BALTIMORE POLICE DEPARTMENT – EDUCATION AND TRAINING SECTION

LESSON PLAN

COURSE TITLE: Crisis Intervention Training

LESSON TITLE: Working with Youth

PREPARED BY: Ginna Wagner, LCSW-C, BCARS Director
DATE: 12/30/20
Revised: 2/22/2021

TIME FRAME	PARAMETERS
Total Lesson Hours: 90 min Day/Time:	Audience: CIT candidates Training Space(s): Classroom

PERFORMANCE OBJECTIVES	ASSESSMENT TECHNIQUE
1. Through facilitated discussion and a mind-mapping exercise, participants will identify why it is important to know how to work with youth with mental illness and trauma in a way that does not further traumatize them to the satisfaction of the facilitator. 2. Given a case study, participants will identify the kinds of situations in which they should contact BCARS and be able to describe how to access BCARS services to the satisfaction of the facilitator. 3. Given a sorting activity, participants will identify the signs and symptoms of behavioral health disorders common in youth and the services available to the satisfaction of the facilitator.	Case Studies Facilitated Discussion Mind-Mapping Exercise Group Activity T-Chart Sorting Activity

4. Given a case study and through facilitated discussion, participants will identify the role of behavior as communication particularly as it relates to children with a trauma history to the satisfaction of the facilitator. 5. Through facilitated discussion, participants will identify the way that trauma impacts the developing brain and the window of stress tolerance to the satisfaction of the facilitator. 6. Through facilitated discussion, participants will be able to identify the basic stages of child development and be able to discuss how memory is stored to the satisfaction of the facilitator.	

INSTRUCTOR MATERIALS

- BCARS Power Point
- Intervention Cards for group activity *(These will need to be cut and distributed as "sets" for partners to sort.)*
- USB containing PTSD interaction clips

EQUIPMENT/SUPPLIES NEEDED

- YouTube video "Adverse Childhood Experiences (ACEs); Impact on brain, body and behaviour"
- Computer with projector for Power Point and video case studies
- Internet access
- Paper and pens
- Chart paper and markers (1 per group)

STUDENT HANDOUTS

Needed: 1 copy for each student

- Title(s):Working with Youth (Chart)
- Sorting Activity (Intervention Cards)

METHODS/TECHNIQUES

Presentation-based training combining a presentation on mental illness in youth and a video on ACEs
Mind-mapping
T chart
Intervention Sorting Activity

REFERENCES

GENERAL COMMENTS

This lesson plan is intended for use with a subject matter expert in youth, behavioral health, and crisis, ideally with an LCSW-C or LCPC license, preferably a BCARS staff member. It is not intended for a generic instructor.

LESSON PLAN

TITLE: Working with Youth

PRESENTATION GUIDE	TRAINER NOTES
I. ANTICIPATORY SET **CIT Instructor Introduction:** Our next presenter will provide information on youth mental illness and the impact of trauma. She is a representative from BCARS – Baltimore Child and Adolescent Response System which is the crisis stabilization program for youth in Baltimore City. It's important to have a separate lesson on working with youth in crisis because as we know, children are not just small adults. Their brains are still growing so they are still developing language and communication skills which can have a significant impact on their behavior. The long-term goal of the public behavioral health system is to expand services to allow for trained clinicians and peer workers to assess individuals experiencing a mental health crisis, specifically youth. As the city works towards building a comprehensive system of crisis response, it is important for police to be aware of issues specific to youth and families so that you can respond and de-escalate using developmentally-appropriate, trauma-informed techniques. There is a high level of distrust of the police in Baltimore City, particularly among youth. It's very important when working with youth to be real with them. It's not uncommon to come into contact with youth who are dealing with problems and dynamics that are typically associated with adults, like caring for small children, making sure there is food in the home, etc. One officer told me, "Baltimore kids have seen it, done it and know it. Some of them have been forced to grow up and to know grown up things".	**Time: 5 minutes** *CIT Coordinator or member of BPD's Crisis Response Team (CRT) will introduce the BCARS presenter and the presentation format.* **Slide 1** Baltimore Child and Adolescent Response System BCARS

ASK: Are there other things that you have experienced as officers that you think are specific to Baltimore youth?

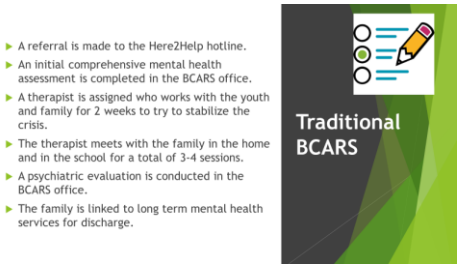
BCARS Presenter Introduction:
Good Afternoon,
I'm _____ a (state position) with BCARS. As Ms. Wexler (or the name of the facilitator) said, BCARS stands for Baltimore Child and Adolescent Response System which is a crisis stabilization program for youth in Baltimore City who are on Medical Assistance or are uninsured and are having some type of psychiatric or behavioral crisis. BCARS has 2 main programs: the traditional program and the DSS Foster Care Stabilization Service. In FY19, BCARS received just over 1,100 eligible calls, assessed 345 youth and admitted 298 youth in our traditional program. For youth in foster care we received 130 referrals, assessed 74 youth and admitted 47 youth into the program.

The process for the traditional program is that calls come in through the Here 2 Help hotline (410-433-5175) which is staffed by Baltimore Crisis Response Inc. who have also presented as part of your training. The operators there take the initial call, enter the information into the computer system and then we access it from there and call the family and the referral source back. Once the intake call is processed the youth and family are scheduled to come into the BCARS office for a comprehensive mental health assessment by a licensed clinician. We try to schedule youth to come in the next business day if possible and we do not schedule more than 24 hours out so that we can accommodate the most acute youth. We have transportation available so that getting to our office is not a barrier. Once the youth is assessed we staff the case with the clinical supervisor and assign a therapist. Most youth that are assessed are admitted into the BCARS program. The therapist works with the youth and family for 2 weeks in the home, in the school, in the community or some combination of them, wherever the

Desired Response:

- Yes, youth in Baltimore have to deal with a lot of crime and shootings, poverty, distrust of adults.

Slide 2



issues are occurring to try to stabilize the youth's presentation. There is also a psychiatric evaluation completed on the youth by a Child and Adolescent Psychiatrist in the office as part of the program and if medication is prescribed there is a follow up appt. At the end of the program the referral information is completed, and the youth and family are linked to long term mental health services.

Baltimore City DSS Stabilization

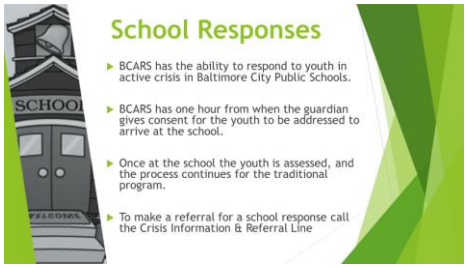
The Department of Social Services (DSS) Stabilization program is a 6-week program designed to help stabilize youth in their family and or foster care placements. It is very similar to the traditional program except that there is a Behavior Specialist assigned to the case as well. At the end of the program the referral information is completed, and the youth and family are linked to long term mental health services.

Slide 3

School Responses

BCARS also has the ability to respond to Baltimore City Public Schools for a youth in active crisis once consent has been obtained from the guardian. We have one hour from when the guardian gives permission for us to assess the youth for us to get to the school. Once there the assessment is completed, and the traditional program services begin. To make a referral for a school response you would follow the same process for making a referral to the traditional program by calling the Here 2 Help hotline. An example would be a youth who appears suicidal and there is a concern about sending them home or if a child's behavior is out of control and school staff cannot calm them down. In addition to BCARS many schools have mental health therapists imbedded in the school to work with children on their assigned caseloads.

Slide 4



Today we will be taking a look at mental illness and trauma in youth including the signs and symptoms of behavioral health disorders, brain development, trauma and how to access BCARS Services.

In addition to BCARS there are agencies such as Hope Health that provide care coordination services to

families. Children may also qualify for wrap around programs through agencies like Wraparound Maryland. Therapeutic Behavioral Support Services are available through the Brighter Stronger Foundation for youth who qualify and there are multiple Psychiatric Rehabilitation Providers or PRP's available in Baltimore. PRP services will work to support youth in the community to learn skills that will help them better manage their needs. Catholic Charities has a respite program available. Maryland Coalition of Families is also an excellent resource as they can provide peer supports to the parents in addition to other services.

MIND-MAPPING: Group Activity

I need everyone to come together with your partner or at your tables and create a "Mind Map" about what you know about mental illness and trauma in youth. In the center of the page draw a circle and write mental illness and trauma in youth. Then as a group discuss whatever comes to mind when you think about this and write it down on the paper. We will discuss this as a group in a few minutes.

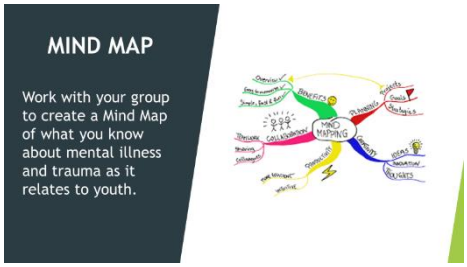
ASK: What were some of the things that came to mind when asked about mental illness and trauma in youth?

PERFORMANCE OBJECTIVES

Throughout this course, we will meet the following objectives…

1. Participants will identify why it is important to know how to work with youth with mental illness and trauma in a way that does not further traumatize them.
2. Participants will identify the kinds of situations in which they should contact BCARS and be

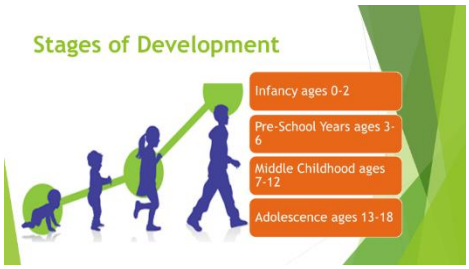
Slide 5



Anticipated Responses:

- ADHD
- out of control
- Depression
- Bipolar
- abuse
- neglect
- bullying

Slide 6

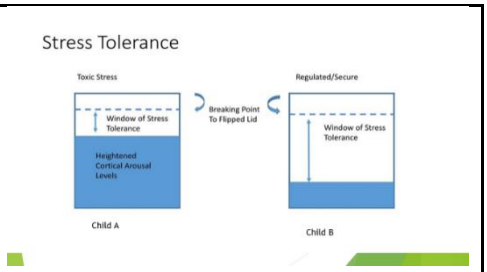
able to describe how to access BCARS services. 3. Participants will identify the signs and symptoms of behavioral health disorders common in youth and the services available. 4. Participants will identify the role of behavior as communication particularly as it relates to children with a trauma history. 5. Participants will identify the way that trauma impacts the developing brain and the window of stress tolerance. 6. Participants will be able to identify the basic stages of child development and be able to discuss how memory is stored.	
II. INSTRUCTIONAL INPUT **<u>Child Development</u>** Child Development can be broken down into 4 main stages: Infancy; Pre-school years; Middle Childhood years and Adolescence. In infancy, ages birth through 2 years old, the brain is developing thousands of neurons per second and that slows down as the child ages. When we're first born, all we can do on our own are the built-in bodily functions that are in the basic hard wiring – the brainstem. Maintain our body temperature, breathe regularly, etc. Infants are learning and changing rapidly. During this time, they are developing new skills like walking and talking, they develop relationships with their caregivers and family members, and this lays the foundation for relationships later in life. The next stage, Pre-school years are ages 3-6. Kids are learning their letters and numbers, and they are learning to develop friendships. They develop fine motor skills, like the ability to write, and they become more independent from their caregivers. Middle Childhood years, ages 7-12 are marked by an increase in complex learning, they can typically follow	**Time: 70 minutes** **Slide 7** 

more than one command at a time and, according to child development experts, children begin to understand the concept of rules and consequences. At about age 11 – there's the start of the 'pruning' process that helps our brains become more efficient. When patterns have been used consistently, they become permanent. If not, they may be lost or hard to maintain. Use it or lose it. The brain is still developing in adolescence, ages 13-18, and early adulthood and the parts that are developing are related to self-control, judgment, controlling emotions & organization. In addition, there are a number of physical and hormonal changes that are taking place. Recent studies are showing that the brain isn't fully developed until around age 25. This helps explain why it's actually normal for teens to take risks, make inappropriate decisions and do things that to an adult with a fully formed brain do not make sense. Often adults will say that the child "should have known better" but is this a realistic expectation of a developing brain? Trauma, abuse, neglect, lead exposure, in utero exposure to drugs or alcohol – these are just some of the factors that impact brain development particularly in young children. Lead exposure is a huge risk factor in Baltimore. In 2002 childhood lead poisoning was listed as the chief environmental disease afflicting children in Baltimore. From 2000-2010 the number cases of children with high levels of lead had dropped by 84% In 2016, it was estimated that 56,000 children were at risk for lead poisoning in Baltimore City. By 2018 the number of Maryland children with elevated lead levels decreased by 14%. Lead levels are only checked in children ages 0-6.Lead poisoning contributes to lower IQ scores, problems with attention and behavioral problems. **Stress Tolerance** Now we are going to talk about the window of stress tolerance that everyone has. For youth who have	**Slide 8**

experienced trauma that window can be much smaller than it would be for a child who has not experienced trauma. Let's take a look at Child A (toxic stress) and Child B (regulated/secure). Child A is a traumatized child. They have experienced abuse and neglect, they move a lot and have been homeless, they struggle in school, they have a mental health diagnosis, etc. Child B is a child who has not really experienced trauma in their lives. Things are stable and healthy at home and they do pretty well in school, they have friends, etc. If you look at the slide you will see a baseline in blue. This is level of stress that the child is experiencing simply by waking up in the morning. Child A has a much larger baseline than Child B due to the stressors in their life. The dotted line shows the breaking point for the child which is the point at which the child acts out. As you can see the window of stress tolerance for Child A is much smaller than the one for Child B. The window of stress tolerance is how much stress or things going wrong or being triggered the child can handle before they reach the breaking point. Child A cannot handle very much stress compared to Child B and this is because of their baseline.

As an officer responding to a youth in crisis it will be important to take into account the high levels of stress and anxiety the youth and their families are experiencing. It's important to gather as much information as possible about the trigger or triggers for the youth, not just for the current situation but in general so you know what you need to avoid to prevent things from escalating further. It's also a good idea to try and figure out what triggers happy things for the youth – are they interested in video games, are they a Ravens fan, find something to connect with them on. It is also important to keep in mind that when you are responding to a call regarding children and teens it will likely take more time than a similar call might take for an adult.

Behavior
All behavior is communication. All behavior is purposeful. By "purposeful", I don't mean that it is



Slide 9

done on purpose, but rather there is a reason for it. When working with children consider the following:

- What is the purpose of the behavior? Try to get to the root/source of the behavior.
- What is being communicated to you? What do they need?

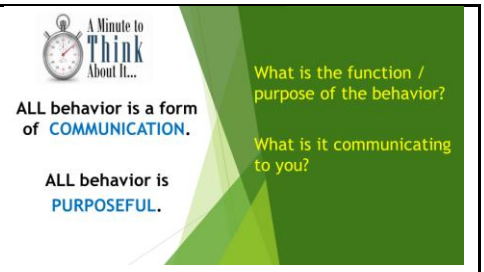
What if you were never taught how to regulate your emotions? What if your caretaker suffers from mental illness and that is what you have seen? What if you haven't developed the verbal skills to be able to "say" what the problem is? Because kids can't always identify their feelings it's not possible for them to put them into words, so they act them out. All behavior is communication. Everything that we do communicates something to those around us. If we scratch our nose, we are communicating that our nose itches. If we start yelling, we are communicating that we are stressed out and upset. Most times negative behaviors are triggered by stress. We have to look past the behavior to see what may be driving it in order to address the problem. The behavior is a symptom of the stressor.

ASK: What is the reason the child is upset or acting out?

EXPLAIN: Think back to the NAMI training. It's important to note that you should ask "What happened?" or "What is happening?" to allow the child an open-ended way to respond. Think about when a child says, "Look at my drawing!" You shouldn't say, "I love the cat and dog you drew." Maybe it's a lion and a tiger. Instead say, "Tell me about your drawing." This will allow for the child to tell you, honestly, what they drew. Same goes for communicating feelings and emotions.

ASK: Can we help the child calm down by helping them identify what the problem is and what they are feeling?

ASK: What are some ways we can do that?



Anticipated Response:

- They are stressed and cannot communicate their needs
- Something happened

Anticipated Response:

- Yes

Anticipated Responses:

- Let them try to talk it out

	and let the feelings out. • Find out what they like from the caregiver and try to engage them in talking about that.
GROUP ACTIVITY: In your group, discuss strategies you have used in your police work with youth to be able to help them regulate their emotions. Record your responses on the chart paper. You will have about 3-4 minutes to record. Now, we'll have each group share 2 of the strategies they recorded. One person will need to hold the chart paper for the group to see. *(If using sticky chart paper, have one person from each group post on the wall before sharing.)* Please try not to repeat.	*The instructor should distribute chart paper and a marker to groups.* **Anticipated Responses:** • Getting down on their level • Taking deep breaths • Slowing down the questioning • Actively listening and repeating back what you hear to be sure you are understanding. • Discussing interest-based topics • Not rushing them to speak
ASK: What are some strategies you have used in your police work with youth to be able to help them regulate their emotions? It's important to treat each youth as an individual and listen to what they have to say. Ask them how you can help them or what do they need from you to help resolve the problem. Be sure when you ask them a question that you are giving them time to answer and giving them a chance to "let it out". You will be surprised how much information you can get just by getting them to talk and then letting them finish. Working with youth is not something that can be rushed so that you can respond to the next call. If you approach it like that you are going to cause the youth to either become more upset or to shut down and neither of those responses are going to help you resolve the problem. Letting them vent and get it all out greatly reduces the chances of things escalating. Let them feel heard and have a sense of control. Next, we are going to talk about trauma and its impact on the developing child.	*If there are misconceptions, the instructor should address immediately and modify the chart to reflect the appropriate response.*
ASK: What are some types of trauma? Why are they considered trauma?	**Anticipated Responses:** • Answers will vary but

should be to the satisfaction of the facilitator. Refer to slide 12 for examples.

ACES: Adverse Childhood Experiences
I have a video that discusses ACEs or Adverse Childhood Experiences which you reviewed with Ms. Wexler.

Recent research shows that 56% of youth in Baltimore City have experienced one ACE with 30% experiencing more than 2 ACEs. These are just the numbers that are gathered by researchers. The actual number is likely significantly higher.

Slide 10

ACE's 10 Primary Categories of Trauma
When working with kids in Baltimore in particular, it's important to remember that these youth have seen and experienced things that no child should have to experience. This means they may have a lower stress tolerance and/or difficulty communicating needs due to trauma. As one Baltimore City officer told me, "whatever you think they may have experienced, the reality is likely much worse for these kids."

Slide 11

ACE's 10 Primary Categories of Trauma include the following:

- Physical abuse
- Verbal abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- An alcoholic parent
- A mother who is a victim of domestic violence
- Family member in jail
- Family member diagnosed with a mental illness
- The disappearance of a parent through divorce, death, or abandonment

Slide 12

Additional Types of Childhood Trauma
Additional types include:

- Community violence
- Community poverty and neglect t
- Frequent moves

- Bullying
- Racism
- Loss of loved ones

It's important to be familiar with various types of trauma when working with children because the way that potentially traumatic events are handled can have an impact on how traumatized the child is by the incident. I say "potentially traumatic events" because everyone processes trauma differently. Children can experience the exact same trauma, and their response to it will be different for each child. Some children may act out, some will become withdrawn and avoid reminders of the trauma while others may appear to be ok initially only to have trauma symptoms surface at a later time. In addition to the traditional ACEs, there are things like community violence, community poverty and neglect, frequent moves, bullying, racism, loss of loved ones, etc. that all have the potential to be traumatic experiences. It will be important not to go into a situation with a pre-conceived notion of how someone "should" be responding. There is no right or wrong way to respond to a trauma and as an officer you need to be able to recognize trauma responses in kids such as difficulty self-regulating, difficulty sleeping or eating, various aches and pains that are not necessarily connected to an injury.

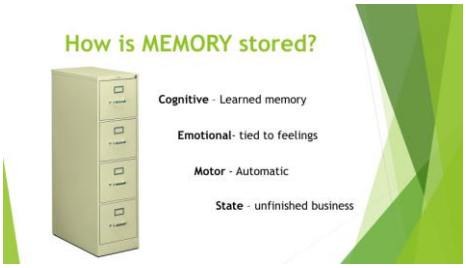
ASK: How can your knowledge of trauma and ACEs impact the work that you do as police officers?

How is MEMORY stored?
Another important concept when discussing trauma is to look at how memory is stored. Cognitive memory, which is at the top, is the most accessible. It's things that you have learned and remember automatically, like the alphabet or how you get home from work. It's the easiest to access because it's automatic.

Anticipated Response:

- It's important to be aware of trauma and ACE's in order to help put a person's behavior into context so you can understand the dynamics of the situation.

Slide 13



The next way memory is stored is emotional memory. It's a memory tied to a strong emotion. For example: I can remember things about the day that my Mom died six years ago like it was yesterday, but I can't remember anything about the day before that. That's because the memories are tied to a strong emotion. Next, there is motor memory, and it is an automatic memory like how you drive a car, etc. You don't have to go through the steps in your mind each time you get in the car to drive somewhere because it is automatic. This is where automatic physical responses to say being hit are stored. This is important for traumatized youth because if you are used to being physically abused and somebody comes at you, your response will likely be automatic to either defend yourself or to lash out. The final drawer is the state memory, and that is where your unfinished business and unconscious memories are stored. These come into play when you are triggered, and you don't know why. Maybe you smelled a cologne, and it's the same cologne your abuser wore. You don't stop and say, "Hmmm that smells familiar. I think it's the cologne that he wore." You just have an immediate physical and emotional reaction to it. This is also important to remember for yourselves as officers because there may be things about a person or a situation that are triggering for you and you don't know why. **ASK:** Why do you think it would be important when interacting with youth for you to approach them calmly? It's important to be real with kids and treat them with respect. Kids will know when you are lying. Kids are also perceptive and will pick up on things like your tone of voice and your body language and respond to it accordingly. The youth may perceive you as just another adult, particularly teens who often think that most adults just don't or can't or won't understand them. **CASE STUDY: PTSD Interaction Part 1** For this next exercise, you will use the T-Chart I have	**Anticipated Response:** • You don't know what might trigger them more. *The instructor should distribute the T-Chart – "Working with Youth" for participants to record responses after viewing.* *NOTE: The instructor could also have participants take out a piece of paper and create their own T-Charts.* *Show PTSD interaction clip* **Slide 14**

given you to record your thoughts. You'll notice that there are 2 case studies. This T-Chart has what the officer does incorrectly to trigger the response of the young woman on the left-hand side and what you would do differently on the right-hand side. Take a look at this short case study. It's a young woman who is likely experiencing a trauma response. While viewing, be thinking about what the officer does wrong and how you would approach her differently. After we watch, I will give you a minute to record your response before we discuss. *<Show first clip>* Take a minute to record your response. **TURN & TALK:** With the person next to you, discuss what you recorded. In a minute, we will share as a group. **ASK:** What did the officer do wrong? **ASK:** What would you do differently? **CASE STUDY: PTSD Interaction Part 2** Now, let's take a look at the second part of this case study. Again, you will use the T-Chart to record your responses under Case Study 2. However, on this T-Chart, you will record the changes made by the officer and why those changes were made. After viewing, I will give you a minute to record.	 *The instructor should facilitate around to partners as they are sharing with one another listening to responses and preparing to clear up any misconceptions.* **Anticipated Response:** • approached her too quickly • started raising his voice • tried to touch her **Anticipated Response:** • stay calm • explain to her why you are concerned **Slide 15**  *The instructor should facilitate around to partners as they are sharing with one another listening to responses and preparing to clear up any misconceptions.*

<Show second clip> Take a minute to record your responses. **TURN & TALK:** With the person next to you, discuss what you recorded. In a minute, we will share as a group. **ASK:** What changes were made by the officer? **ASK:** Why were those changes made? **EXPLAIN:** Taking your time and being understanding of what someone is going through can be less triggering to the victim and can lead to your desired outcome. After seeing that case study, think about speaking with a younger individual. **ASK:** What are some things that you could do to make let's say an "eight" year old calm down and speak with you? The next topic we are going to review is mental illness and children. **Mental Illness & Children** **ASK:** "Does mental illness exist in children?" (Wait for audience response). **EXPLAIN:** The answer is yes, it does. Mental illness	**Anticipated Responses:** • he remained calm • he didn't try to touch her **Anticipated Response:** • to keep her as calm as possible **Anticipated Responses:** • get down on their level • speak in a calm tone of voice • get them to start talking **Slide 16** *The instructor should click to reveal the question and then click again to reveal the statistic.* **Anticipated Response:** • Yes, mental illness does exist in children  **Anticipated Responses:**

impacts about 1 in 5 children and can have profound effects on their behavior and development.

ASK: What are some diagnoses you can think of?

Common Diagnoses

We see a wide variety of diagnoses with our youth. Some of the most common diagnoses we see at BCARS are listed here (show slide 8).

ADHD is the most common diagnosis that we see at BCARS. According to the CDC the estimated number of children ever diagnosed with ADHD was about 9.4%. Boys are also more likely to be diagnosed with ADHD. A child with untreated attention deficit hyperactivity disorder may have difficulty concentrating and moving from topic to topic quickly. They may have difficulty sitting still or be very fidgety. It is important to minimize external stimuli, such as a lot of noise or people, to help them focus. It is very difficult for them to tune things out so turning off the lights on the police cars and talking to them in an area with minimal distractions can help.

Anxiety and Mood Disorders, such as depression, are the next most common. CDC statistics indicate that 7.1% of children aged 3-17 have diagnosed anxiety and 3.2% have diagnosed depression. There are a lot of things for kids to be anxious about – they are worried about school, their families, their safety, their futures, problems in the community, etc. With anxiety disorders, youth can present with agitation, panic attacks, an inability to focus, crying, avoidance, tantrums, etc. Youth experiencing anxiety disorders need a lot of reassurance from adults, and for them to express positive but realistic expectations. Mood disorders such as depression or bi-polar disorder can

- ADHD
- Depression
- Bipolar

Slide 17

look very different for kids than for adults. It is important to remember that with teens, depression can actually be expressed through anger. Youth can also present with problems with sleep, appetite, self-esteem, etc. In situations like this, it is important to listen more than you talk, give the individual the time they need to verbalize what is wrong and avoid power struggles.

Behavioral and conduct disorders include Oppositional Defiant Disorder (ODD) which is a type of behavior disorder. Behavioral and conduct problems affect about 3.5% of children. Children with ODD are typically uncooperative, defiant, and hostile towards others. Avoiding power struggles is key here. A youth with ODD will outlast you in a power struggle every time.

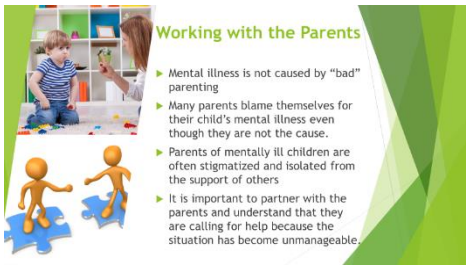
For Autism Spectrum Disorders, there is a wide variety of symptoms and presentations and they affect about 1% of children. Children may present as a neuro typical child who struggles with social interactions or they may be completely non-verbal and unable to care for themselves. The best way to deal with this is to slow things down, and make sure that you are giving the child an opportunity to process your directives. If the child becomes very fidgety, does not make eye contact, appears agitated or "in their own world," they are likely overwhelmed with the situation and need time to process it. This will be discussed in more detail in the Intellectual Disabilities portion of the training.

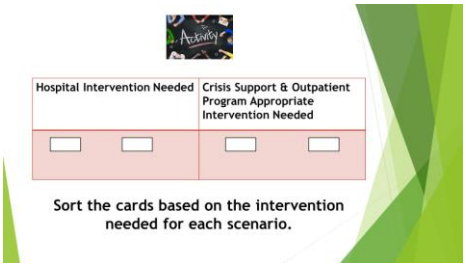
A similar dynamic can occur in learning disabilities, particularly expressive/receptive language disorders. With these, there is a problem with the way the brain processes something, so what you say and what the child's brain processes and hears are two different things. Or they may not be able to recognize facial expressions and body language, so you may have a stern look on your face, but the child may not understand your displeasure, or that this is a serious situation.

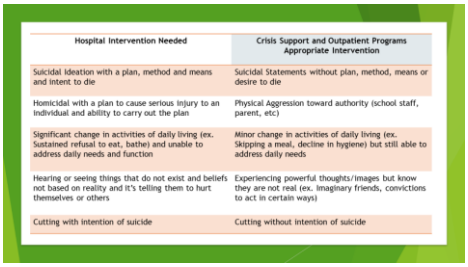
Working with the Parents

Mental illness is not caused by "bad" parenting. It's not a matter of disciplining the mental illness away. Many parents blame themselves for their child's mental illness

Slide 18



and face stigma and social isolation as a result of their child's behaviors. It is important to partner with parents and understand that they are calling for help because the situation has become unmanageable. When responding to calls for kids of all ages it will be important to be able to talk to the parents to get information on the child and get a sense about what is causing the crisis. Try to find out some things about the kids like what they like to do to try to connect with them. Ask the parents if there are any triggers that should be avoided. As the responding officer you are going to have to be able to effectively engage with both the parents and the youth. There may be times when it appears that the parent is actually the one in crisis. This is normal and can be anticipated that some parents will become overwhelmed and escalated when their children are in crisis. It will be important to help them calm down so that they can help you help their child. It's also important as the responding officer to let them know that you are not there to take sides, you are there to help resolve the crisis. Any information you can gather from the youth's family or friends will help you be able to utilize all of your resources to calm down the situation.	
III. EVALUATION/CLOSURE **<u>Intervention Determination</u>** As you learned yesterday when we looked at the disposition table in the Policy training, the preferred outcome in your interactions with people with behavioral health disabilities is not arrest, it is de-escalation and when indicated, referral or diversion to services. BPD policy intentionally gives officers discretion not to charge individuals with offenses, including for behavior related to mental health disabilities, or take them into custody. That is of course true for youth as well as adults. Now we will take a look at cards that were passed out to you. **SORTING ACTIVITY:** With your partner (or group) read through the cards and sort them based on which intervention would be best. *(Sort by putting to left and right on your table. Refer to visual on slide.)* Determine	**Time: 10 minutes** **Slide 19**  *Pass out intervention cards. Give audience 3-5 minutes to separate the cards into columns. The goal of the exercise is for participants to be able to match up the individuals' presentation with either a hospital intervention or*

if the intervention should be handled at the hospital or if outpatient programs would be more beneficial. You will have 3-5 minutes to sort. **Answer Key** Take a look at the slide and compare your answers. It is important to consider the expressed ability of the parents to assure the child's safety through the use of natural supports and existing treatment providers in determining disposition. As you can see If the youth presents with a plan, a method and means and intent to die, and they are not able to be immediately evaluated by an existing treatment provider or mobile crisis team, they need to go to the hospital for an evaluation for inpatient treatment. If the youth is making suicidal statements such as, "I don't want to live anymore" but there is no identified plan, method, means or desire to die, then crisis support and outpatient programs are more appropriate. Many youth who are receiving treatment have treatment teams of providers like therapists and psychiatrists that will need to be consulted in collaboration with the parents to determine the best course of action. When it comes to activities of daily living (ADLs) often times the treatment team is able to come together and develop a plan to avoid hospitalization if the youth's daily needs are able to be met with supports (e.g., their family). Things like increasing the number of therapy or PRP sessions or adjusting medications are ways to avoid unnecessary hospitalization. Again, working with their treatment team is critical. What's important for *our* purposes, and in line with our principle of the least police-involved response, is determining when hospital intervention is necessary. The left-hand column of this slide shows you when our intervention and transport to the emergency department is necessary. The right-hand column describes where crisis and community supports are appropriate. As CIT officers, it's very likely that we'll have to respond to a call for service where these criteria on the	*crisis support and outpatient programs. The desired outcome is a clearer understanding of when diversion is more appropriate.* **Slide 20** 

right-hand side are presented. In these instances, we are expected to use our capacity as CIT officers to connect these youth and families to crisis support like BCARS. It is important to note that the Emergency Petition process as it is done in Maryland has the potential to be traumatic for the child and their families and is also not a preferred outcome.

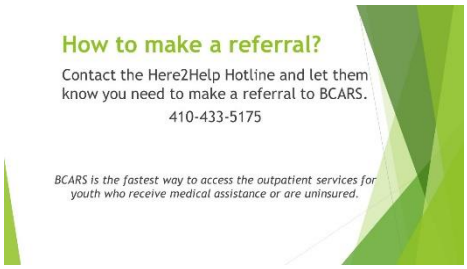
If a youth is presenting as homicidal with a plan to cause serious injury to an individual or group of individuals and has the ability and the capacity to carry out the plan, then they need to immediately go to the hospital for an evaluation for inpatient treatment. If they are displaying physical aggression towards others, then crisis support and outpatient programs are the appropriate intervention. If someone is having auditory or visual hallucinations and "it's" telling them to hurt themselves or others, then an evaluation for hospitalization may be warranted. If someone is experiencing powerful thoughts and images but they know they are not real of if these thoughts and images exist but there is not an imminent safety risk, then crisis or outpatient services may be more appropriate.

Cutting is a maladaptive coping skill for many people as it is a physical release of emotional pain. If someone is cutting with the intention of suicide or the cuts are deep enough to warrant medical attention, then an emergency evaluation for hospitalization may be appropriate. If the person is cutting to release emotional pain but has no desire or intention of dying, which is often the case, then crisis and outpatient services may be more appropriate.

Referral to BCARS

BCARS is usually the fastest way to get a youth assessed in Baltimore City outside of going to the emergency room. As a reminder the process for making a referral to BCARS is to call the Here 2 Help Hotline at 410-433-5175 and let the operator know you need to make a referral for BCARS. They will gather initial information which will then be followed up on by the BCARS intake coordinator either the same day or the next business day depending on when the referral is

Slide 22



placed. We do not currently have the capacity to respond to a scene in real time like the adult mobile crisis team does however this is something that the system is working towards changing in the future as 24 hours can be a long time to wait when someone is in crisis. There is a walk-in clinic that will see youth in Towson at the Sheppard Pratt Crisis Walk-in Clinic (CWIC) that operates on a first come first served basis Monday through Friday 9am to 10pm and Saturdays 1pm-5pm. They are closed on Sundays. The number for Sheppard Pratt is 410-938-3000 and ask for the CWIC clinic. It is a good idea to call them when sending a family there to see what their availability is and what their wait time will be, so the family knows what to expect. There are numerous outpatient providers in the city but many of them have waiting lists. **ASK:** What questions do you have? Thank you all for listening to my presentation. Anyone can make a referral to BCARS by calling the Here 2 Help hotline with BCRI 410-433-5175. ▪ Do you have any final questions for me about BCARS? Thank you again for your participation today.	

Working with Youth

Case Study 1

What did the officer do incorrectly?	What would you have done differently?

Case Study 2

What changes were made by the officer?	Why were those changes made?

Intervention - Sorting Activity

Suicidal Ideation with a plan, method and means and intent to die	Cutting without intention of suicide
Suicidal statements without a plan, method, means or desire to die	Hearing or seeing things that do not exist
Minor change in activities of daily living *(ex: Skipping a meal, decline in hygiene)* but still able to address daily needs.	Hearing or seeing things that do not exist and beliefs not based on reality and it's telling them to hurt themselves or others
Experiencing powerful thoughts/images but know they are not real *(ex: Imaginary friends, convictions to act in certain ways)*	Cutting with intention of suicide
Homicidal with a plan to cause serious injury to an individual and ability to carry out the plan	Significant change in activities of daily living *(ex: Sustained refusal to eat, bathe)* and unable to address daily needs and function