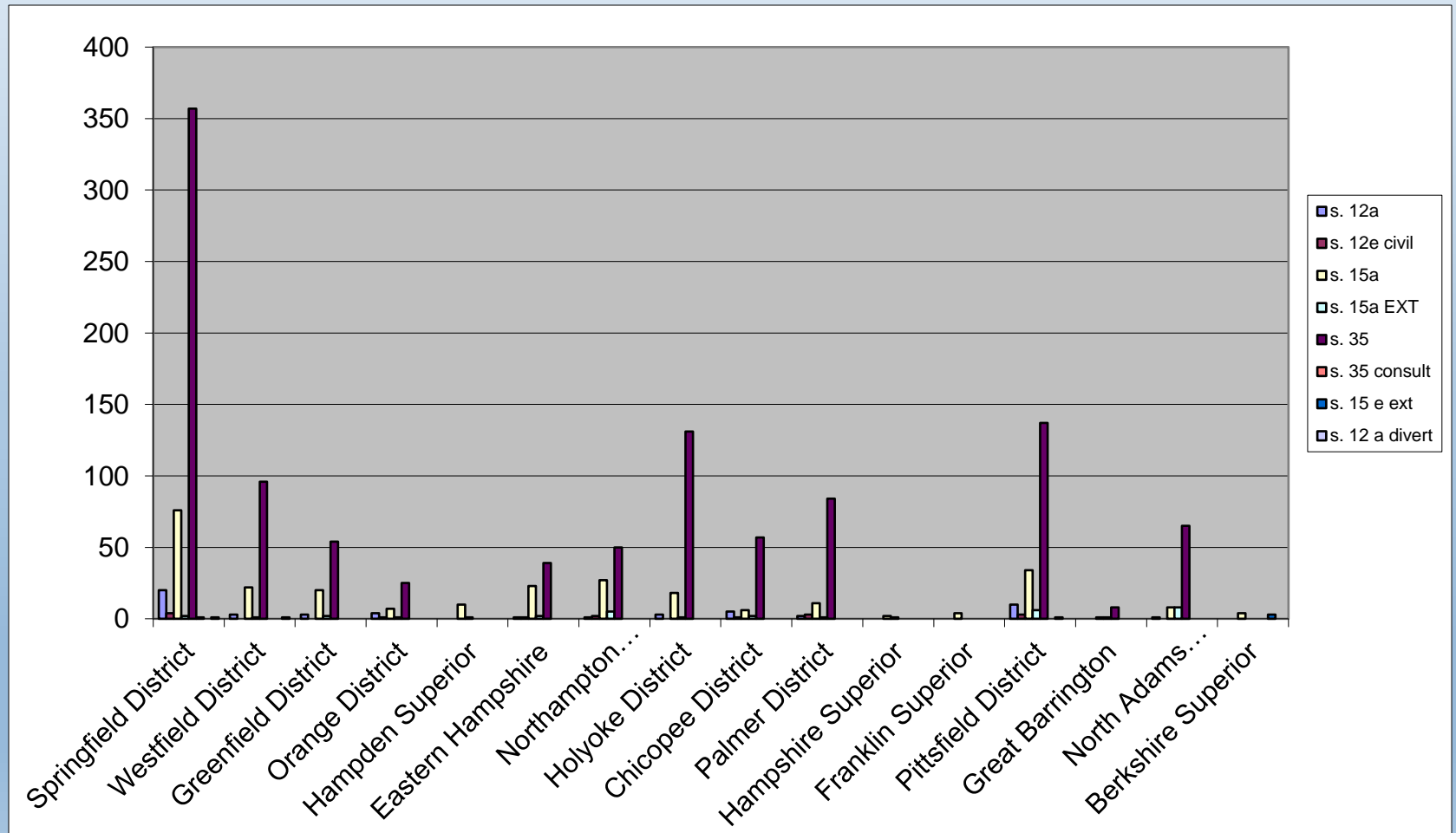
OTHER DMH POLICE TRAINING EFFORTS

- **ANNUAL MENTAL HEALTH AND LAW ENFORCEMENT CONFERENCE (JUNE)**
- **OTHER SPECIALIZED TRAININGS (EX: MHFA FOR PUBLIC SAFETY, ADVANCED CIT, BLUE COURAGE, DISPATCH, CIT-Y, ETC.)**
- **LOCAL MH-LE COLLABORATIVE MEETINGS (5 LOCAL ONES)**
- **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 22



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*: 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

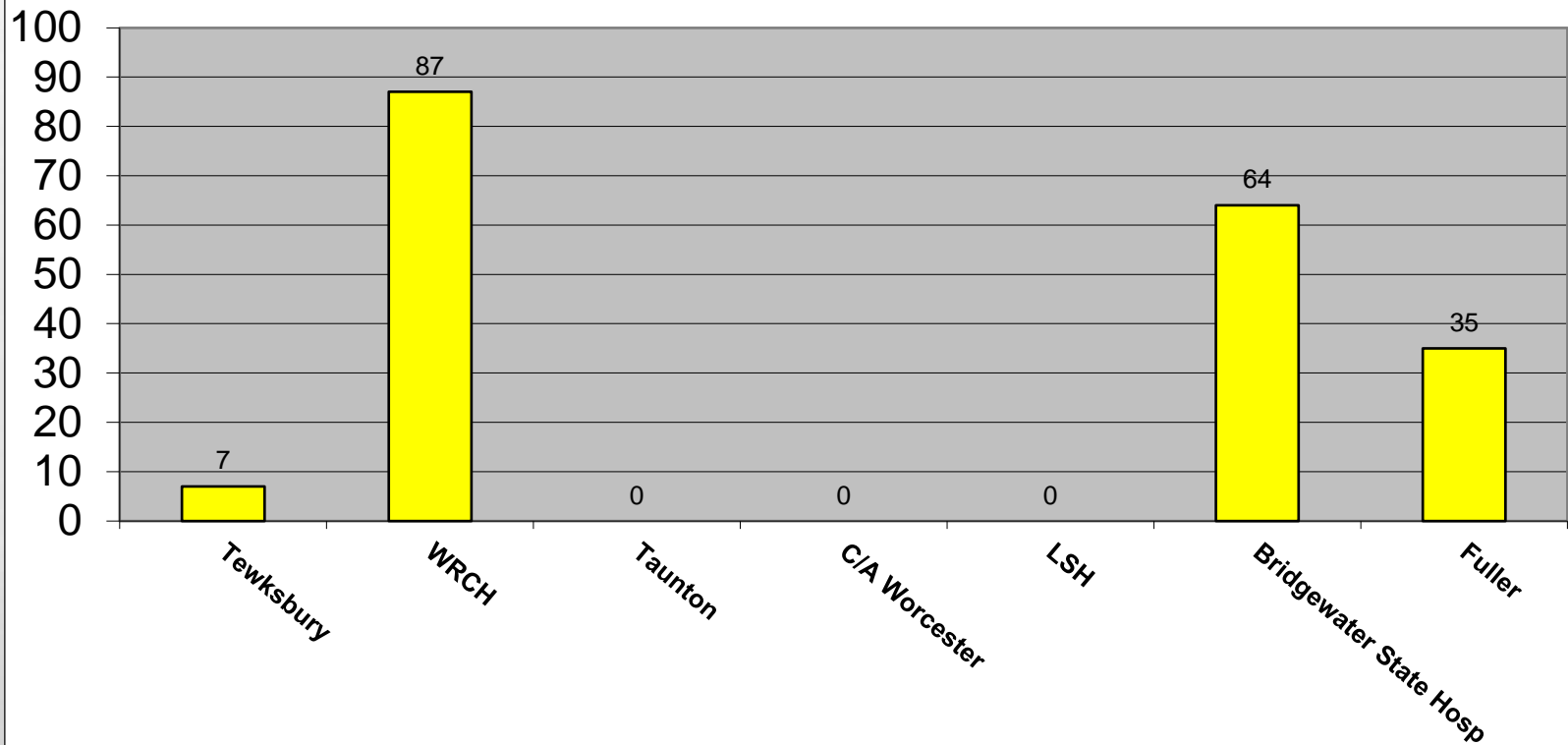
- **AGE 19 AND OVER**
- **EVALUATION AND COMMITMENT FOR TREATMENT**
- **FORENSIC CASES COMPRISE OVER 50% OF ALL ADMISSIONS**
- **CIVIL AND VOLUNTARY PATIENTS**
- **PRE-ARRAIGNED PRISONERS IN POLICE CUSTODY VIA SEC.18(A)**

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 22

Total Number of Inpatient Forensic Admissions Per Facility, FY 2022



§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

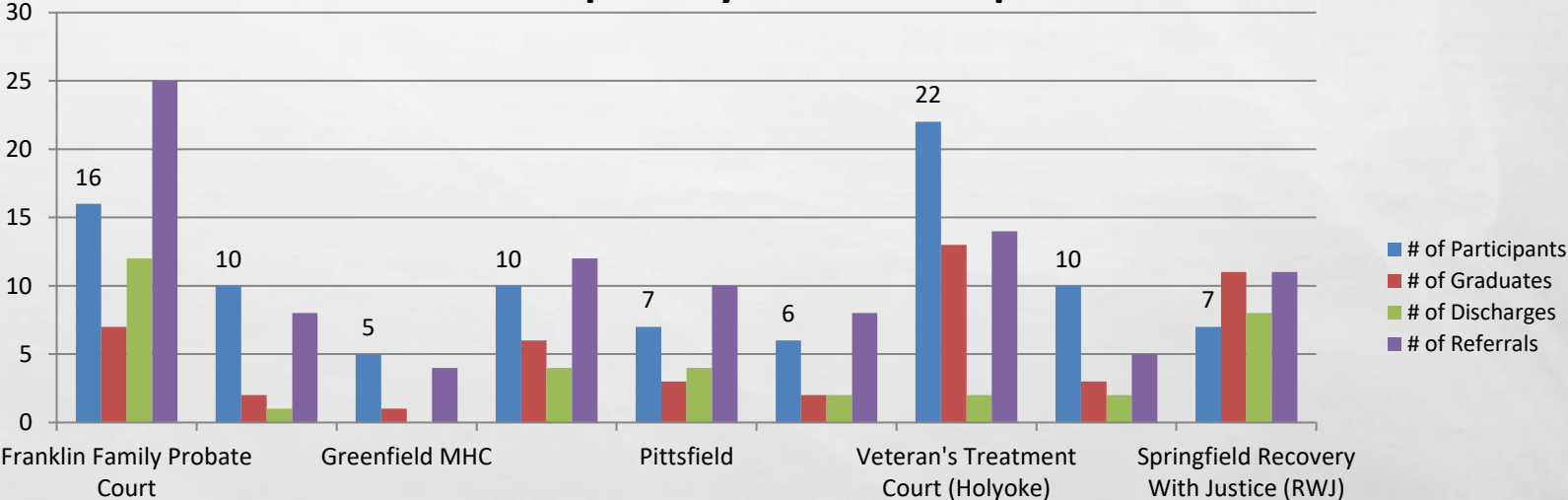
- **§16 (A): COURT ORDERED INPATIENT EVALUATION OF A CRIMINAL DEFENDANT AFTER A FINDING OF INCOMPETENCE TO STAND TRIAL (IST) OR NOT GUILTY BY REASON OF INSANITY**
- **§16(B) AND §16(C): COURT ORDERED COMMITMENT FOR CONTINUED TREATMENT OF A PERSON WHO HAS PREVIOUSLY BEEN FOUND EITHER IST OR NGI. NEED 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 ALSO HAS A 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 22

WM Specialty Court Participants



§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

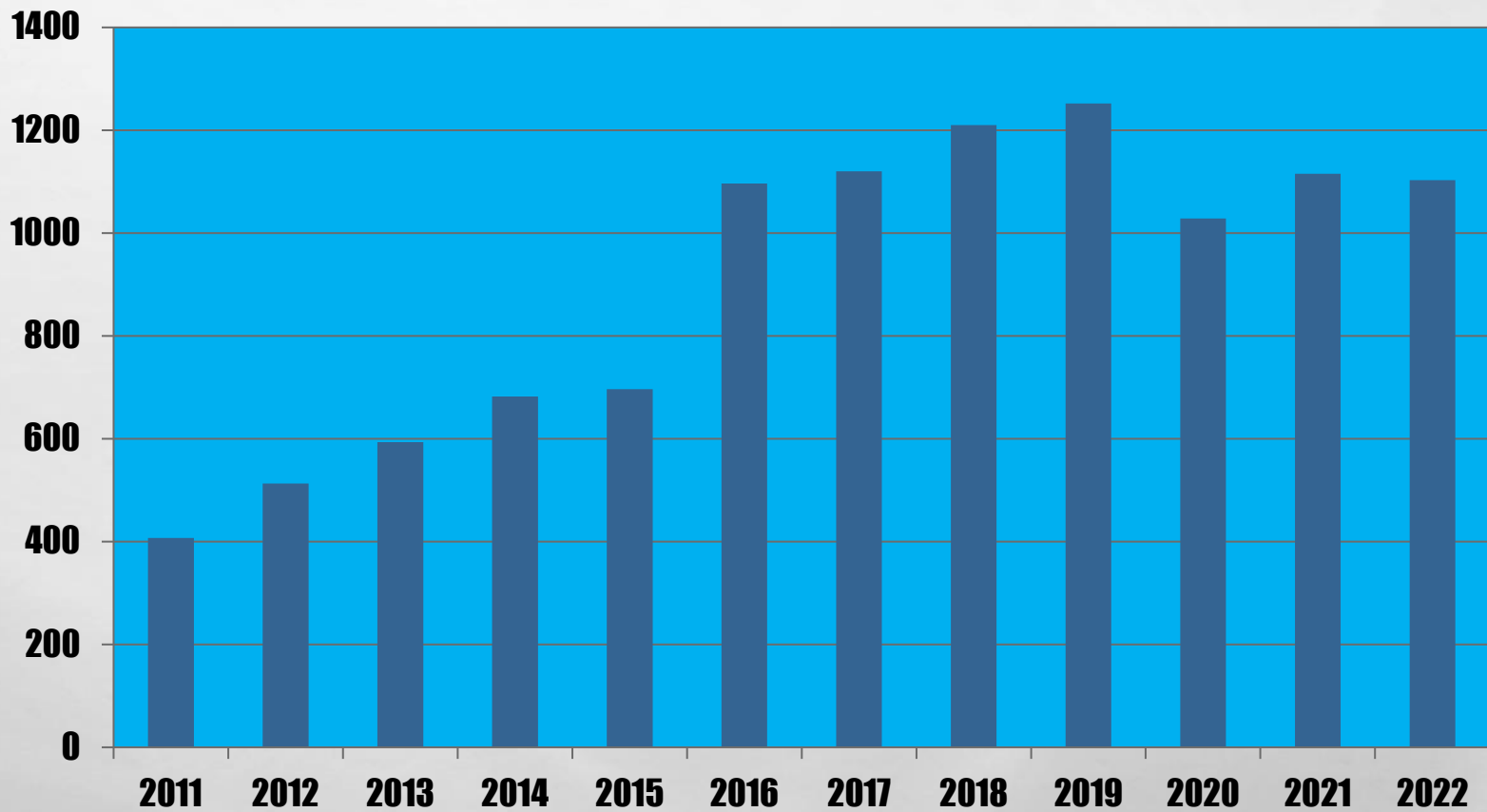
- **CIVIL COMMITMENT OF SUBSTANCE ABUSER FOR UP TO 90 DAYS, BECAUSE OF IMMINENT SERIOUS RISK TO SELF OR TO OTHERS BECAUSE OF ALCOHOL OR DRUG USE.**
- **WHO CAN PETITION? SPOUSE, BLOOD RELATIVE, GUARDIAN, POLICE OFFICER, PHYSICIAN OR COURT OFFICIAL**
- **CAN BE EITHER AN ADVERSARIAL PROCESS OR “UNCONTESTED”**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

§ 35 TREATMENT FACILITIES

- **WOMEN ON CIVIL §35'S GO TO:**
 - **WATC (WOMEN'S ADDICTION TREATMENT CENTER) IN NEW BEDFORD**
 - **DMH'S RAP (RECOVERY FROM ADDICTION PROGRAM) IN TAUNTON**
 - **RCA – RCA DANVERS FACILITY**
 - **BHN – NEW VIEW**
 - **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 HAVE OPENED**
- **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

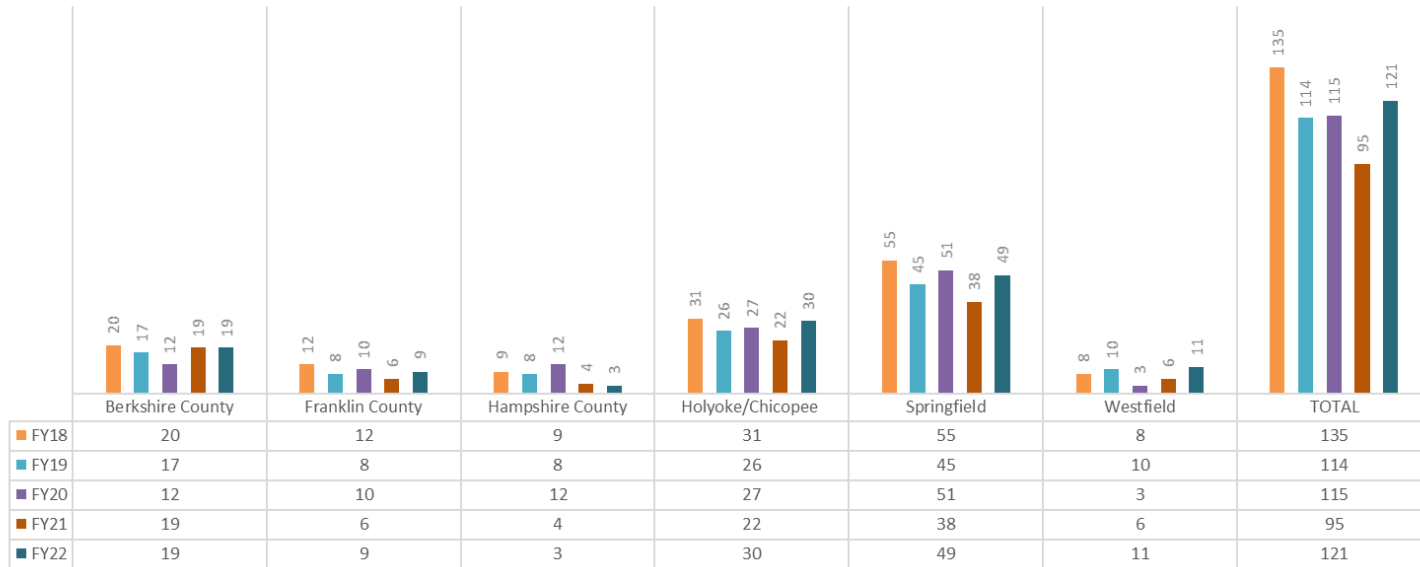
- **SOME STATUTORY OBLIGATIONS ARE SHARED WITH BRIDGEWATER (§15B'S, §16'S, AND §18'S THAT REQUIRE STRICT SECURITY).**
- **CONCEPT OF “STRICT SECURITY” – LEGAL TERMINOLOGY, NOT DEFINED –HOW DO OUR ACC STAFF VIEW IT?**
- **BSH, A DOC STATE HOSPITAL: MINIMUM, MAXIMUM, ITU, MED WEST/INFIRMARY**
- **BSH CHANGES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

IND. ENROLLED IN FTT IN WESTERN MA, BY DMH SITE OFFICE
FYS 18-22



QUESTIONS AND EVALUATIONS

CONTACT INFORMATION:

JOHN BARBER

(413) 587-6244

JOHN.BARBER@MASS.GOV

PRESENTATION #4

1:00-2:00 pm

Mental Health in Elders

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

Presentation # 6

3:00pm - 4:00pm

Department of Developmental Services (DDS)



DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

CIT PRESENTATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AND
ACQUIRED BRAIN INJURY

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

The Department's mission is to create, in partnership with others, innovative and genuine opportunities for individuals with intellectual and developmental disabilities to participate fully in their communities and meaningfully engage as valued members.

DDS works with adults to connect them with an array of employment and day program supports, community living and other residential aid, and family support.

DDS works with children to provide family support and supplement educational services through specialized programs.

Services are individualized and planned using a person-centered approach.

Information above from DDS website : <https://www.mass.gov/orgs/departments-of-developmental-services>



THINGS TO BE MINDFUL OF:

- Someone's disability may not be visible. Diagnoses like ASD, Deafness or hard of hearing, processing disorders, etc. are not visible to the eye.
- Example: Someone diagnosed with echolalia will repeat the things that have been said to them. This may be interpreted as offensive or noncompliant
- Some physical disabilities may limit someone's movement and may not be able to do what other bodies can.
- Brain Injuries vary and can have different symptoms presented.
- Escalation of a situation- recognition that if police are involved the situation has reached a difficult level
- Working with other professionals involved- looking for cues

DIFFERENCES IN POPULATIONS SERVED

- Processing difficulties: Frontal lobe function- Executive functioning difficulties
- Intellectual/Developmental and Brain Injury differences
- Differences in service models offered to populations served
- Intersection of disability-mental health-substance abuse
 - Co-occurring illnesses
- Guardianship/Legally Competent Person
- Service limitations

RESOURCES FOR ASSISTANCE

Springfield Westfield Area Office- 436 Dwight St. Suite 205 Springfield MA 01103


Area Director- Elaine Baillargeon 413-784-1339

Central West Eligibility Department: 140 High St, Suite 30, Springfield MA 01105

Phone number: 413205-0940

Central West Risk Manager: Adam Holst, 140 High St., Suite 30, Springfield MA 01105

Phone number: 413-205-0950



MORE RESOURCES

- Brain Injury Association of Massachusetts(BIAMA): <http://www.biama.org/>
- Department of Developmental Services(DDS): <https://www.mass.gov/orgs/departement-of-developmental-services>
- State Head Injury Program(SHIP): <https://www.mass.gov/service-details/statewide-head-injury-program-ship>
- MASS Advocates Standing Strong (self advocacy group): <https://www.wearemass.org/>