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** – Rita Curley

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 helpless 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

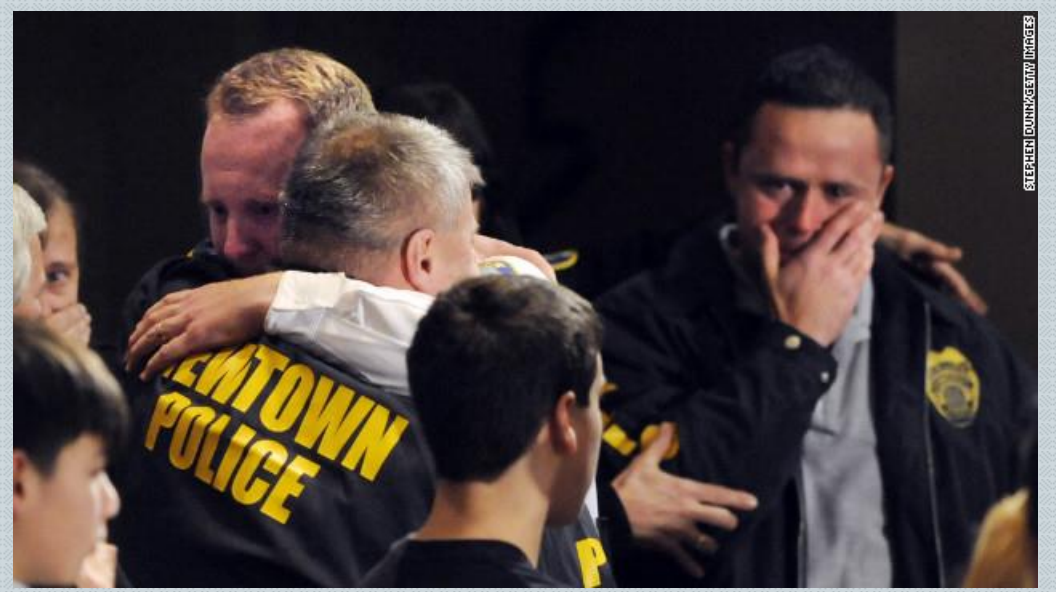
How Does Trauma Affect You?

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

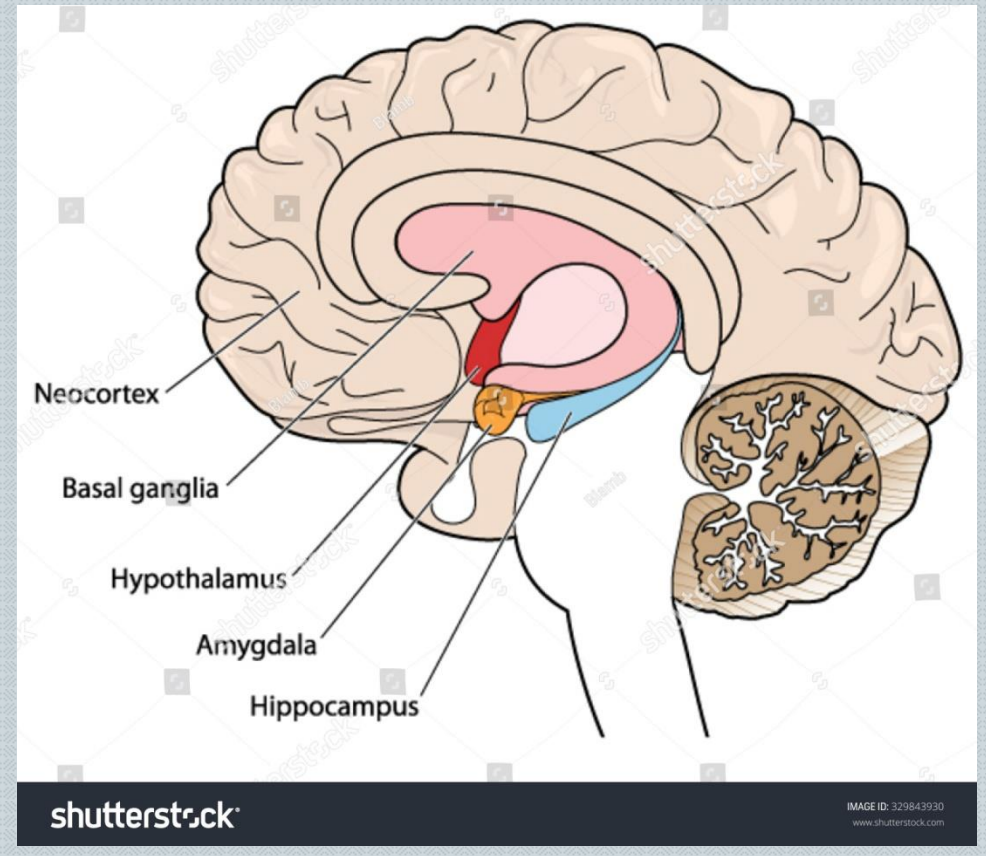
Are you allowed to feel the pain?



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

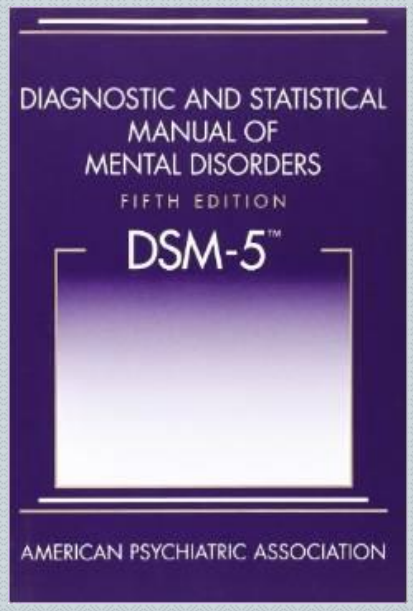
One time event or chronic underlying mental health condition

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 dysregualted and maladaptive

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

Neutrotransmitter/ Neurohormomonal System (Noradrenergic, Serotonergic, Hipothalamic-Pituitary-Adrenal axis (HPA axis)

What have you seen in your work?

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!

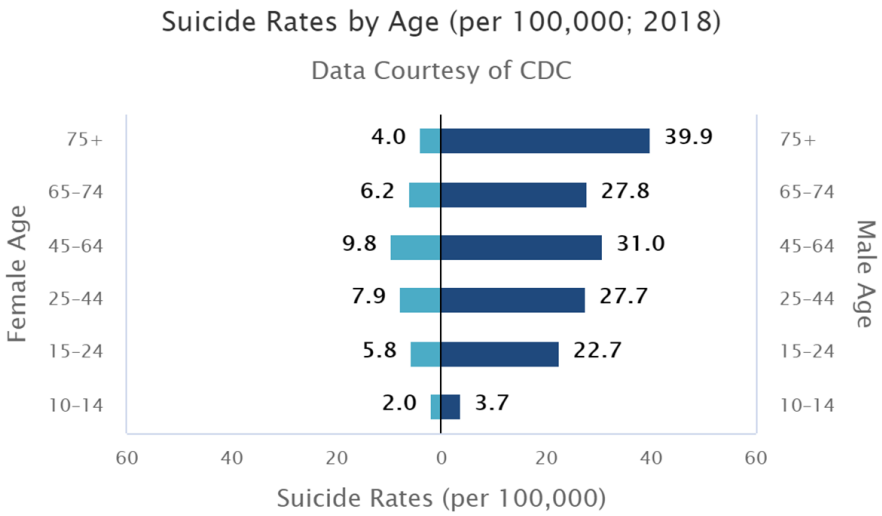
Activation of Memories

- 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



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

Men in the Middle Years are highest risk age/gender

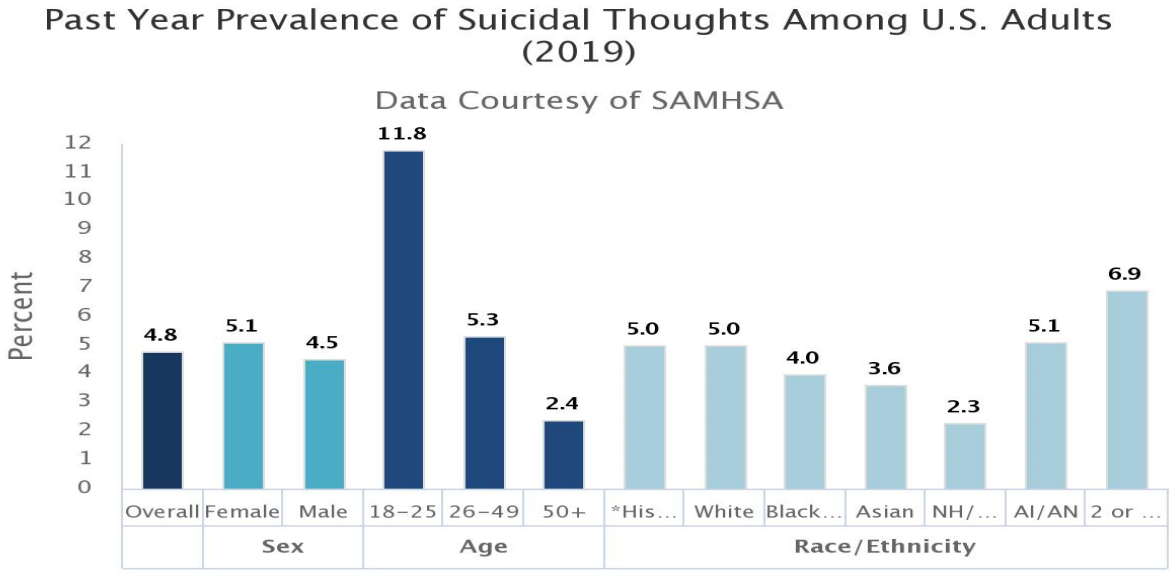
Black women are lowest risk demographic

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

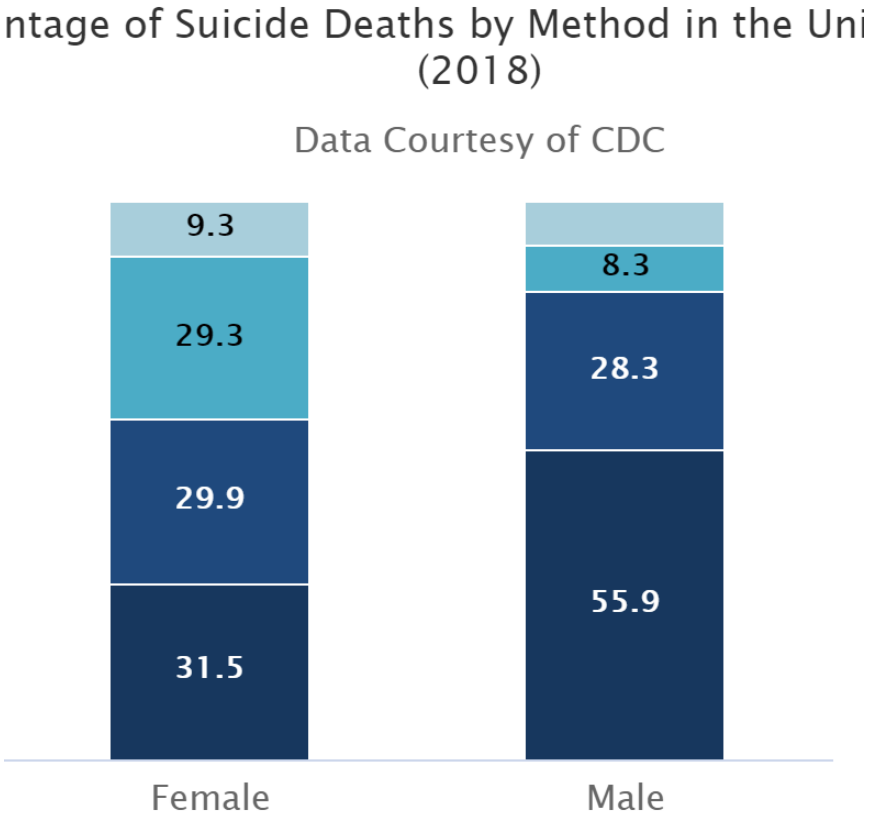
Nearly ½ of all transgender people will make a suicide attempt at some time during their lifespan

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



WHAT EXPLAINS THE DISCREPANCY?

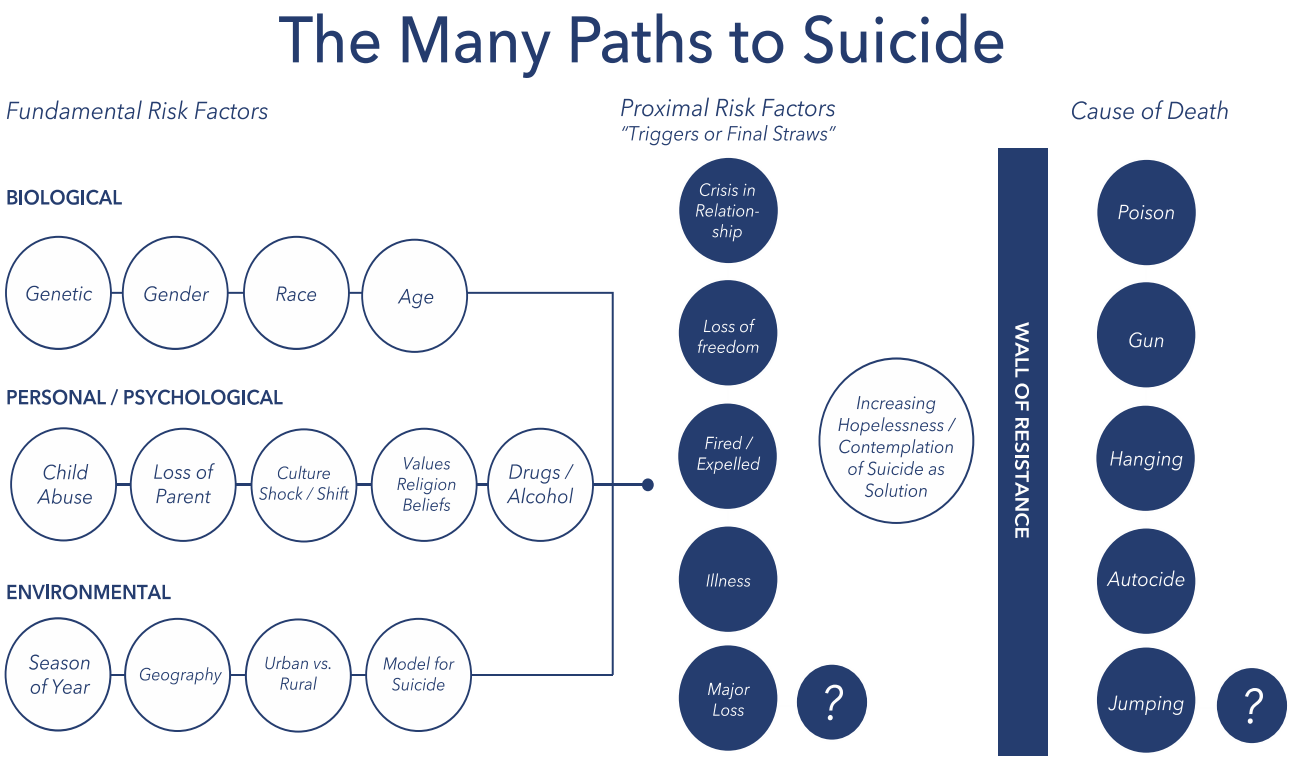
Access to lethal means!



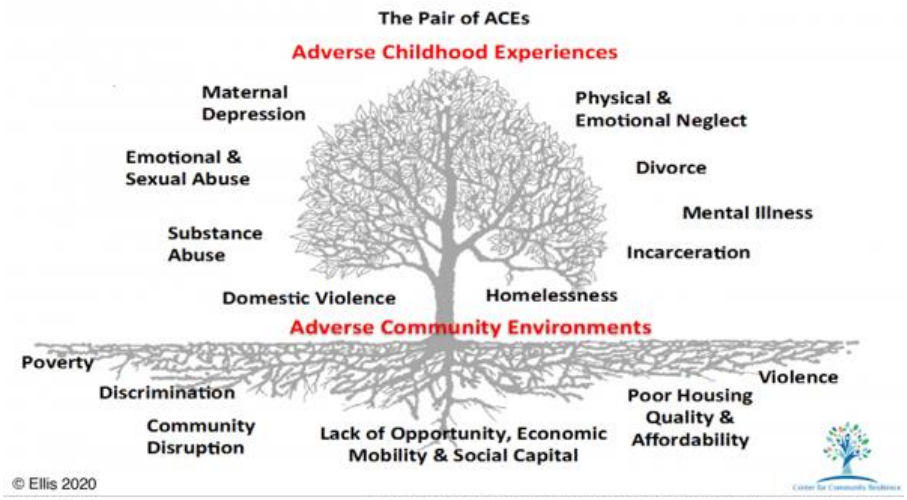
MOST IMPORTANT THING I AM GOING TO SAY……

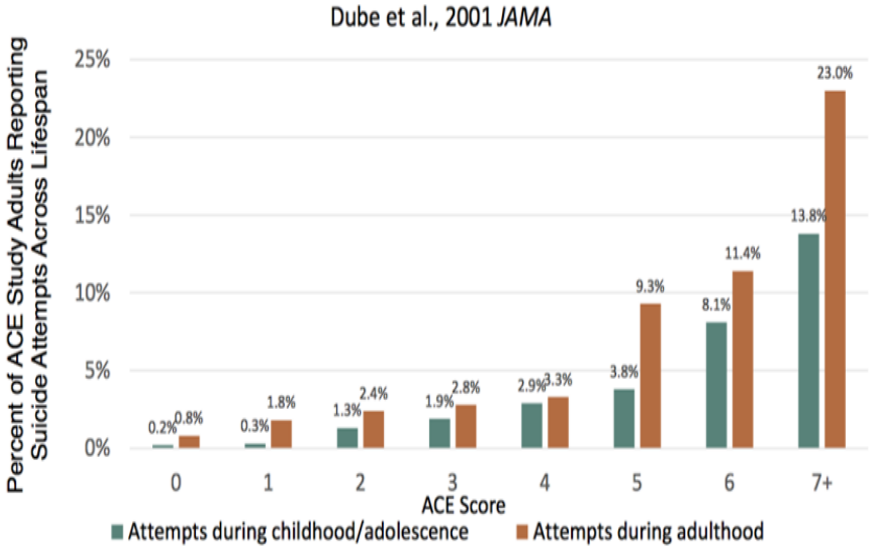
Suicide is a multi-factorial event. It is almost never caused by only one thing or event.

SUICIDE AS A MULTI-FACTORIAL EVENT



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 <u>seriously.</u>

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 that 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?"

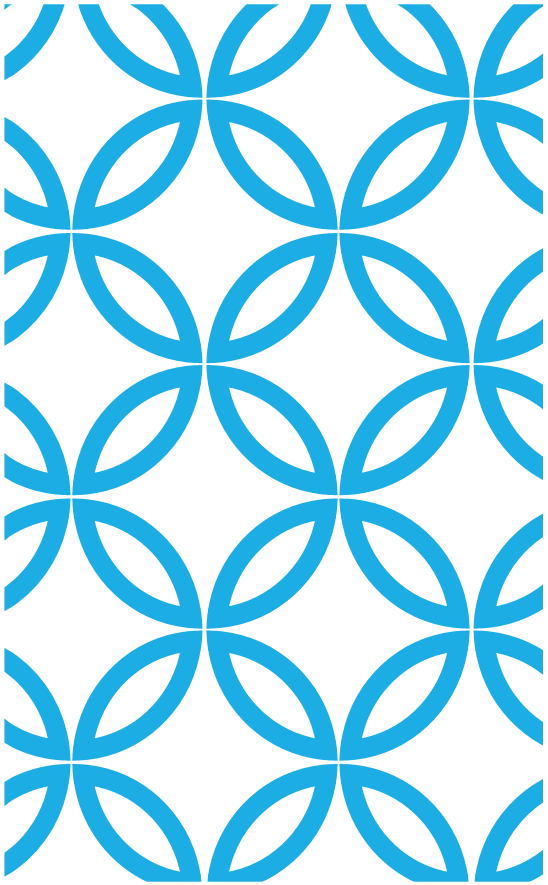
- "You seem really upset; I wonder if you're thinking
  about suicide?"
- "Are you thinking about killing yourself?"

* 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.

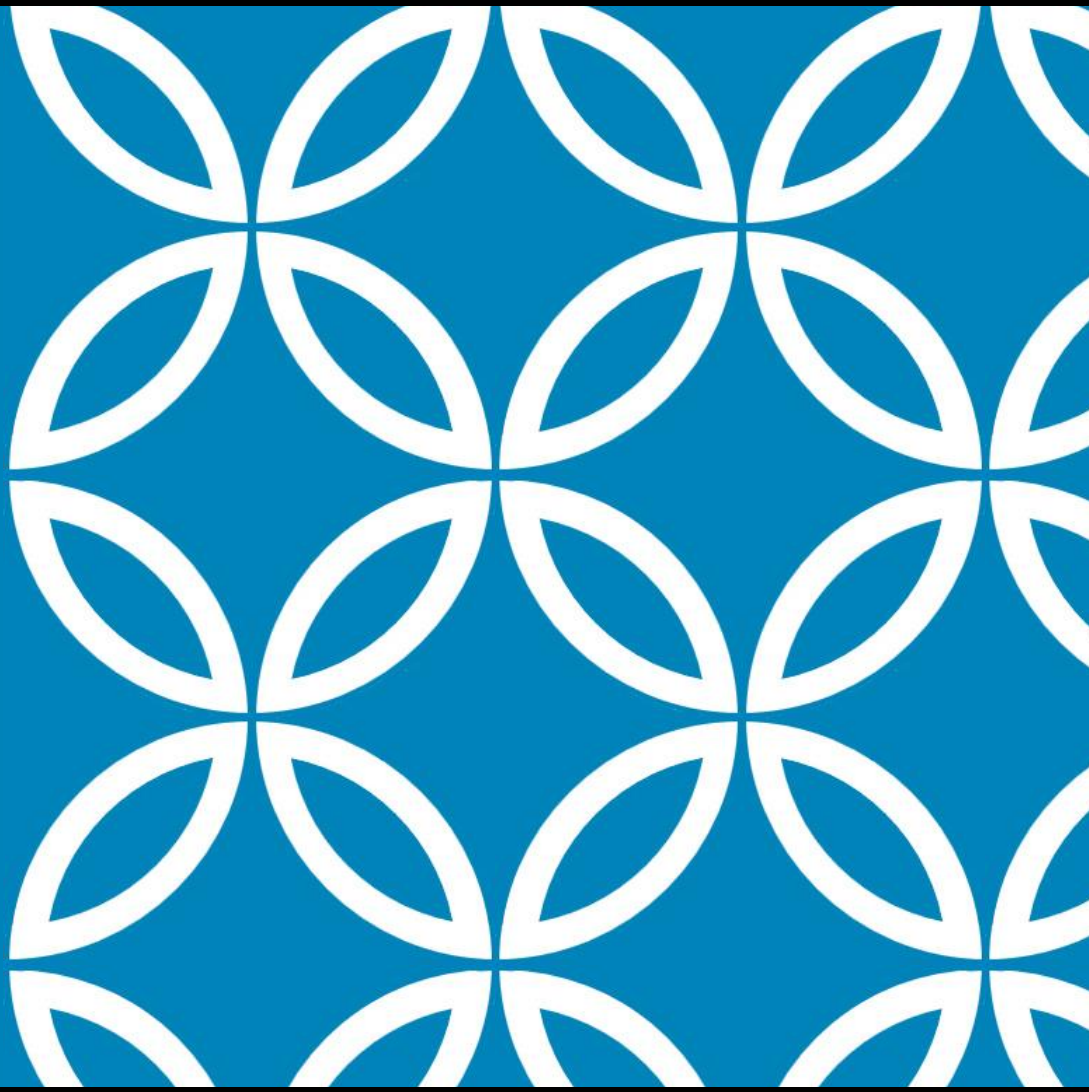
R: REFER

- 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

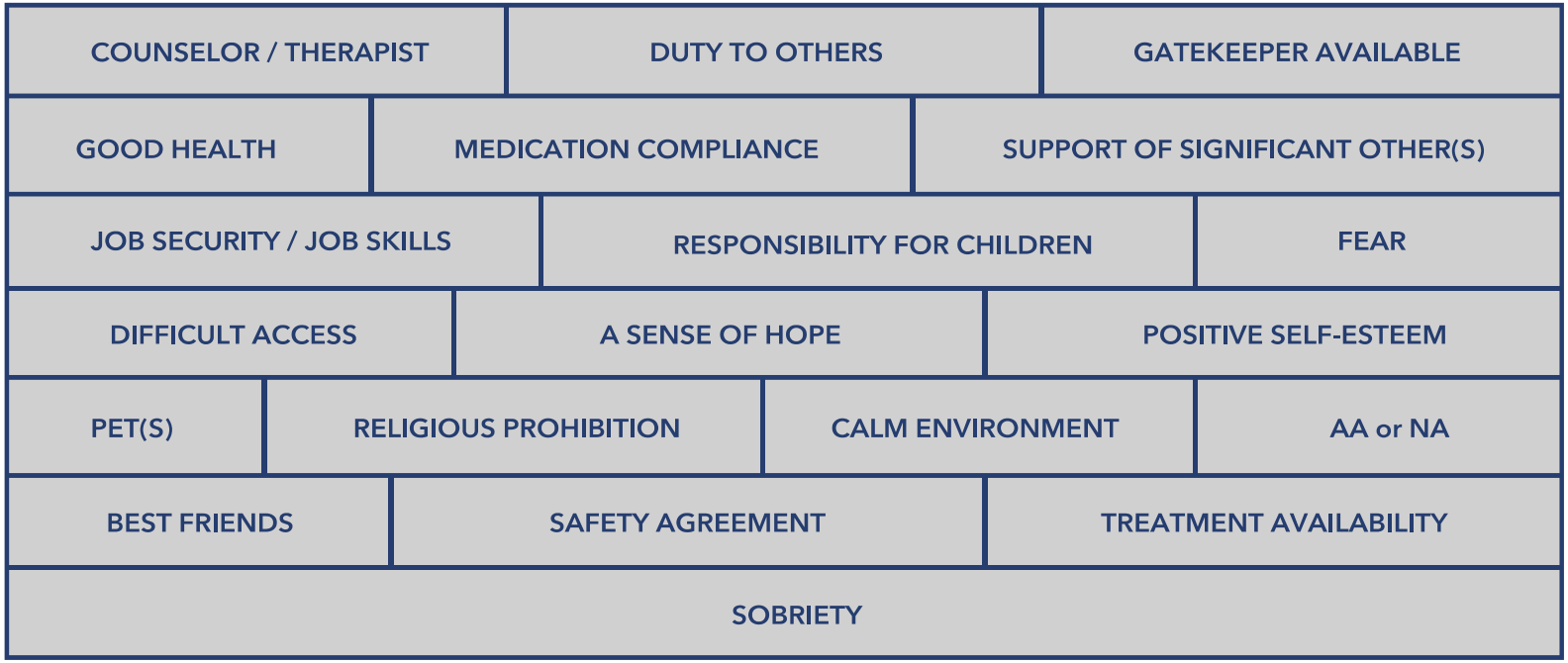
suicidepreventionlifeline.org

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

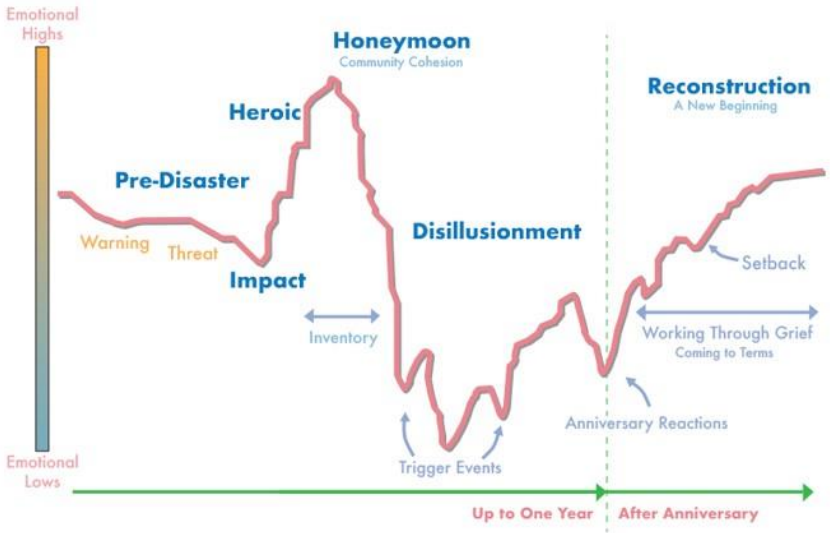


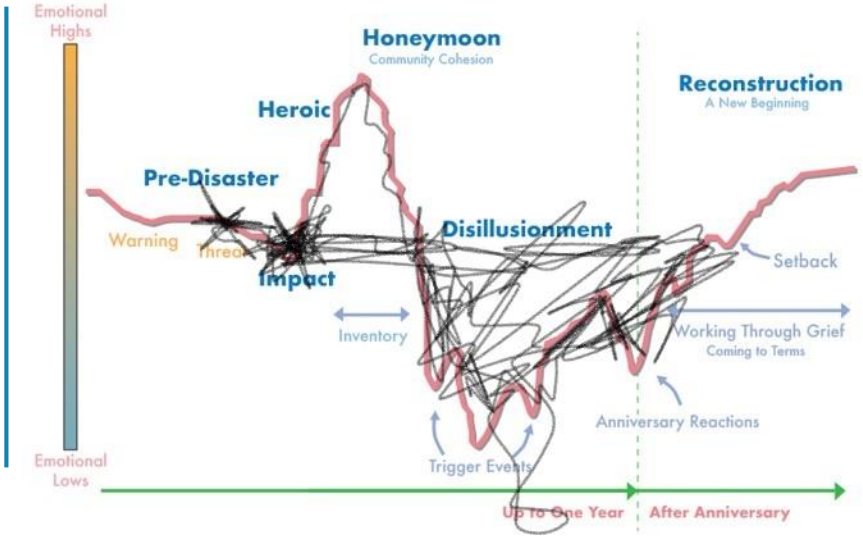
SELF CARE AS A NECESSITY

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



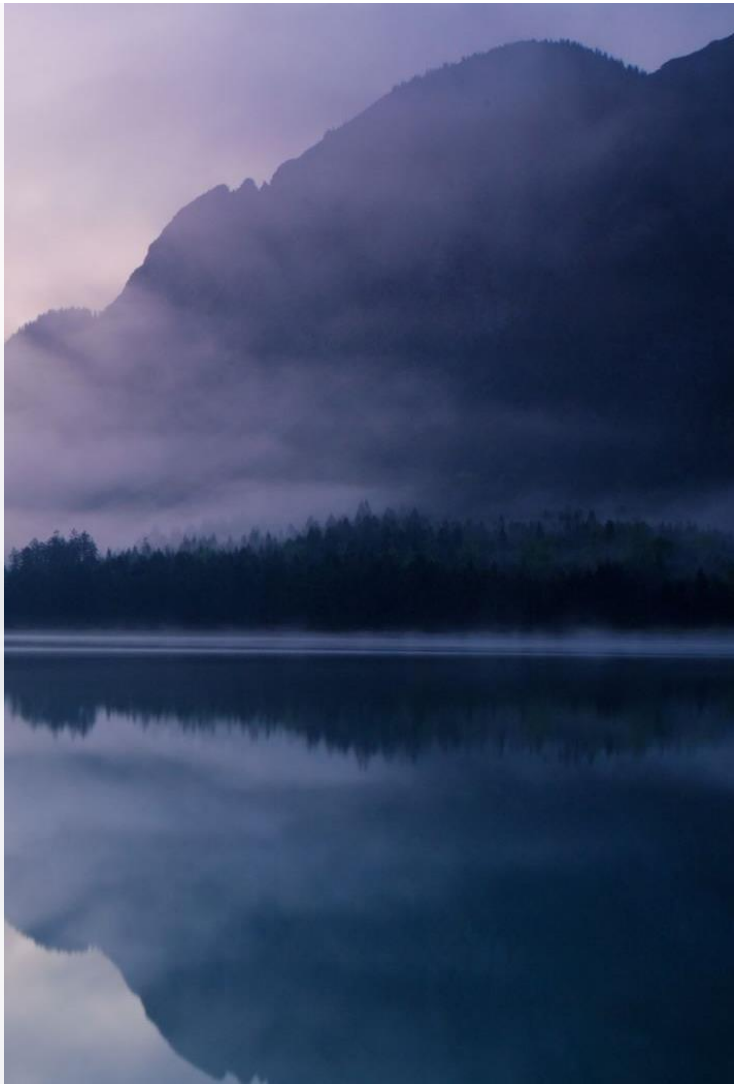


COVID 19

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

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

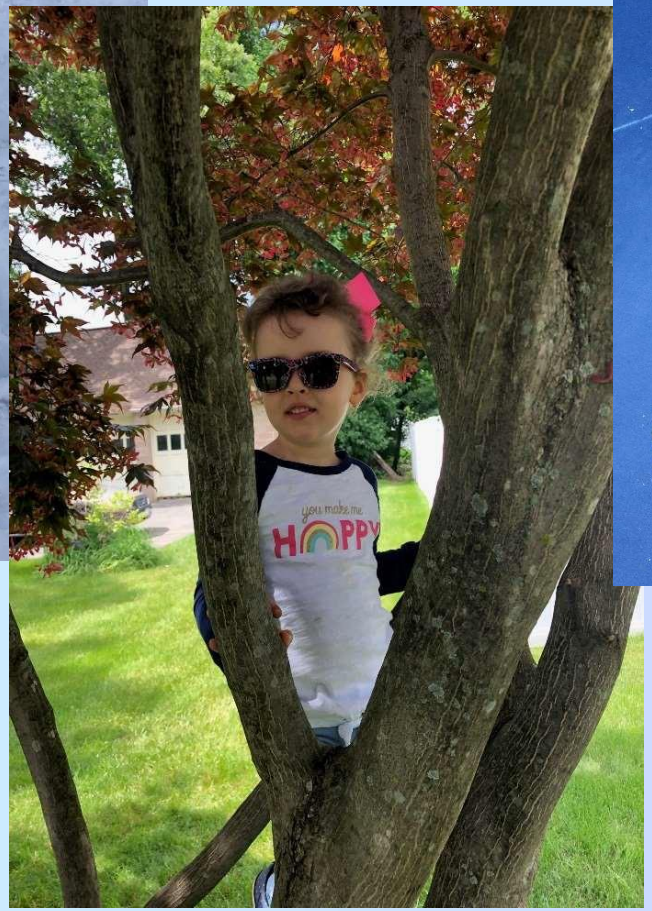
10:30am- 12:00pm

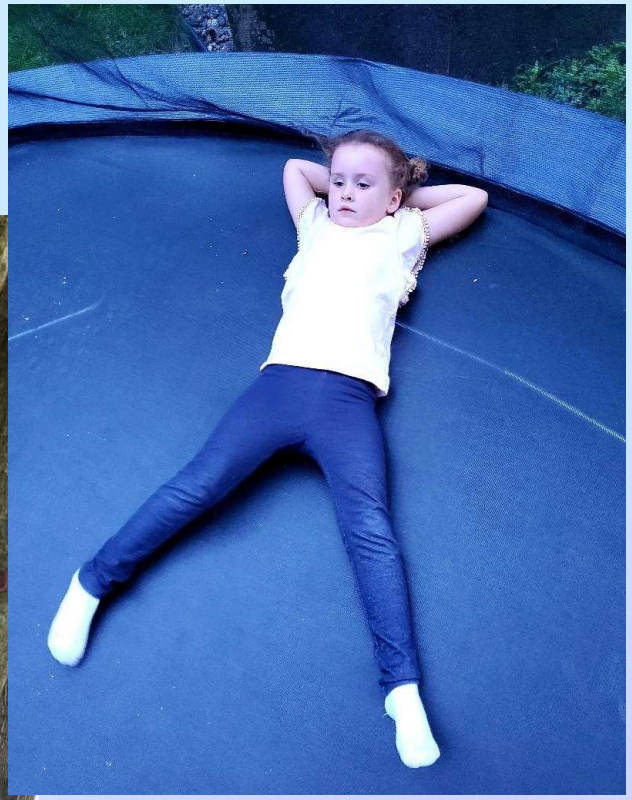
ALEC – Autism and law Enforcement Education Coalition

Rita Curley

Law Enforcement Autism Training

Catherine



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What is Autism?

Autism Spectrum Disorder (ASD) is a developmental disability that usually appears during the first three years of life.

Autism is a neurological disorder that impacts:

- Social interactions
- Communication and language skills
- Behavior

Prevalence

- About 1 in 44 children has been identified with Autism Spectrum Disorder (ASD) according to estimates from CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network (2021).
- ASD is reported to occur in all racial, ethnic, and socioeconomic groups.
- ASD is more than 4 times more common among boys than among girls.

Prevalence

- ASD is growing at a rate of about 10-17% per year.
- A new case of autism is diagnosed every 20 minutes.
- There are no known causes of Autism; however, it is generally thought to be triggered by abnormalities of brain structure or function.

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

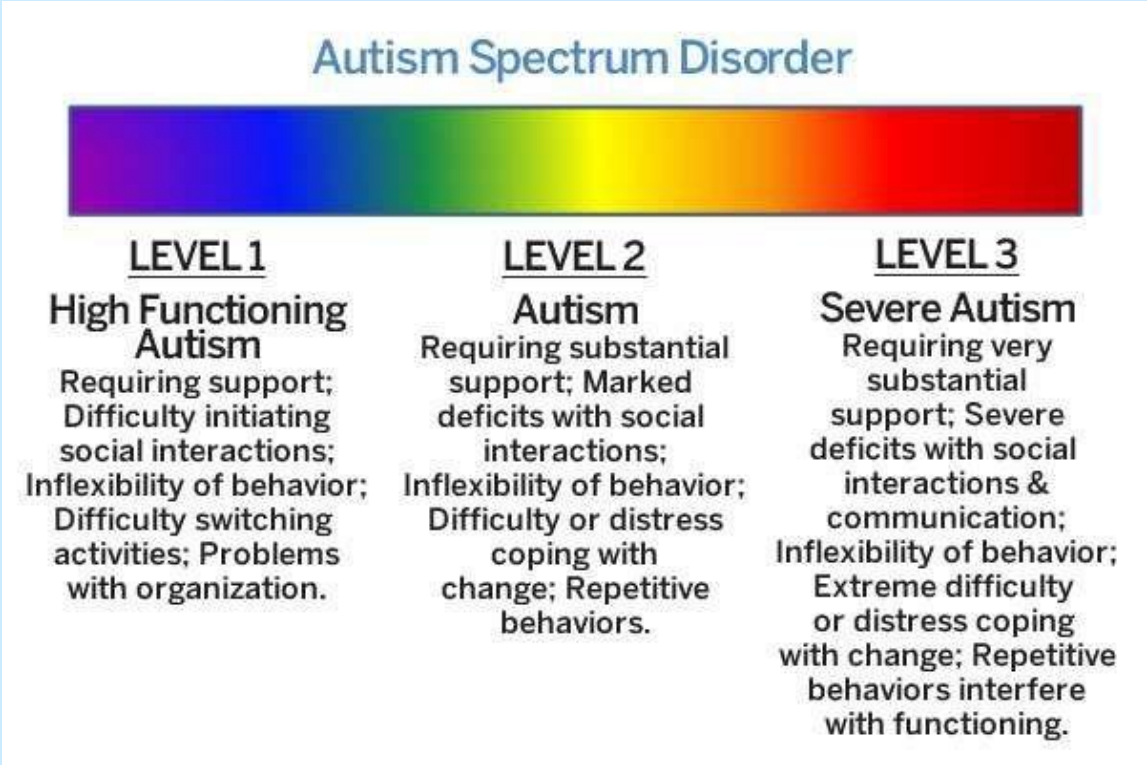
   Typically high intellect and verbal abilities, but still lack common social skills

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

Autism is a spectrum disorder with varying levels of functioning

- Low functioning (Level 3)
- Middle functioning (Level 2)
- High functioning (Level 1)

The Autism Spectrum



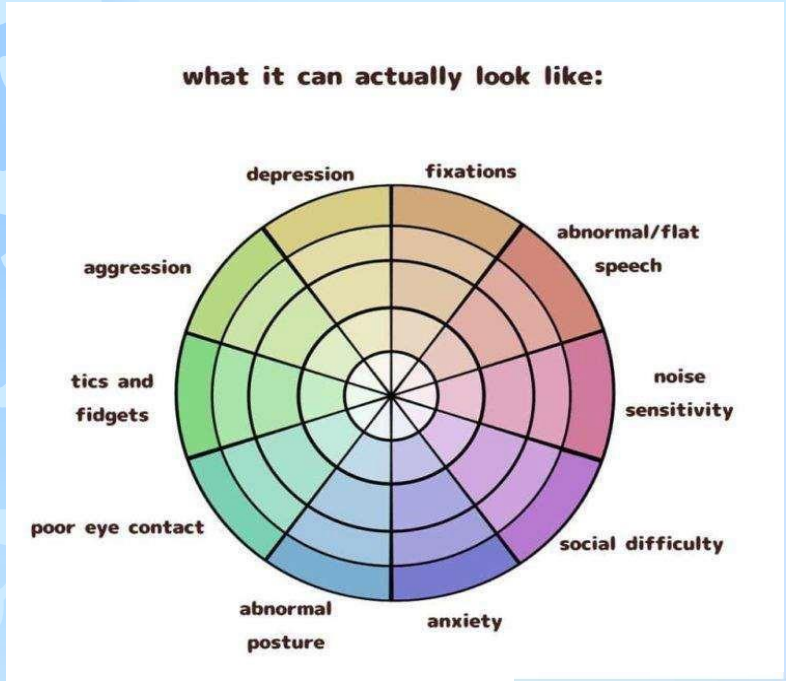
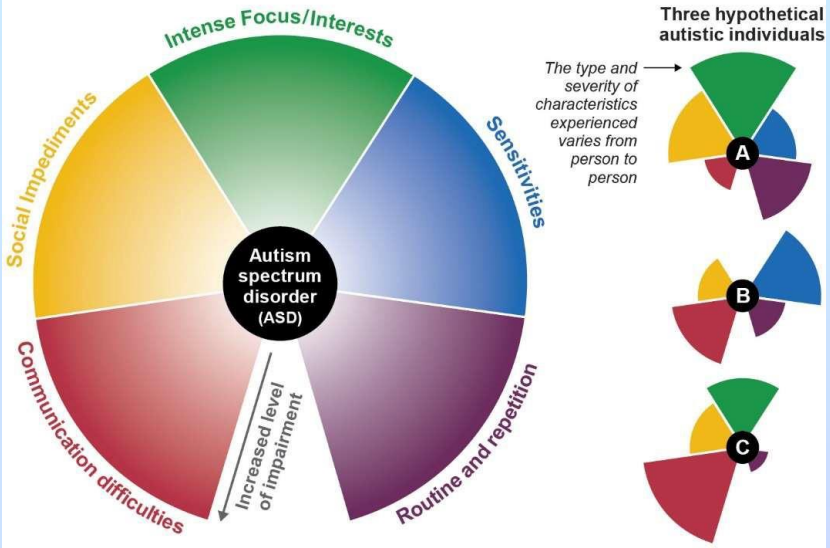
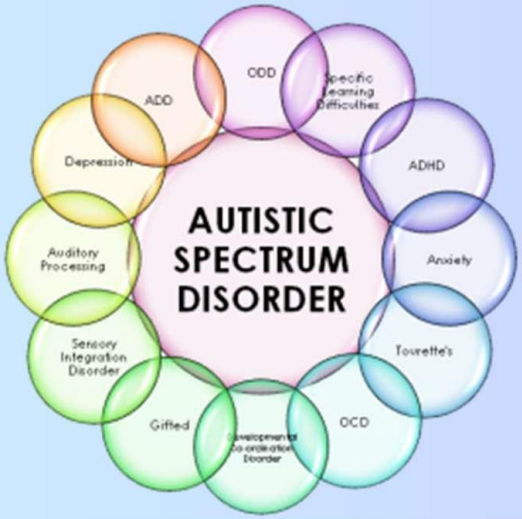


Figure 2: Variation in Autism Spectrum Disorder Characteristics

GAO grouped the characteristics associated with autism into five broad categories, with some overlap between categories.



Source: GAO analysis of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). | GAO-17-109

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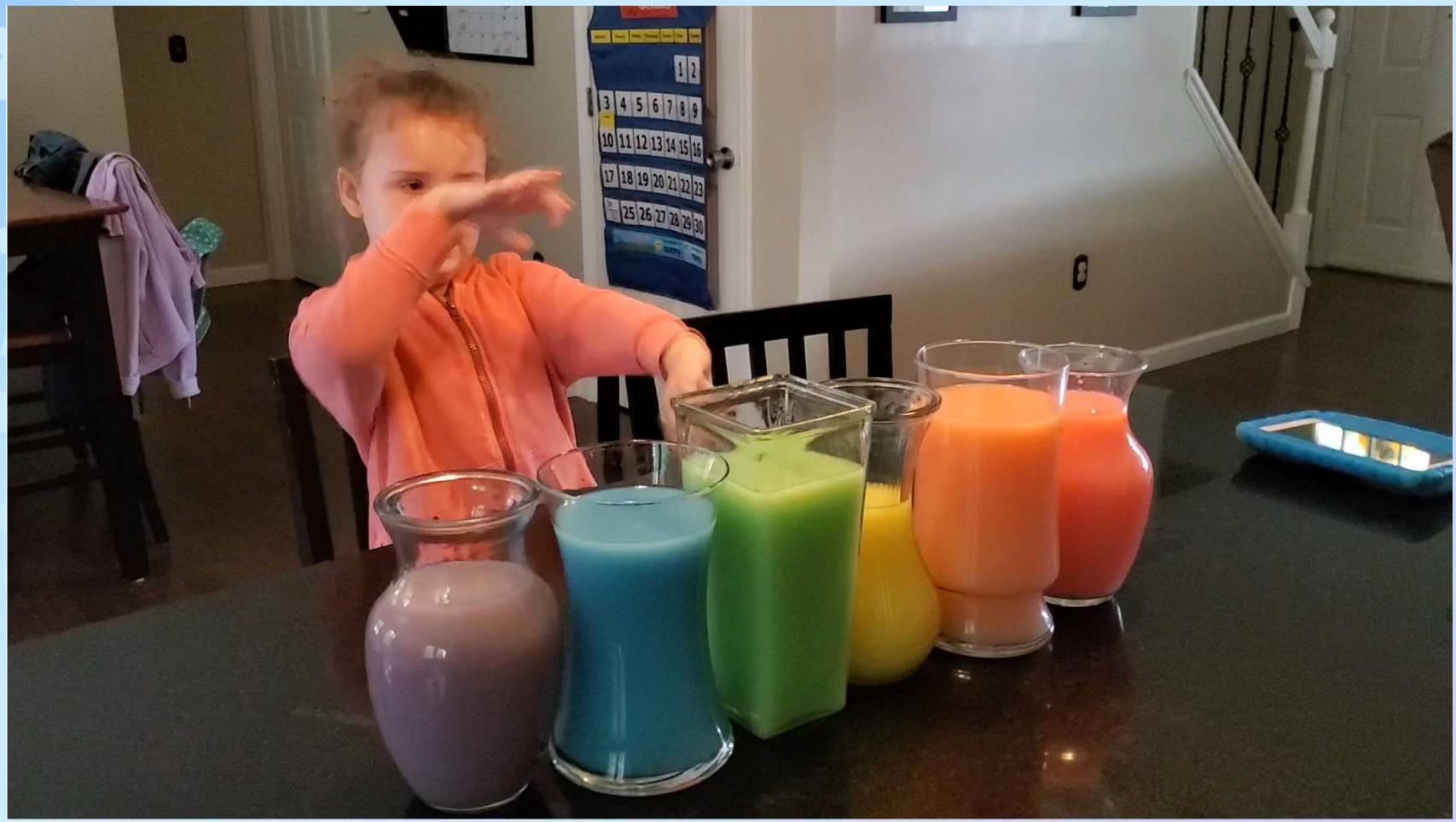


- “When you have met an individual with autism, you have met one individual with autism.”

  -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
- Often diagnosed in conjunction with co-morbities (OCD, PICA, ADHD, SPD, chronic illnesses, etc.)
- 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

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

- Loud noises and other sensory stimuli may overwhelm a person and cause sensory overload

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

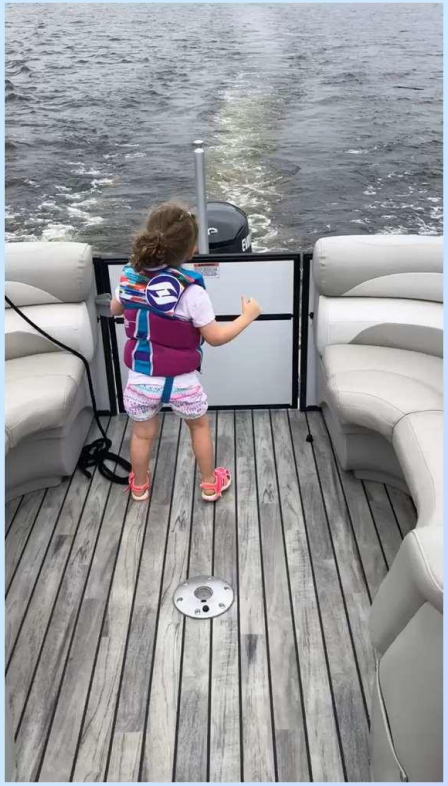
Body Language

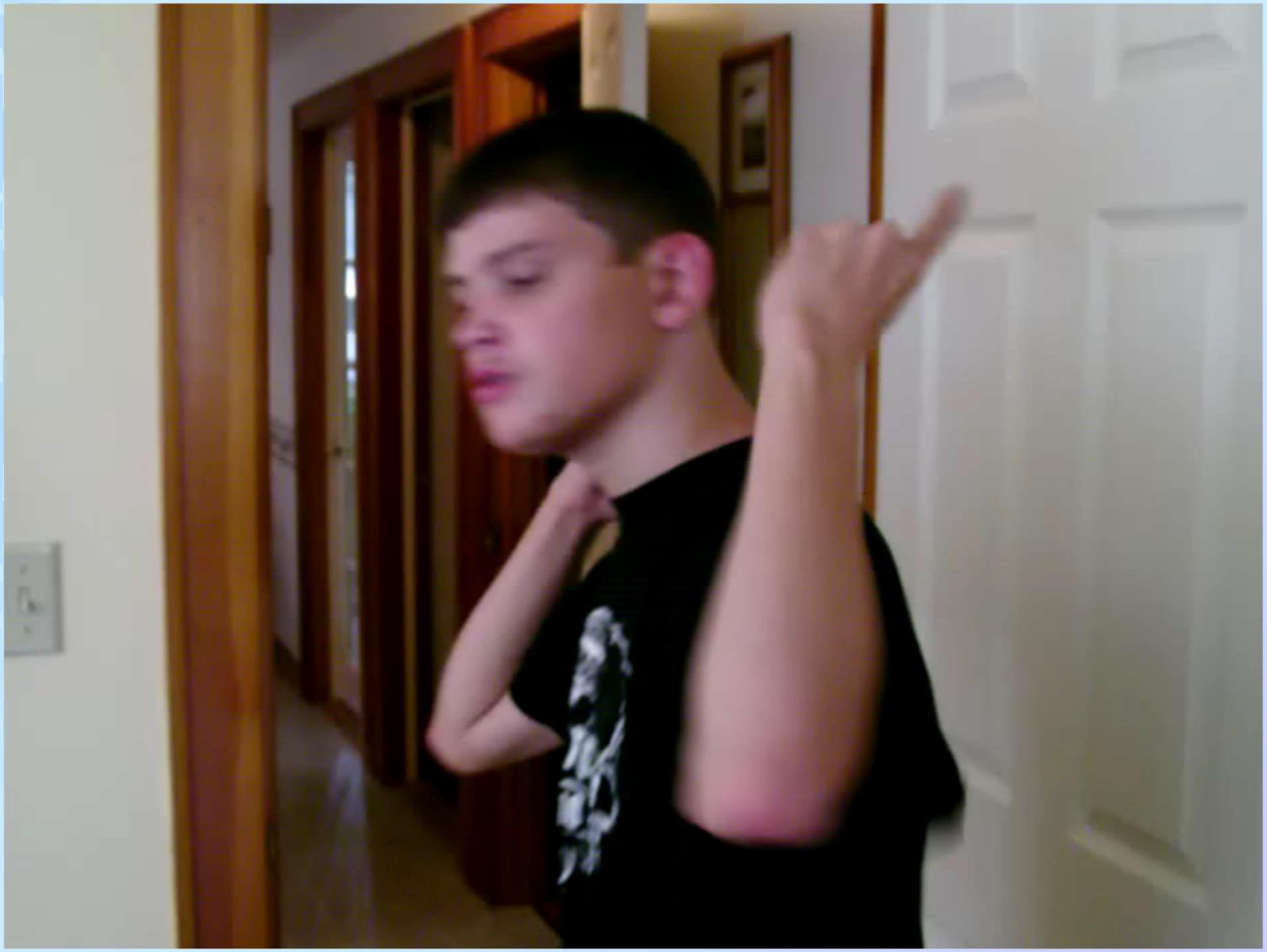
- Appear to be poor listeners
- Little or no eye contact
- Flat facial affect
- May have an inappropriate reaction to the situation (laughing when afraid)
- It is common for people with ASD to have seemingly inappropriate reactions to situations, commands and body language.
- May invade your personal space, be unaware of personal boundaries (close talker or inappropriate affection)

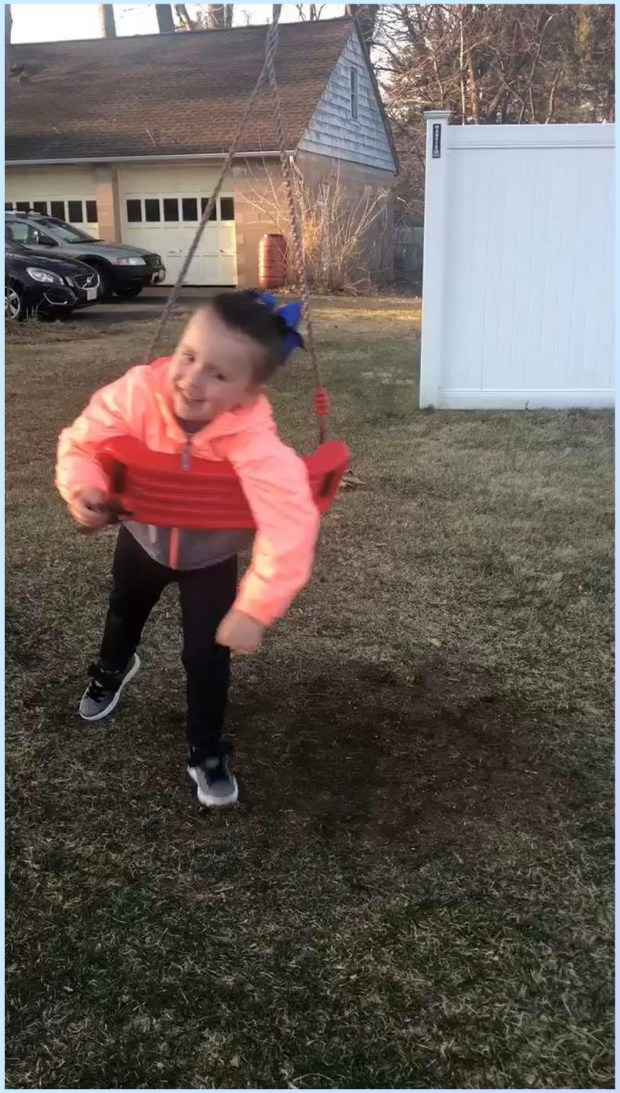
Body Movements

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 (Stimming)
- Tend to wander without reacting to surroundings







Sensory Impairment

Hypersensitive/Hyposensitive

- Sights
- Hearing
- Smell
- Touch
- Taste

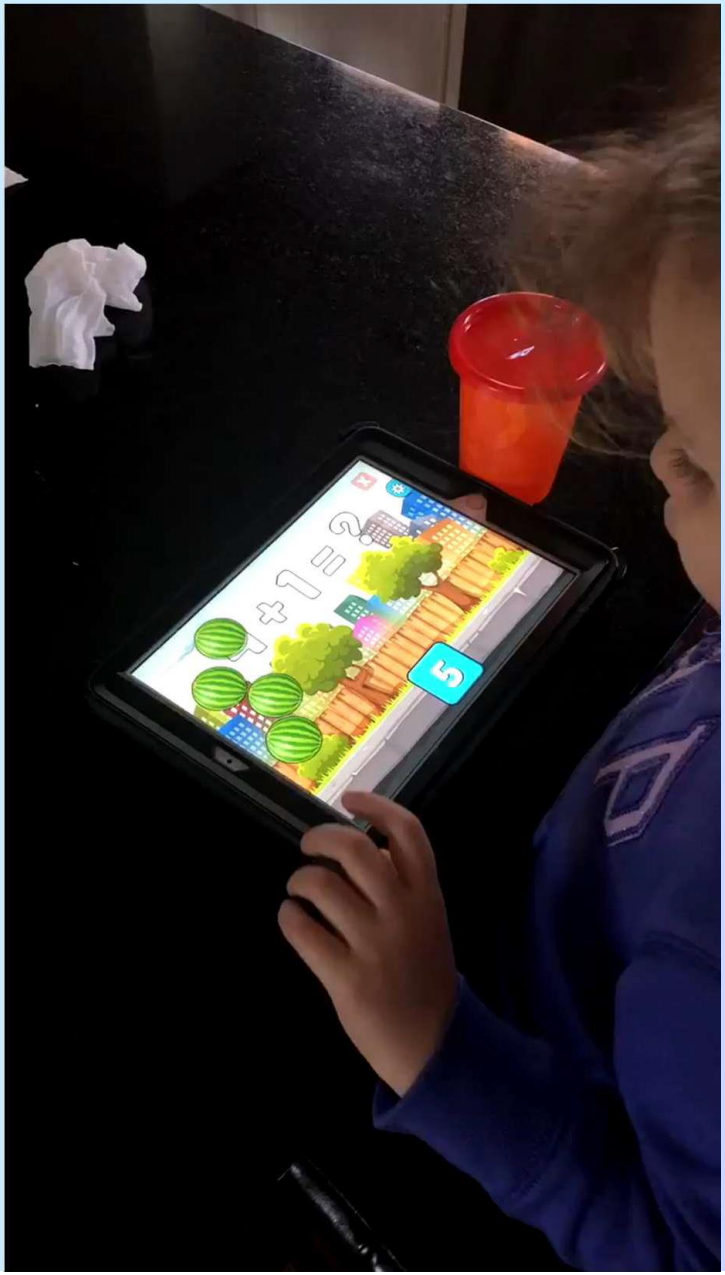
Dangers of Hyposensitivity

Little Sense of :

- Pain
- Fear
- Danger
- Safety

How to Best Approach a Person with ASD

- Try to utilize communication cards (PECS) or devices to communicate
- When using cards or devices, point to the symbols or words that you are trying to communicate while speaking (reinforce)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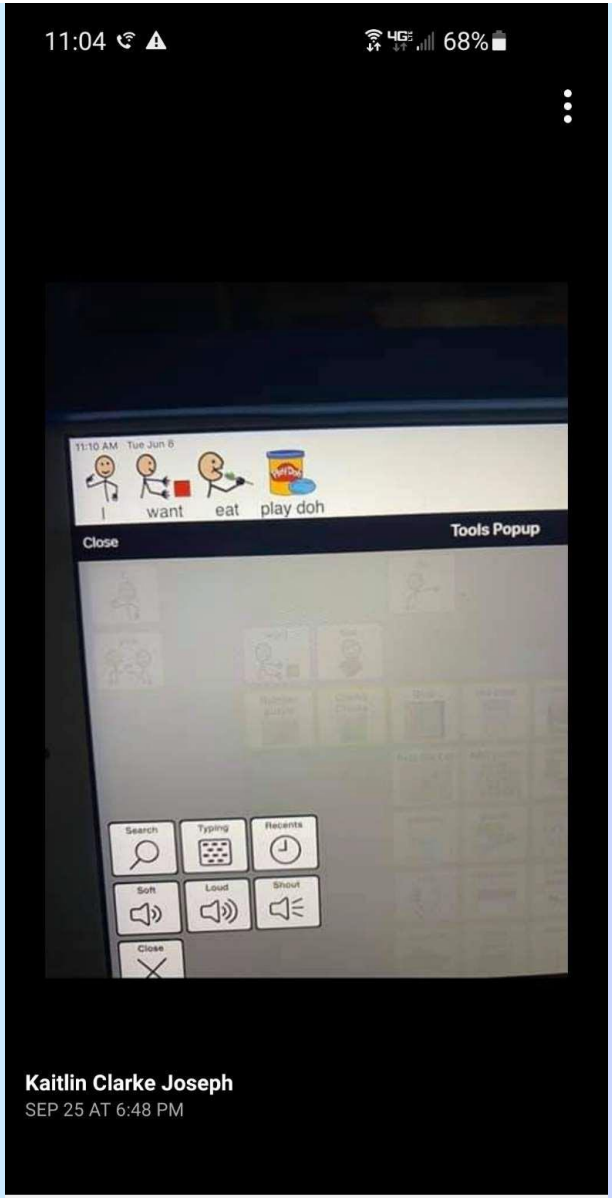
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Kaitlin Clarke Joseph
SEP 25 AT 6:48 PM

When Speaking to a Person with ASD

- Be Patient, and give ample time for them to respond
- Stand in front of the person
- Use calm, simple language
- Be literal and specific
- Avoid slang words and phrases
  - These will likely be taken as literal directions
  - ie: “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
- When using sign language, repeat the words that you are trying to communicate (reinforce)

Repetitive Behavior

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

Self Injurious Behavior

- 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”) as it 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.

- 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)

Police Interactions

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!

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


abc 15
ARIZONA
STARTS NOW

Roll Call DVD

Dennis Debbaudt

autismriskmanagement.com

- No one expects a responding officer to be able to diagnose a child or adult's Autism in the field.
- Introduction 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
- Biting, pinching
- 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

- Autism field responses will require more time to resolve
- Be as patient as the situation will safely allow
- Make sure person is unarmed
- Approach in a quiet, non-threatening manner

Response

- Be Patient and Calm
- Gather correct information
  - Speak with a parent or caregiver
  - Check call history in area
  - Review biographical information forms

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.

De-escalation of 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 (only if officer safety is not jeopardized by doing so).

- If the individual is stimming, do not interrupt if they are not hurting themselves or someone else, but be aware that these behaviors can be severe, (ie. a person slapping, pinching or even biting themselves).

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. Do this using 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 of Behavior

- 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.

Custody

- 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 an individual has to be restrained, it is best to sit the individual upright or roll the individual to his/her side while monitor breathing to avoid positional asphyxiation .

Custody

- Alert supervisors of your discovery of the person's Autism.
- Consider a medical evaluation for seizure disorder, or a mental health evaluation over custody if it can be avoided.
- 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 Considerations

- Persons with Autism tend to be very literal
- Little or no understanding of sarcasm, humor or hypothetical situations
- 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 to something preferred or controlling the conversation

Interview Considerations

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

Interview Considerations

- Persons with Autism may act in a “fake it until you make it” manner to hide their disability from you.
  - ie. Pretending to read a consent form when they cannot
  - You should read all paperwork aloud with the person with Autism in a respectful manner to be sure that they understand

Interview Considerations

- Have sensory friendly kits ready at your station for Victims with ASD
- When possible, work with your District Attorney's Office to obtain resources more appropriate for interviewing a person with a disability
  - ie. Children's Advocacy Center

Conducting an Interview

- Treat with the same respect you would others/Presume Competence
- Use the person's 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 (use a timer)
- Maintain a calm environment and minimize distractions
- Use clear and simple language
- Ask one question at a time
- Increase allowed processing time
- Observe for methods of non-verbal communication

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
  - The Marshall Project 2017-”Downloading a Nightmare”

Typical Police and Autism Offender Interactions

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

Other Police Interactions due to Autism

- Many Individuals with ASD wander
- Possibly the call first responders get most often

Challenges 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
- 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

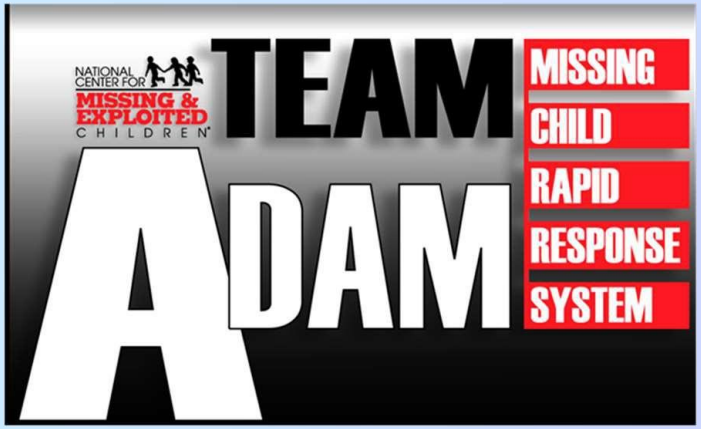
Hazards

Remember that the first responder should check attractive hazards first:

- Water (pools, lakes, rivers, etc.)
- Construction sites
- Drainage areas
- Train and Traffic
- Bright Lights or other loud noises

Missing Children Strategies

- **Team Adam will deploy on cases of missing children with special needs**

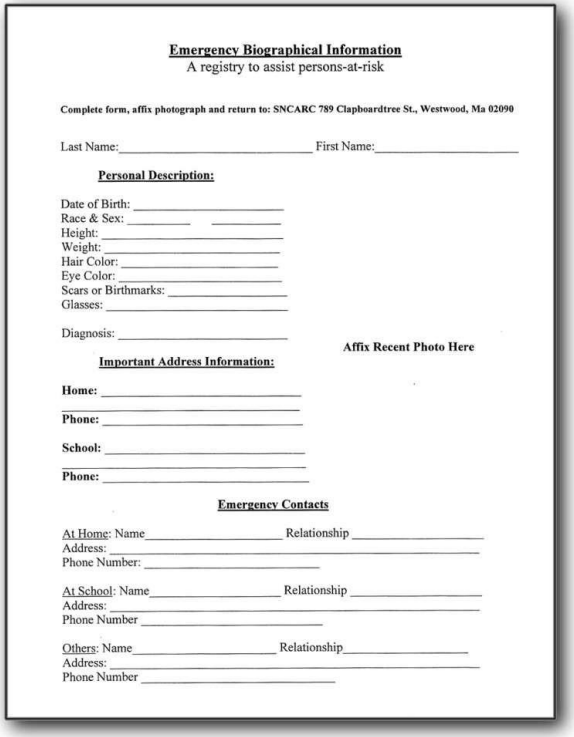


Missing Children Strategies

SafetyNet™ by LO/JACK®

Missing Children Strategies

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: _____

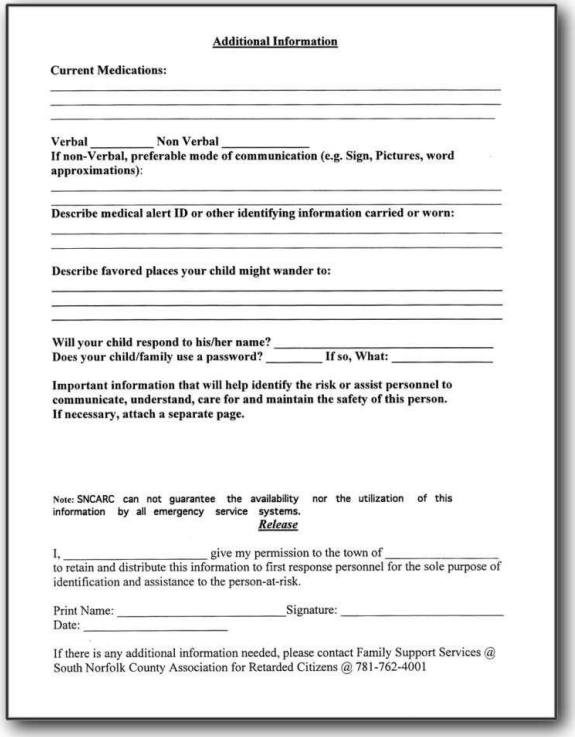
School: _____
_____
Phone: _____

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: EDWARD "TED"

Personal Description:

Date of Birth: _____
Race & Sex: W M
Height: 5'2½"
Weight: 100
Hair Color: BROWN
Eye Color: BLUE
Scars or Birthmarks: _____
Glasses: NO

Diagnosis: AUTISM + 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

Helpful Information to Gather

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

Emergency Contact Temporary Tattoos

Cell Phones

- Location Services
- ICE information
- Helpful Emergency Apps

Medic-Alert

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 even after rescue.
- A first responder must stay with the person at all times.

Helping a Person with ASD

- 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, cell phone, or a laptop/ipad 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, and 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 person answering "yes" to all questions
- C-Spines will be difficult
- Befriend the patient
- BOLT RISK even into traffic

Window Decals

Seat Belt Covers

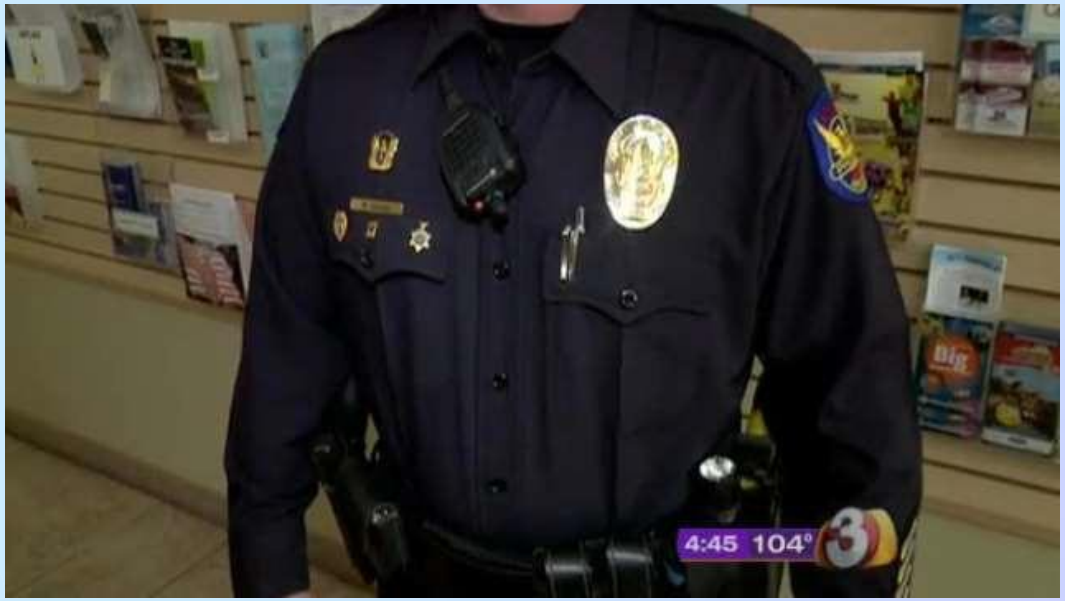
Sensory Issues

- 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

Common Reactions

- Aggression
- Abnormal strength
- Regression
- Sensory Overload
- Meltdown (different than a tantrum)

- They may fixate on an object on your body such as a badge, buttons.



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

Community Days

Community Days

- Consider offering a “sensory friendly” experience for persons with ASD in your community
  - No lights and sirens or loud noises
  - Open area to avoid over crowding
- It is a welcome opportunity for persons with ASD to meet and become familiar with First Responders, which may help if they are ever involved in an Emergency

- 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

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.

PRESENTATION # 5

2:00-3:00pm

Mental Health Disorders

Nicola Howe, MSW

Mental Health Disorders

Nicola Howe, MSW

Overview of Mental Health

- The origin of the mental hygiene movement can be attributed to the work of Clifford Beers in the United States, born in New Haven, CT in 1876
- In 1908 he published a book “A Mind that Found itself (the book based on his personal expereince of admissions to three mental health hospitals)
- Mental Health Hygiene was established in Connecticut in 1908
- From 1909 onwards the internationalization of activities led to the creation of National Associations concerned with mental hygiene, in France, South Africa and Italy in 1920 and Hungary in 1924.
- From these National Associations the International Committee on Mental Hygiene was created and later superseded by the World Federations of Mental Health
- By 1937 the U.S. National Committee for Mental Hygiene stated that it sought to achieve its purposes by
  - promoting early diagnosis and treatment, Developing adequate hospitalization, Stimulating research
  - Securing public understanding and support of psychiatric and mental hygiene activities, Instructing individuals and groups, Cooperating with governmental and private agencies whose work touches at any point the field of mental hygiene
- In 2001, the WHO dedicated its annual report (The World Health Report – Mental Health: new knowledge, new hope) to mental health (Ellis et al., 2021)

Background

- 1 in 5 U.S. adults experience mental illness each year
- 1 in 20 U.S. adults experience serious mental illness each year
- 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year
- 50% of all lifetime mental illness begins by age 14, and 75% by age 24

Background

- A mental health condition isn't the result of one event.
- Linking causes –
  - Genetics
  - Environment
  - Lifestyle Influence/ Stressful job, family life etc
  - Biochemical Processes/ Basic Brain structure
  - Traumatic events

Mental Health Diagnosis

- A medical professional determines a diagnosis by interviewing you about your history of symptoms.
- Sometimes a doctor will require a couple of medical tests to rule out possible physical ailments, but we cannot evaluate mental health itself through blood tests or other biometric data.
- Doctors use their experience to determine how your set of symptoms fit into what we know about mental health and will refer you to a mental health professional for an evaluation.
- Doctors and therapists use a diagnosis to advise you on treatment options and future health risks.

Mental Health Evaluation

- A mental health evaluation gives a doctor, counselor, psychologist or other licensed professional a picture of the way a person feels, reasons, thinks and remembers. Through a series of questions and physical tests, a professional can diagnose a number of mental disorders.
- Evaluation may include:
  - Mental health symptoms
    - Troubling thoughts and behaviors
    - Events that may make the symptoms worse
    - How long the symptoms last
    - How often the symptoms occur

Biopsychosocial Assessment

- A Biopsychosocial Assessment is an assessment typically conducted by therapists and counselors at the beginning of therapy, which assesses for biological, psychological, and social factors that can be contributing to a problem or problems with a client.
- It's considered a holistic assessment, looking at a client on all different levels, including culture (ADDRESSING FRAMEWORK), education and work history, family and marriage difficulties, and medical issues to better identify an individuals needs.

Mental Health Status Exam

The mental status examination is a structured assessment of the patient's behavioral and cognitive functioning.

- Appearance
- General Behavior
- Level of consciousness
- Attentiveness
- Mood and affect
- Thought and Perception
- Attitude and Insight
- The reaction invoked in the examiner
- Higher cognition abilities
- Alertness, language, memory, constructional ability, abstract reasoning

Using the DSM - Coding

- The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook widely used by clinicians and psychiatrists in the United States to diagnose psychiatric illnesses. Published by the American Psychiatric Association (APA), the DSM covers all categories of mental health disorders for both adults and children.
- It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in research on mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions.
- Generalized Anxiety Disorder (GAD) DSM-5 300.02 (F41.1)

ICD 10 – Coding

- World Health Organization (WHO) authorized the publication of the International Classification of Diseases,10th Revision (ICD-10), which was implemented for mortality coding and classification from death certificates in the U.S. in 1999. The U.S. developed a Clinical Modification (ICD-10-CM) for medical diagnoses based on WHO's ICD-10 and CMS developed a new Procedure Coding System (ICD-10-PCS) for inpatient procedures.
- **Therapists use the DSM-5 codes for diagnostic and treatment purposes and ICD-10 codes are used for reimbursement**.

Common Mental Health Disorders that Affect Behavior

- The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) places mental disorders in discrete categories on the basis of clinical signs and symptoms

- Mood disorders
- Psychotic disorders
- Anxiety disorders
- Trauma Related Disorders
- Personality disorders
- Substance Use Disorder

Mood Disorder: The Signs/Symptoms

- According to the Mayo Clinic:
  - General emotional state or mood is distorted, inconsistent with your circumstances and interferes with your ability to function
  - Extremely sad, feeling empty inside, irritable with everything
  - Depressed or alternating mood with being excessively happy (mania)
  - Mood disorder may increase risk of suicide

- According the DSM-5 Diagnostic and Statistical Manual of Mental Disorder:
  - Feelings of intense sadness, feeling hopeless, empty, depressed, excessive guilt

  - What cause a Mood Disorder:
    - Many factors an imbalance of the brain chemicals, irritability, hostility, aggression
    - Life events: stressful life changes
    - Runs in a family, sensitive to failure or rejection
    - Decrease energy
    - Relationship or loss of employment,

Psychotic Disorder: The signs/symptoms

- Social misconduct
  - Intimidating, threatening, coercing, hate speech, safety
- Schizophrenia
  - Delusions / hallucinations
  - People who show bizarre behaviors
  - Disorganized thinking and speech
  - Unusual or Unpredictable mental health behaviors
- Substance/Medication-Induced Psychotic Disorder
  - Withdrawal of substance use (bugs crawling in my skin or my spouse is trying to prison me)
  - A schizophrenic episode triggered by substance use
  - Many people abuse methamphetamines experience psychotic symptoms due to their drug use
- Unspecified Schizophrenia Spectrum

Anxiety Disorder: The Signs/Symptoms

- Mayo Clinic stated:

➢ Anxiety disorders can also affect mood and often occur along with depression. It can impair a person's ability to function at work, school, and in social situation

- ❑ Nervousness, restless or tense, withdrawal from social activity
- ❑ Having an increased heart rate, breathing rapidly (hyperventilation)
- ❑ Sweating, trembling
- ❑ Feeling weak or tired
- ❑ Trouble concentrating or thinking about anything other than the present worry
- ❑ Recurring fears and worries about routine parts of everyday life

Trauma-related Disorder: The Signs/Symptoms

- The DSM-5 (Diagnostic and Statistical Manual of Mental Disorder) explains trauma-related disorder as exposed to death, threatened death, actual, affect veterans/war soldiers

➢ PTSD – Posttraumatic Stress Disorder (symptoms create distress or functional impairment, e.g social, occupational)

- ❑ Physical reactivity after exposure to traumatic reminders
- ❑ Flashbacks, nightmare, unwanted upsetting memories
- ❑ Overly negative thoughts and assumptions about oneself or the world
- ❑ Exaggerated blame of self or others for causing the trauma
- ❑ Decreased interest in activities
- ❑ Feeling isolated
- ❑ Risky or destructive behavior
- ❑ Emotional distress after exposure to traumatic reminders

Personality Disorder: The Signs/Symptoms

- DSM-5 explains as

➢ A pervasive patterns of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood and present in a variety of context

- ❑ Lack of remorse, as indicated by being indifferent to or rationalizing
- ❑ Reckless disregard for safety of self or others
- ❑ Risk taking – engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard for consequences, boredom, anxiousness, intense feelings of nervousness, feeling fearful, fears of falling apart or losing control

➢ Avoidant Personality Disorder

- ❑ Impairments in self functioning
- ❑ Low self-esteem associated with self-appraisal
- ❑ Socially inept
- ❑ Excessive feelings of shame or inadequacy

Substance Use Disorder:
The Signs/Symptoms

- Drug addiction also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substance such as alcohol, marijuana and nicotine also are considered drugs.
  - Maintaining a supply of the drug, Driving under the influence, risky activities, Neglected appearance – lack of interest in clothing, grooming or looks
  - Behavior changes
  - Erratic behavior
  - Aggression
  - Rapid speech
  - Dilated pupils
  - Confusion, delusions and hallucinations
  - Irritability, anxiety or paranoia


Criteria for Substance Abuse Disorders
Cravings to use the substance
Wanting to cut down or stop but not managing to
Taking the substance in larger amounts or for longer than you're meant to
TIME FOR WORK
Neglecting other parts of your life because of substance use
Continuing to use, even when it causes problems in relationships
Using substances even when it puts you in danger
verywell

Co-occurring Disorders

- DSM-5 explains that approximately two-thirds of individuals with illness anxiety disorder are likely to have at least one other comorbid major mental disorder. Individuals with illness anxiety disorder may have an elevated risk for somatic symptom disorder and personality disorders
- Most individuals who have mental illness that law enforcement ends up arresting have both mental health and substance use disorder
- Depression symptoms that develop during or soon after substance use or withdrawal or after exposure to a medication.
- Untreated substance use disorders reflect an estimated $417 billion in annual costs related to crime, health care services, and lost work productivity. This estimate does not capture the many social costs of drug overdose and suicide.

The Effect of Mental Health on Individual/family Behavior

- Individual behavior

It's normal to feel a whole range of emotions, such as guilt, fear, anger and sadness (Grieger, 2018).

- Leads to social isolation, dangerous behaviors
- Relationship differences/difficulties
- Long-term disorder can drive a person to commit suicide
- Problems with tobacco, alcohol and other drugs
- Work-related issues or school related issues
- Sleep problems, triggers other chronic illness
- Homelessness

The Effect of Mental Health on Individual/family Behavior

- Family behavior

Mental health issues can be a extremely painful and traumatic time for all of the family

- Frequent family conflicts
- Emotional strain on families
- Financial impact
- Shamefulness

Mental Health Knowledge Importance for Law- Enforcements/Correctional Officers

- Officers are often the first responders to incidents involving people with mental health
  - Erratic behavior
  - Someone threatening to harm themselves or other
- Reduces the risk of injury for the both the officer and the individual
- De-escalation techniques learn in CIT in any tense encounter (even if the situation does not involve mental health crisis
  - Safe distance
  - Let the person vent
  - Validate the person's feelings

Mental Health Knowledge Importance for Law- Enforcements/Correctional Officers

- Effective programs and training can help officers de-escalate mental health situations and get people the help that they need
- Officers will quickly recognize the signs of mental health behavior
- Help the officers to develop approaches to protect themselves from an erratic dangerous mental health individual and avoid deaths
- Officers will understand untreated mental health & therapeutic language

Treatment

- People with a serious mental illness have a higher rate of service use than the general population of people with any mental illness (69% versus 45%) but treatment and services vary in quality and timeliness of delivery
- Among adults who reported an unmet need for mental health care in the past year, the most common reasons were inability to afford the cost of care (48%)
- believing that the problem could be handled without treatment (26.5%)
- not knowing where to go for services (25%)
- not having the time to go for care (16%)

Treatment

- they did not feel a need for treatment at the time (10%),
- they thought that treatment would not help (9%)
- they had fear of being committed to an institution or having to take medicine (9%),
- they had concerns about confidentiality and the potential negative effect on employment (8%)
- they did not want others to find out (6%)
- they had no insurance coverage or inadequate coverage of mental health treatment (6% to 9%).

Treatment

- Mood Disorder:
  - Treatment: For most people can be successfully treated with medications and talk therapy (psychotherapy), self-care, antidepressants, and support
- Psychotic Disorder:
  - Long-term treatment with Antipsychotic medication may lead to a modest decrease in the intensity of delusion. Assessment of the risk of violence based on bizarre. Careful evaluation of the individual and the symptom particularly if the delusions involve an identifiable individual Anxiety Disorder:
  - Treatable evidenced by months of consistency with psychotherapy, medication/mood stabilizer

Organizational Support

- Crisis Intervention
- Community Mental Health Teams (CMHTs)
- Social or Community Care
- Religion
- Family
- School
- Residential Care
- Hospital Treatment/Behavioral/Psychiatric

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

INTELLECTUAL DEVELOPMENTAL DISORDER (IDD)	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

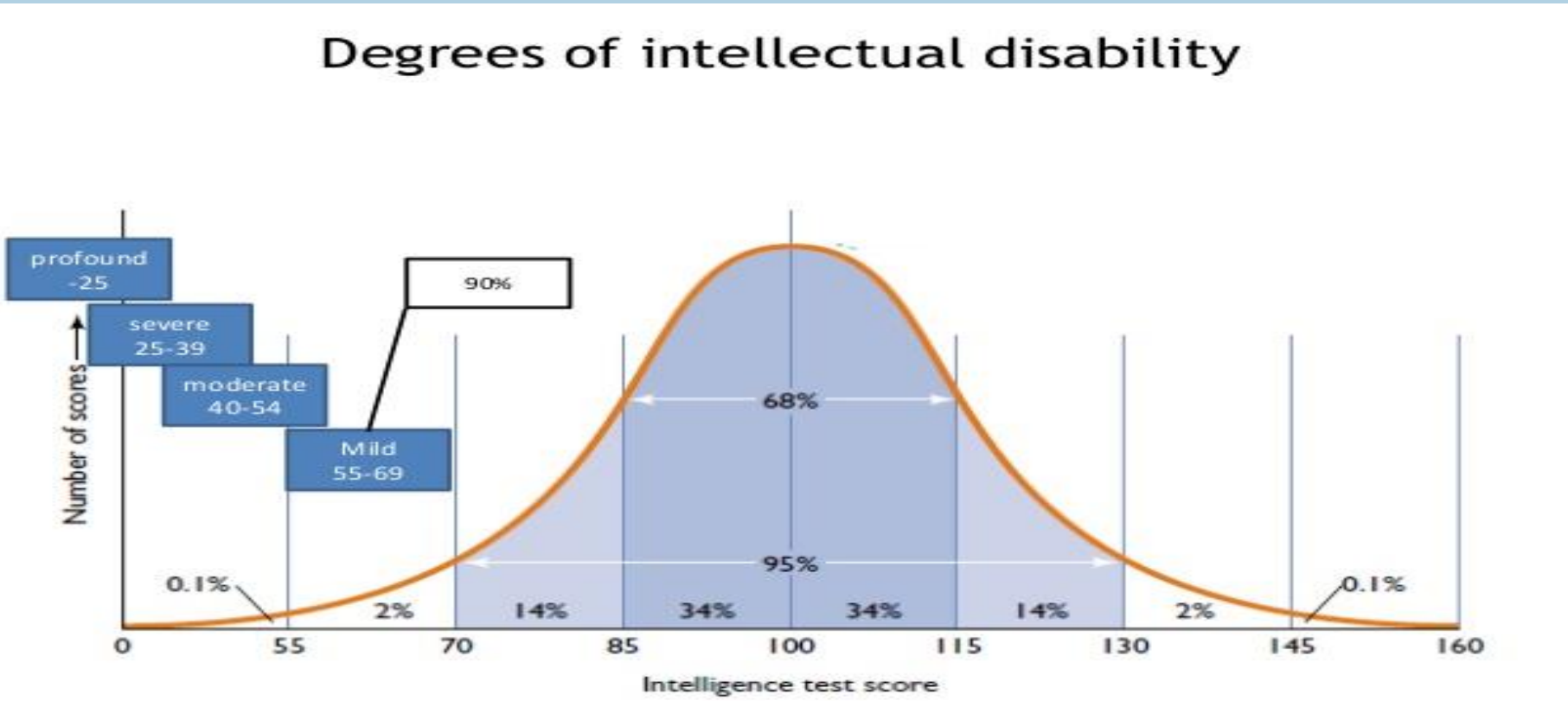
CHARACTERISTICS OF IDD

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



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 7days 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/rWSdaL8glOU

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