

# Connecticut General Assembly

## Police Transparency & Accountability Task Force

### Improving Police Interactions with The Disability Community Subcommittee Minutes 9/8 to 11/3/20

#### Minutes

Tuesday, September 8, 2020  
11:00 a.m., via Zoom

*Attendees: Jon Slifka (Chair), Alvin Chege, Chief Tom Kulhawik, Doris Maldonado, Commissioner James Rovella, Rayla Mattson*

*Others: Sarah D'Agostino (interpreter), Ken Barone, Deb Blanchard, Andrew Clark, Kelan Lyons (CT Mirror)*

- I. Review subcommittee charge
  - a. *Chair Slifka gave a brief overview of the subcommittee's charge. He indicated that he has contacted several organizations to come forward and give presentations to subcommittee members. His recommendation is to meet once a month, with 30 min for presentations and 30 minutes for Q&A. He also would like a synopsis from police as to what is currently done in training. This would be a fact-finding phase, done in conjunction with the Task Force's public listening sessions. After this phase, the subcommittee would then focus efforts on developing recommendations, while recognizing that each disability presents its own unique challenges. Com. Rovella suggested Karen Boisvert from POSTC would be able to provide background info on current police training.*
- II. Review of Task Force priorities document
  - a. *(combined w/discussion of agenda item III)*
- III. Discussion regarding other priorities for consideration
  - a. *Ms. Maldonado asked how the subcommittee is getting input from all voices? She indicated that large communities don't have access to technology. She also asked that youth voice be heard, and the proceedings be accessible in multiple languages. Ms. Mattson asked if local police departments knew about the Task Force. Chief Kulhawik confirmed that they did and that the issue was important to chiefs as well. Mr. Barone recommended reaching out to the New Haven chief, as they are in the process of developing a mental health crisis unit.*

**PTATF Priorities:** <https://www.ctpolicetransparency.com/about>

**Minutes**  
**Tuesday, September 22nd, 2020**  
**11:00 a.m., via Zoom**

*Attendees: Jon Slifka (Chair), Alvin Chege, Marc Pelka, Chief Tom Kulhawik, Doris Maldonado, Rayla Mattson*

*Others: Colleen Hajdasz (interpreter), Ken Barone, Deb Blanchard, Andrew Clark, Kelan Lyons (CT Mirror), Rod O'Connor*

*Presenter: Karen Boivert (POSTC)*

**I. Presentation on Current Police Trainings/Practices**

**a. Karen Boivert: Presenter**

- i. Ms. Boisvert presented on a series of four documents previously shared with subcommittee members. She gave an overview of both basic and in-service training offerings focused on the disability community.*

**II. Questions and Discussion on Presentation**

- a. Ms. Maldonado offered some suggestions as to how to improve training. She offered free resources from UCONN that are designed to assist individuals who have interactions with the disability community. Mr. Chege asked if any part of the training addresses a deaf person who happens to be on the spectrum too? How can police possibly be trained for all circumstances they may face? The academic world is ready to provide classes to police on the deaf community. Also, is there any way to bring ASL interpreters to police training? Mr. Chege would like to be a liaison for this if that would be accepted. Ms. Mattson – is this coordinated at all with the public school system? A: not in basic training. Maybe in in-service. They do train armed security in school systems. Is in-service the same as continuing ed?: A: Yes. (Every 3 years need to show 60 hrs of in-service training). What about other types of training? ADD as an example? A: if there is a need, then we should look at that with basic training. For in-service, more at the discretion of departments. But these goals and objectives are being modified, and she is taking notes. Mr. Pelka: Does POSTC have preferred trainers that are recommended to departments (i.e. those that have positive reviews, updated w/evidence-based practices)? For someone seeking ASL services w/police, what is the typical practice (i.e. CT Relay phone line)? A: Yes, there is a preferred list. All instructors must be certified in the topic they are presenting (bio, lesson plan, field experience, etc.) Depending on the level of certification they receive, there are requirements for continued certification. This information is available on the POSTC website. Monitored and audited on a regular basis to ensure compliance. As to second question, not sure. Mr. Chege: per the CT Relay line and police tools for this community. It is important that these are available to prevent a situation from unnecessarily escalation. Would like this inserted in goals. Chair Slifka: with respect to current training, is the instruction given from individuals/organizations from the disability community? Is there any follow up done after situations occur w/disability community? A: Doesn't believe DMHAS brings in other organizations for basic training. For in-service, she knows of some instances. They did develop a train the trainer program. As for follow-up,*

*evaluations are sent out after the training. No follow up in the field. Ms. Maldonado: are there youth and/or consumer voices present in these trainings? This would help officers. There are organizations that can help. Mr. Chege: What is the length of the training in total? A: 921 hours. Equivalent to about 6 months of curriculum in an academic environment. Field training is next: 400 hours – or approximately 3 months. So about 9 months total. Once an officer is certified, there are requirements for training to be re-certified. Also, Field Training Officers have to have 3 years of experience in the field, be in good standing and be certified.*

### **III. Discussion on Next Steps**

- a. Chair Slifka would suggest getting representation from various disability communities to present to the subcommittee. He's had several organizations reach out to ask to participate. Autism seems like a natural starting point, as it has received the greatest attention in our conversations thus far. Ms. Maldonado suggested the CT Developmental Disabilities Council.*



Area 410 Goals and  
Objectives.pdf



Area 404  
Juvenile.pdf



In-Service Lesson  
Plan Developmental



Basic Training  
Lesson Plan area 410

**Minutes**  
**Tuesday, October 6, 2020**  
**11:00 a.m., via Zoom**

*Attendees: Jon Slifka (Chair), Alvin Chege, Undersecretary Marc Pelka, Chief Tom Kulhawik, Doris Maldonado, Rayla Mattson, Daryl McGraw*

*Others: Maria (ASL interpreter), Ken Barone, Deb Blanchard, Andrew Clark, Rod O'Connor, Makenzie Ozycz, Henri Alphonse, Jeff Spahr, Mary Kate Mason (DHMAS)*

*Presenter: Walter Glomb*

- I.** Presentation from Walter Glomb on perspective from Autism and I/DD Community
  - a. At the request of the chair, Mr. Glomb presented on the Connecticut Council on Developmental Disabilities. Handouts were provided to members prior to the meeting. The presentation focused on nine activities the subcommittee can focus on: 1) A comprehensive approach that focuses on the functional needs of the individual. 2) Community engagement; 3) Standardize information collection process for local dispatch centers; 4) Review and revise training; 5) School resource officers – are they properly prepared w/requisite student forms and other pertinent information. 6) Procedural safeguards – what regulations are necessary. 7) Training for families – how to better understand law enforcement 8) Better reporting for transparency and accountability; 9) Protocols for engaging crime victims from the disability community.*
- II.** Questions and Discussion on Presentation
  - a. Members asked questions and addressed issues raised by Mr. Glomb. Marc Pelka – 1) Update on Implementation of Use of Force reporting. Not currently info collected on disabilities but are receptive to that. 2) Community/Police engagement grant program in process based on recent release of State of CT bond funds. Doris Maldonado – Department of Correction assessment and cultural component w/in the disability community are important facets to focus on as well. Mr. Glomb – CT DOC has a pretty good assessment tool for incoming individuals to confinement. This is a possible template for crossover w/police. As for cultural competency, it is important that this garners more action from all involved. Mr. Slifka has contacted the new DOC Commissioner. He is willing to come and present as requested. ALEC (Autism and Law Enforcement Education Coalition) – has done training on disabilities for some CT police agencies. An individual from the organization will be presenting at the next meeting. Mr. Chege – are there DMV indications on licenses or otherwise that highlight disabilities? To members' knowledge, there is no indication other than certain physical disabilities than impact driving. Ms. Mattson – asked about trainings and standards for school resource officers. Mr. Barone updated members on ongoing revisions to the Use of Force form and invited members to offer suggestions. Mr. Clark informed members about the Public Awareness Subcommittee and intentions for youth listening sessions.*

## **MINUTES**

**Tuesday, October 20, 2020**

**11:00 a.m., via Zoom**

*Attendees: Jon Slifka (Chair), Alvin Chege, Chief Tom Kulhawik, Doris Maldonado, Rayla Mattson, Com. Rovella*

*Others: Maria Cooper (ASL interpreter), Ken Barone, Deb Blanchard, Andrew Clark, Makenzie Ozycz, Henri Alphonse, Beth Gard, Mary Kate Mason (DHMAS), Mitchel Jobble, Holly LaBrecque*

*Presenter: Sgt. Ryan Roettger on Project Alec*

- I.** Presentation from Ryan Roettger on Project Alec
  - a. *Sgt. Roettger has provided this training to over 7,000 officers. The training has been offered free through grants, etc. but the funding is running out and there is concern of it being available in the future.*
  - b. *Questions: Doris Maldonado – questions. How long is the training? 4 hours of mandated training. CT*
- II.** Questions and Discussion on Presentation

## **Improving Police Interactions with The Disability Community Subcommittee**

### **Minutes**

**Tuesday, November 3rd, 2020**

**11:00 a.m., via Zoom**

*Attendees: Jon Slifka (Chair), Alvin Chege, Marc Pelka, Chief Tom Kulhawik, Doris Maldonado, Rayla Mattson*

*Others: Suzanne Terrio (ASL interpreter), Ken Barone, Deb Blanchard, Andrew Clark, Makenzie Ozycz, Henri Alphonse, Mary Kate Mason (DHMAS), CT-N*

*Presenters: (C.A.B.L.E) Louise Pyers, Chief John Rich*

- I.** Presentation from Louise Pyers, Executive Director, CT Alliance to Benefit Law Enforcement (CABLE)
  - a. *Ms. Pyers and Chief Rich shared their screen and presented on a powerpoint.*
- II.** Questions and Discussion on Presentation
  - a. *Doris questions – how have trainings been accessed throughout out the state? Number of towns, etc. A- 114 agencies in CT have taken advantage of CIT training. Many go to POSTC for info on trainings. Although they are POSTC certified, POSTC does not mention CABLE as an option. Also connected through DMHAS to all crisis intervention responders in the state. Availability on Zoom has been a big*

plus. Does anyone have data on results of CIT trained officers vs non-trained officers? A- been collecting the data since May. Have old data from 40hr training – 2008 study (Stanford, Waterbury, New Haven, New London). W/in those PDs, over 1,500 individuals were referred to mental health assistance through CIT contact. Will hopefully have data from new trainings in January/Feb 2021. What is training on cultural responsiveness? A- we have community interaction training (implicit/explicit bias, etc.). There is training currently on implicit bias. It is great at bringing awareness, but CABLE has added action steps to this awareness. Will be reaching out to disability community for recommendations. Chief Rich: training adapts to changing times.

- b. Question: Alvin Chege - We are disheartened from the recent killing of Walter Wallace Jr. by Philadelphia Police Department who has been noted to have mental health needs. What can be done administratively and substantively in 9-1-1 response? Does the system automatically require police involvement? Or is there bias/discretion exercise (perhaps in a prejudicial manner) in determining when police are dispatched? Do ambulance crew have the resources (training, professional staff) to respond to a mental health emergency? this is situation if it happens in Connecticut. A: Chief Rich – doesn't like to comment on actions of officers until all is known. Anytime a police officer uses deadly force, it is tragic for all involved. In Ledyard, 911 dispatch tries to evaluate to determine response to life safety issues – sometimes police are a part of this. Can be police/fire/EMS. Whether or not police have ability to respond to crisis, EMS is usually not the first responder in high crisis, potential harm situations. Louise: what she has learned is that many of these situations are extremely complex. Many people call 911 because they believe an incident is out of control or unsafe – thereby necessitating PD. What she would like to see is folks calling, saying: **this is a mental health call, there are no weapons involved, and it appears to be a crisis situation.** Would love to see a day where this is done as a team, and the police are there mainly for safety. We all need to be a team and work together on this. It can be worked out – if we do it together.

- c. Question: Rayla Mattson: who covers the cost? A: in the past, DHMAS fully covered the cost in the past. For those departments that had CIT in place, DHMAS would also cover OT, etc. Now, providing 11 CIT training per year. Numbers are down to 40 a session. Although an increase in funding, no increase in funding for DHMAS. Do you collaborate with other organizations who provide similar trainings? Do departments get trained differently by separate organizations (had a situation in her town where officers from different towns came in and wanted to handle differently)? A: the CIT training is consistent for every department they train in the state. Only one group – CABLE – offers CIT training. Don't have control over other trainings. Chief Rich: A great point. In Ledyard and other department, they have developed a **special needs registry** (Autism, ABI, Alzheimers, etc) is entered into CAD system, along with pictures, with suggested responses when behavior starts to escalate. Ms. Mattson: unfortunately, it's not statewide. She tried in her town, and no one could answer about putting this info into her town's system. Maybe should be considered for statewide access.

- d. Question: Mr. Chege – follow up to Pennsylvania question - Would CIT trained officers in CT be called out in a case like this? Although not a fan of tasers (and their misuse), it appears these officers weren't equipped with this less lethal equipment, why not? (When the absence of these less lethal weapons probably has nothing to do with the “de-fund”). A: there is a level of training required through

*POSTC, just not to the degree of CIT. Taser policy and usage varies per department.*

- e. Question: Andrew Clark – can you tell us more about the officer wellness training you do, as well as the upcoming police accountability bill training and also comment on any need for additional data and evaluation ? A: they have a number of training components on officer well-being. CABLE is very invested in making sure officers get what they need. Chief Rich:*
- f. Question: Chair Slifka – your organizations has trained across the state, what barriers exist that we can address? What recommendations about availability of resources in more rural areas? A: Chief Rich – as a former state police officer, there is an opportunity to integrate more into CSP training. CABLE has finite capacity – in order to offer a good product and at scale, it becomes difficult. Ms. Pyers: the interest and enthusiasm from police departments to send officers to CIT training has grown over the years. Can't keep up with the demand. There is not CIT introduction at the academy level – which is disappointing. Because mental health training is mandated by the state – can't use CIT. Don't push to have CIT mandated, but the 16 hour block could become one – if funded.*

### **III. Discussion on Next Steps**

- a. Next meeting, no speakers. Will take a step back and begin to put together a running document on recommendations due both January 1 and in the long term.*

#### 404 JUVENILE LAW/ DEALING WITH JUVENILES (14 hrs)

##### INSTRUCTIONAL GOAL:

This course will cover the rights of juveniles, the disposition of juveniles taken into custody, juvenile court procedures, proper attitudes, methods, and techniques that an officer should use when dealing with juveniles. The societal pressures of adolescents, characteristics and problems of youths will be emphasized as will the need for strong juvenile community relations and an overview of the community agencies that work with youths.

##### PERFORMANCE OBJECTIVES:

- 1) Define the purpose of the "Juvenile Law."
- 2) Identify the scope of and the authority of the Juvenile Court. This will include:
  - a) Age requirement
  - b) Circumstances under which a juvenile comes under the jurisdiction of the Juvenile Court
  - c) Referral resources and procedures
  - d) "Automatic Transfer" and "Discretionary Transfer."
- 3) Recognize the circumstances under which an officer may take a juvenile into custody.
- 4) Identify the advisement requirements regarding constitutional rights of a juvenile taken into custody.
- 5) Identify the procedural alternatives open to an officer before taking a juvenile into custody.
- 6) Identify each of the juvenile's rights regarding parent notifications and telephone calls before being placed into detention.
- 7) Identify the requirements pertaining to the segregation of juveniles from other prisoners.
- 8) Identify legal restrictions on maintenance of arrest information on juveniles, including when fingerprints and photographs can be taken.
- 9) Identify the laws regarding confidentiality of juvenile related records and to whom and under what conditions such information may be released.
- 10) Define "Serious Juvenile Offenses."
- 11) Define "Serious Juvenile Repeat offender."
- 12) Define the following terms and identify the Connecticut statutes pertaining to them, as well as proper police procedures for their compliance.
  - a) "Family with Service Needs"
  - b) "Child from a Family With Service Needs"
  - c) "Neglected Child"
  - d) "Uncared for Child"
  - e) "Termination of Parental Rights"
  - f) "Emancipation of Minor"
  - g) "Status Offenses"
  - h) "Protective Custody"
- 13) Identify techniques for handling incidents, such as wandering, that involve juveniles and adults with Autism Spectrum Disorder (ASD), cognitive impairment, or Nonverbal Learning Disorder (NLD). **(This section pursuant to P.A. 19-147).**
- 14) Identify the Connecticut statutes relative to "Non-Judicial" and "Judicial" disposition alternatives in juvenile cases including restitution.
- 15) Identify youth service agencies in Connecticut.
- 16) Identify the relationship between the needs of youth, societal pressures and juvenile delinquent behavior.
- 17) Identify the day-to-day problems of adolescents which may provide motivation for delinquent behavior.



- 18) Identify the general behavioral characteristics of most adolescents.
- 19) Recognize police responsibilities when dealing with juveniles.
- 20) Identify the ways a patrol officer can contribute to the prevention of delinquency.
- 21) Identify various successful police youth programs.
- 22) Identify the potential effects of officer juvenile contacts on:
  - a) The officer and his department
  - b) The Juvenile
  - c) The family
  - d) The community
- 23) Define juvenile delinquency and list five causes of juvenile delinquency.
- 24) Compare terms used in the criminal court with terms used in juvenile court.
- 25) Interpret the 1967 U.S. Supreme Court decision re: Gault.
- 26) Define truancy and outline procedures for returning a child to school.
- 27) Identify the federal and state court decisions dealing with school searches, arresting and interviewing of juveniles.
- 28) List the four main referrals made for juveniles with delinquency problems.
- 29) Re: Runaways
  - a) List reasons for running away.
  - b) List prevalent forms of victimization.
- 30) Compare and contrast delinquency prevention and delinquency control.
- 31) Describe "Victim's Rights" in relation to juvenile offenders.
- 32) Identify the Connecticut statutes relative to Parental liability for acts of juveniles.
- 33) Describe proper police procedures for juveniles as they apply to:
  - a) Arrest /Arrest Options
  - b) Searching
  - c) Issuing of Summons
  - d) Detention
  - e) Release
  - f) Testifying in Juvenile Court
  - g) Report Writing
  - h) Booking
- 34) Identify basic procedures related to taking into custody a person detained by a citizen.

#### 410 LAW ENFORCEMENT & CITIZENS WITH SPECIAL NEEDS (4 hrs)

##### INSTRUCTIONAL GOAL:

This course will focus on recognizing and dealing with persons who have special needs, persons in crisis, and persons demonstrating social/emotional deviance such as neurotic or psychotic behaviors. Other forms of behavior stemming from emotional problems will be explained.

##### PERFORMANCE OBJECTIVES:

- 1) Recognize legal requirements regarding emergency detention and commitment of mentally ill persons.
- 2) Identify proper procedures to conduct investigation regarding a reportedly mentally ill person.
- 3) Identify commonly available community resources available to emotionally disturbed persons.
- 4) Identify proper procedures to take custody of and transport mentally ill persons.
- 5) Identify non-language factors which contribute to a negative response from people such as disrespectful attitude, officious tone of voice or manner, use of body language.
- 6) Identify language style factors which contribute to a negative response from the public such as profanity, derogatory language, ethnically offensive terminology, inappropriate use of police jargon.
- 7) Identify major indicators of subject's mental or emotional state.
- 8) Identify factors which affect perception by an individual, such as past experiences, maturity, mental condition, physical condition, environment, emotional involvement.
- 9) In role play, identify good and bad intervention/mediation practices.
- 10) Identify techniques for defusing subject's crisis or stress symptoms such as acknowledging his ordeal, provide active listening, ask diversionary questions, explain options and procedures that will occur.
- 11) Identify factors to be considered when handling mentally disturbed or irrational persons, such as to ignore verbal abuse, avoid excitement, use restraining force sparingly.
- 12) Demonstrate problem solving skills.
- 13) Recognize aggressive behavior.
- 14) Recognize the principles of interpersonal mediation/counseling techniques.
- 15) Demonstrate the ability to use interpersonal mediation/counseling techniques to encourage subject cooperation, disclosure, etc.
- 16) Recognize those situations when short term crisis intervention mediation/counseling is needed.
- 17) Explain the etiology of a crisis.
- 18) Explain the history of mental illness and its use as a defense in court.
- 19) Explain the history of the integration of mentally troubled people into society.
- 20) Recognize the symptoms and how to effectively communicate and assist persons with "Special Needs" such as
  - a) Hearing Impaired,
  - b) Visually Impaired,
  - c) Intellectual Disability,
  - d) Mobility Impaired,
  - e) Autism Spectrum disorder,
  - f) Persons with neurological disorders such as Alzheimer's, and, Parkinson's.

- 21) Identify federal and state laws relative to "Persons with Special Needs" such as Americans with Disabilities Act, Rehabilitation Act of 1973, Guide Dog Laws, Equal Access Laws, Laws dealing with interpreters.
- 22) Identify commonly available community social service agencies.

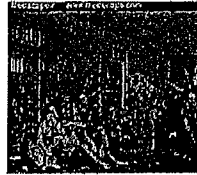
## CITIZENS WITH SPECIAL NEEDS- MENTAL ILLNESS

- DEINSTITUTIONALIZATION
- MI & THE JUSTICE SYSTEM
- PSYCHIATRIC DISORDERS
- VIOLENCE AND MENTAL ILLNESS
- CRISIS INTERVENTION
- PSYCHIATRIC FOLLOW UP

## Keep an Open Mind Video

## ASYLUMS

- BEDLAM



## Early Treatment Video

### Early Treatment of Mental Disorders

Courtesy: History of Medicine Division,  
National Library of Medicine

## Lobotomy Video



## STATISTICS (Mental Health)

- US, STATE & COUNTY PSYCHIATRIC HOSPITALS
- 1950 - 592,853
- 1970 - 432,520
- 1980 - 162,093
- 2003 - < 80,000
- 2013 - < 60,000

## MENTAL HEALTH STATISTICS (CONT.)

- In 1955 there were 340 public psychiatric beds available per 100,00 people
- By 2005 the number dropped to 17 per 100,000

Treatment Advocacy Center, 2008

## STATISTICS

### (Criminal Justice) (2003)

- 2.1 million Americans incarcerated
- 1 in 5 with serious mental illness
- *"Jails and prisons have become the nations default mental health system"*
- *"The level of illness ...has been growing more severe in the past few years"*

Sunday New York Times, April 23, 2006

- *"Study found that prison compounds the problems of the mentally ill, who may have trouble following the everyday discipline of prison life, like standing in line for a meal"*
- *Some exhibit their illness through disruptive behavior, belligerence, aggression and violence"*

Sunday New York Times, April 23, 2006

## COMPETENCE TO STAND TRIAL



- Understanding charges
- Basic understanding of court proceedings
- Ability to assist in one's defense
- Restoration to Competency

## NOT GUILTY BY REASON OF INSANITY

- < 1/2 of 1% of all cases
- Unable to understand wrongfulness or to control conduct due to MI or MR
- In CT will be under jurisdiction of PSRB



## NGRI Video

## JAIL DIVERSION

- Alternative to incarceration
- Minor Offenses
- Mental Illness
- Appropriate dispositions
- Police and Judicial training



## WHAT is MENTAL ILLNESS?

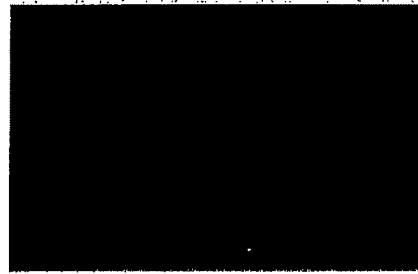
A Disturbance in:

- Thought
  - Emotion
  - Behavior
- MENTAL ILLNESS takes away CONTROL of Behavior and Choices

## What Causes Mental Illness?

- Genetics
- Trauma
- Medical Illness
- Medication
- Substance Abuse

## MI Video-Psychotic Experience



## Types of Mental ILLNESS

- Disturbance of THOUGHTS
- Most severe
- Break with REALITY
- Confusion between thoughts & reality
- Usually requires medications
- Schizophrenia, Paranoia, other psychoses

## Characteristics of Thought D/O

- *Hallucinations : Brain sensations experienced as real*
- *Delusions : Fixed false beliefs that others don't believe to be true & interferes with functioning*
- *Speech Irregularities : Clanging, echolalia*
- *Delusions of Reference : over-interpretation of common events*

## Emotional Disorders

- Most Common Disorders
- Extreme emotions of sadness and euphoria – either alone or together
- Emotions interfere with life
- Risk of Suicide
- Examples: Depression and Bipolar illness

## Behavioral Control D/O

- Often begin in childhood (as ADHD)
- IMPULSIVE (act w/o thinking)
- Behavior often accompanied by ANGER
- Examples: ADHD, Explosive D/O, Sexual deviance

## SCHIZOPHRENIA

- DELUSIONS
- HALLUCINATIONS
- DISORGANIZED SPEECH
- GROSSLY DISORGANIZED OR CATATONIC BEHAVIOR
- NEGATIVE SYMPTOMS
- Approx 1-2% of population

## PARANOIA

- MAY BE PRESENT ALONE OR WITH ANOTHER DISORDER
- MAY READ HIDDEN MEANING
- MAY BE SUSPICIOUS OF OTHERS
- OFTEN ON THE DEFENSIVE
- DELUSIONS MAY BE GRANDIOSE OR PRESECUTORY
- TIME AND REALITY MAY BE DISTORTED

## MANIA

- GRANDIOSITY
- DECREASED NEED FOR SLEEP
- PRESSURED SPEECH
- RACING THOUGHTS
- DISTRACTIBILITY
- PSYCHOMOTOR AGITATION
- LOSS OF INHIBITION

## ANXIETY DISORDERS

- PANIC ATTACKS
- AGORAPHOBIA
- OCD
- PTSD
- GENERALIZED ANXIETY
- WITH PANIC DISORDER THERE IS AN INCREASED RISK OF SUICIDE

## SEXUAL DISORDERS

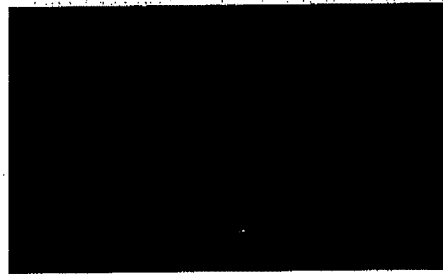
- **Pedophilia:** Sexual activity with a child, usually 13 years or younger, or in the case of an adolescent, 5 years younger than the pedophile.
- **Voyeurism:** Sexual fantasies urges or behaviors involving observing an unknowing and non-consenting person, usually unclothed and/or engaged in sexual activity, to produce sexual excitement.
- **Exhibitionism:** Sexual fantasies, urges, or behaviors involving surprise exposure of the individuals genitals to a stranger.

## Depression & Suicide

## Sx of Depression

- Depressed Mood
- Loss of Interest or Pleasure
- Significant Weight Change
- Insomnia or Hypersomnia
- Poor Concentration
- Fatigue
- Feelings of Worthlessness or guilt

## Terry Wise Video



## Police, Depression & Suicide

## Reasons for Police Suicide

- Legal Trouble - 15%
- Relationships - 32%
- Stress - 11%
- Critical Incident - 6%
- Illness - 3%
- Financial - 7%
- Psychological - 12%





## Primary Factors in Police Suicide

- Divorce
- Use of Alcohol (not alcoholism)
- Depression
- Failure to get help (most officers who committed suicide never sought counseling)

## Warning Signs

- Clinical Depression
- Significant personal loss
- Drug or Alcohol abuse
- Previous Suicide attempts
- A marked negative change in behavior
- Anniversary reactions
- Reckless behaviors



## Stress, PTSD & Suicide

- PTSD coupled w/ alcohol abuse = 10 x risk of suicide
- PTSD due to witnessing death, devastation, abused children = over 3x risk
- PTSD witnessing homicide of another officer = 2.5 x risk

## Badge of Life Video

## Citizens & Depression/Suicide

## Reasons for Suicide

- |                      |                             |
|----------------------|-----------------------------|
| • <u>Recent Loss</u> | • Ending "Pain"             |
| • Poor Health        | • No way out                |
| • Financial problems | • Shame                     |
| • Depression         | • "Join" deceased loved one |

### Adult Depression & Warning Signs

- Similar symptoms : Mood and lethargy usually very noticeable
- History of gestures/attempts
- Obvious guilt or shame
- Sudden, unexplainable relief from depression

### Youth Warning Signs

- Increase in moodiness, withdrawal, isolation
- Sudden drop in school grades, performance
- Decrease in interests, activities
- Giving away possessions
- Saying good-bye or hinting about not being around in the future

### Risk Factors for Suicide (All)

- Family History
- Depression
- Male
- Young adult or senior
- History of prior attempts or threats

### Protective Factors

- Effective clinical care for depression, MI
- Family & community supports
- Skills in problem solving, conflict resolution & non-violent ways of handling disputes
- Cultural & religious beliefs that discourage suicide & support self preservation

### Bullying, Etc....

- New "epidemic" of suicides blamed on
- Bullying
- "Social Networking" (facebook, etc)
- Texting

### CRISIS AND DEPRESSION

- Can be unpredictable and dangerous
- Person often has trouble making decisions
- Negotiator must be firm & manipulative
- You can try to talk about other topics to divert their attention
- LISTEN ! Don't Rush!

## Issues when responding

- Weapons ?
- Age
- Location
- Present situation
- Who is involved ?
- Psychiatric Hx ?
- Medications?
- Prior attempts ?
- Recent Hx
- Suicide by cop

## BORDERLINE PERSONALITY DISORDER

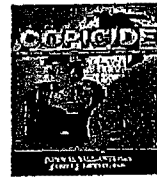
- Unstable mood
- Unstable relationships
- Intense anger
- Self-destructive behavior
- Impulsivity
- Feelings of emptiness

## Borderline

- You are either good or bad – no GRAY areas
- Often self mutilate
- Sometimes for attention
- Sometimes to "feel"
- Scene will have lots of DRAMA

## Suicide by Cop

- Victim Precipitated Homicide



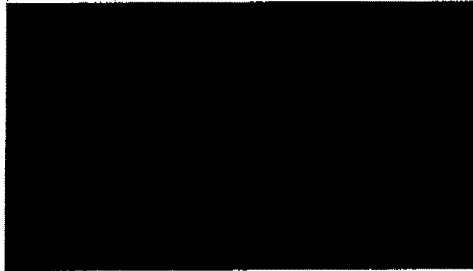
## Suicide by Cop

- Police can be confronted in a calculated & deliberate manner by people suffering from one, or combination of suicidal tendencies, mental illness and substance abuse
- Victims may cause or contribute to a police shooting intentionally or unintentionally

## ....More

- Subject may call 911 to dispatch officers
- In most cases subject refuses to drop weapon
- May act in a threatening manner
- May act dangerously in front of police

## Suicide by Cop Video



## Mental Retardation- Cognitive Deficits

## Characteristics of MR

- Increased anxiety, impulsivity, volatility
- Difficulty following directions
- Decreased ability to problem solve and increased efforts to use force

## Strategies with MR

- Reassurance and calm approach
- SIMPLE instructions : one command at a time & repeat questions, reinforce answers
- Praise cooperation
- Remove distractions

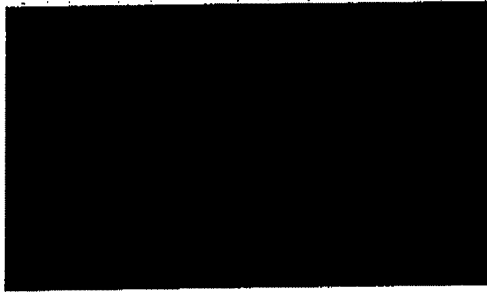
## TBI's or Advanced Age

- Impaired Processing:
  - Easily over stimulated
  - Slow to respond
  - Confusion
  - "Word finding" difficulty
- \* Emotional volatility : get upset easily, exaggerated responses

## Strategies for TBI's, Elderly

- Make eye contact
- Speak SLOW & SOFT (not exaggerated)
- Ask about hearing – "Can you hear me all right?"
- WAIT for a response
- Don't TOUCH without letting them know
- Be prepared for ANYTHING!

## Alzheimer's Video



## Autism Spectrum

- Autism crosses all racial, geographic and socio-economic boundaries
- Affects more males than females (4:1)
- Current incidence is approximately 1 in 150 births – and rising!
- 10/6/09 – 1 in every 100 births
- Can be found in all age groups

## More on Autism

- Autism is NOT caused by
  - Poor parenting
  - Environmental Trauma
- Autism is NOT the same as MR
- People affected are diverse & can grow & change over time (spectrum disorder)

## Also.....

- Echolalia common (repeating what you just said) – not meant to annoy you
- May appear “rude” or “arrogant”
- Inability to read body language
- Eye contact varies widely
- May be hypersensitive or hyposensitive
- Repetitive words or behavior to calm down

## Important for Police Officer?

- People w/ developmental disabilities are 7 times more likely to come in contact w/ Law Enforcement
- People w/ autism Act & React in unexpected ways
- High percentage w/ autism are children – they will grow up!

## Likely Scenarios

- Elopement : bolting or wandering toward something. May want to be rescued
- Domestic Calls – behavior out of control
- Victim of Bullying or scapegoating (community, schools may call)
- Suspected shoplifting
- Trespassing
- Voyeurism, stalking

## Autism Impacts

- Language skills
  - Almost 50% non-verbal
  - Use alternate means to communicate (signing, picture cards)
  - Receptive and expressive skills unequal
  - Speech may be peculiar in pitch, rhythm
  - Often take things "literally"

## Handling Situations

- Reduce sensory overload
- Do not rush- if possible allow the person to de-escalate themselves
- Avoid physical contact
- Use short, clear sentences (1 step directions)
- Avoid slang or figurative language

## Also.....

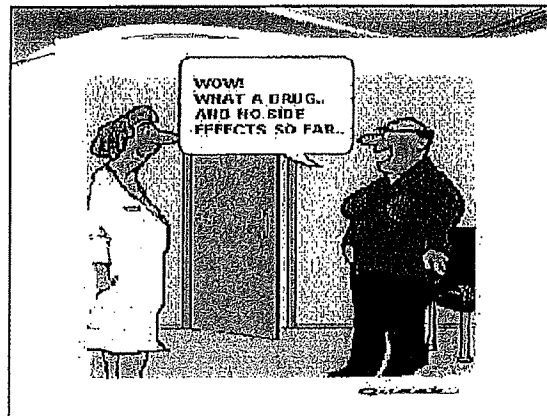
- Provide time waiting for responses (some may need as much as 45 seconds to process a question or request)
- They often give false confessions
- High distractibility
- Self injurious behaviors
- Seemingly irrelevant responses

## Medication compliance



## Why don't people take their meds?

- It is easy to forget
- In fact 1/3 of general population take meds as prescribed
- 1/3 don't even get the script filled
- Another 1/3 take incorrectly or not completely

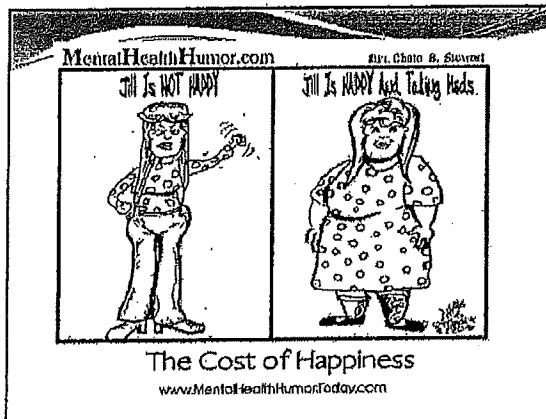


## Side effects

- Sedation
- Blurry vision
- Drooling
- Slurred speech
- Stiffness in arms & legs
- tremors

## More.....

- Hair loss
- Acne
- Dry mouth
- Constipation
- Stomach upset/nausea
- Diarrhea
- Weight gain



## OUTPATIENT COMMITMENT

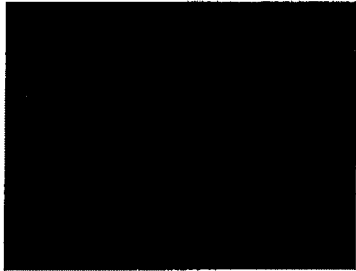
- Mental health law allowing court-ordered community-based treatment of individuals with mental illness
- 35 states and the District of Columbia have a form of outpatient commitment
- CT is one of the states that does not
- Concerns include: civil liberties, liability, Non-compliance and criteria that are too restrictive

## Alternatives to Outpatient Commitment

- Conditional Release is widely used in New Hampshire
- Jail Diversion, Probation and Parole
- California uses conservatorship/guardianship
- Within many states availability varies considerably by locale

## Substance & Alcohol

### Drunk Video



### Dilated

- Stimulants

- Cocaine
- Crack
- Meth

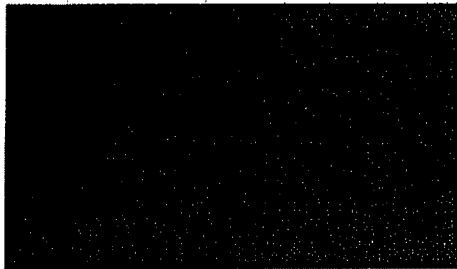
### Stupid Video

### Pinpoint Pupils

- Depressants

- Heroin
- Opiates

### Excited Delirium Video



## **VIOLENCE**

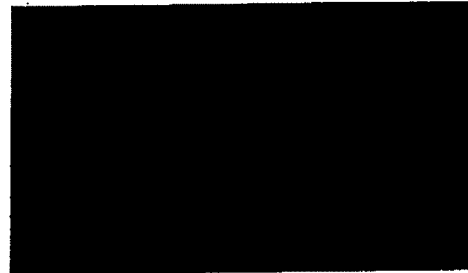
WHAT ARE THE RISK FACTORS?



## VIOLENCE AND MENTAL ILLNESS

- **MYTH:** PERSONS WITH MENTAL ILLNESS ARE MORE VIOLENT THAN THE GENERAL POPULATION
- **FACT:** WHEN TREATED, PERSONS WITH MENTAL ILLNESS EXHIBIT APPROXIMATELY THE SAME LEVEL OF VIOLENCE AS THE GENERAL POPULATION

## Violence & MI - Video



## GENERAL RISK FACTORS FOR VIOLENCE

- History
- Gender
- Age
- IQ- 85 and below
- Socioeconomic status
- Psychopathy
- **SUBSTANCE ABUSE**

## VIOLENCE AND MENTAL ILLNESS

- **SUBSTANCE ABUSE**
- **NON-COMPLIANCE WITH MEDS**
- **COMMAND HALLUCINATIONS**
- **PARANOIA (with TCO)**
- **DEPRESSION**

## MENTAL ILLNESS & HOMICIDE

- Approximately 95% of all homicides committed each year are by people who DO NOT have a mental illness
- A person without a mental illness is 400% more likely to commit a homicide than one with a mental illness
- A person with schizophrenia is 100 X more likely to commit suicide than homicide

## WRAPPING UP

## CIT

- Crisis Intervention Team
- Collaboration between DMHAS & Police
- Police receive 40 hours special training
- Referral Mailbox in Records Room
- Leave info there or call
- Cell Phone: 203-521-0089

## CIT Video

## CIT

- Crisis Intervention Team
- Collaboration between DMHAS & Police
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## CIT Video

## Responding to Individuals with Developmental Disabilities

***Peter Tolisano, Psy.D., ABPP***

Board Certified in Clinical Psychology  
Director of Psychological Services  
Connecticut Department of Developmental Services

***Tracey M. Sondik, Psy.D.***

Director of the Behavioral Intervention Service  
Connecticut Valley Hospital  
Department of Mental Health and Addiction Services

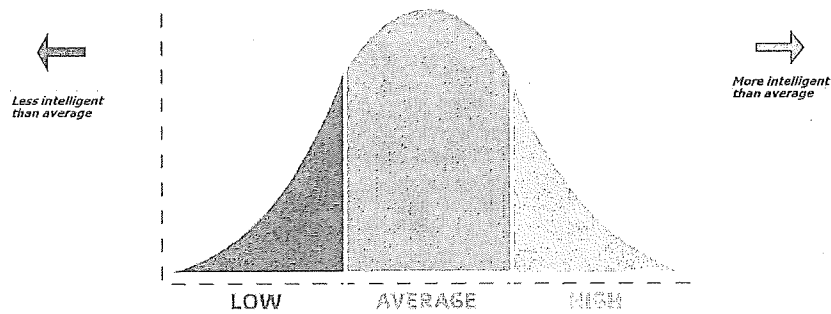
***Jennifer Krom, MA, LPC***

Director of Autism Services  
Beacon Health Options

## Goals of the Presentation

- Better identify the cognitive and adaptive deficits that are associated with developmental disabilities
- Learn about the functioning of focal regions in the brain
- Understand the basics about autism spectrum disorder
- Change the way in which behaviors are perceived
- Appreciate that all behaviors serve a function
- Increase knowledge about proactive and reactive strategies

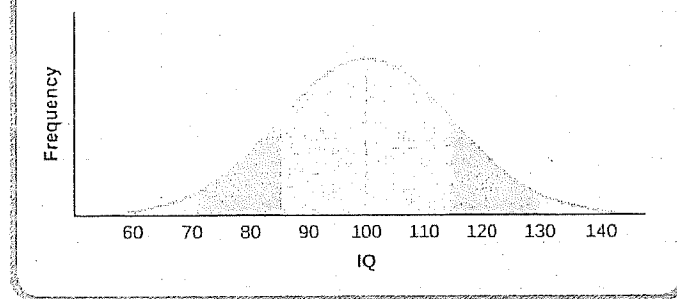
## Understanding Intellectual Disability



I/DD are noted to have over 250 causes:

- 25% are syndromal (e.g., Down, Fetal Alcohol, Rhett, Fragile X, Cornelia de Lange)
- 75% are non-syndromal (e.g., problems during the birth process).

## Intelligence Quotient Score



**Intellectual Developmental Disorder** (formerly mental retardation) has a three part definition. (1) an IQ score of 70 or below (standard error of measurement  $\pm 5$  points) with (2) concurrent deficits in adaptive functioning, and (3) that had an onset during the developmental period from birth to 18 years old.

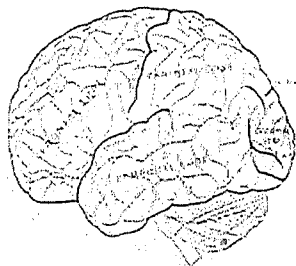
## Degrees of intellectual disability

- MILD intellectual disability
  - has an IQ 50-70
- MODERATE intellectual disability
  - has an IQ 35-49
- SEVERE intellectual disability
  - has an IQ 20-34
- PROFOUND intellectual disability
  - has an IQ less than 20

### Degrees of Severity

- Mild 85%
- Moderate 10%
- Severe 3%
- Profound 2%

## Brain Regions



The brain has three main parts:

- Frontal lobes for higher-order thinking and executive functions: These include a sense of time and context, planning, inhibiting and initiating action, self-monitoring, and empathic understanding. The "high road."
- Limbic system that governs emotions. Key areas are the amygdala and the hippocampus. The "low road."
- Brainstem that controls vital physical functions and survival responses.

## Categories of Intellectual Functioning

### Verbal Comprehension:

- General knowledge and reasoning skills. Related to formal and informal education.
- Language is central our ability to label, organize and manage our internal experiences and the external environment.
- Difficulty putting feelings and needs into words makes individuals prone to frustration, aggression, and depression.

### Perceptual Organization:

- Visual-spatial skills.
- Ability to create solutions, especially in novel situations.

## Categories of Intellectual Functioning

### Working Memory:

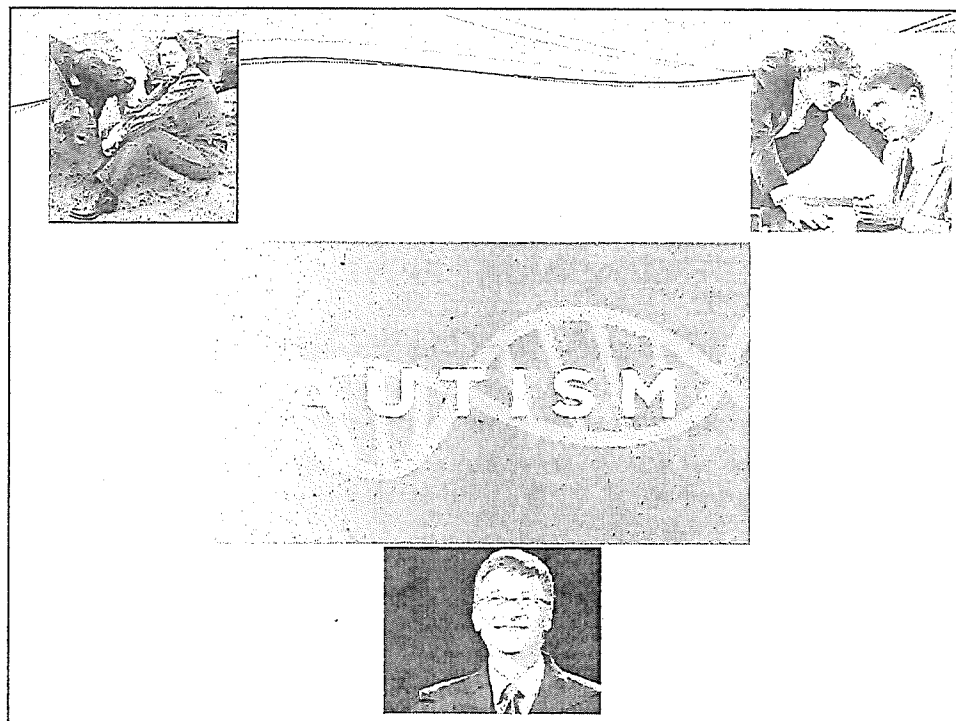
- In-the-moment reasoning tied to attention, concentration, and short-term memory.
- Important to learning, flexibility, planning, and self-monitoring.
- Sensitive to anxiety and depression.
- Related to trauma responses and anger management

### Processing Speed:

- Ability to work quickly and efficiently.
- Sensitive to motivation and persistence.
- PS may negatively effect overall cognitive functioning.

## Adaptive Functioning

- ❖ Based on performance of daily activities at a given age, rather than ability. That is, understanding an individual's functioning through a "developmental lens" with age-equivalents.
- ❖ Refers to how effectively people cope with common life demands across multiple environments.
- ❖ Domains of Practical, Conceptual, and Social skills.
- ❖ Specific areas may include the following:
  - ☐ Self-care (e.g., hygiene and grooming)
  - ☐ Expressive and Receptive Communication
  - ☐ Social and Community Activities
  - ☐ Independent living skills (e.g. housekeeping)
  - ☐ Health and safety
  - ☐ Vocational abilities
  - ☐ Self-direction



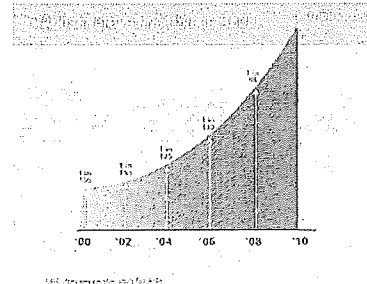


## Statistics

- About 5:1 male-to-female. In 2014, it occurred in 1 in 42 boys, as compared to 1 in 189 girls.

### A Steady Increase in Prevalence:

- × birth year of 1992- rate 1 in 150
- × birth year of 1996-rate of 1 in 125
- × birth year of 2000-rate of 1 in 88
- × birth year of 2002-rate of 1 in 68
- Its found across all cultures and socioeconomic groups.



## Why is the Prevalence of Autism Increasing?

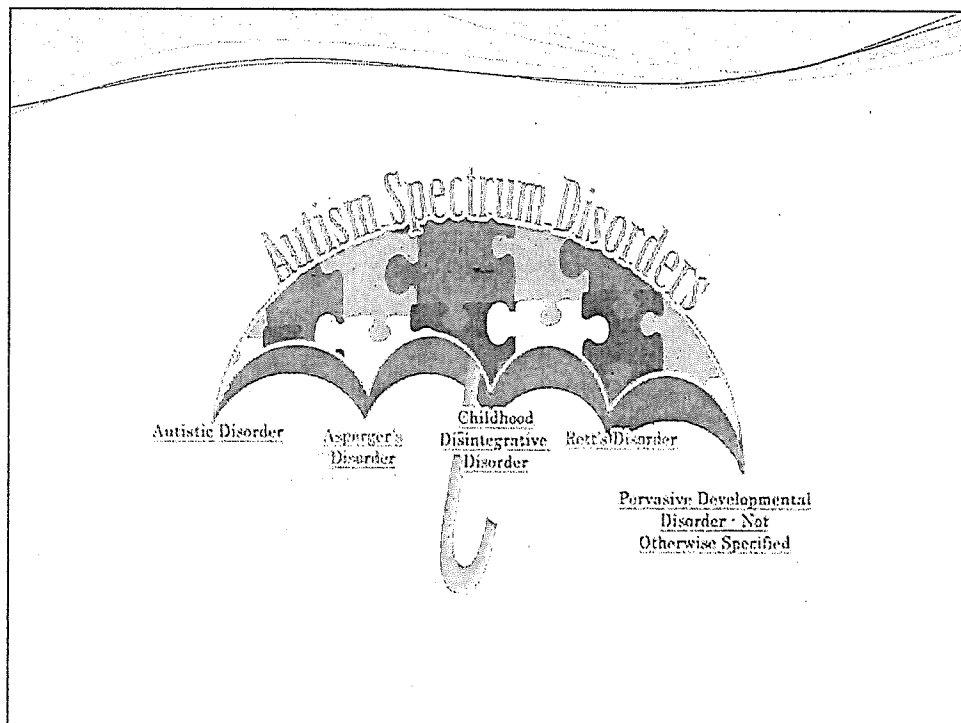
- Probably genuine rates and previous underestimates
- Diagnostic changes with a broadening of categories
- Better tools and identification process (i.e., ADOS)
- More awareness (e.g., mental health providers, pediatricians, schools, media, parents)
- Improved access to services (e.g., waivers) and associated treatments (e.g., Applied Behavior Analysis, speech therapy)



## Autism

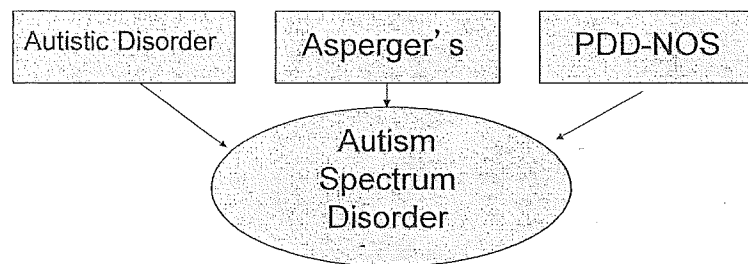
- It's called a spectrum condition because of its extreme complexity.
- Functional capabilities and needs vary widely from person-to-person. For example, some can access language, transition in the daily routine, and perform self-care, others may require assistance.
- Some may use rocking, flapping, spinning, etc. for self-regulation.
- They may easily become overwhelmed in a crisis and engage in challenging behaviors that might be misinterpreted as disrespectful. These might include invading personal space, giggling, speaking loudly, talking about unrelated topics.
- Some may not feel or express physical pain (sensory integration dysfunction)
- Some may process information better when avoiding eye contact and may look like they don't want to pay attention.

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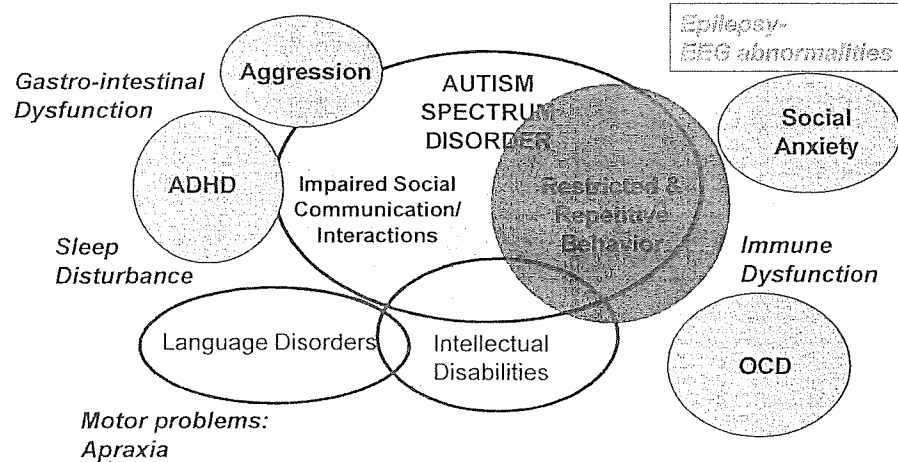


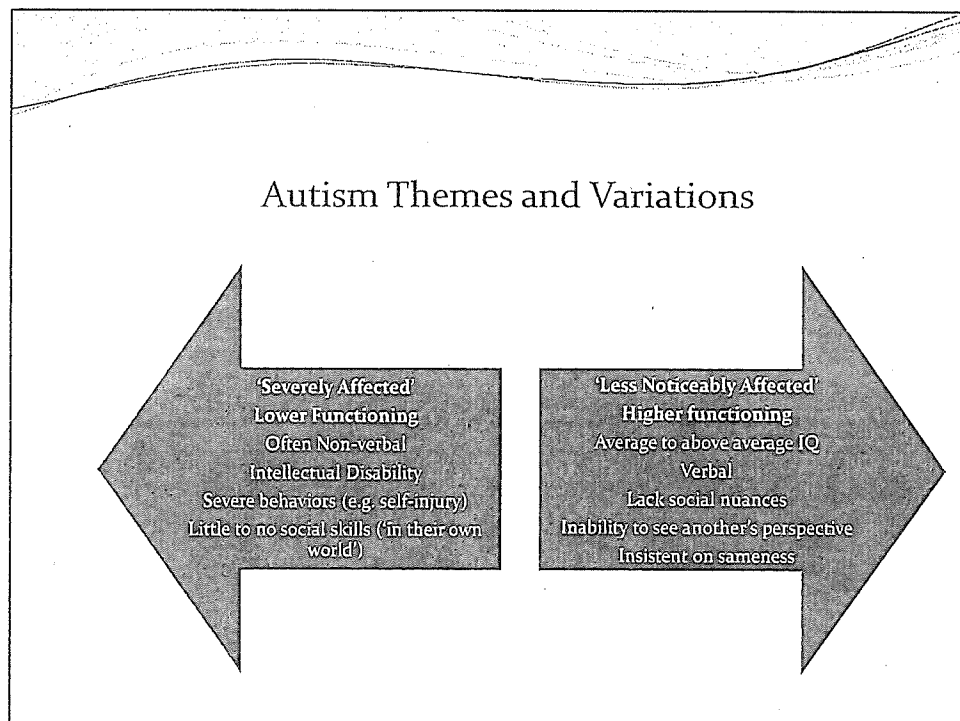
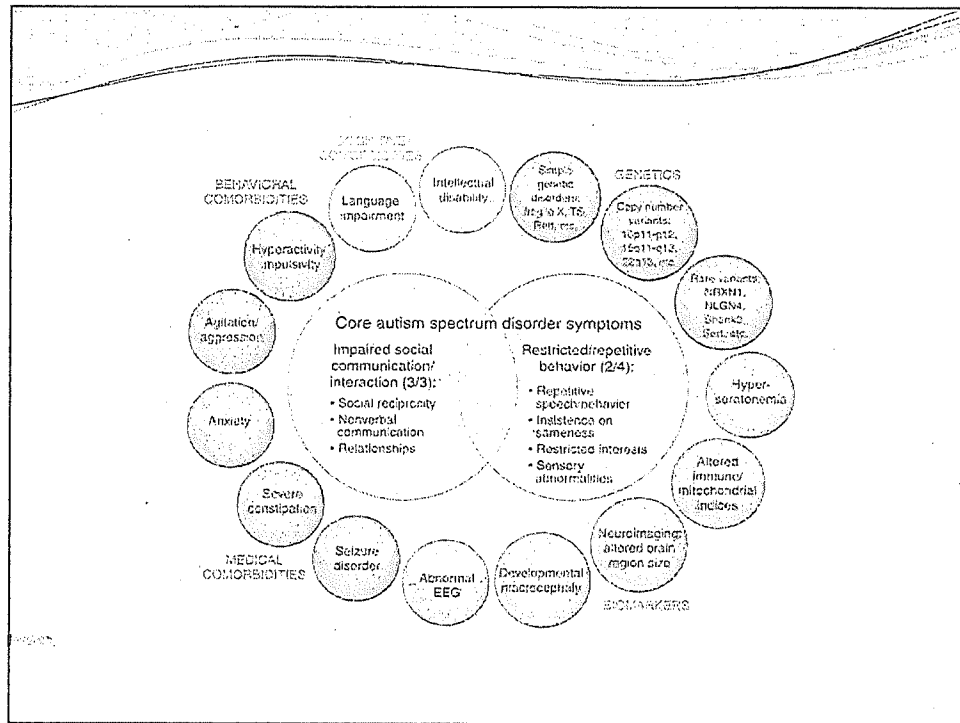
## Diagnostic and Statistical Manual (DSM-5) Changes in 2013

Distinctions can be difficult across the spectrum and with other disorders



## Conditions and Symptoms Associated with Autism Spectrum Disorder





## Autism Spectrum Disorder

### Theory of the Mind:

- Those with an autism spectrum diagnosis often have significant difficulty understanding and appreciating that others may have thoughts, feelings, opinions, intentions, and plans that are different from their own.
- Difficulties with intuition, can result in the following:
  - Misreading body language (e.g., tone of voice, facial expression, posture).
  - Misinterpreting social cues
  - Problems with reciprocation
  - Difficulty understanding expectations
- Painful awareness of social differences and challenges with "fitting in" socially may give rise to episodes of anxiety and depression.

## Autism Spectrum Disorder

- Cognitive Functioning:
  - Often rigidly cling to beliefs, convictions, or rules.
  - Autism is frequently misassociated with intellectual disability.
  - On the contrary, strong language skills can easily be misinterpreted as advanced communication/social skills, which can lead others to mislabel their actions as purposeful and manipulative.

## Awareness

- Sensitives to even everyday stimuli can be uncomfortable or intolerable, especially for those with autistic features. For example, turn off sirens and flashing lights when possible or place canine partners out of sight.
- Consider physical fragility.
- Check for any special or assistive equipment. These could be signs of mobility issues.
- There is often a higher probability of neurological compromise (e.g., seizure disorder) with developmental disabilities.
- *A person might not be aware of their own deficits!*

## Awareness

- Look for mental health difficulties (e.g., unusual behaviors, poor reality testing, "fight or flight" responses related to past trauma)
- Self-protective responses may not be intended as aggressive.
- Don't assume that the person is intentionally trying to be difficult, as some challenges might be out of their control. For example, inability to access vocabulary might cause problems reporting events accurately or memory deficits might lead to problems understanding multi-step directions.
- Look for signs of misunderstanding and poor comprehension, especially the use of psychosocial masking (e.g., nodding in agreement, politely saying yes) to adaptively conceal impairments.

## Communication Challenges

- Some people with disabilities can understand even if they can not express themselves (expressive language disorder).
- On the contrary, some who speak may not understand or may say things out of context (receptive language disorder).
- It's okay to ask the person to repeat themselves or to demonstrate (contextual grounding) something for you.

## Communication Tips

### Language

- ☐ Speak clearly, calmly, and softly
- ☐ Show interest and concern
- ☐ Use direct and short phrases
- ☐ Avoid slang expressions, idioms, and metaphors (e.g., "knock it off," "cut it out," or "settle down")
- ☐ Watch for words that are "triggering" which may exacerbate agitation, such as "If/then" statements, as the person might need think contingencies are achievable.

## Communication Tips

- Ask the person to repeat back information to check for understanding.
- Try other ways to communicate through alternative (non-speech) methods, such as drawings, pictures, cues, gestures, signs, or an I-Pad.
- Try to speak with the person directly even if a staff member or person without a disability is present. However, there might also be times to seek information and assistance from others at the scene, especially those who might know the individual well, such as family and friends.
- Always speak respectfully in the person's presence. Use "person-first" language (e.g., An individual with disability).
- Share what you learn about the person with others who will be assisting.

## *The Power of Acknowledging Perspectives:*

- ❖ Active listening by being attuned (e.g., undivided attention)
- ❖ Accurate reflection to defuse negative emotions
- ❖ Validation only means *acknowledgement*, not necessarily agreement
- ❖ In the Crisis Cycle, when possible *sufficiently* validate before giving any corrective feedback, such as redirecting, limit setting, or finding solutions.
- ❖ Remember any contextual factors (e.g., holidays)



## Communication Tips

### Choices

Offering two to three choices when possible provides the person with a sense of control. *These choices may lead to a similar outcomes (e.g., de-escalation). Be mindful that overly negotiating may lead to confusion and disorganization for those with developmental disabilities.*

### Reinforcement

Give verbal praise immediately (within 30-60 seconds) and explicitly, rather than delayed.

### Compassionate Inquiry

Give them a better sense of self (e.g., *What does {positive behavior} say or tell us about you?*)

### Verbal Maps

Help them connect words and actions

### Shaping

Reward "successive approximations" to the desired goal

## Communication Tips

### Setting and Reviewing Expectations

- Allow them extra time to process and respond
- Have realistic expectations.
- Be consistent with language, especially between responders.
- Rephrase questions or restate directives as needed.
- *Learning problems may interfere with understanding what constitutes "appropriate" behavior. Therefore, directives should be very specifically convey the expectation...*

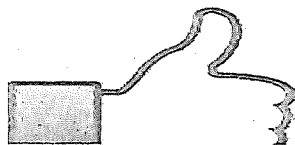
## Communication Tips

### *The Importance of Stating Directives in Affirmative Language*

- ❖ Tell the person what you want them to do, rather than what you do not.
  - "Use an 'inside' voice," instead of "Stop talking so loudly"
  - "Keep your hands down," rather than "Don't hit"
  - "Let's relax with some slow breathing," not "Stop being so anxious"
- ❖ Watch for engrams (a mechanism of memory in response to external stimuli). These "hot spots" that get activated in the brain cause people to only hear the triggering part of a message!

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## Positive Behavior Supports



A comprehensive approach that views behaviors as goal-directed and interconnected with physiology, situational context, cultural factors, as well as a person's thoughts and feelings.

### *Intelligence and Behavior*

- *Intellectual impairment is often related to behavioral problems with delaying gratification, controlling impulses, and tolerating frustration.*
- *The best approach is building on cognitive strengths and minimizing weaknesses. For example, providing information using pictures, rather than words, to someone with visual-spatial strengths and verbal limitations.*

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## **Positive Behavior Support**

### **Support for Positive Behavior**

Support = Encouraging, increasing, and strengthening

Positive Behavior = desirable, adaptive, and prosocial

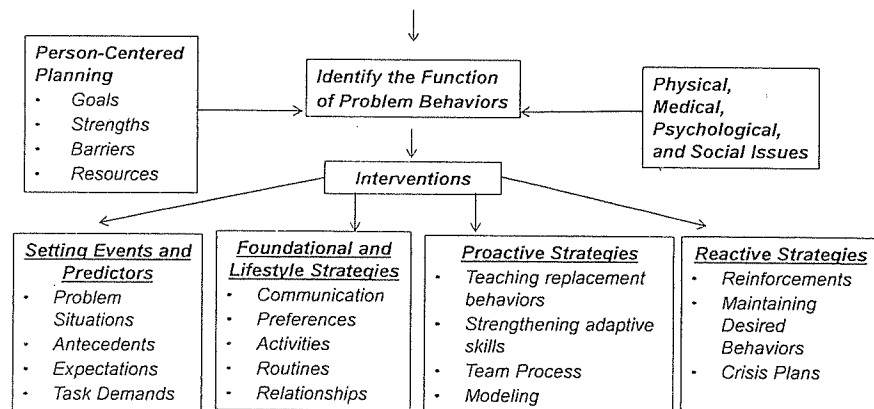
*Avoids the use of aversive, humiliating, or stigmatizing interventions*

## Positive Behavior Support

### Hallmarks and Strategies:

- Proactive setting of expectations
- Teaching acceptable behaviors
- Building on existing appropriate behaviors
- Improving quality of life
- Integrity with implementation

## Positive Behavior Support Flowchart



## Positive Behavior Support

### *Targeted* Positive Behaviors:

❖ *To achieve, instill, increase, and maintain*

- Increase emotional regulation through coping strategies, self-soothing, healthy diversions, and opportunities to learn self-control.
- Become more adaptive and self-reliant by building autonomy, mastery, confidence, and self-direction.
- Increase prosocial skills and participation in community activities

## Positive Behavior Support

### *Behaviors of Concern:*

- ❖ *Those to decrease or eliminate.*
- ❖ These include verbal outbursts, physical aggression, property destruction, perseveration, poor boundaries, and refusals.

### Criteria for a Behavior of Concern:

- Interferes with his or her growth, development, or progress.
- Interferes with his or her ability to make decisions and to achieve goals.
- Results in a psychotropic medication being prescribed to modify the behavior.
- Poses a risk to the health and safety of the individual and others.

## Positive Behavior Support

### Setting Events and Vulnerabilities

- Situations in the environment combined with individual's deficits
- Think about setting events broadly (e.g., unstable blood sugar, seizure activity, undiagnosed sleep problems, medication side effects)

### Antecedents (or Triggers)

- What occurred immediately before the behavior?
- Fast versus slow precipitants?
- *External* (e.g., a conflict earlier in the day) versus *Internal* antecedents (e.g., feeling isolated and lonely)
- Lifestyle issues (e.g., interpersonal disappointments, problems accessing preferred activities)
- The "*universal trigger*" is often "*enforcing rules*" rather than thinking flexibly when giving direction and guidance.

## Positive Behavior Support

### Precursors

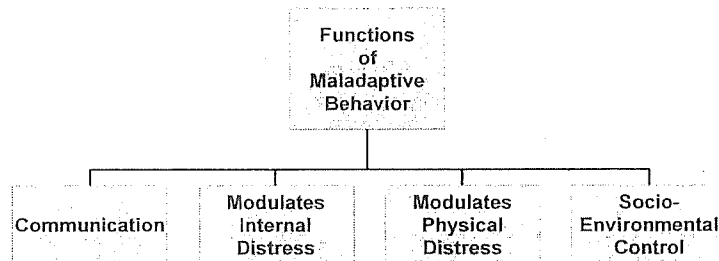
- What noticeable actions in body language came before the behavior of concern? (e.g., pacing, pressured speech, rolling their eyes, clenching their fists)

### Maintaining Consequences

- What occurred immediately after the behavior of concern?
- How did the caregivers respond? Is there inadvertent reinforcement?

## Functional Assessment of Behavior

*Better Understanding Why Individuals Engage in Maladaptive Behaviors Especially Those Seen with Intellectual Disability and Psychiatric Disorders*  
(Robert Souvner, 1991)



*Be aware that functions differ for each individual.  
Some might be readily apparent and others might not be noticeable.*

*Behaviors might serve multiple functions.*

### Asking the right questions!

- Is the challenging behavior a *symptom of a medical disorder*?
- Is it a *side effect of medication*?
- Is it the *result of skills deficits*?

*The following are some examples of how situations could have been avoided before assuming that the challenging behavior was due to mental illness or developmental disability...*

### Case Example One

*Mr. Jones has severe cognitive deficits. He is non-verbal. He has no history of being aggressive or destructive. One evening, he began ragefully throwing the furniture in his group home. He was taken to the local emergency room and seen by a psychiatric crisis specialist. Mr. Jones was admitted to a psychiatric hospital with a diagnosis of psychosis.*

### Case Example Two

*Ms. Smith is a woman in her thirties diagnosed with autism. She does not communicate much with words, but has strong opinions about her likes and dislikes. For many years, Ms. Smith attended a local regional center. She always refused to participate in group activities and community outings, during which she would scream, throw things, and occasionally disrobe. The center's staff was incredibly frustrated by Ms. Smith's behavior. There were numerous meetings about ways to address her unacceptable behavior, but nothing worked.*



## Positive Behavior Support

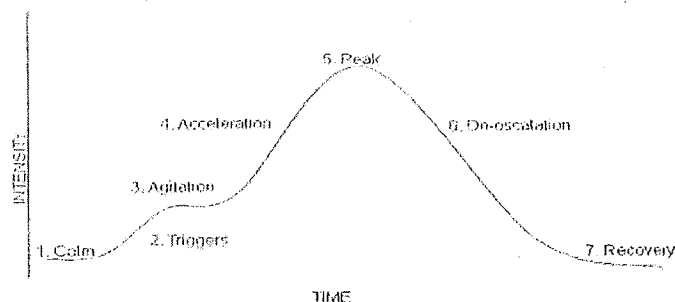
### Caregiver Qualities

- Supportive
- Respectful
- Strengths-based
- Collaborative
- Empowering
- Give choices
- Build self-esteem

*\*Key factor in resilience for traumatized children:  
A person who believes in them*

## Positive Behavior Support

### Proactive Versus Reaction Intervention Points



## Benefits of Proactive versus Reactive

A	B	C
<b>Proactive</b>		
Interventions to prevent problem behavior	Emphasis on teaching alternative behaviors	Positive reinforcement of desired behaviors
<b>Reactive</b>		
Limited focus on antecedent interventions	Little focus on teaching new behavior	Punitive response to negative behavior

## Positive Behavior Support *Reactive Strategies*

- ❖ Caregivers' actions after a behavior of concern occurs.
- ❖ For limited use about 5 to 10% of the time.
- ❖ These should be used to help situations from escalating. For example, prompting alternative behaviors, using distractions, redirecting away from triggers, or establishing control when there is harm to self or others.
- ❖ May include crisis response, police involvement, respite care, and hospitalization.
- ❖ Reactive interventions are affected by state-dependent learning. We may lose up to 25 IQ points when upset.

## Positive Behavior Support

### Overarching Goal

*Our aim is the presence of targeted adaptive and prosocial behaviors through instruction, not just the absence of challenging behavior.*

## Crisis Intervention Tips for those with Developmental Disabilities

- A process of “defusing” and “deflating” as we try to coach calmness in a situation without physical intervention when possible.
- Strive for three practical goals: **Safety, Connection, and Empowerment**
- General Techniques:
  - ☐ Show concern
  - ☐ Conceal emotions like anger and fear
  - ☐ Give hope about generating solutions
  - ☐ Ground in current reality
  - ☐ *Do not focus only on negative actions*
  - ☐ Congratulate steps toward regaining control
  - ☐ Focus on the individual’s interests and goals in life

## General Interaction Tips

- ❑ Announce yourself (name and role).
- ❑ Share your identification when possible.
- ❑ Have only one person act as the primary “interactor.”
- ❑ Don’t talk down to the person. Take an empathic stance.
- ❑ Avoid correcting behaviors. Give directives for positive behavior instead.
- ❑ Asks questions in a step-by-step manner.

## General Interaction Tips

- ❑ Tell them honestly what will or is likely to happen using everyday language.
- ❑ Avoid sudden and unpredictable movements.
- ❑ Avoid stopping their repetitive behaviors unless there is a risk of injury, as it they might be a means of self-regulating.
- ❑ Look for sensory aids and allow the person to hold a soothing item if safety is not jeopardized.
- ❑ Show the person what you want them to do if possible, rather than just stating it.

## General Interaction Tips

- ❑ Ask the person how you can best assist because the person with a disability can actually be their own best emergency manager.
- ❑ Taking time to explain something might actually save time in the long-run.
- ❑ Alleviate sources of distress when possible.
- ❑ Ignore self-talk that the person uses for coping unless it interferes in emergency procedures.
- ❑ A delayed or absent response to your questions or commands may not necessarily reflect a willful lack of cooperation.

## Ask about Existing Crisis Plans

*Proceed from least to most restrictive*

### Aggression:

- ❑ *Proactive Interventions:* Avoid confrontations and use a gentle approach.
- ❑ *Reactive interventions:* Give space. Provide distractions (country music, cold beverages).

### Elopement:

- ❑ *Proactive interventions:* Avoid loud crowds. Be sensitive to room filling with people.
- ❑ *Reactive interventions:* Give him space to walk off anxiety.

## Emergency Services Disability Form

I am a firefighter/EMT and prior to this a paramedic. I have a son with moderate Autism. During my career, which has spanned 32 years, I have seen a huge uptick in patients who have some sort of disability. Some are physical, some developmental. Each can come with their own set of challenges during an emergency and each situation is often different. Yet, even as the majority of dispatch centers in our state have come online with CAD( computer aided dispatch) I have yet to see a standardized resource that would allow a “head’s up” to police, fire and EMS as they respond to emergencies.

Of the 167 towns in CT and 133 dispatch centers we have no standard practice when it comes to collecting information on the needs of people with disabilities within each town.

As I attempted to gain access to someone in each of our towns that could answer my simple question, “Do you have a form/method for people with disabilities in your community to register information regarding their needs during an emergency?”, I discovered that not only didn’t every town have a system in place but that often these systems were hard to find, harder to access and often after the information was gathered it just sat somewhere. Updates to information wasn’t any easier to make.

I would like to suggest that our State consider developing such a form, with input from people with disabilities that span motor, mental health issues, developmental disabilities, and intellectual disabilities. I think family members, guardians, social workers and providers that deal directly with people with disabilities should have input. Police, fire and EMS professionals who have children or grandchildren with disabilities should have a seat at the table. These people can form a team that will take into consideration factors that would affect care in different instances and, I believe, create the most effective document.

I would like there to be easy access and easy drop off procedures once completed. Also, just as parents receive a copy of their rights during PPTs, I think

making people aware of this document and how it can help should be something we strive for across as many fields as possible that people with disabilities or their families would regularly access. An example would be during PPTs. School staff could offer the document and some information about it to parents. Doctors' offices.....the form could be offered along with information. Physical therapy, Occupational therapy, mental health appointments, etc.

I think we are missing an opportunity to serve people with disabilities in a safe and thoughtful manner and we are leaving the public safety community in the dark by not creating the ability to have this type of awareness during emergencies. I hope you will consider helping me make this a reality.

Sincerely,

Leslie Prior



# Improving Relations Between The Disability Community & Law Enforcement

BY: NICK GLOMB  
PARTNERS IN POLICYMAKING 2018



What is my projects about?

My project was created to learn about things that can change. My project is the beginning steps of helping Self Advocates get along with Law Enforcement, and help Law Enforcement get along with Self Advocates.

- Communicate with self advocates to inspire meaningful conversation about building upon and repairing relations between the Disability Community and Law Enforcement Community.
- Communicate with Law Enforcement to help them understand how the disability community works, and also inspire conversation about how things can start to change.
- Continue building relations with both Self Advocates, their loved ones, and Law Enforcement in hopes of continuing conversation, and fostering the relation between both parties.

# Self Advocates

1. How do you protect your basic human rights?

Answer-Talk to others, advocate.

2. How do you think relations between the disability community and law enforcement can be improved?

Answer-increase awareness and training, police K-9 units coming to speak

# Attorney

1. How do you identify a person with a disability?

- Answer- *I'm not sure that you always do, or can. What's import is to not make assumptions as to what a persons level of understanding or abilities are, and that way not be caught unprepared when you come across someone who may require a higher level of need or care.*

2. How can an attorney advocate for a person with a disability?

- Answer- *This varies greatly depending on the type of representation. But attorney's should always keep their clients interests at the forefront of any negotiation, and certainly being aware of a client's disability is a big part of that*

# Law Enforcement

1. Upon finding out that an individual has a disability is there a specific protocol on how to provide service to them?

- Answer- "the basic rule of thumb is to exercise more patience and communicate in a way that both sides understand the common objective. Often times putting in a little more time, leads to a better experience for civilians' and police."
- Answer #2- MPD has policy and procedure in providing assistance with each situation

2. How does an individual with a disability introduce and interact with an officer?

- Answer- "in a respectful and non-threatening manner. Any information the person is willing to provide the officer regarding their specific disability."
- Answer #2-"talk to officer and supervisor and ask what is expected of them during contact with police"



# What Was Learned?

I learned a lot through this process. I learned that all people are treated as equals, regardless of their background. We are all to be treated with dignity and respect. Within this project I learned that Self Advocates and Law Enforcement alike both need more educational opportunities on how to work together to communicate better, learn about and develop better understandings of each other. I am looking forward to continuing to talk to law enforcement and self advocates in order to keep the conversation going!

Testimony to the  
Improving Police Interactions with the Disability Community  
Subcommittee of the  
Police Transparency & Accountability Task Force

by  
Walter Glomb, Director  
Connecticut Council on Developmental Disabilities

October 6, 2020

I am Walter Glomb, the Director of the Connecticut Council on Developmental Disabilities and I am here to speak about improving police interactions with individuals who live with developmental disabilities in Connecticut. Thank you for the opportunity to speak to this subcommittee about this critical topic.

The Connecticut Council on Developmental Disabilities is entirely funded by the federal Administration on Community Living to assist the State of Connecticut in developing a comprehensive system of community services, individualized supports, and other forms of assistance that enable individuals with developmental disabilities to exercise self-determination, be independent, be productive, and be integrated and included in all facets of community life. This includes having safe and inclusive communities.

Developmental disabilities are lifelong mental or physical impairments that result in substantial functional limitations in three or more areas of major life activity and may include intellectual disabilities, autism, behavioral disorders, psychiatric disabilities, epilepsy, blindness, deafness, and mobility impairments.

I will not dwell on the many specific examples of tragic outcomes of interactions between police and people with disabilities when behaviors were misunderstood and misinterpreted. The fact that we are here is testimony to the problem. Whether it is the death of a young man with autism by the use of force by a police officer or the wrongful conviction of a man with Dandy Walker syndrome, these outcomes are unacceptable and we all must do all that we can do to prevent them.

How? I would suggest three categories of activities:

- ✓ Community engagement
- ✓ Training
- ✓ Accountability

I would offer two examples of community-centered approaches that were suggested by participants in Council programs. The first is facilitated discussions between local law enforcement and members of the community who have developmental disabilities. Such discussions inform local law enforcement about the specific needs and concerns of the people in their community and allow police officers to explain their methods to those individuals. The second is improved quality of information about people who have disabilities in local computer aided dispatch systems. Though most dispatch centers in Connecticut have the capacity for this information, there is no standard practice for collecting information on the needs of people with disabilities within each town. Besides having information about individuals embedded in

dispatching systems, there are now mobile phone apps that connect to beacons worn by individuals and broadcast personal data to the first-responder's phone.

For training, the Connecticut General Statutes already require some training about juveniles with autism spectrum disorder or nonverbal learning disorder, and about serious mental illness. There is nothing about autistic adults; nothing about behavior disorders; nothing about intellectual disabilities; nothing about dementia, epilepsy, deafness, blindness, or other developmental disabilities. Why is training required only for those two narrow populations? What training is offered to support the Blue Envelope program and why is such a program limited to people with autism? Why not expand the training to a broader spectrum of disabilities that could be misunderstood by a law enforcement officer? What is the role of technology in training? The same company that developed the taser now offers a virtual reality system to train police officers about how to handle situations involving people with disabilities.

Police officers in schools are a special case. The treatment of students who have an Individualized Education Program (IEP) is governed by special federal and state laws. Are these officers adequately trained in the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act? Do these officers know which students have IEPs? How are parents and educators addressing interactions with police officers in students' IEPs?

Other states have taken the lead. The Arc of the United States has a National Center on Criminal Justice and Disability that is funded by the U.S. Department of Justice Bureau of Justice Assistance and offers the Pathways to Justice program. The Vera Institute of Justice has a National Initiative to Improve Police Responses to Persons with Mental Health and Developmental Disabilities. In New Jersey, people with disabilities are included in emergency drills. The state of Maryland has implemented a training developed at Loyola University Maryland. Massachusetts has the Autism and Law Enforcement Education Coalition (ALEC), which fosters better understanding of autism spectrum disorders by public safety personnel. I encourage this subcommittee to hear from an ALEC trainer.

Some states have passed statutes for procedural justice and protections for people with intellectual disabilities who are interviewed or questioned by law enforcement officers.

Likewise, individuals with disabilities may need to be educated about how to behave in engagements with police officers. What training is available from public safety officials for individuals with developmental disabilities and their families?

Training is worthless if it is not reflected in the behavior of police officers. This is an issue for supervision in any organization, how to hold people accountable for their actions? For a start, an organization needs data, i.e. it needs reliable reporting of incidents that involve people with disabilities. Do we record the disability, if any, of the victims of use of force by police officers?

Finally, let us remember that people with disabilities are also victims of crimes and may experience a higher rate of crime. For example, individuals with disabilities are seven times more likely to be victims of sexual assault than those without disabilities. Training and community engagement must also address communication with victims who may be unable or unwilling to communicate by conventional means.

Thank you.

# **Autism Awareness for the First Responder Law Enforcement**

## **Program Agenda:**

Autism Awareness, Law Enforcement. This training will provide first responders with an overview of Autism Spectrum Disorder (ASD), growth rates, theories, common characteristics, effective communication methods, behavioral symptoms, sensory issues, and some practical skills on how to effectively interact and respond to an emergency involving a person with ASD.

Autism and Law Enforcement Roll Call Briefing Video was developed for use in conjunction with approved training curriculum and by qualified trainers. It is intended to bring meaning and understanding to people with autism when this condition is discovered during field situations.

Responding to the autism emergency. Information on how first responders can recognize an individual with ASD and discuss how actual incidents were handled. Special tactics, response techniques, rescue techniques, patient care, search and rescue, water rescue, and actual incidents will be discussed.

This program was developed by police officers that are parents of children with Autism Spectrum Disorder. This program is from the Autism and Law Enforcement Education Coalition (ALEC) in Massachusetts. The program was developed in collaboration with:

Massachusetts DDS/Autism Spectrum Division  
The South Norfolk County Arc  
The Family Autism Center  
The Autism Society of America  
PA Premise Alert

## **Learning Objectives:**

To prepare law enforcement personnel for a response to an incident involving a person with Autism Spectrum Disorder (ASD).

How to identify characteristics and behaviors of a person with ASD.

How to effectively communicate with a person with ASD.

Discuss special tactics, rescue techniques, and patient care.

How to build relationships with the ASD community.





STATE OF CONNECTICUT  
DEPARTMENT OF EMERGENCY SERVICES &  
PUBLIC PROTECTION  
Police Officer Standards and Training Council

SUSAN E. RAINVILLE  
DIRECTOR OF FIELD SERVICES DIVISION  
CONNECTICUT POLICE ACADEMY

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Office: (203) 427-2621

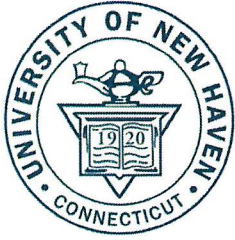
Fax: (203) 238-6119

Website: [www.ct.gov/post](http://www.ct.gov/post)

Sgt. Roetger,

Thank you so much for instructing our police officers in Connecticut on ASD. We appreciate the heartfelt commitment and dedication you give to this important topic in order to prepare and educate first responders.

Attendees indicated the program was educational and beneficial to their job, praising your professionalism, knowledge and passion. We would appreciate hosting a future session at your convenience. You convey a clear message to police officers on serving, helping people and being instrumental in calming situations. Thank you for your excellent presentation.  
Susan Rainville



# University of New Haven

## Department of Criminal Justice

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John DeCarlo, PhD  
Chair of Criminal Justice  
[jdecarlo@newhaven.edu](mailto:jdecarlo@newhaven.edu)  
203-931-2983

March 16, 2018

Sergt. Ryan Roettger  
Southbridge Police Department  
1 Mechanic St.  
Southbridge, MA 01550

Dear Sergt. Roettger:

A handwritten signature in blue ink that reads "Ryan" with a long, sweeping underline.

We would like to personally thank you for your presentation on February 15, 2018. We are grateful for the time and effort you took to share your years of research, your depth of understanding on autism awareness for the first responder, and your personal experiences with Connecticut's policing community. Judging from the comments of those who attended, the seminar was very successful.

Since we are entering a new growth phase at the Center for Advanced Policing, we hope that you will consider being involved in future seminars. We were pleased to have your participation at this outstanding event, and we thank you for valuable contribution.

Best regards,

A handwritten signature in blue ink that reads "John DeCarlo" in a cursive style.

John DeCarlo, Ph.D.

**Fwd: UNH autism class**

Ryan Roettger [Ryan@chasetactical.com]

**Sent:** Wednesday, February 21, 2018 4:33 PM

**To:** Ryan Roettger

Regards,

**Ryan S. Roettger**

NE Sales Manager

Chase Tactical, LLC



Fax: (800) 709-7059

[Ryan@ChaseTactical.com](mailto:Ryan@ChaseTactical.com)

[www.ChaseTactical.com](http://www.ChaseTactical.com)

D-U-N-S # 079550189

"Outfitting Warriors Around The World"

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Begin forwarded message:

**From:** Matthew Solak <[MSolak@willimanticpolice.org](mailto:MSolak@willimanticpolice.org)>

**Date:** February 21, 2018 at 10:23:42 AM EST

**To:** "[ryan@chasetactical.com](mailto:ryan@chasetactical.com)" <[ryan@chasetactical.com](mailto:ryan@chasetactical.com)>

**Subject:** UNH autism class

Good morning, Sergeant Roettger- how are you? I received your email from Officer Dan Rovella, whom I work with at the Willimantic Police Department, and wanted to send you a quick email and advise you that I found the Autism and LE class you taught at the University of New Haven last week to be one of the most professional, timely, and educational Police trainings I have attended. As a thirteen year cop, who has been involved in CIT training for over ten years and well as several local mental health work groups here in Willimantic, I had "presumed" that I had a decent working knowledge of autism prior to attending your class, and I could not have been more wrong. Your class, delivered with an intense and personal focus that truly drew in the students (really, when was the last time you were at a training class and the whole class volunteered to stay late the instructor could continue teaching ...? ;-)) completely opened my eyes to the wide variety of autism disorders, and most timely and relevantly, how individuals with these disorders interact with

society at large and law enforcement in particular. The personal investment that you have put into your teaching product is evident, and I can think of no better instructor for a matter as sensitive as this than a Police Officer and parent who also has a daughter with ASD. As a new parent of five-month old twins, your personal stories and recollections had a far greater impact on me than they likely would have prior to the birth of my son and daughter.

I hope you are successful in getting this class into the "mainstream" of Police training through the CT. Police Academy and regional/statewide recerts, as I think it is something that every Officer needs to be highly cognizant of. As I mentioned to you at the conclusion of class, I have family that also resides in Tolland, and my wife and I live in Ashford, right off of RT. 74, so I am local to northeastern Connecticut, and if you or your family need anything personally or professionally from the Willimantic Police, please do not hesitate to contact me directly. Thank you again for the excellent class-

Respectfully,

Lieutenant Matthew Solak # 295

**Willimantic Police Department**  
**22 Meadow Street, Willimantic CT. 06226**  
**P: 860.465.3135**  
**F: 860.465.3125**

[Willimanticpolice.org](http://Willimanticpolice.org)  
[Facebook.com/willimanticpolice](https://Facebook.com/willimanticpolice)



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**Fwd: Autism Seminar-Thank You-Dr Isenberg**

Ryan Roettger [Roet1073@aol.com]

**Sent:** Saturday, February 17, 2018 6:49 AM

**To:** Ryan Roettger

Begin forwarded message:

**From:** Ryan Roettger <Roet1073@aol.com>

**Date:** February 15, 2018 at 4:38:51 PM EST

**To:** [firerescueautism@yahoo.com](mailto:firerescueautism@yahoo.com), [bcannata@arcsouthnorfolk.org](mailto:bcannata@arcsouthnorfolk.org)

**Subject:** Fwd: Autism Seminar-Thank You-Dr Isenberg

Begin forwarded message:

**From:** Jim Isenberg <[izofam@aol.com](mailto:izofam@aol.com)>

**Date:** February 15, 2018 at 4:30:59 PM EST

**To:** [roet1073@aol.com](mailto:roet1073@aol.com)

**Cc:** John DeCarlo <[JDeCarlo@newhaven.edu](mailto:JDeCarlo@newhaven.edu)>, Sara R Jeffries <[sdudel@unh.newhaven.edu](mailto:sdudel@unh.newhaven.edu)>, David Lambert <[DLambert@newhaven.edu](mailto:DLambert@newhaven.edu)>, Linda Dominguez <[LDominguez@newhaven.edu](mailto:LDominguez@newhaven.edu)>

**Subject:** Autism Seminar-Thank You-Dr Isenberg

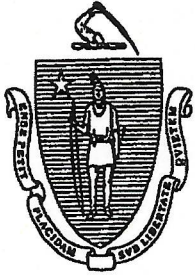
Ryan

I want to thank you for the outstanding Autism seminar that you provided today as part of the University of New Haven's Center for Advanced Policing program. Your knowledgeable, engaging presentation was clearly well received and much appreciated. I'm glad that I was able to join a part of the session as I was impressed with your approach to the officers as you offered numerous invaluable suggestions that will guide their work in the future. I'm glad that you were able to present this excellent seminar and hope we will have other opportunities to share your leadership in this important area with other police officers in CT and across the Northeast region.

Again, many thanks for today's important seminar and we look forward to your future involvement with our program.

With best wishes,

Dr Jim Isenberg  
Center for Advanced Policing  
University of New Haven



# The Commonwealth of Massachusetts

Trial Court of the Commonwealth  
Probate and Family Court Department  
Suffolk Division  
Probation Department

24 New Chardon Street - P.O. Box 9667  
Boston, Massachusetts 02114  
Area Code (617) 788-8360  
Fax (617) 788-8959

FIRST JUSTICE  
John M. Smoot

ASSOCIATE JUSTICES  
Elaine M. Moriarty  
Jeremy A. Stahlin  
Nancy M. Gould

CHIEF PROBATION OFFICER  
Mary F. Prior

FIRST ASSISTANT CHIEF  
PROBATION OFFICER  
Stephen B. Patien

ASSISTANT CHIEF  
PROBATION OFFICERS  
Marguerite C. Riley  
Timothy O. Daley

September 22, 2014

Captain William Cannata  
Family Autism Center/The Arc of South Norfolk  
ALEC  
789 Clapboardtree Street  
Westwood, MA 02090

Dear Captain Cannata:

I can't thank you enough for the spectacular presentation given to our probation officers, courtesy of ALEC and Officer Ryan Roettger of the Southbridge Police Department at our Fall MPPA meeting which took place on September 19.

The issue of first responder autism training is very real in our work as probate and family officers. Probate probation officers handle families in crisis every day and strive to find answers for the Court. We often interview children, (whose numbers are increasingly on the autism spectrum), and make recommendations to the Court on issues of parenting time and custody.

Officer Roettger's presentation provided our officers with suggestions of the skills needed when meeting and interacting with children who are on the spectrum, as well as their caretakers. We often consider ourselves 'experts' in the area of interviewing children, however, the growth of this population demands that we expand our knowledge to include the needs of families who experience autism, and communicate those needs to the Court. Officer Roettger's personal experience in this field provided a unique perspective into this issue.

Should you ever need assistance on a probate/family matter, please feel free to call me at 617-788-8242.

Sincerely,

Patrice M. O'Brien  
Assistant Chief Probation Officer  
Suffolk Probate Court

cc: Officer Ryan Roettger, Southbridge Police Department