

# DAY 4 – CIT TRAINING



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

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

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

**Suicide Prevention** – Sarah Gaer

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

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

# Psychological Trauma



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

**LICENSED PSYCHOLOGIST  
DESIGNATED FORENSIC PSYCHOLOGIST**

# The Basics - We know this!



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

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

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

# Prevalence of trauma



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

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

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

# Police Work is Dangerous



# Complex Trauma



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

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

\* handout - New Yorker article

# Adverse Childhood Experiences


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

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

\* Handout – ACES

# How Does Trauma Affect You?





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

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



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

# Are you allowed to feel the pain?

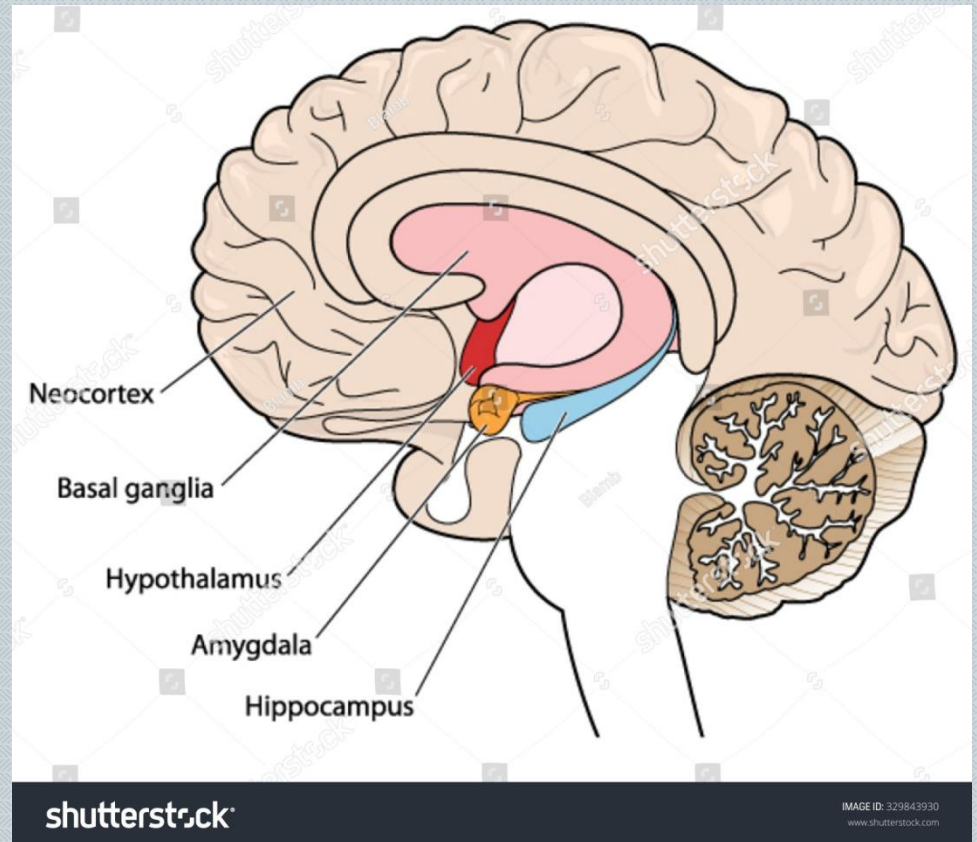


# Neurological Response to Threat



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

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



# Fight Flight Freeze



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



# *Everybody is different*



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

One time event or chronic  
underlying mental health  
condition

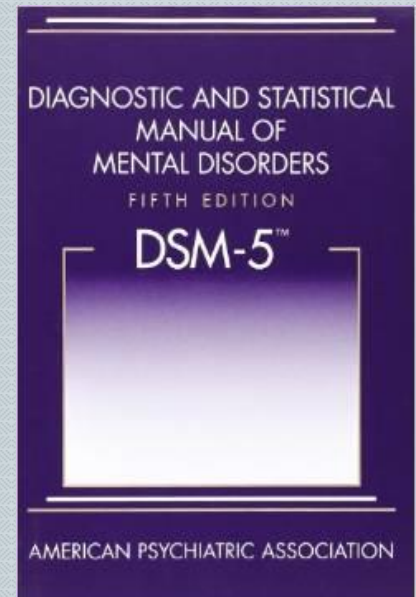
May not meet diagnostic  
classification for PTSD but....

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

# A diagnosis



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



# PTSD criteria



## Intrusive Symptoms

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

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

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

# PTSD Criteria



## Dissociation



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

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

# PTSD Criteria

## Negative alterations in cognitions and mood

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

## Alterations in arousal and reactivity

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

# Biological Perspectives



*In PTSD multiple neurobiological systems are dysregulated and maladaptive*

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

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

# What have you seen in your work?



# End of Presentation

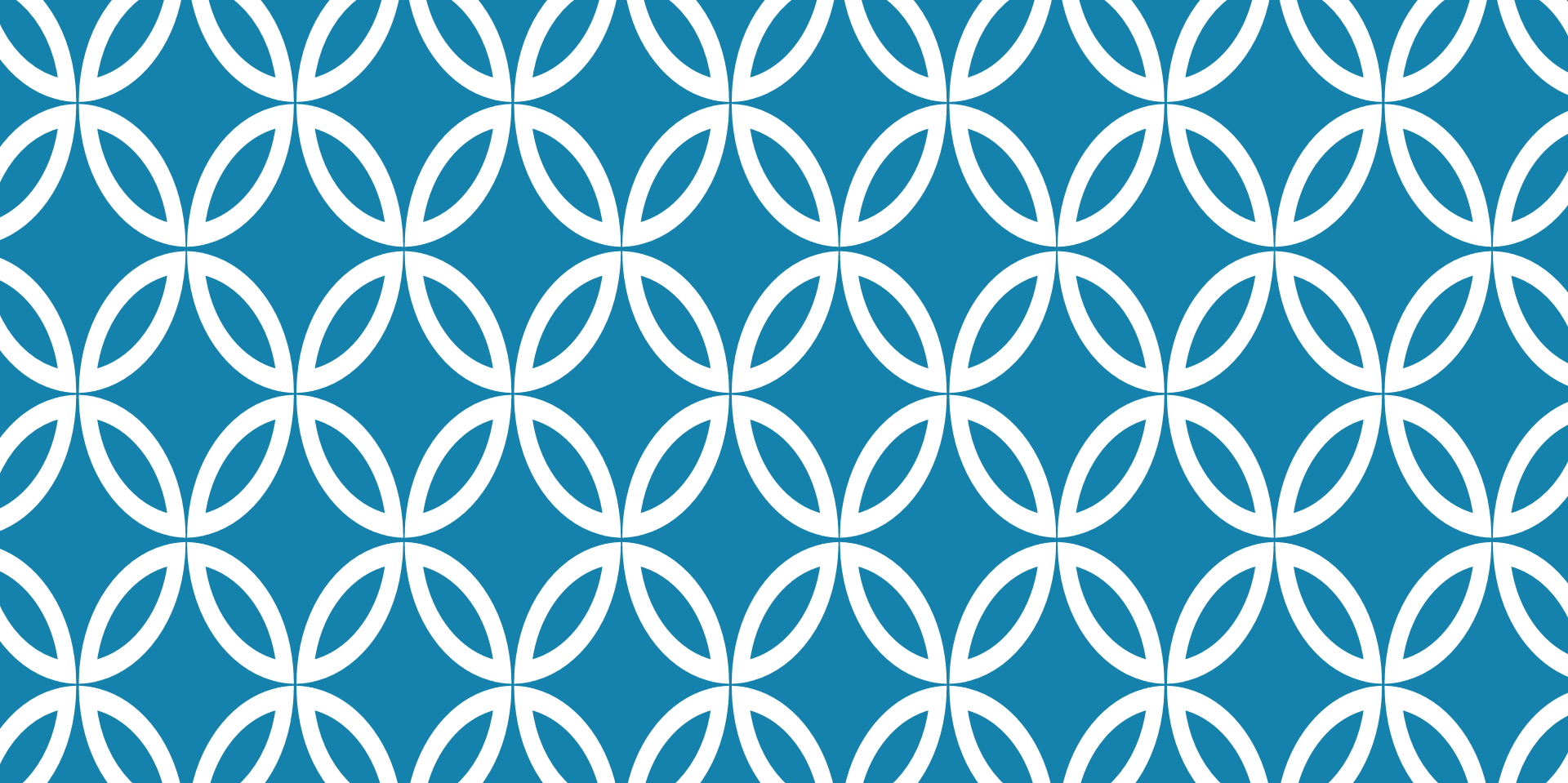


- Question and Answers

## Presentation # 2

---

**9:00-10:30am Suicide Prevention – Sarah Gaer**



# **QPR: QUESTION, PERSUADE, REFER**

Sarah Gaer, MA  
Suicide Prevention & Trauma  
Response Consultant  
QPR Master Trainer



# WHAT TO EXPECT

---

Overview of Suicide and Risk

Learn how to ask someone about suicidal intensity

Learn how to persuade them to get the support that they need

Learn how to refer them to resources

Identify Resources available

Consider the importance of self care

# TRAINING EXPECTATIONS: SUICIDE IS A SENSITIVE TOPIC

1

Please be sensitive to the experiences of others

2

Please be willing to reconsider your beliefs

3

Please take care of yourself: If you need a break, take it but please come back.

4

Please do not throw objects at your trainer.

# FOR ATTEMPT & LOSS SURVIVORS:

THANK YOU FOR BEING HERE!



## Activation of Memories

- Tyranny of Hindsight
- Challenging of current coping mechanisms:  
Anger, denial

# PREFERRED LANGUAGE

Suicidal thoughts vs Suicidal Intensity

Committed, Completed vs died by suicide

Successful vs Failed

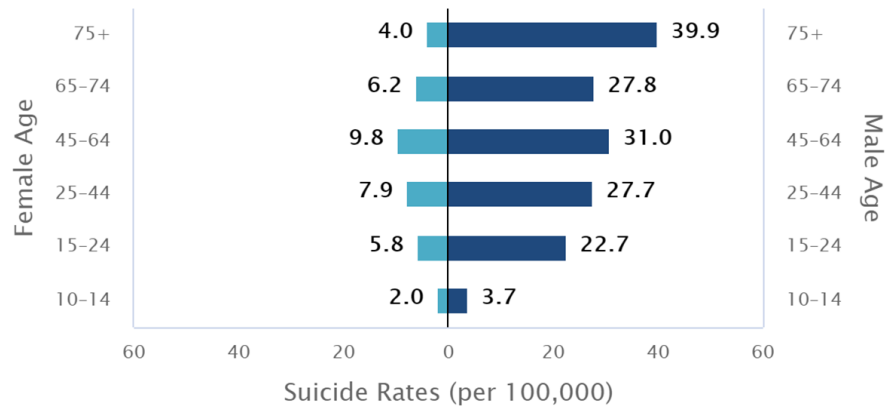
Serious vs level of lethality

Attention seeking vs Attention needing

# SUICIDE RATES BY AGE & GENDER

Suicide Rates by Age (per 100,000; 2018)

Data Courtesy of CDC



White men are at the highest risk – making up nearly 70% of all suicides

Men in the Middle Years are highest risk age/gender

Black women are lowest risk demographic

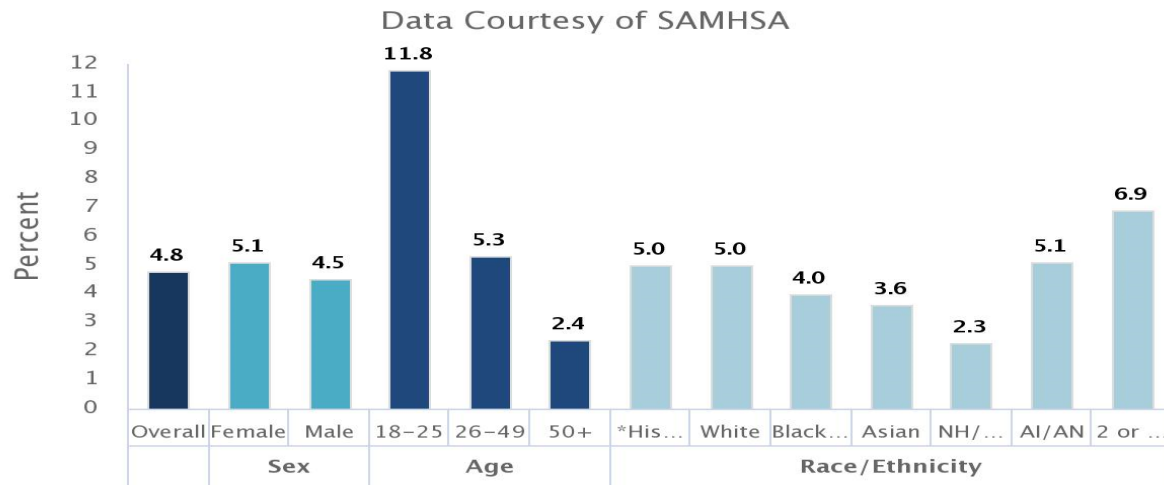
For children: Black male children are the highest risk

Recent years there have been spikes in suicide deaths among LatinX men and attempts among LatinX female youth

Nearly 1/2 of all transgender people will make a suicide attempt at some time during their lifespan

# AND RESEARCH INDICATES THESE NUMBERS ARE ON THE RISE.....

Past Year Prevalence of Suicidal Thoughts Among U.S. Adults (2019)

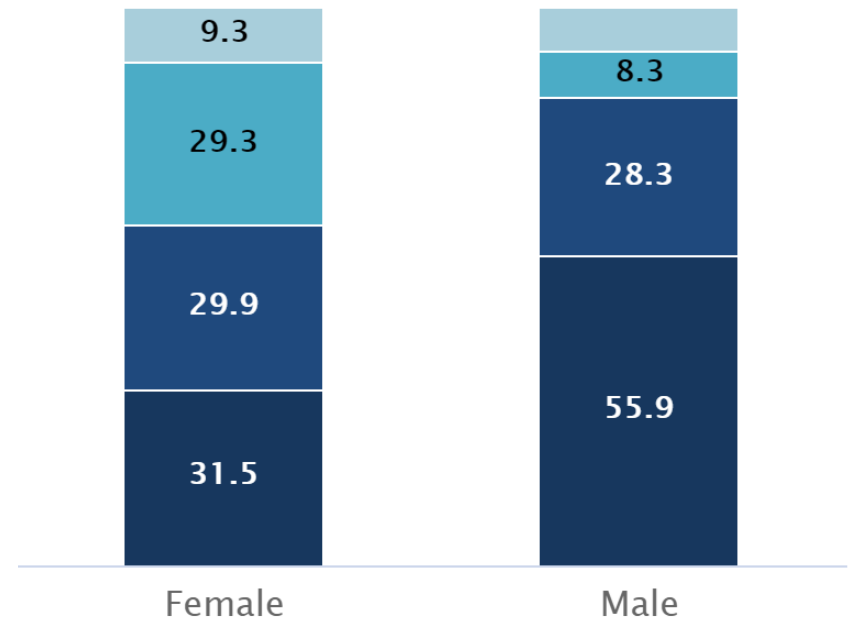


# WHAT EXPLAINS THE DISCREPANCY?

**Access to lethal means!**

Percentage of Suicide Deaths by Method in the United States (2018)

Data Courtesy of CDC





**MOST IMPORTANT  
THING I AM  
GOING TO  
SAY . . . . .**

---

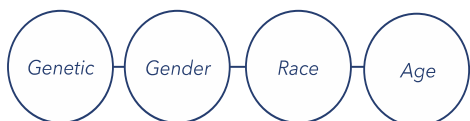
Suicide is a multi-factorial event. It is almost never caused by only one thing or event.

# SUICIDE AS A MULTI-FACTORIAL EVENT

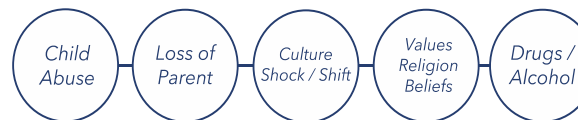
## The Many Paths to Suicide

Fundamental Risk Factors

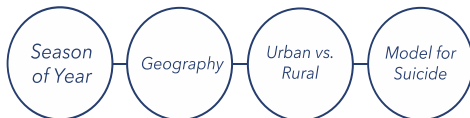
### BIOLOGICAL



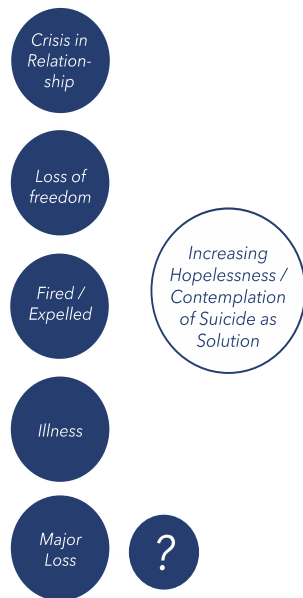
### PERSONAL / PSYCHOLOGICAL



### ENVIRONMENTAL



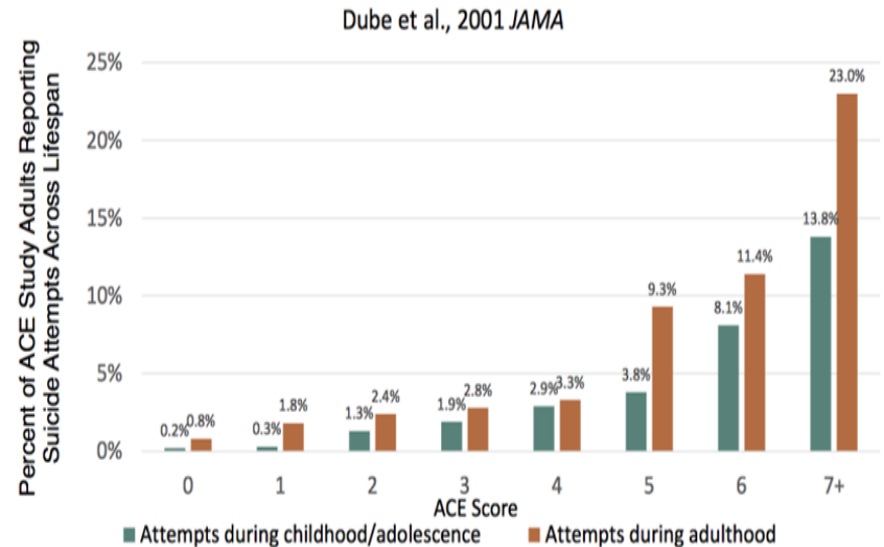
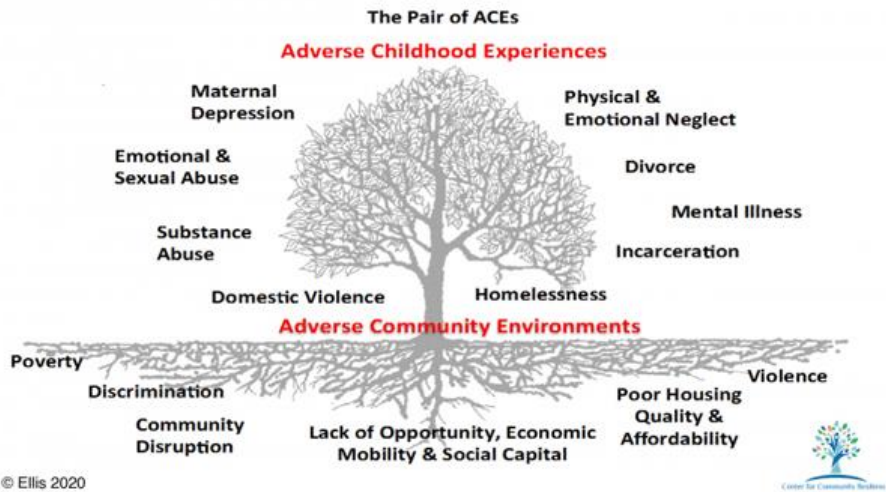
Proximal Risk Factors  
"Triggers or Final Straws"



Cause of Death



# INVISIBLE RISK: ADVERSE CHILDHOOD EXPERIENCES



# QPR: WHAT DOES IT STAND FOR?

Q =  
Question

P =  
Persuade

R =  
Refer

# QPR

QPR is not intended to be a form of counseling or treatment.

QPR is intended to offer hope through positive action.

# SUICIDE: MYTHS AND FACTS

- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

How can I help? Ask the question.

## MYTHS AND FACTS (CONT)

- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.
- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction..
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question.

# SUICIDE CLUES & WARNING SIGNS

The more clues and signs observed,  
the greater the risk.

Take all signs seriously.

# DIRECT VERBAL CLUES

- “I’ve decided to kill myself.”
- “I wish I were dead.”
- “I’m going to commit suicide.”
- “I’m going to end it all.”
- “If (such and such) doesn’t happen, I’ll kill myself.”

# INDIRECT VERBAL CLUES

- “I’m tired of life, I just can’t go on.”
- “My family would be better off without me.”
- “Who cares if I’m dead anyway.”
- “I just want out.”
- “I won’t be around much longer.”
- “Pretty soon you won’t have to worry about me.”

# BEHAVIORAL CLUES

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

# SITUATIONAL CLUES

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor or teacher
- Fear of becoming a burden to others



# TIPS FOR ASKING THE SUICIDE QUESTION

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; QPR Card, phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it!



## Q: QUESTION

### Less Direct Approach:

- “Have you been unhappy lately?  
Have you been very unhappy lately?  
Have you been so very unhappy lately that you’ve  
been  
thinking about ending your life?”
- “Do you ever wish you could go to sleep and never  
wake  
up?”

## Q: QUESTION

### Direct Approach:

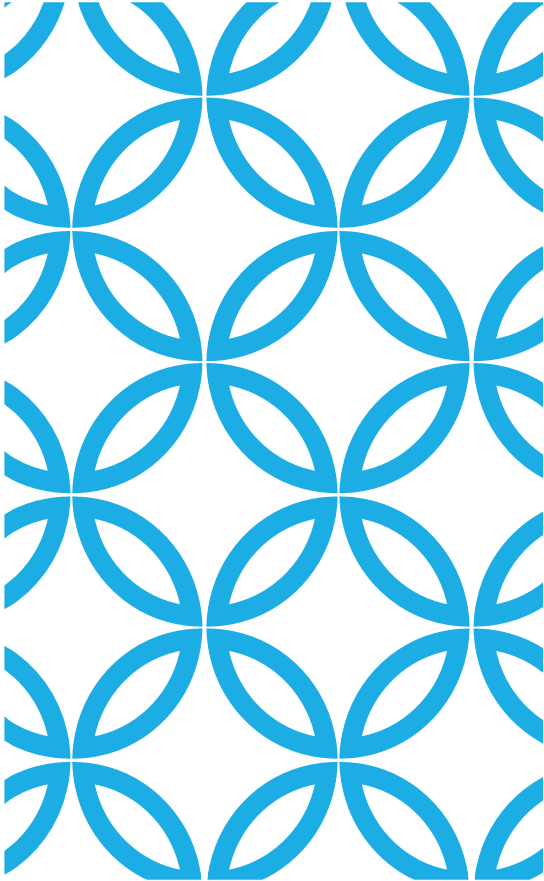
- “You know, when people are as upset as you seem to be, they sometimes wish they were dead. I’m wondering if you’re feeling that way, too?”
- “You seem really upset; I wonder if you’re thinking about suicide?”
- “Are you thinking about killing yourself?”

\* Note: If you cannot ask the question, find someone who can!

# Q: QUESTION

## How NOT to ask the suicide question:

- “You’re not thinking of killing yourself, are you?”
- “You wouldn’t do anything stupid would you?”
- “Suicide is a dumb idea. Surely, you’re not thinking about suicide?”



## KEY POINT!

---

If someone says they are suicidal, NEVER leave them alone!

# P:PERSUADE

## How to Persuade someone to stay alive

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

# P: PERSUADE

## **Then Ask:**

- “Will you go with me to get help?”
- “Will you let me help you get help?”
- “Will you promise me not to kill yourself until we’ve found some help?”

YOUR WILLINGNESS TO LISTEN AND TO HELP  
CAN REKINDLE HOPE AND MAKE ALL THE  
DIFFERENCE.

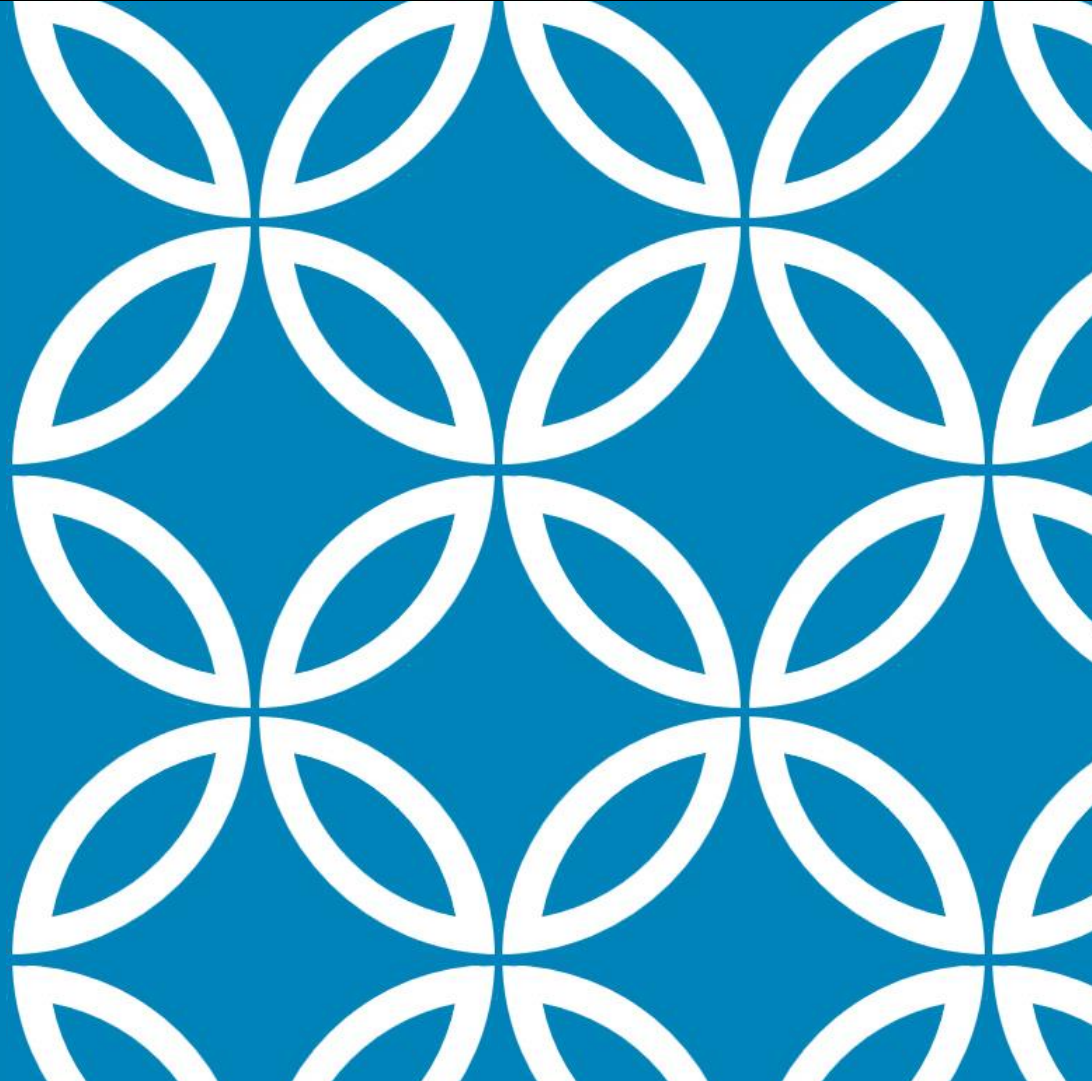
## R: REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

## REMEMBER

---

Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.



## FOR EFFECTIVE QPR

Say: “I want you to live,” or “I’m on your side...we’ll get through this.”

Get Others Involved. Ask the person who else might help.  
Family? Friends? Brothers?  
Sisters? Pastors? Priest? Rabbi?  
Bishop? Physician?

## FOR EFFECTIVE QPR (CONT)

Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.

Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

# REMEMBER

**WHEN YOU APPLY QPR, YOU PLANT THE  
SEEDS OF HOPE. HOPE HELPS PREVENT  
SUICIDE.**

## RESOURCES:

National Suicide Prevention Lifeline: 1-800-273-TALK

Text Line: 741741

[suicidepreventionlifeline.org](https://suicidepreventionlifeline.org)

Trevor Project (LGBTQ) <https://thetrevorproject.org>

Hey Sam – Youth – 24years of age. Peer Support Text  
Line 9am-9pm 1-877-832-0890

# Wall of Resistance to Suicide

## *Protective Factors*

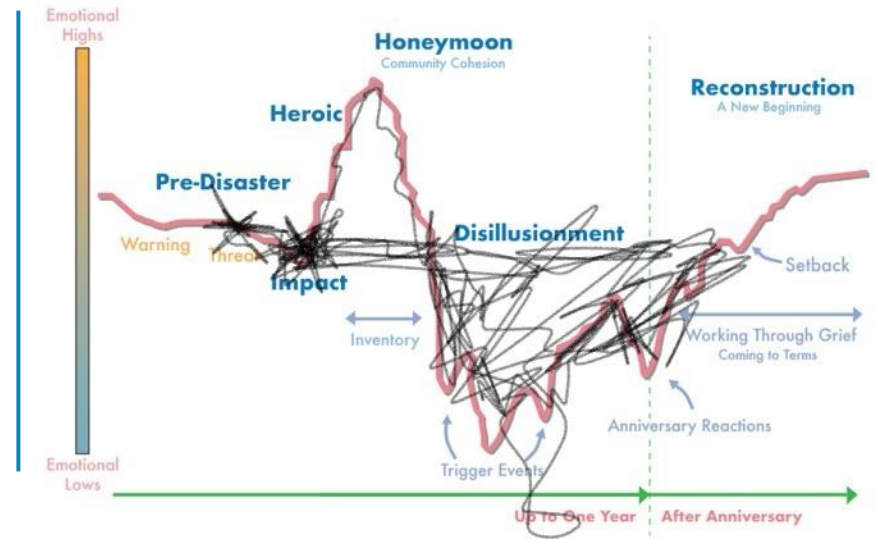
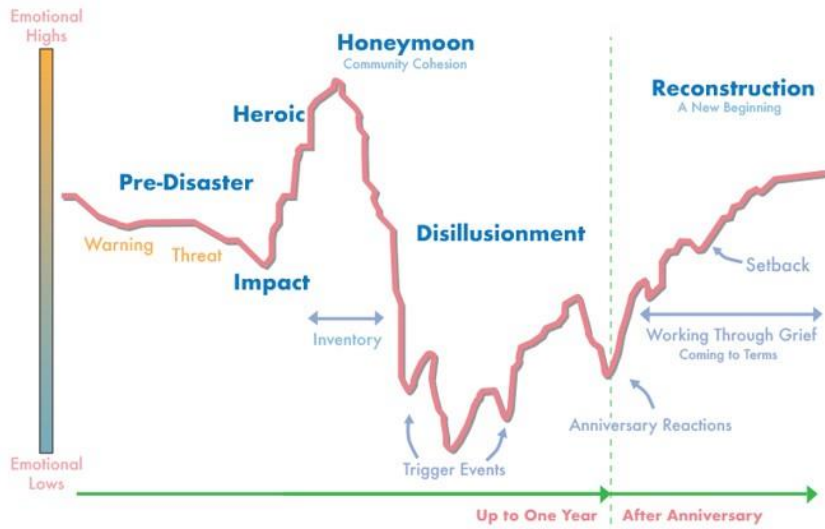
COUNSELOR / THERAPIST	DUTY TO OTHERS	GATEKEEPER AVAILABLE	
GOOD HEALTH	MEDICATION COMPLIANCE	SUPPORT OF SIGNIFICANT OTHER(S)	
JOB SECURITY / JOB SKILLS	RESPONSIBILITY FOR CHILDREN	FEAR	
DIFFICULT ACCESS	A SENSE OF HOPE	POSITIVE SELF-ESTEEM	
PET(S)	RELIGIOUS PROHIBITION	CALM ENVIRONMENT	AA or NA
BEST FRIENDS	SAFETY AGREEMENT	TREATMENT AVAILABILITY	
SOBRIETY			

# SELF CARE AS A NECESSITY

Interacting with someone who is potential experiencing suicidal intensity can be frightening, frustrating, exhausting and very sad.

It is extremely important that you create your own support system.

And pay special attention to your body and personal needs. Exercise, healthy eating & social connection



COVID 19

Community/Global Soul  
Exhaustion

# SOUL CARE

Culture

Art

Nature

Meaning

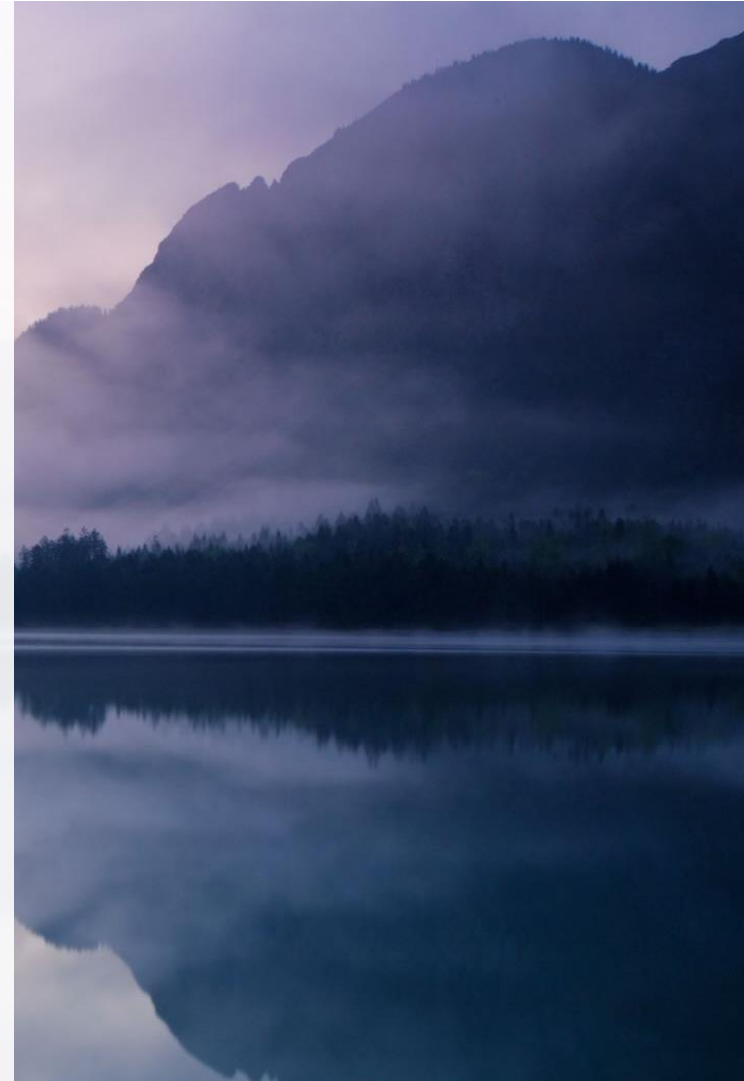
Joy

Friendship

Creativity

Self-  
expression

Spirituality



Twitter: @SarahGaer

Facebook: Sarah Gaer

LinkedIn: Sarah Gaer

Email: [Sarahgaer@gmail.com](mailto:Sarahgaer@gmail.com)

Books – available on Amazon

**Suicide Prevention &  
Postvention:**

The Price

Guts, Grit & The Grind – Series  
1-4

**Adverse Childhood  
Experiences Children's Book:**  
Good Night Grace



*SarahGaer.com*

# QUESTIONS



# PRESENTATION # 3

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

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

**Sgt. Melissa Lyman**

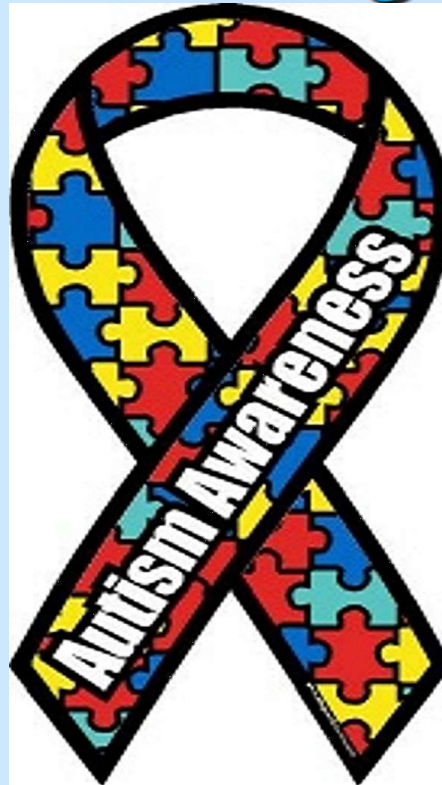
# PRESENTATION # 3

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

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

Det. Lt. Victor Caputo,  
Northampton Police Department

# Law Enforcement Autism Training

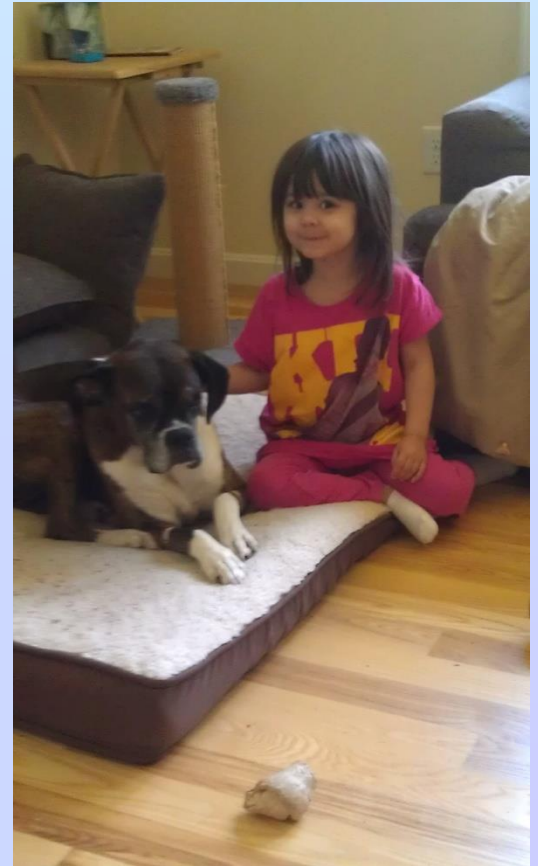


© 2022

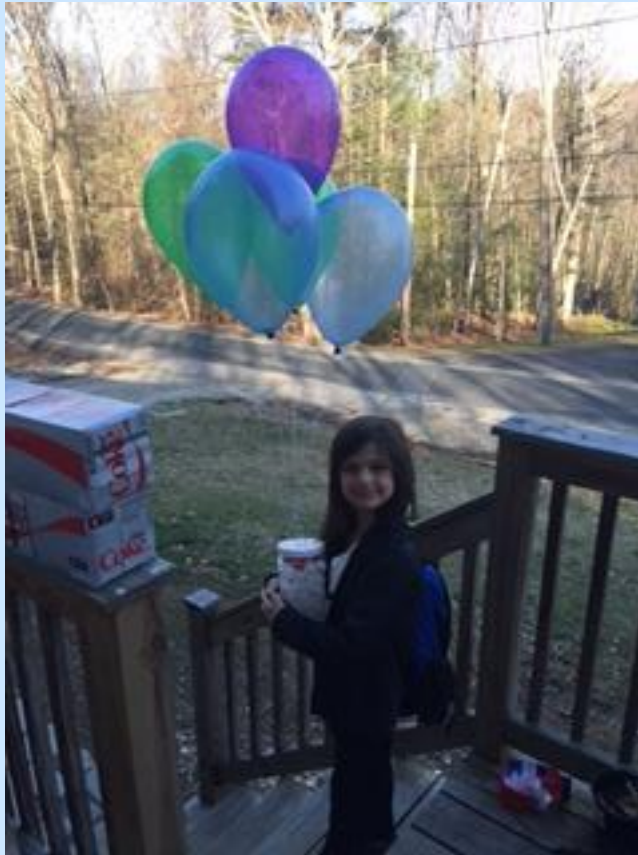
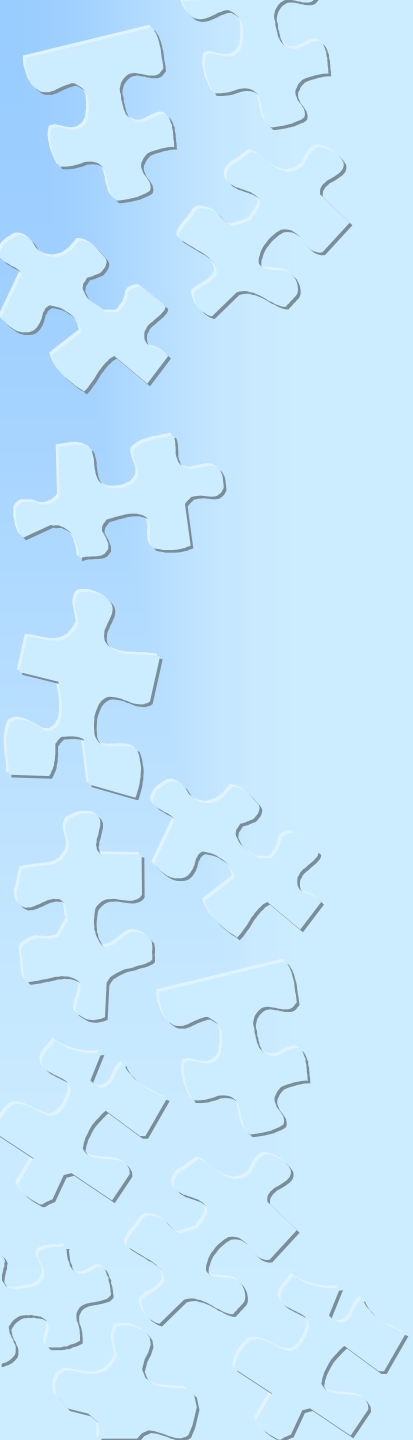


# **What Is Autism?**











# What is Autism?

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



# What is Autism

Autism is a neurological disorder that impacts:

- Social interactions
- Communication and language skills
- Behavior



# Autism is a spectrum disorder with varying levels of functioning

- Low functioning
- Middle functioning
- High functioning



# The 5 Categories of Autism

## 1) Autism

Language and communication deficits with challenging behavioral traits

## 2) Childhood Disintegrative Disorder

Complete loss of language at age 2 with little subsequent improvement

## 3) Retts Syndrome

90% affected are female who are multiply and severely disabled

## 4) Asperger Syndrome

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

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



# **Autism Facts**



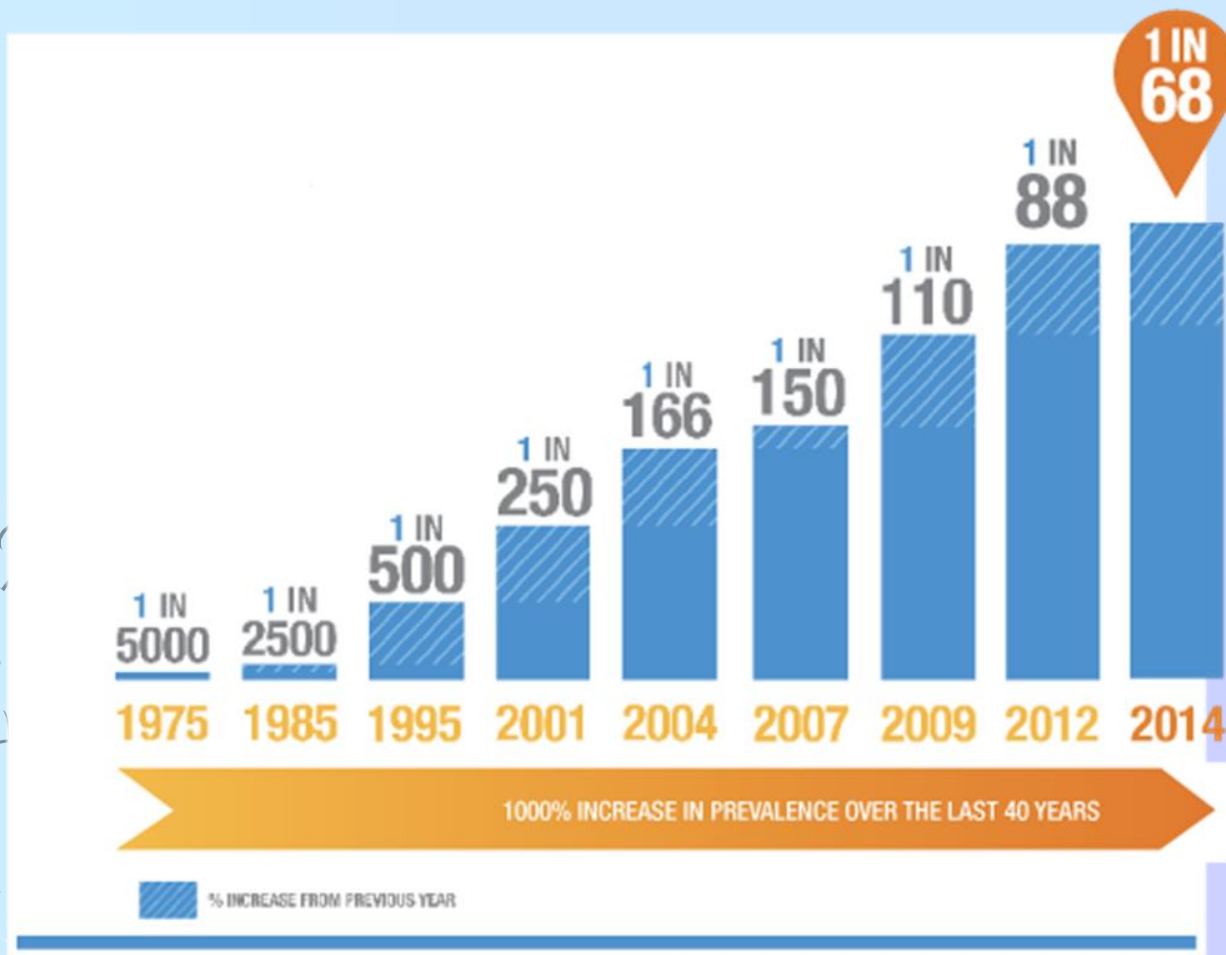
- More than 3 million people live with ASD in the United States


- 1 in 50 people are born today have ASD


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

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

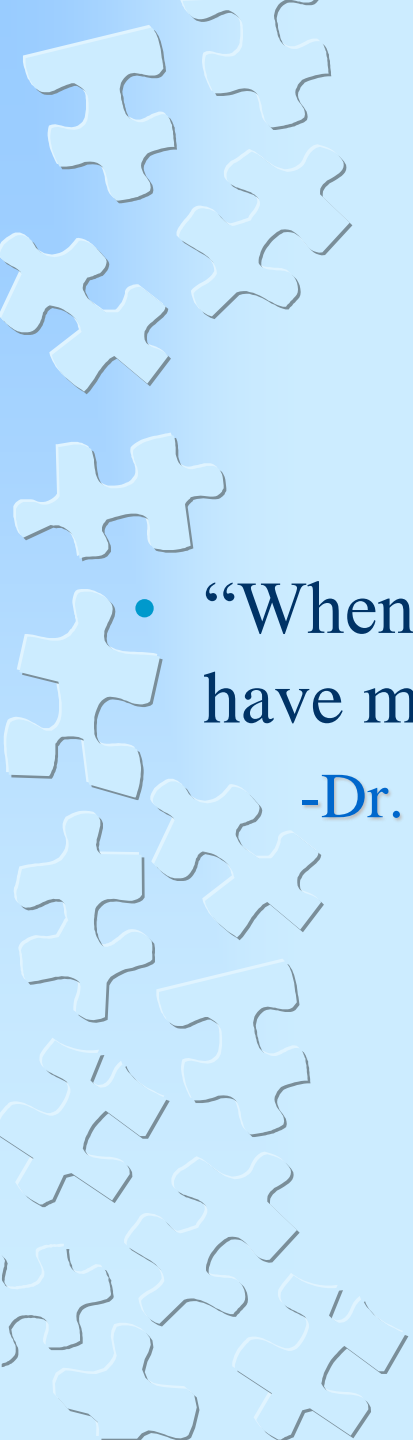
# PREVALENCE STATISTICS



- 
- Autism knows no racial, ethnic, or 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 with black outlines, 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.



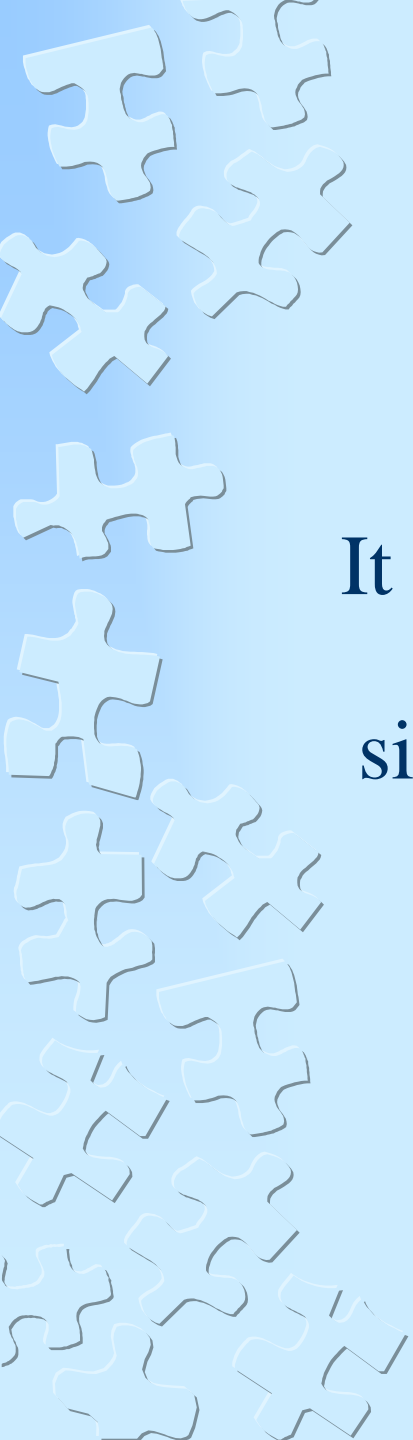
A decorative graphic on the left side of the slide consists of several white puzzle pieces of various shapes and sizes, arranged in a vertical column. The background is a light blue gradient.

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



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





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



# **How to Recognize Someone with ASD**

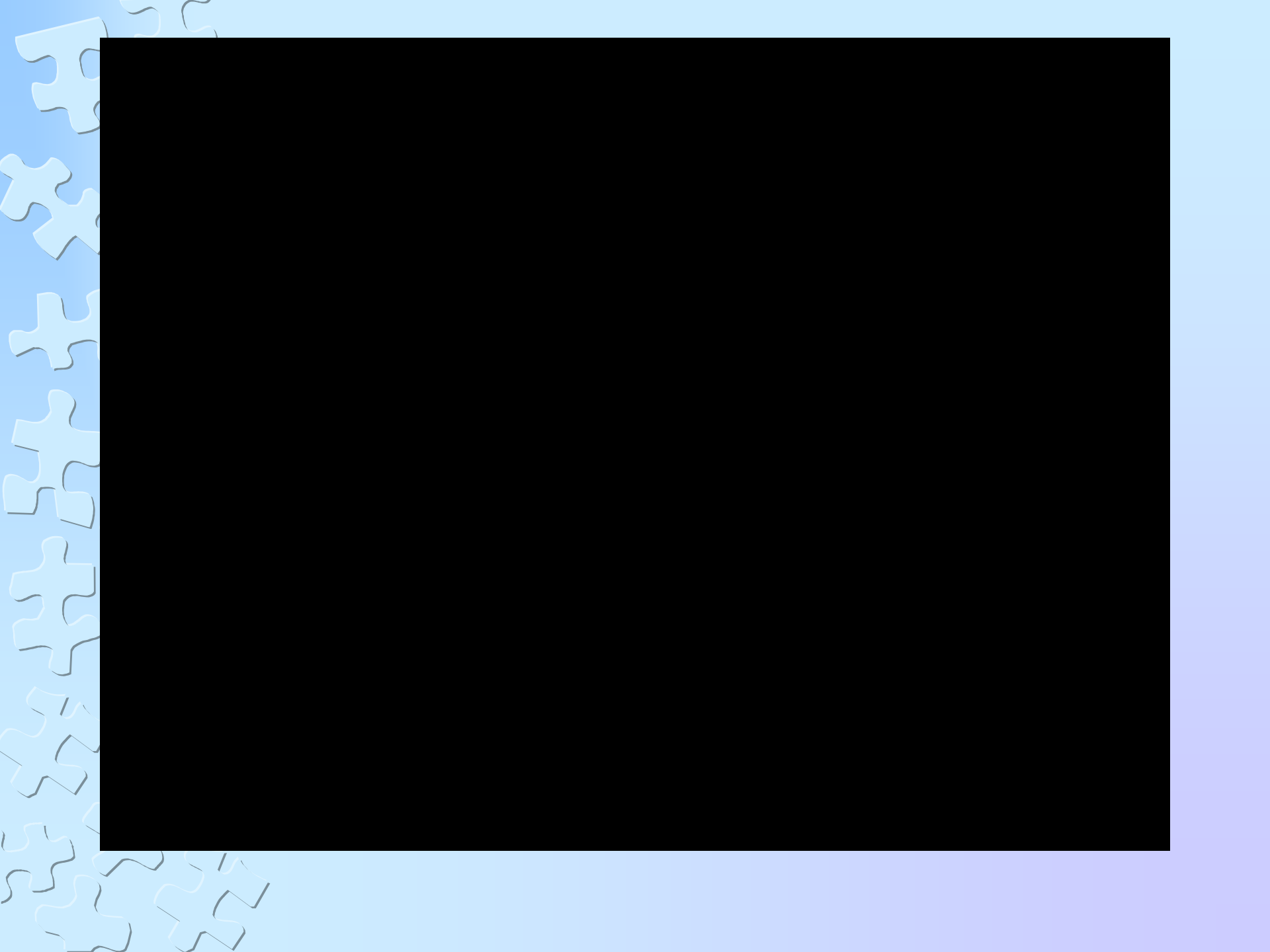


# Common Speech Patterns

- 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





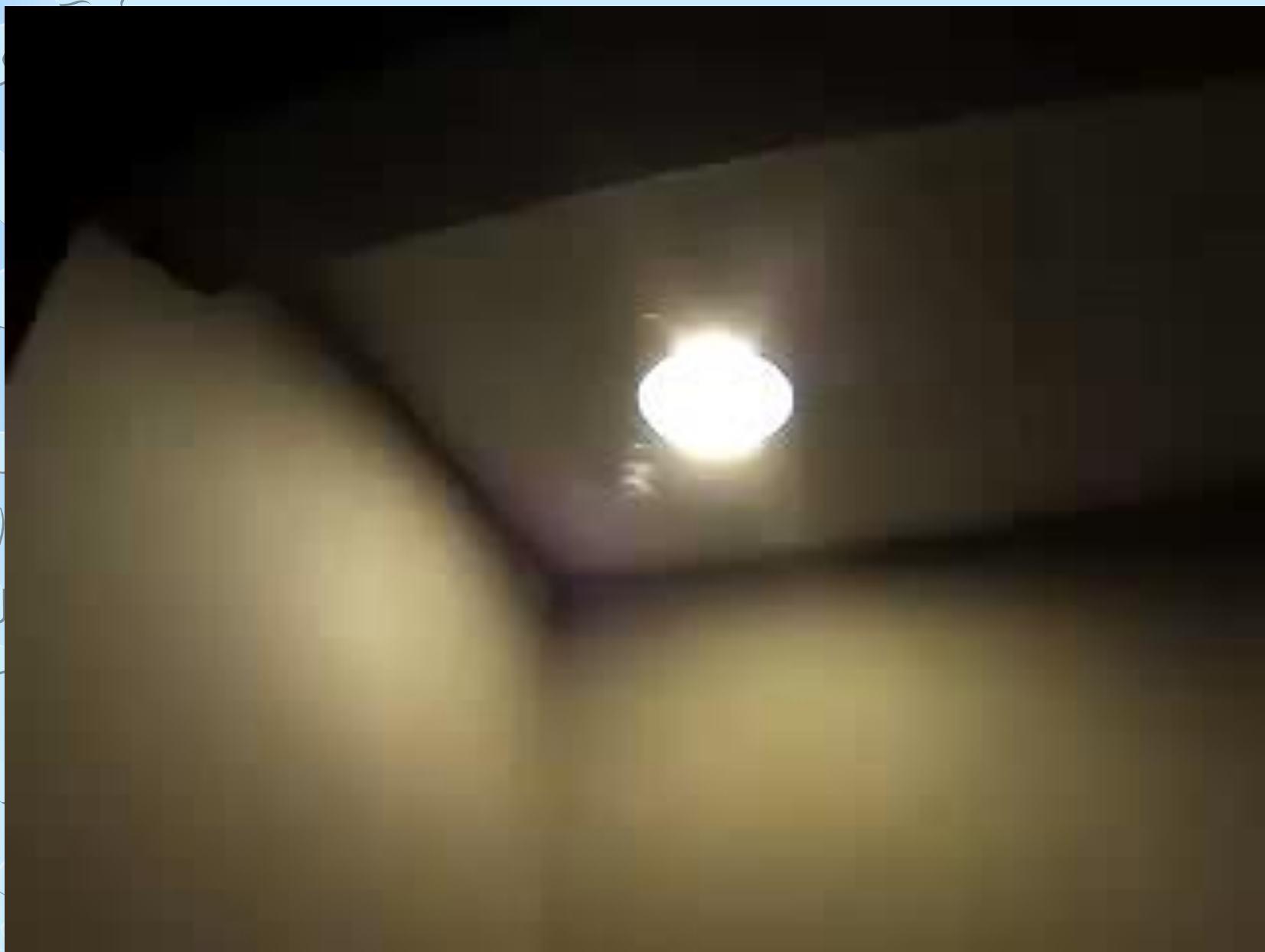


# Sensory Impairment

## Hypersensitive/Hyposensitive

- Sights
- Hearing
- Smell
- Touch
- Taste





# Little Sense Of:

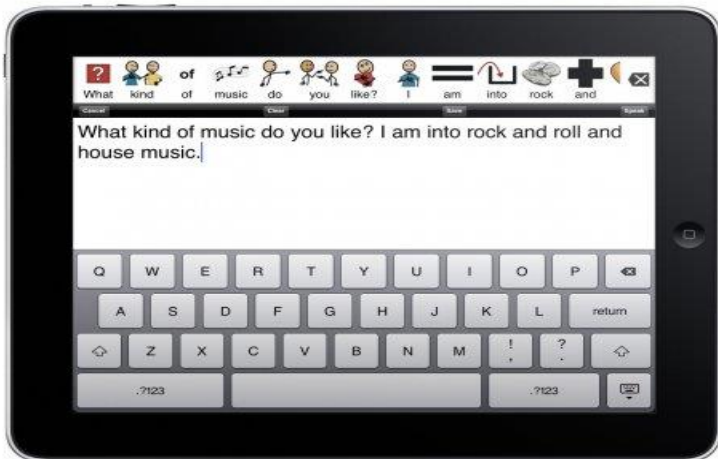
- Pain
- Fear
- Danger
- Safety

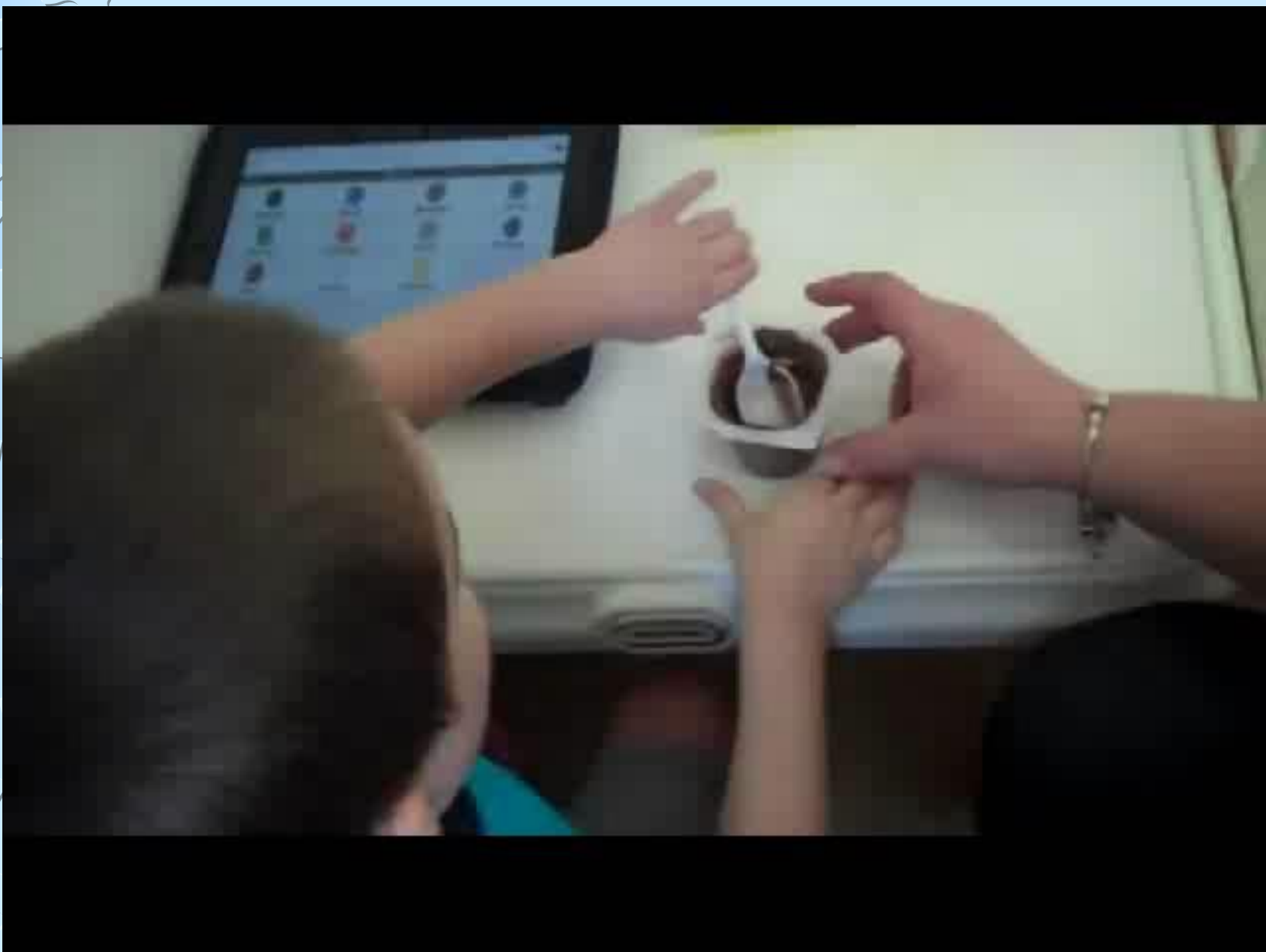




# **How to Best Approach a Person with ASD**

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

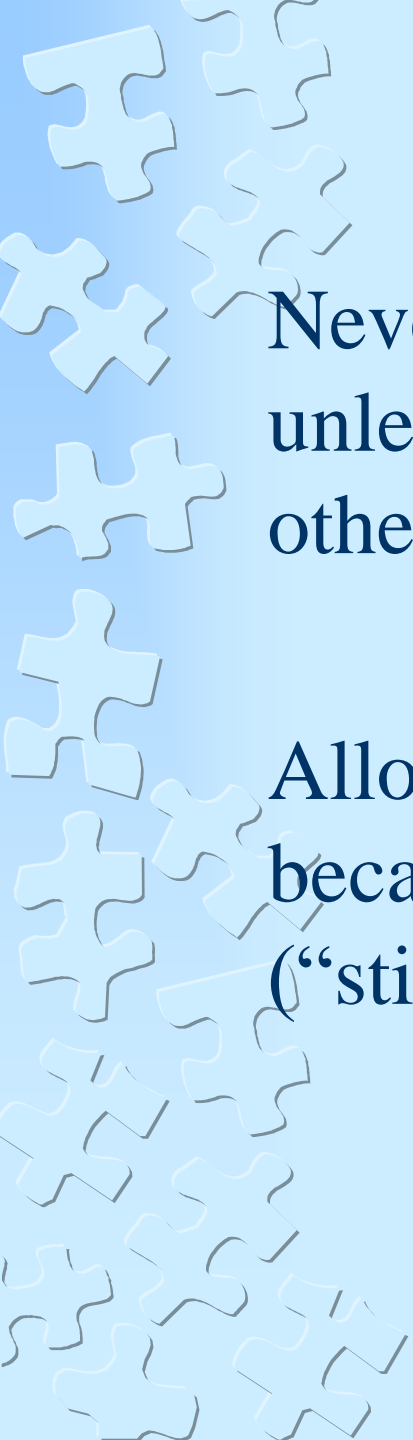
- Sit down
- Get in
- Wait here
- Stop

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

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

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



# **Avoiding Unfortunate Situations**



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



- Be Patient and Calm.

- Get correct information

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

etc).




# Roll Call DVD

Dennis Debbaudt

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

# Police Response



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

# Behaviors generating 911 calls

Escalated behaviors may be in the form of:

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

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



# Behaviors generating 911 calls

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

# Response

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



# Response

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



# Response

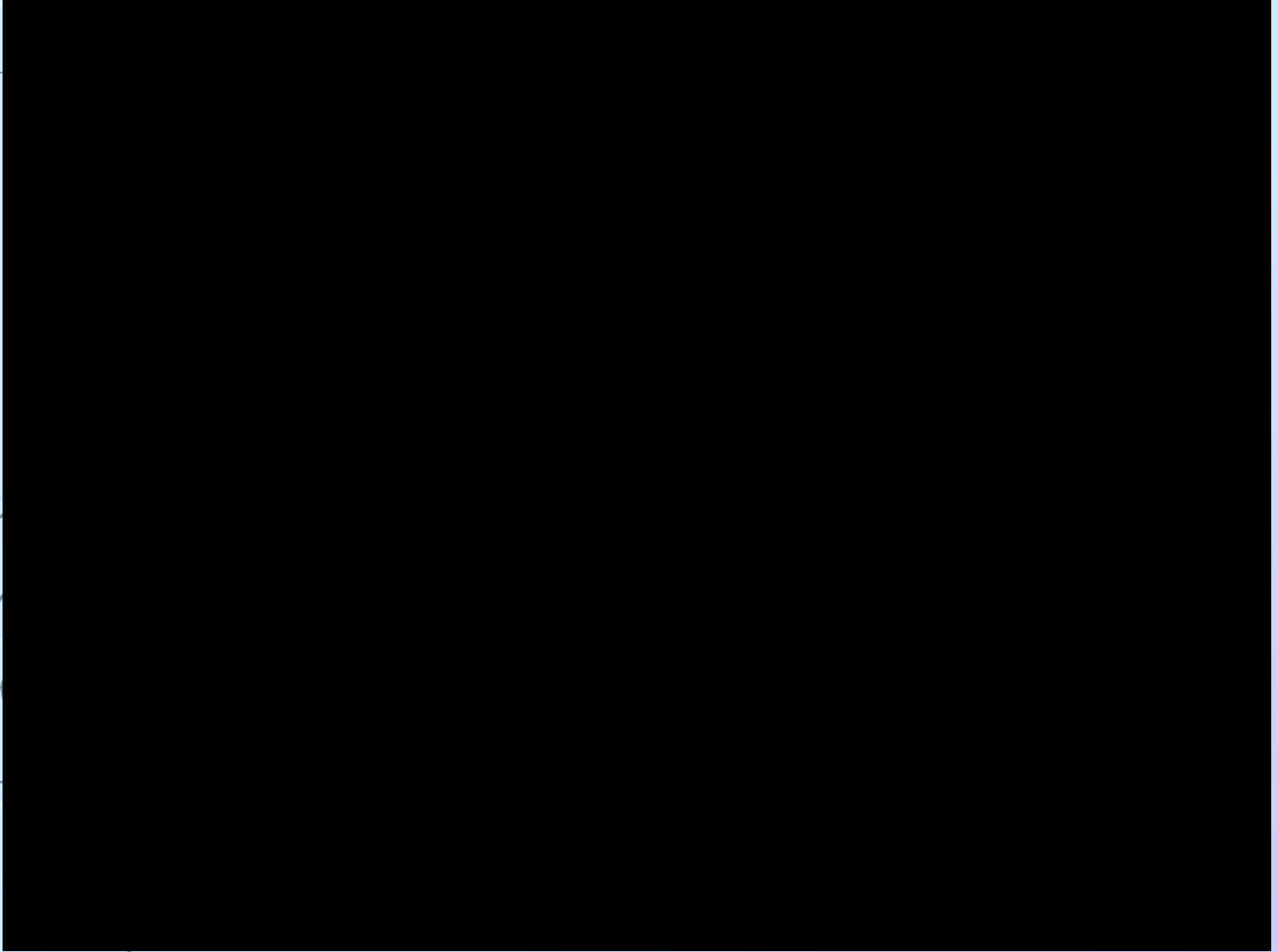
- Police dogs or mounted patrol may be present. Be aware that these animals may cause the person to quickly move towards or away from the animals.
- If possible, move the person away from crowds of strangers to a quiet place or make the scene as quiet as possible.



# Stimming Behavior

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

# Self Injurious Behavior





# De-escalation of Behavior

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

Remember that calm creates calm.

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



# De-escalation of Behavior

## Personal Space

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

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



# De-escalation of Behavior

## Positioning & Time

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



# De-escalation on the Scene

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

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

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



# Hypotonia

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



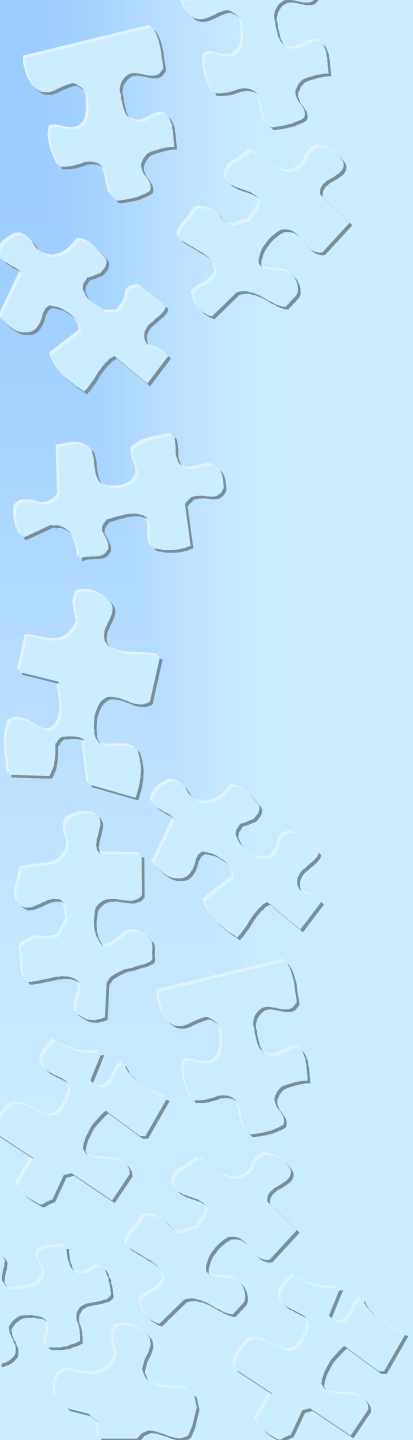
# Custody

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

Consider a medical evaluation for seizure disorder.

The person may have medication requirements or special dietary needs.

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



# Interview



# Why ASD is tricky

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



# Why you need to know

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



# Conducting an Interview

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



# Typical Police and Autism Offender Interactions

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



# Typical Police and Autism Offender Interactions

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



# Wandering-Elopement

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



# THE CHALLENGE OF WANDERING

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



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

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

# Missing Children Strategies

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



Parents or caregiver to develop and carry a handout.



# Emergency Biographical Information Form

## Emergency Biographical Information

A registry to assist persons-at-risk

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

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

### Personal Description:

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

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

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

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

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

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

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

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

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

Affix Recent Photo Here

### Important Address Information:

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

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

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

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

### Emergency Contacts

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

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

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

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

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

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

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

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

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

## Additional Information

### Current Medications:

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

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

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

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

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

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

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

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

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

### Release

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

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

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

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

**Emergency Biographical Information**

A registry to assist persons-at-risk

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

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

**Personal Description:**

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



Diagnosis: 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

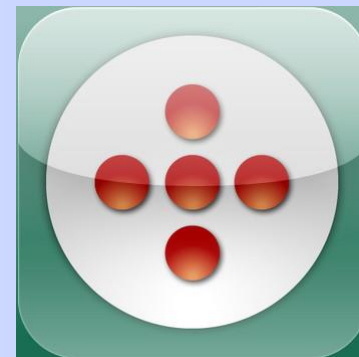
# Emergency Contact Temporary Tattoos

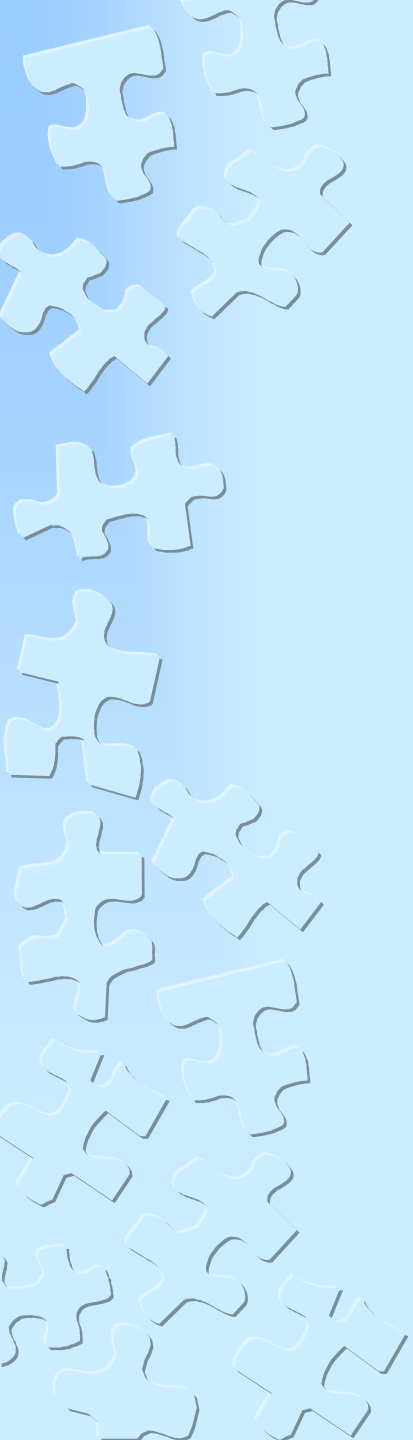


# ICE



# Phone Apps



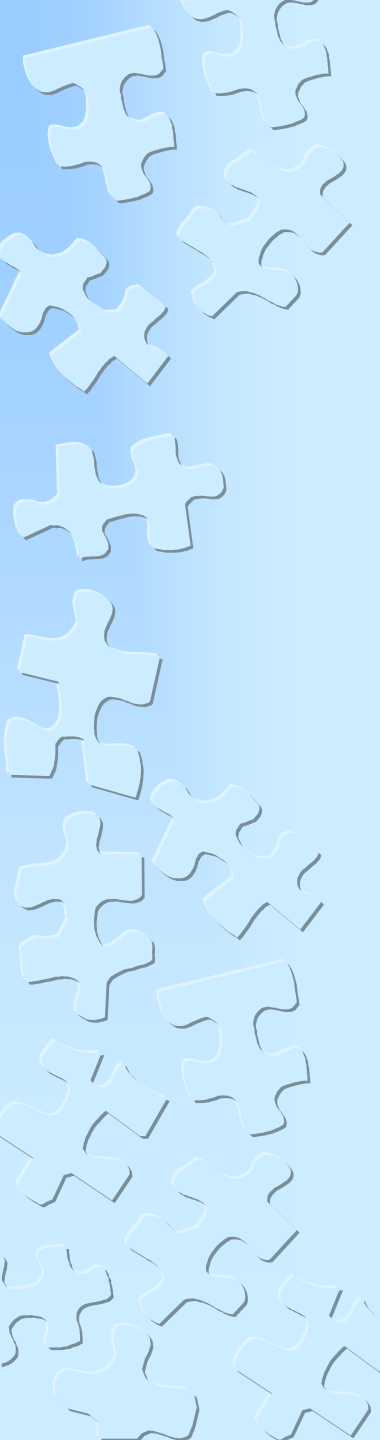


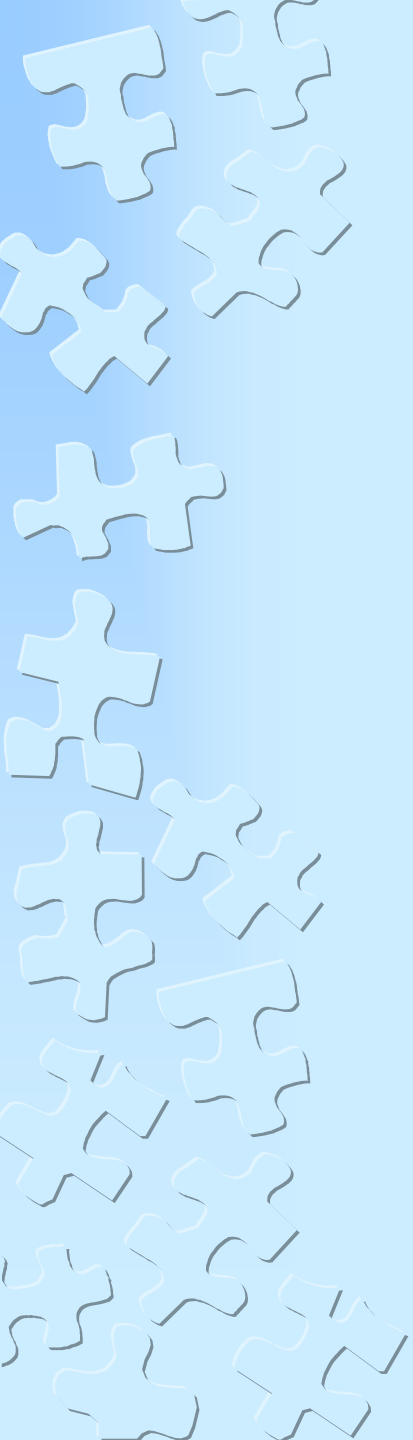




# Rescue from Heights

- 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







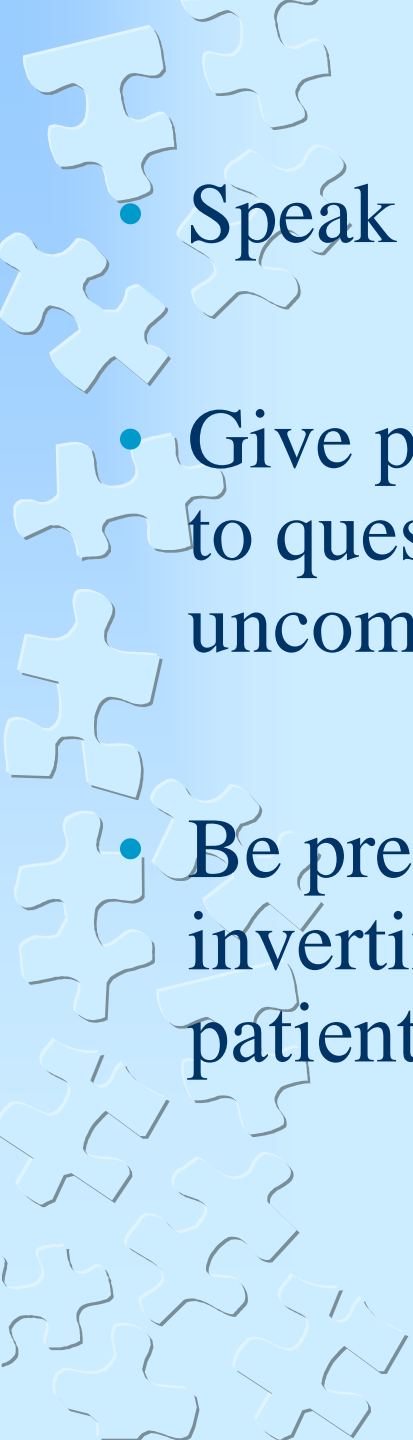
# Bolt Risk


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

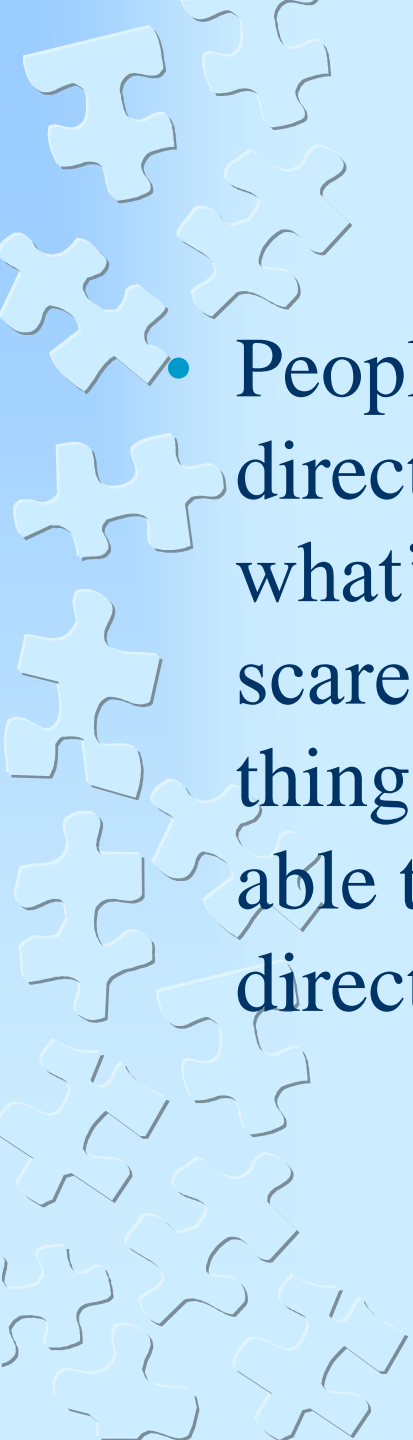


# Routines

- 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

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





# MVA's

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



# Sensory Issues

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

# Reactions

- Aggression
- Regression
- Sensory Overload



# Super Strong



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

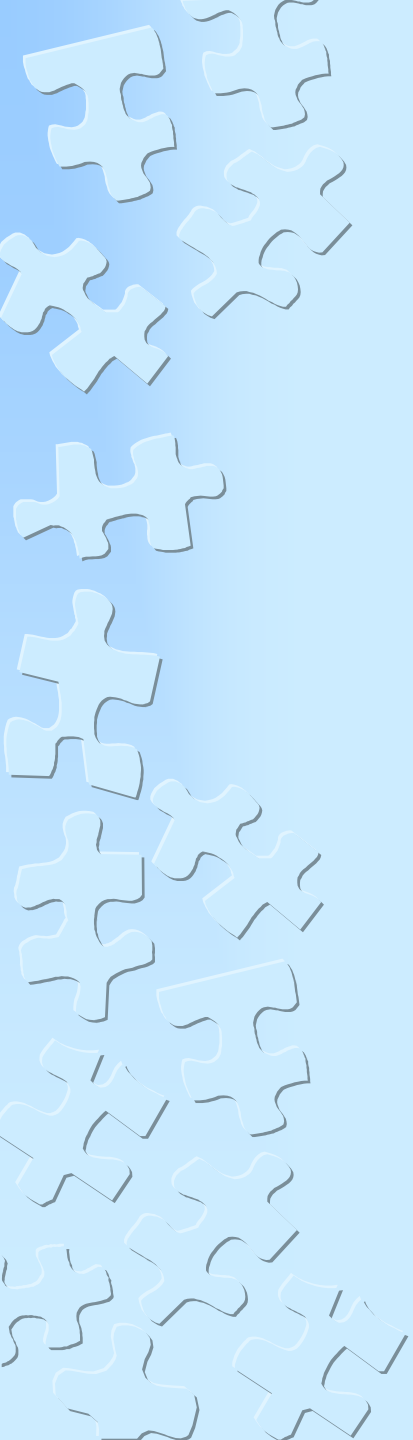


- They may also fixate on your personal gear such as a hat, radio, cuffs and flashlight.

# Community Day




# Community Day



# Community Day



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

# Credits

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



# 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 #4**

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

## **Mental Health in Elders**

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

# Mental Health Issues in Older Adults



JENNIFER COX, LICSW  
BAYSTATE HEALTH

# Mental Illness vs. Cognitive Impairment



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

# Living with cognitive impairment



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

# It's all in your approach



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

# Communication strategies



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



**THANK YOU**

# Presentation # 5

---

## **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  
OCTOBER 17, 2022**

# **DMH FORENSIC SERVICES**

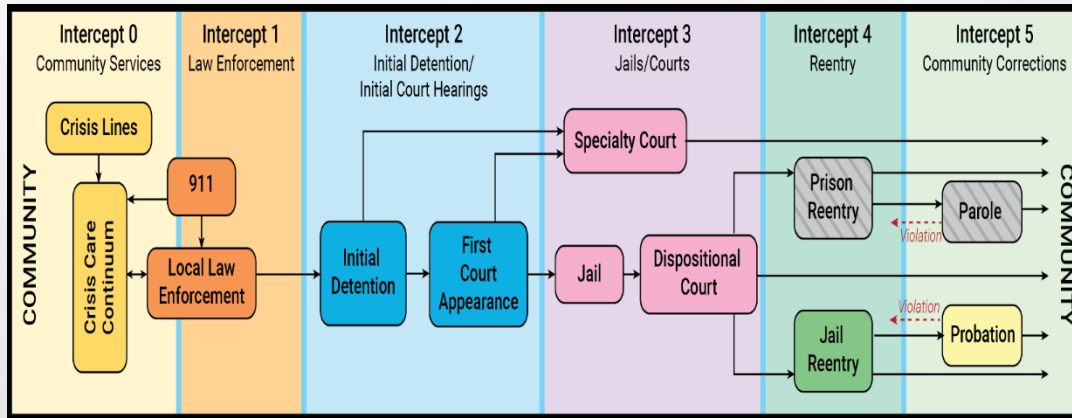
**DMH FORENSIC MENTAL HEALTH SERVICES  
(FORENSIC SERVICES)**

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

# DMH FORENSIC SERVICES OVERVIEW

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

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



# POLICE-BASED JAIL DIVERSION

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

# JAIL DIVERSION PROGRAM TYPES

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

## **WHY JAIL DIVERSION MATTERS**

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

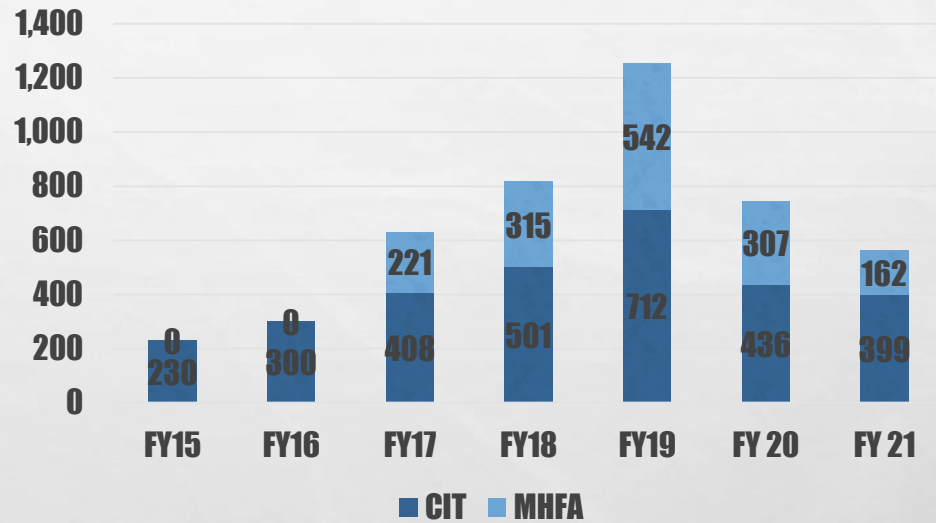
# CO-RESPONSE IMPACTS

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

# PUBLIC SAFETY

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

## DMH GRANT SUPPORTED POLICE OFFICER TRAINING FY 16-22



# CIT TRAINING RESULTS

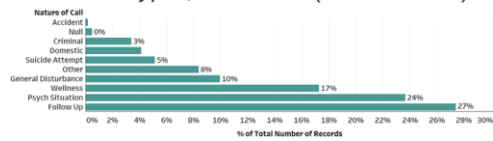
- **STUDIES INDICATE THAT CIT TRAINING DEVELOPS POSITIVE PERCEPTIONS AND INCREASED CONFIDENCE AMONG POLICE OFFICERS**  
12
- **ADDITIONALLY, CIT OFFICERS HAVE VERY EFFICIENT CRISIS RESPONSE TIMES**
- **INCREASED DIVERSIONS FROM ARREST AND INCARCERATION AMONG THOSE WITH MENTAL ILLNESS**
- **IMPROVES THE LIKELIHOOD OF TREATMENT CONTINUITY WHILE SIGNIFICANTLY DECREASING POLICE OFFICER INJURY RATES**

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

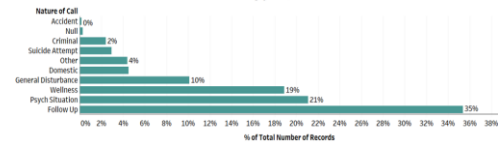
2. [HTTP://WWW.CITINTERNATIONAL.ORG/TRAINING-OVERVIEW/163-MEMPHIS-MODEL.HTML](http://www.citinternational.org/training-overview/163-memphis-model.html)

# JDP Call Types

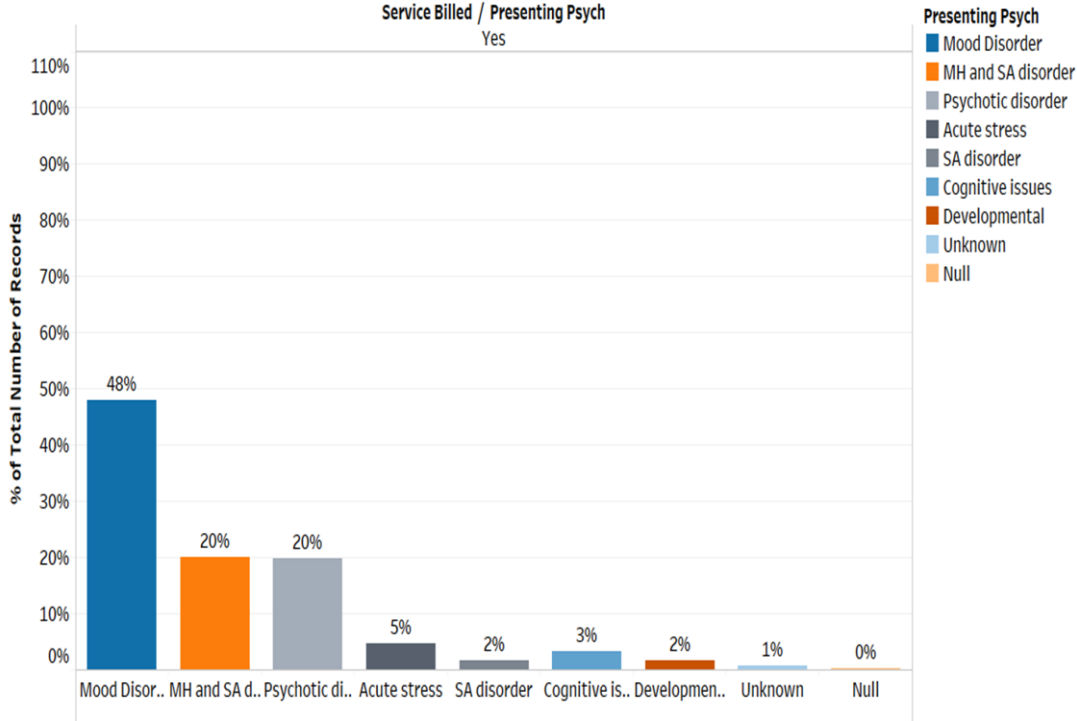
JDP Call Types, statewide (FY14 to FY21)



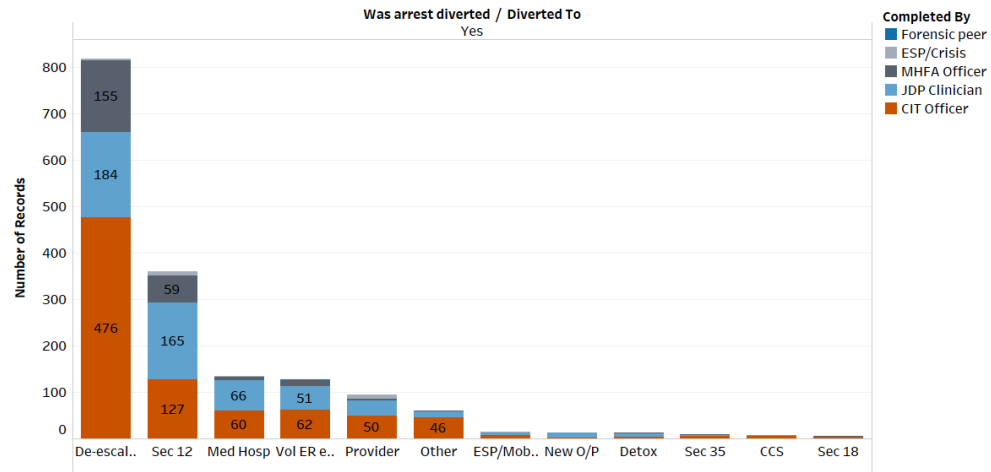
FY21 JDP Call Types, statewide



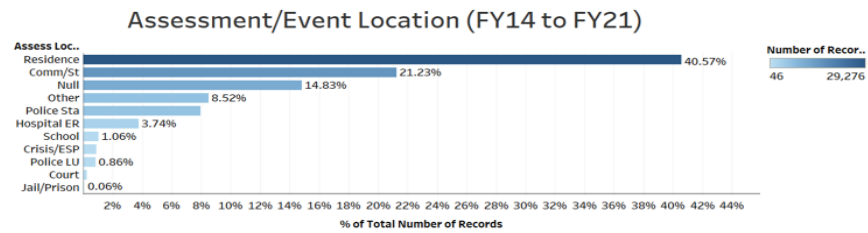
# Primary Behavioral Health Issue



# Diverted to by Model (FY21)



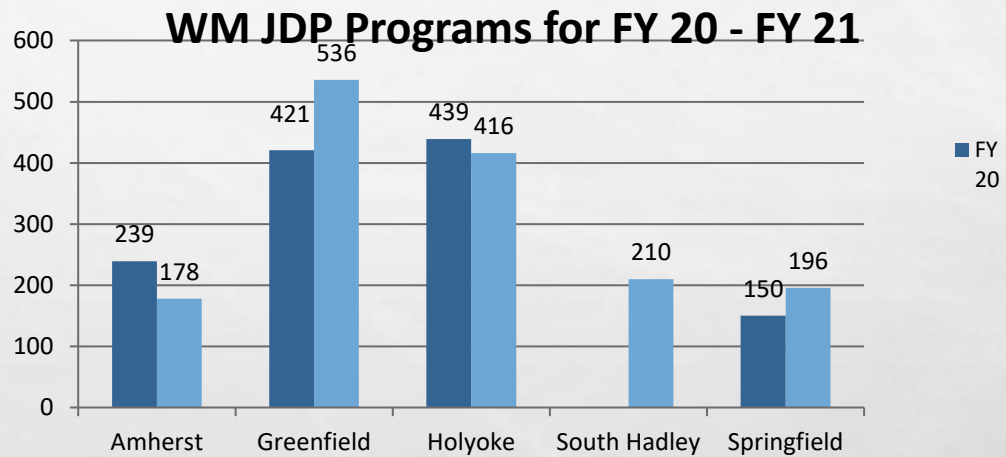
# JDP Assessment/Event Locations



## WM DMH JDP GRANTEES

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

# WM JDP DATABASE INPUTS



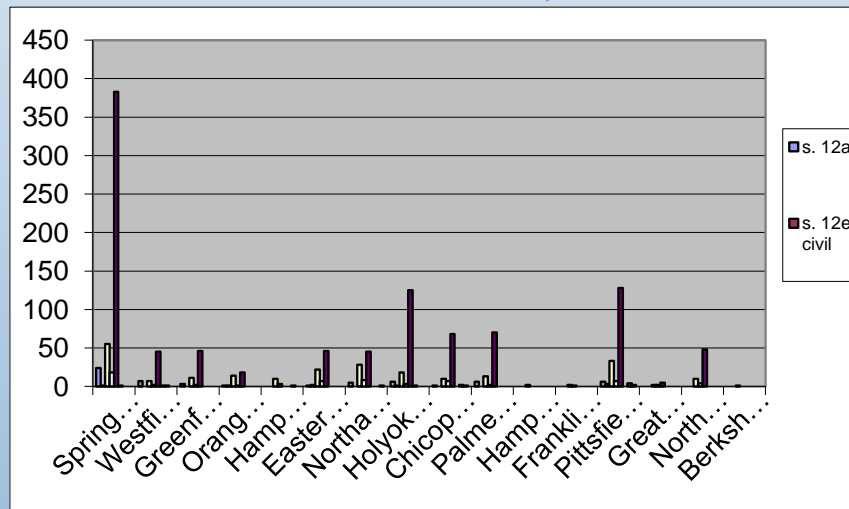
## **OTHER DMH POLICE TRAINING EFFORTS**

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

# COURT CLINIC EVALUATIONS

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

## TYPES OF WM COURT ORDERED EVALUATIONS COMPLETED, FY 21



## **MGL CHAPTER 123, §15A AND §15B**

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

## LEGAL BASIS FOR COMPETENCY TO STAND TRIAL

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

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

# WHY DOES COMPETENCY MATTER?

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

# CST AND CR TIMELINES

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

# NGI: NOT GUILTY BY REASON OF INSANITY

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

## **NGI CRITERIA**

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

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

# FORENSIC HOSPITALIZATION

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

## **DMH INPATIENT UNITS**

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

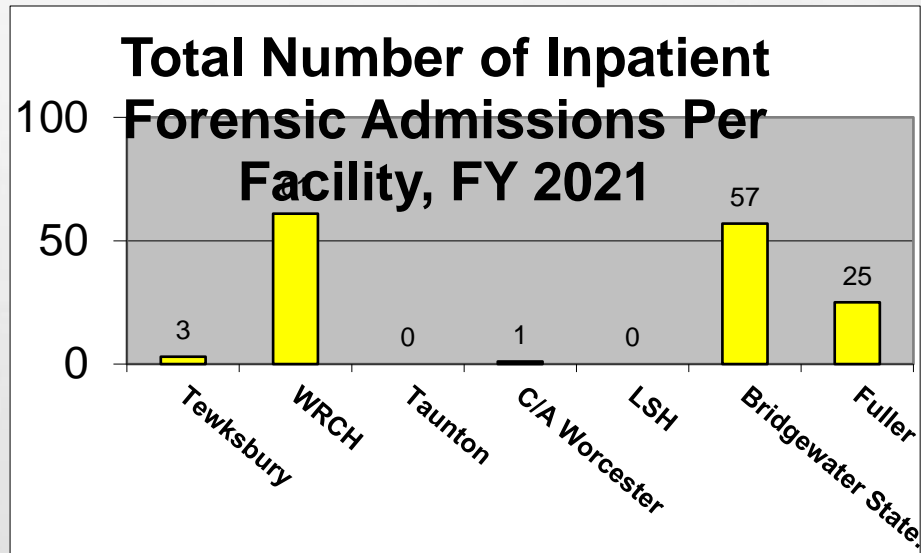
# DMH ADULT INPATIENT

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

# DMH ADOLESCENT INPATIENT

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

## WM FORENSIC HOSPITALIZATIONS AND PLACEMENTS, FY 21



## **§15E: “AID IN SENTENCING”**

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

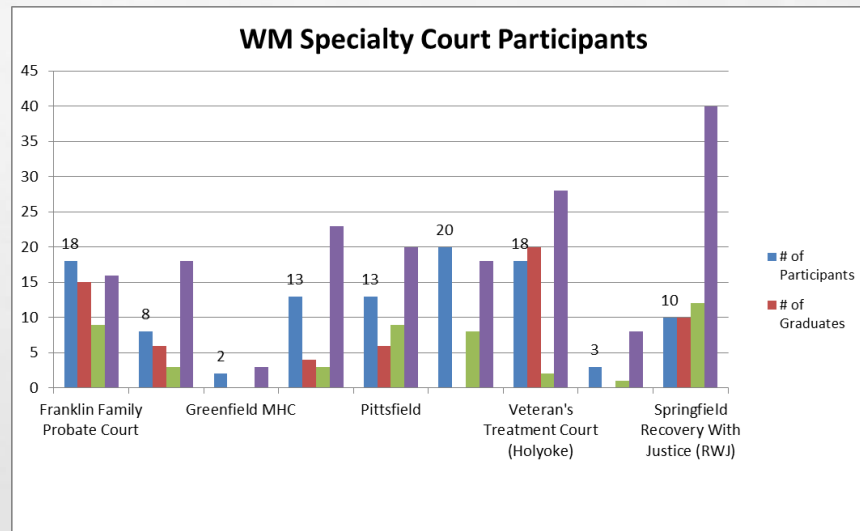
# SECTION 16'S

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

## **WESTERN MA SPECIALTY COURTS**

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

# WM SPECIALTY COURT DATA – FY 21



## **§18A TRANSFER**

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

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

# CIVIL COMMITMENT §35'S

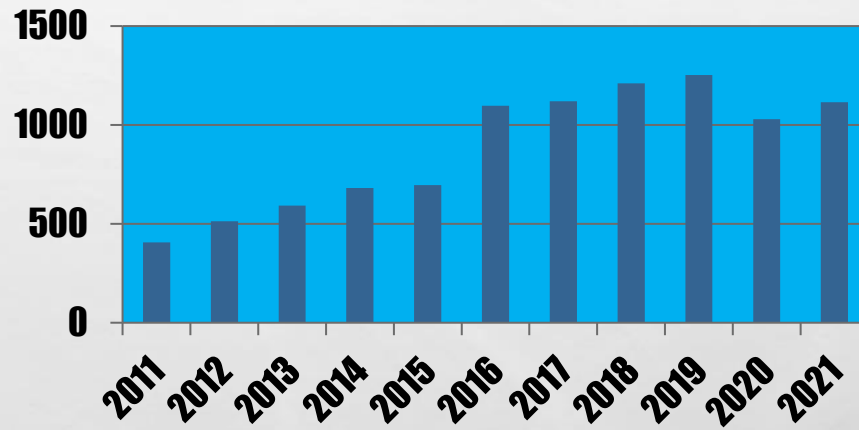
- **CIVIL COMMITMENT OF SUBSTANCE ABUSER FOR UP TO 90 DAYS, BECAUSE OF IMMINENT SERIOUS RISK TO SELF OR TO OTHERS BECAUSE OF ALCOHOL OR DRUG USE.**
- **WHO CAN PETITION? SPOUSE, BLOOD RELATIVE, GUARDIAN, POLICE OFFICER, PHYSICIAN OR COURT OFFICIAL**
- **CAN BE EITHER AN ADVERSARIAL PROCESS OR “UNCONTESTED”**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

## **§ 35 TREATMENT FACILITIES**

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

# WM §35 TRENDS

**WM Court Ordered s.35 evals**



# **SPOTLIGHT ON S. 35'S AND OPIATE EPIDEMIC**

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

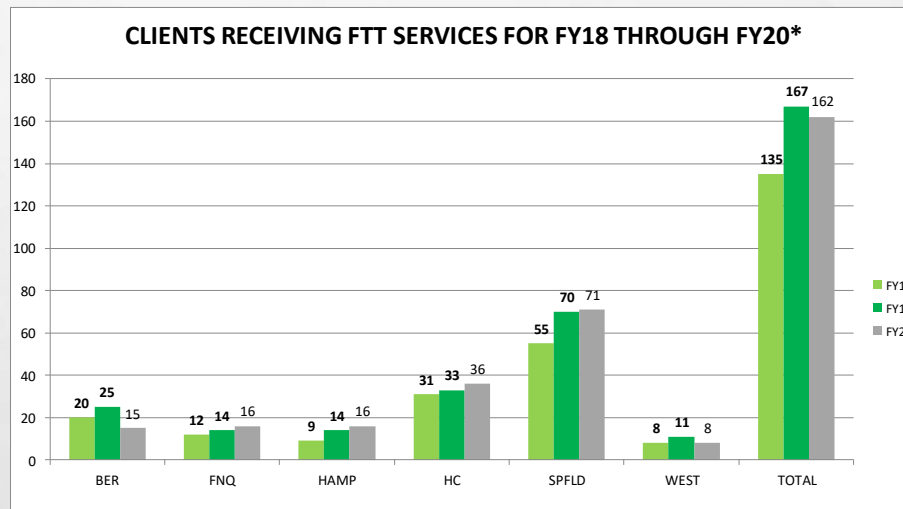
## **BRIDGEWATER STATE HOSPITAL**

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

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

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

## FTT IMPACT IN WESTERN MASS



# QUESTIONS AND EVALUATIONS

## CONTACT INFORMATION:

**JOHN BARBER**

**(413) 587-6244**

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

# PRESENTATION # 6



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

**DDS Services**

Angel Delgado

Professional Development Facilitator,  
Department of Professional Development  
BHN

# NEURODEVELOPMENTAL DISORDERS

Introduction

A GROUP OF CONDITIONS WITH ONSET  
DURING THE DEVELOPMENTAL PERIOD

- Typically manifest early in development
- Often before entering school
- During elementary school
- Must be diagnosed by age 18
- Cause of many disabilities

# NEURODEVELOPMENTAL DISORDERS

- **Intellectual Developmental Disorder (Intellectual Disability)**
  - Global Developmental Delay
- **Communication Disorders**
  - Language, sound, stuttering
- **Autism Spectrum Disorder**
- **Attention-Deficit/Hyperactivity Disorder (ADHD)**
- **Learning Disorders**
  - Specific learning disorders; reading, writing, math
- **Motor Disorders**
  - Tourettes, Tics; Motor or Vocal

## WHAT CAN CAUSE A DISABILITY?

- Genetic or inherited conditions
- Problems at birth
- Problems after birth
- Poverty and cultural deprivation
- Problems during pregnancy
- Accident or injury

## DISABILITIES PRODUCE IMPAIRMENTS

- Personal,
- Social
- Academic
- Occupational Functioning

## IMPAIRMENTS RANGE

- Developmental deficits vary from very specific limitations to global impairments of social skills or intelligence

NUERODEVELOPMENTAL DISORDERS  
*FREQUENTLY CO-OCCUR*

<b>INTELLECTUAL DEVELOPMENTAL DISORDER (IDD)</b>	Speech and Language Disabilities	Down Syndrome	Mental Health Disorders
Specific Learning Disabilities	Visual/Hearing Impairments Blindness/Deafness	Cerebral Palsy	Other Health Disabilities (Epilepsy)
Autism Spectrum Disorders	ADHD	Traumatic Brain Injuries	Fragile X Prader Willi Syndrome

## CHARACTERISTICS OF IDD

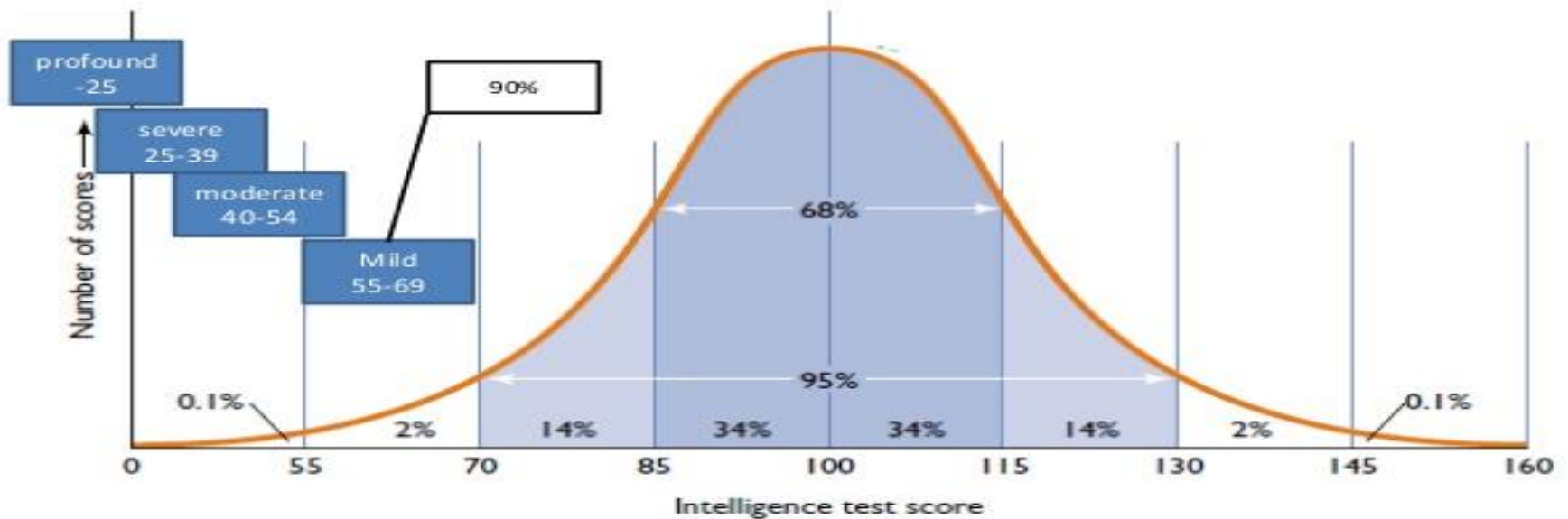
### Limitations in Intellectual Functioning

- Problem-solving
- Reasoning
- Attention
- Abstract thinking
- Remembering information
- Planning
- Judgment
- Learning from experience

### Limitations in Adaptive Functioning and Self-Determination

- Unable to meet standards of personal independence
- Social Responsibility
- Social Participation
- Communication
- Academic or occupational
- May have behavioral disturbances

## Degrees of intellectual disability



IQ alone does not determine the level of functioning for a person with IDD-IQ will alert to further testing in areas of adaptive functioning to produce an overall functioning level.

## SOME TRAITS TO CONSIDER WHEN INTERACTING

- Limited vocabulary
- Speech impairment
- Unable to read or write
- Say what others want to hear
- Have difficulty understanding directions or answering questions
- Takes things at face value
- Behavior may be unusual
- Easily influenced and anxious to please
- Easily victimized
- Easily frustrated
- Difficulty making changes
- Unable to pick up on social cues

## A FIRST RESPONDER APPROACH

- Speak directly to the person
- Keep sentences short
- Use simple language
- Speak slowly and clearly
- Ask for concrete descriptions
- Break instructions down to smaller parts
- Use pictures, symbols and actions to convey meaning
- Take time giving or asking for information
- Repeat questions more than once
- Avoid confusing questions about reasons for things
- Don't speak louder
- Use firm and calm persistence if the person is non-compliant
- Avoid yes or no answers—*they may answer either way just to get the questioning to stop*

## LEVELS OF LIVING SUPPORTS & WHAT YOU MAY ENCOUNTER

- Family of Origin
- Adult Foster Care/Shared Living
- 24 Hour Residential
- Independent

## FAMILY OF ORIGIN

- Supports provided by family members
- Typically parents / Elderly parents
- May receive respite services
- May receive family support services for recreation
- May or may not attend a day program or supported employment



## ADULT FOSTER/SHARED LIVING SUPPORTS

- Person living with a foster family/non-disabled adult peer
- Supports provided by foster provider/adult peer are paid
- Supports can range from high to low intensity



## 24 HOUR RESIDENTIAL SUPPORTS

- Supports are needed 24 hours/day 7 days wk
- Provided by “Residential Support Specialists”--*staff*
- Group living environment (3-5 individuals)
- Typically 1-2 staff
- Individuals have varying levels of intellectual disabilities
- May or may not have behavioral challenges
- Some may engage in violent behavior
- High percentage of individuals have been abused
  - Sexually, Physically, Emotionally & Financially



VIDEO

**staten island**

<https://youtu.be/rWSdaL8gIOU>

# INDEPENDENT

- Person lives in own apartment
- Minimal to low intensity of support provided by “case managers”



## WHO YOU CAN CONTACT

- **Department of Developmental Services**

- DDS Franklin/Hampshire 413-586-4958
- DDS Springfield/Westfield 413-784-1339
- DDS Holyoke/Chicopee 413-535-1022
- DDS Berkshires 413-447-7381

- **Contracted Vendors:** such as but not limited to: BHN, CHD, Guidewire, MHS, Nonotuck, etc.
- All have Program Directors, House/Program Supervisors
- On call management and administrative personnel 24/7
- There are required staff to client ratio's

QUESTIONS?

THANK YOU