SUD Overview

May 2, 2018

D.C. Department of Behavioral Health (DBH)

64 New York Ave, N.E.

Tricialand Hilliard, NCC, LGPC

Treatment Program Coordinator

Agenda

Substance Use Disorders Division Overview
- Assessment and Referral (ARC)
- Treatment
- Recovery

DBH Discretionary Grants
- State Youth Treatment Grant (SYT)
- Cooperative Agreements to Benefit Homeless Individuals (CABHI)
- State Targeted Response (STR) District Opioid Targeted Strategy (DOTS)

- Partnerships in the District
- Family Treatment Court
- Child and Family Service Administration
- Department Of Employment Services
- Department Of Health
- Department of Corrections

Today’s Goal

This session will focus on providing an in-depth overview of DBH’s Substance Use Disorders Division’s efforts to address substance use from prevention, through treatment and to recovery.
Small Groups

What DO you KNOW

How Do I Access Services?

The Department of Behavioral Health provides prevention, intervention and treatment services and supports for children, youth and adults with mental and/or substance use disorders including emergency psychiatric care and community-based outpatient and residential services.

Assessment and Referral Center (ARC)
ARC Services

- **Description of Services:** ARC provides same day assessment and referral for individuals seeking treatment for substance use disorders. Qualified clinicians conduct a comprehensive assessment that includes the nature of the addiction, use history, any mental health care needs, and overall health status. Once the appropriate level of care is determined, an individual can choose from a list of providers certified to offer treatment tailored to personal experience and life circumstances.

- **Referral Services** include Withdrawal Management, Medication Assisted Treatment, Outpatient (Basic and Intensive), Residential and Recovery Support.

- **Priority Populations** are individuals living with HIV/AIDS, women with children and pregnant women.

- **Easy Access to Services:** ARC services are provided on a walk in basis. Those seeking services must be at least 21 years old, a District resident, and bring a photo ID.

- **Language and Sign Language Interpretation Services:** Assistance is available for limited or no English speaking individuals.
ARC Services

Process:
- Front Desk – screening for residency
- Intake – Creation of medical record, consents, demographics
- Eligibility Screening – Insurance Coverages including Medicaid
- Medical Screening –
  - Medical triage
  - Vitals and medication screening
  - Breathalyzer & Urinalysis
  - TB screenings and planting
- HIV & Hep C education, counseling, testing and linkage. Services are voluntary
- Clinical screening – TAP assessment
- Dental services – screenings
- Referred out – to choice of certified Provider
- Not Eligible for treatment Services – given shelter listings, Prevention Centers, DUI/DWI, RSS etc.
Mobile Assessment and Referral Center (MARC) Services

- **Description of Services:** MARC is a mobile outreach vehicle that travels throughout all eight wards to provide substance use disorder services and mental health services. Upon scheduling, the MARC will participate in community fairs and events throughout the District. Qualified practitioners engage individuals to determine readiness for treatment and complete GAIN SS. Trained staff will conduct anonymous pre and post HIV/AIDS counseling and Hepatitis C testing, education regarding disease prevention and linkage to health care services.

- **Easy Access to Services:** The MARC will link you to the ARC to continue services and to provide a choice of certified providers for the appropriate level of care.

- **Hours of Operations:** Mondays through Friday, 10:00 am -2:00 pm
Treatment Services
Addicted to Drug?
What is Addiction?
Access to SUD Treatment Services

Access and Referral Center (ARC)

Easy Access to Services:

Walk-in or call walk into the ARC without an appointment or call (202) 727-8473 to schedule an appointment. You must be at least 21 years old, a District resident, and bring a photo ID.

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ARC

- Screener
- SUD Placement
- Provider Referral
  - Authorization for services

Youth Services

Easy Access to Services:

Walk-in or call walk into any SUD certified Youth provider. must be at least 12-20 years old, a District resident.

Transitional Age Youth

Walk-in or call walk into any SUD certified Youth provider. must be at least 21-26 years old, a District resident.

** Assessment must be OP or IOP for the Youth or TAY population.
** Detox Youth services
Who Do We Service

• Adults
  • Men (individual)
  • Women (individual)
  • Special populations: HIV/Homeless/LGBTQQIA2

• Children
  – Adolescents /Youth (12-20 years old)
  – Transitional Age Youth (21-24 years old)

• Families and Caregivers
  – Pregnant women (21 and older)
    • Women with Child (ren) or Pregnant women
Did You Know?

- Substance Use Disorder
- Co-Occurring Disorder
- Mental Health Condition

Substance users in the District, FY17

3,412 Client Admissions with: Admitted
Over 91% are African-American
70% Male, 30% Female
All Wards represented
Most prevalent age: 52-61 years old
Primary substances used are *Heroin, Alcohol, Cocaine/Crack, Marijuana, PCP
Framework System of Care

A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their consumers.

- Stroul & Friedman, 1994

SUD System of Care

**Adults**

- Level 1
  - Outpatient Treatment (OP)
- Level 2.1
  - Intensive Outpatient (IOP)
- Level 2.5
  - Day Treatment
- Level 3 “All Residential”
  - Women and Child(ren)
- Level 3.1
- Level 3.3
- Level 3.5
- Level 3.7
  - Withdrawal Management
- Level R - Recovery Support Services

**Youth/ Transitional Age Youth**

- Level 1
  - Outpatient Treatment (OP)
- Level 2.1
  - Intensive Outpatient Treatment (IOP)
- **Youth Residential**

*One Agency. One Mission. One Voice.*
Core Treatment Services

- Assessment/Diagnostic and Treatment Planning
- Initial, Comprehensive, Ongoing, Brief Assessments
- Clinical Care Coordination
- Case Management
  - HIV Case Management
- Crisis Intervention
- Substance Use Disorder Counseling
  - Group/ Psych-ED, Individual, Family
- Drug Screening
  - Toxicology
  - Urinalysis
## Level of Care (LOC) & ASAM Criteria

<table>
<thead>
<tr>
<th>SUD Level of Care</th>
<th>Length of stay</th>
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</thead>
<tbody>
<tr>
<td>Outpatient (Level 1)</td>
<td>180 days (6 months)</td>
</tr>
<tr>
<td>Intensive Outpatient (Level 2.1)</td>
<td>60 days</td>
</tr>
<tr>
<td>Day Treatment (Level 2.5)</td>
<td>60 days</td>
</tr>
<tr>
<td>Clinically Managed High Intensive Residential (Level 3.1)</td>
<td>90 days</td>
</tr>
<tr>
<td>Clinically Managed High Intensive Residential (Level 3.3)</td>
<td>90 days</td>
</tr>
<tr>
<td>Medically Managed High Intensive Inpatient (Level 3.5)</td>
<td>28 days max (45 days)</td>
</tr>
<tr>
<td>Medically Monitored Intensive Inpatient (Level 3.7)</td>
<td>3-5 days (max 10 days)</td>
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</table>
Youth/ Transition Aged Youth  
Adolescent Substance Treatment Expansion Provider (ASTEP)

<table>
<thead>
<tr>
<th>Number</th>
<th>Provider</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Federal City Recovery Services (HYPPER)</td>
<td>8</td>
</tr>
<tr>
<td>2.</td>
<td>Latin American Youth Center (LAYC)</td>
<td>1</td>
</tr>
<tr>
<td>3.</td>
<td>Riverside Treatment Center</td>
<td>6</td>
</tr>
<tr>
<td>4.</td>
<td>Hillcrest Children and Family Center-Transition aged Youth (TAY)</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>Community Connections-Transition aged Youth (TAY)</td>
<td>6</td>
</tr>
</tbody>
</table>

*** Level 1 – 180 days of Treatment

Evidence Based Program (EBP)
Adolescent Community Reinforcement Approach (ACRA)

Intake Process - Youth

- Intake
- ASTEP Provider
- Substance Abuse Assessment
  - Level of Care Determined
  - Client Chooses Provider
- Referral
  - Client remains at provider or is referred out
# Medicated Assisted Treatment Providers (MAT)

**Level of Care 1 (OP) - 180 days of treatment**

<table>
<thead>
<tr>
<th>MAT Providers</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. United Planning Organization (UPO)</td>
<td>Ward 6</td>
</tr>
<tr>
<td>2. Foundation for contemporary Mental Health- Partners in Drug Abuse Rehabilitation and Counseling (PIDARC)</td>
<td>Ward 2</td>
</tr>
<tr>
<td>3. Good Hope</td>
<td>Ward 8</td>
</tr>
</tbody>
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**One Agency. One Mission. One Voice.**
Case Scenarios

Consumers Story

Kelly, a pregnant 21 years old and has been using marijuana for 2 years. She recently got a job at McDonalds and needs help trying to shake her bad habit. She needs to know where to go to access SUD treatment services. She needs services before she starts orientation on in 2 months. She needs to be able to go to work and provide for her two additional children. What should she do? Where can she go? What can be offered to her?

Program Que/Key Words

Bullet Key words that will Que staff to this service type

- Level of Care (LOC)
- ARC
- ASAM Criteria
- Access to Treatment Youth vs Adult
Recovery Support Services
Population Served

Our providers serve District residents who are at least 21 years old.

Eligibility Criteria

Level-R Recovery Support Services are for individuals who have an identified need for recovery support services and:

- (a) Are actively participating in the Department treatment system;
- (b) Have completed treatment; or
- (c) Have a self-identified substance use issue that is not assessed as needing active treatment.
Description of Program:

Recovery support services provides non-clinical services for individual in treatment or in need of supportive services to maintain their recovery.

Number of Providers

There are seven (7) providers, which three (3) of them provide Environmental Stability Services.

Number of capacity

- RSS Authorize/reauthorize (90 days)
- ESS authorize (6months)

Type of Services offered:

- RECOVERY SUPPORT EVALUATION
- RECOVERY SUPPORT MANAGEMENT
- RECOVERY COACHING (Recovery Mentoring & Coaching)
- RECOVERY SUPPORT SERVICE: LIFE SKILLS SUPPORT SERVICES
- SPIRITUAL SUPPORT SERVICES
- EDUCATION SUPPORT SERVICES
- RECOVERY SOCIAL ACTIVITIES
- ENVIRONMENTAL STABILITY
RECOVERY PLANS

• Typically, recovery plans are divided into life domains, such as:
  – Recovery from use of alcohol and other drugs.
  – Living and financial independence.
  – Employment and education
  – Relationships, social support, and community connection
  – Medical health.
  – Leisure and recreation
Environmental Stability
Case Scenarios

Consumers Story

Alicia went through treatment services at APRA ten years ago. She recently lost her job after working five (5) years with the company. With being unemployed and having free time, Alicia started hanging with old friends from her addictive past. As a result, she started developing relapse triggers.

Program Que/Key Words

Bullet Key words that will Que staff to this service type

- APRA (SUD)
- Relapse triggers
- Addictive past
Recovery is the Goal

From Caterpillar to Butterfly

Healing from “Dis-ease” with Passion and Purpose
Grants

State Youth Treatment Grant (SYT)

Cooperative Agreements to Benefit Homeless Individuals (CABHI)

State Targeted Response (STR) District Opioid Targeted Strategy (DOTS)
DBH Partnerships

- Family Treatment Court
- Child and Family Service Administration
- Department Of Employment Services
- Department Of Health
- Department of Corrections
What have you learned?
“The District of Columbia is a thriving community where prevention is possible and recovery from mental health and substance use disorders is the expectation”

If you know someone who needs Substance Use Disorders Services call the 24 Hour Access Help Line at 1(888)7-WE-HELP.
Questions and Answers (Q&A)
Contact Information

Tricialand Hilliard, MS, LGPC
Treatment Coordinator
Tricialand.Hilliard@dc.gov
(202) 727-8944
District of Columbia Department Of Behavioral Health
Substance Use Disorder Services

ALCOHOL AND DRUG ABUSE AMONG AGING POPULATIONS

OBJECTIVES

• Discuss demographics of the aging population especially in relation to the “boomers”

• Provide a short course in the physiology of aging with the focus on how it influences substance abuse problems in aging adults

• Examine the prevalence of substance abuse in the aging population

• Understand the reasons that diagnosis of substance abuse is so often low on the discrepancy

• Determine ways that social workers can better support this aging population
OUR MISSION

The mission of DBH is to develop, manage and oversee a public behavioral health system for adults, children and youth and their families that is consumer driven, community based, culturally competent and supports prevention, resiliency and recovery and the overall well being of the District of Columbia.
OUR VISION

The District of Columbia is a thriving community where prevention is possible and recovery from mental health and substance use disorders is the expectation.

*Providing the Right Services, At the Right Time, In the Right Amount.*
SUD Prevention

Prevention is creating conditions for healthy families and communities and developing personal skills to reduce the risk and increase protection from alcohol, tobacco and other drug abuse.

Our office is charged with developing prevention messaging, including social marketing campaigns, to build the community’s capacity around priority substance use issues in the District.
PRESENT POPULATION

- In a 2017 report, The US Census Bureau found that 28% of US citizens are 55 years old or older, which accounts for 90,598,700 adults.

- At age 55, Americans can, on average, live another 29 years (78.8 year life expectancy)

- In DC, 21% of residents are 55 years or older with the vast majority being over 65.

As of 2018, Baby Boomers are between 54 and 72 years old.
Question 1: Which is the largest living generation?

- Generation X (1965 - 1976) - Correct
- Baby Boomers (1946 - 1964) - Correct
- Millennials / Generation Y (1977 - 1993) - Correct
- Generation Z / iGen (1994 - Present) - Correct
- Silent Generation / Greatest Generation (1937 - 1945)
Question 2: What was a major event of the Baby Boomer Generation?

- World War I
- World War II
- Civil Rights Movement
- Avent of MTV
UNDERSTANDING BABY BOOMERS

Baby Boomers, Me Generation, Rock and Roll Generation, Save-the-World Revolutionaries

THEN

• Baby BOOM of 1964
• Woodstock Age/Flower Power
• High Substance Use Rate
• Rock and Roll Generation

NOW

• Retirement
• Overall Poorer Health
• Substance Use

RISE OF BABY BOOMERS

• By 2029, all “Baby Boomers” (those born between mid-1946 and mid-1964) will be 65 years and over and will account of 20% of the total US population.

• By 2056, the population 65 years and over is projected to become larger than the population under 18 years.
OLDER POPULATION AND SUBSTANCE USE

• Baby boomers are distinct, compared with past generations, as they were raised during a period of changing attitudes toward drug and alcohol, which resulted in higher rates of use.

• Currently, 4.5 million adults who are 50 and over have a substance use disorder (SUD).

• The prevalence rates of substance use disorder (SUD) have remained high among this group as they age.

• The numbers of older adults needing treatment of SUD are expected to grow substantially in the next few years.
Question 3: Baby Boomers are often referred to as the...

- Flower Child Generation
- The Silent Generation
- The Rock and Roll Generation
- The Greatest Generation

Add another answer
Question 4: By 2029, Baby Boomers will account for ___% of the population.

- Allow Single Choice Only
- Allow Multiple Choices
- Shuffle Answers
- Allow Retry
- Limit Attempts

- 50%
- 45%
- 20%
- 15%

Add another answer
Question 5: What is the most used substance among older populations?

- Prescription Drugs
- Alcohol
- Heroin
- Marijuana
- None of the Above
ALCOHOL USE AND ABUSE IN AGING POPULATIONS
WHAT IS ALCOHOL?

Alcohol is a drug.

• It is classed as a depressant, meaning that it slows down vital functions

• Blood Alcohol Content (BAC) is the concentration or measurement of alcohol in the blood that is typically expressed as a percentage. For example, a BAC of 0.10% means there is one part alcohol for every 1,000 parts blood. **A person is legally drunk with a blood alcohol content (BAC) of only 0.08.**

• Several factors can influence an individual’s BAC including:
  • Duration/Speed of consumption
  • Body type/weight
  • If food is present in the stomach
  • If other medications are present in the body
ALCOHOL USE DATA TRENDS

• In 2014, 65% of U.S. adults ages 60 to 64 and 56% of those ages 65+ reported consuming alcoholic beverages.

• The National Health Interview Survey found that older adult alcohol consumption has steadily increased from 1997 to 2014.

• The study found increases in “current drinker” and “binge drinker” (-consuming five or more drinks in a single day) from 1997-2014.

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Drinker</td>
<td>54%</td>
<td>37.8%</td>
</tr>
</tbody>
</table>
| Binge Drinker    | 19.9%  | 4.9%   | 7.5% (2013)
HEALTH RISKS ASSOCIATED WITH ALCOHOL USE

- Aging can lower the body’s tolerance for alcohol. Older adults generally experience the effects of alcohol more quickly than when they were younger.
- This puts older adults at higher risks for falls, car crashes, and other unintentional injuries that may result from drinking.

While certain health problems are common in older adults, heavy drinking can make some problems worse, such as diabetes, high blood pressure, cancers, memory loss, osteoporosis, congestive heart failure, etc.
RISK FACTORS FOR ALCOHOL ABUSE IN OLDER ADULTS

• Habit of drinking over a lifetime (substance abuse earlier in life)
• Major life changes (retirement, death of spouse, loss of friends, bereavement, etc.)
• Coping with loneliness, isolation, anxiety, depression, insomnia, or regrets
• Loss of ability, memory, respect or social life
• Relief from boredom, trauma or pain
• Co-occurring disorders (mental health)
ALCOHOL AND PRESCRIPTION DRUG USE

Many prescription and over-the-counter medications, as well as herbal remedies can be dangerous or even deadly when mixed with alcohol. Common types of medicines that can be affected are:

- Antidepressants
- Anti-inflammatories
- Antibiotics
- Heart medicine
- Diabetes medicine
- Anti-hypertensive

If someone starts a new medication and continues drinking alcohol, they must be careful and watch for one or more signs that their medicine may be affected.
Question 6: As you age, alcohol tolerance...

- Increases
- Decreases

Add another answer
Question 7: What are risk factors for alcohol abuse in older adults?

- Substance abuse earlier in life
- Major life changes (Retirement, Death of Spouse, Loss of Friends, Bereavement)
- Coping with loneliness, isolation, anxiety, depression, insomnia, or regrets
- Co-Occurring mental health disorders
- All of the Above
Question 8: What is the 2nd most used substance among older populations?

- Marijuana
- Prescription Drugs
- Alcohol
- Heroin
PRESCRIPTION DRUG ABUSE AND ADDICTION
PRESRIPTION DRUG MISUSE

- Misuse means taking a medicine that is prescribed for someone else or taking it for reasons, or in amounts, other than as prescribed.

- For older adults (50+ years old), the leading source of their misused prescription drug is from one or more doctors.

- Prescription drug misuse and abuse can go unrecognized, undiagnosed, or misdiagnosed due to coexisting physical and mental conditions and psychosocial factors.
TYPES OF PRESCRIPTION DRUGS MISUSED

The most commonly abused prescription drug among Older Adults are:

- **Painkillers** Pain relievers, Relaxants, Narcotics, and Opioids
  - To treat degenerations in bones, joints, and muscles; chronic pain; treatment after surgeries; palliative care

*Other prescription drugs used include:*

- **Depressants**: “Downers”, Tranquilizers, Sedatives, and Barbiturates
  - To treat anxiety and insomnia; to reduce stress and anxiety; offers relief for those suffering from insomnia and other sleep disorders

- **Stimulants**: “Uppers”, Amphetamines, and Methamphetamines
  - To treat narcolepsy and attention deficit hyperactivity disorder

DANGERS OF PRESCRIPTION DRUG MISUSE

There are particular dangers to prescription drug misuse for older population, such as:

- Difficult and slower processing of medication
- Adverse and unknown side effects of taking prescription drugs
- Dangerous interaction of prescription drugs
- Increase risk for falls, delirium, fractures, pneumonia, breathing complications, confusion, drug interaction problems, and all-cause mortality
- Increased risk for abuse, addiction, and overdose.

_Elderly drug misuse is often overlooked, which leaves this group more vulnerable._

UNDERSTANDING RISK FACTORS

- Changes in Physiology
- Higher Accessibility
- Multiple Medications
- Drug Interactions
- Multiple doctors and often no “captain of the ship”
- General user errors (forgetting when and instruction on how to take drug, taking at wrong dosage, etc.)
- Mental Illness (depression and anxiety)
- Higher rates of pain, anxiety, and sleep disorders that may require unique combinations of prescriptions over long periods of time
Chronic Pain and Prescription Drug Use

- 40% of older adults have chronic pain that is treated with opioids over long periods of time.
- The sheer magnitude of opioid use among older adults—coupled with the dangerous nature of this class of drugs—increases risk for abuse, addiction, and overdose.
- 83% of older adults, people age 60 and over, take prescription drugs.
- Older adult women take an average of five prescription drugs at a time, for longer periods of time, than men.
Question 9: Which class or classes of prescription drugs are most commonly used among the elderly population?

- Painkillers
- Depressants
- Stimulants
- All of the above
Question 10: Which is not considered prescription drug misuse.

- Taking a medicine for reasons or in amounts other than prescribed
- Using multiple medications as prescribed by a doctor
- Skipping or hoarding medications
- Using medicines with alcohol or medicines that haven't been prescribed to you.
Question 11: Illicit drug use is major issue for the aging population.

- True
- False
The combined 2007 to 2014 NSDUH data indicate that nearly 469,000 older adults used an illicit drug in the past month (marijuana, cocaine (including crack), heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription-type).
Older Adult Marijuana Use

- CDC found that from 2002 to 2014, marijuana use among those 55 to 64 years old rose from 1.1% of the population to 6.1%
- Among those 50 and older, people who have had depression (11.4%) or anxiety in the past year (9%) are much more likely to smoke marijuana than average
- Older adults are more likely to be on prescription medication—particularly painkillers or antidepressants—that may interact negatively with alcohol or marijuana.
HEROIN

• A powerful opiate drug. Heroin looks like a white or brownish powder, or as the black sticky substance known on the streets as “black tar heroin.”

• A heroin overdose causes slow and shallow breathing, blue lips and fingernails, clammy skin, convulsions, coma, and can be fatal.

• Nationally, heroin is not a major concern for older adults, but we are seeing different trends in the District.

• Recently, the district saw a severe spike in overdoses from heroin use. Turns out, the overdoses were a result of fentanyl laced batches of heroin.
DC OLDER ADULT DATA TRENDS

- Washington, D.C. has one of the highest rates of opioid-related overdose deaths in the United States.

- In 2016, there were 209 opioid-related overdose deaths, which is more than double the national rate. Of those opioid overdose deaths, 50% were people 55 and older.

- Many of these deaths are concentrated in the eastern half of the city--Ward 5, 7, and 8--reflecting D.C.’s well-established geography of inequality.

Population of 60 years and older by Wards (2010)
- Ward 1: 8.2%
- Ward 2: 10.1%
- Ward 3: 16.4%
- Ward 4: 16.3%
- Ward 5: 15.8%
- Ward 6: 11.3%
- Ward 7: 13.4%
- Ward 8: 8.6%
Drug overdoses due to opioid use by age group, 2014-2017


D.C. Policy Center | dcpolicycenter.org
Taking it to Scale

Question 14: After learning about substance use in older adults, what are some ways that you, as Social Workers, can better support this generation?
SUPPORTING OLDER ADULTS WITH SUDs

We would like to provide a few ways that you, a social workers, can better support older adults that may have a substance use disorder (SUD):

• Establishing or facilitating social support systems
• Knowing the symptoms and signs associated with substance use and abuse
• Explore ways that SUDs are misdiagnosed and determine ways to combat it
• Assisting with the coordination of healthcare services
SOCIAL SUPPORT SYSTEMS

• For elderly population social support plays a beneficial role in the maintenance of mental health and psychological well-being.

• Social support consists of addressing tangible needs, such as assistance with transportation, home and personal care, and emotional support, to name a few.

• Low social support is associated with poorer perceived health, depressive symptoms, and lower quality of life.
SIGNS OF SUBSTANCE ABUSE OR MISUSE

**Symptom**
- Memory loss and problems
- Insomnia/Sleep complaints
- Unexplained physical complaints
- Depression, anxiety, and persistent irritability
- Neglect of hygiene
- Non-adherence with treatment of medical problems
- Chronic and unsupported health complaints

**Behavioral Signs**
- Decreased motivation
- Drug seeking behavior
- Mood swings
- Incontinence
- Worsening of medical conditions
- Poorer hygiene and grooming
- A loss of interest in hobbies or pleasurable activities
UNDERSTANDING MISDIAGNOSIS OF SUD IN AGING ADULTS

• Denial by the abuser, family, and doctor(s)
• May be fewer social signs of problem like losing a job or legal difficulties
• Substance abuse problems may be overshadowed by other medical problems (i.e. chronic pain, blood pressure, cholesterol, etc.)

• The physical and/or cognitive decline caused by chronic substance may be thought of as the “ravages of aging”
• Having several doctors with limited coordination of care and treatment
• Lack of awareness of “misuse” among patients and their families
Coordination of Care

• As people age, their health issues tend to become more chronic and complex, as multi-morbidity becomes the norm.

• Numerous health workers may be involved with a single person’s care, especially in countries where medical specialists are widely available.

• Older people often find it difficult to use health services even when they are available, due to various barriers.

Question 15: Prescription drugs misuse can go unrecognized, undiagnosed, or misdiagnosed in aging populations due to...

- Substance abuse problems may be overshadowed by other co-existing medical problems
- Denial by the abuser, family, and doctor(s)
- Having several doctors with limited coordination of care and treatment prescribing medications
- All of the above
Current DBH Prevention Strategies for Aging Adults

• Find creative ways to educate this population about opioid and prescription use and misuse

• Provide practical techniques to ensure prescription drugs are taken properly, disposed of properly and not shared

• Warn against taking prescription drugs with alcohol and other substances

• Teach clients how to have meaningful conversations with medical professionals to learn about drugs they are taking

• Teach what to do in the event of an overdose or a medical emergency (i.e., The Good Samaritan Law)
Overdose Prevention: Medication Deactivation Bags and Naloxone

• In 2016 and 2017, DBH partnered with Mallinckrodt Pharmaceuticals, to distribute over 70,000 medication deactivation bags.
• The medication deactivation bags were created to safely dispose of prescription medications that have expired, have been possessed from someone other than a physician, or are simply at risk of abuse.
Campaigns

• Adult – Ages 30-60; Harm/Risk Reduction
  • From January 1, 2014 to November 30, 2016, the D.C. Office of the Chief Medical Examiner investigated a total of 3,952 deaths due to use of opioids – including 83 deaths in 2014, 114 in 2015 and 198 deaths in 2016, respectively.
  • 83% of overdoses were African American and 51 was the average age for an overdose.

• Youth – Ages 12-17, Young adults ages 18-25
  • 891,000 youth between the ages 12 and 17 misused opioids and 239,000 misused pain relievers according to the 2016 National Survey on Drug Use and Health.
  • Tackle the common misperceptions that 1) prescription drugs are safer than other drugs, 2) use of opioids and prescriptions are not as glamorous as some media has made them seem
  • Educates teens and parents about the risks of physical and mental harm,
More Harmful Than You Think

According to a DC youth prevention survey, 11.76% of youth say that they have abused prescription drugs.

Lean is a beverage that is made up of cough syrup containing codeine (an opioid). Misusing opioids can cause stomach pain, sleepiness, and constipation. If misused, opioids can also lead to overdoses and death.

To learn more about the harms of drinking Lean, and misusing prescription pills and opioids, visit moreharmfulthanyouthinkdc.com

More Harmful Than You Think

In 2015, 13.5% of DC students took prescription drugs without a doctor's authorization.

Prescription drugs are made up of strong chemicals that typically require a doctor's prescription. The risk of overdose and death is high if you or someone you know misuses prescription drugs.

To learn more about the harms of drinking lean, and misusing prescription pills and opioids, visit moreharmfulthanyouthinkdc.com

The Good Samaritan Law

Good Samaritan Law (a) Any person who in good faith renders emergency medical care or assistance to an injured person at the scene of an accident or other emergency in the District of Columbia outside of a hospital, without the expectation of receiving or intending to seek compensation from such injured person for such service, shall not be liable in civil damages for any act or omission, not constituting gross negligence, in the course of rendering such care or assistance.

- (1) “Good faith” under subsection (a) of this section does not include the seeking of health care as a result of using drugs or alcohol in connection with the execution of an arrest warrant or search warrant or a lawful arrest or search.

- (3) “Overdose” means an acute condition of physical illness, coma, mania, hysteria, seizure, cardiac arrest, cessation of breathing, or death, which is or reasonably appears to be the result of consumption or use of drugs or alcohol and relates to an adverse reaction to or the quantity ingested of the drugs or alcohol, or to a substance with which the drugs or alcohol was combined.
How to Reach Us

DBH – Substance Use Disorder Services
64 New York Avenue, NE, Washington, DC 20002

Assessment and Referral Center (ARC)
75 P. Street, NE, Washington, DC 20002
(202) 727-8473
7:00am – 6:00pm – Walk-in (no appointment needed)

Access HelpLine
1(888)7WE-HELP or 1-888-793-4357
Domestic Violence & Trauma in DC’s Elderly Population

Introductions
- Curtis Prince – Detective, MPD Financial & Cyber Crimes Unit
- Amy Mix – Supervising Attorney, Consumer Fraud & Financial Abuse Unit, Legal Counsel for the Elderly
- Bridgette Stumpf – Co-Executive Director, Network for Victim Recovery of DC
- Sheila Jones – Chief, DC Adult Protective Services
- Merry O’Brien – Elder Justice Coordinator, NVRDC

Objectives
- Recognize the signs and symptoms of domestic violence in the elderly population
- Discuss trauma associated with domestic violence
- Identify the dynamics associated with the different types of domestic violence
- Discuss effective approaches and techniques to resolution and resources
In Your Work...

- Challenging elder DV cases you’ve encountered?
- What elements made them most challenging?
- How did you resolve/help the client?

A Collaborative Approach to Domestic Abuse in Later Life

Broken Trust: Dot
What Happens When We Don’t Collaborate on Elder Abuse Cases?

- Social worker: Provided support
- Health care: Knew of abuse but did not report or help
- Law Enforcement:
  - Interviewed Dot in her daughter’s presence
  - Told her how lucky she was to have a daughter who kept her at home rather than in a nursing home
- No charges, investigation or prosecution
- APS: No one contacted APS
- Bank: Helped the daughter get her name on Dot’s accounts

Result: Dot lost everything including her home.

DC TROV: The District Collaborative Training & Response for Older Victims

1. Train police, prosecutors, victim advocates, senior services, & courts to recognize, address, investigate, & prosecute EA
2. Increase collaboration amongst agencies & organizations
3. Advocate for effective policies
4. Expand quantity & quality of services to EA victims

Core DC TROV Team

- Metropolitan Police Dept
- Network for Victim Recovery of DC
- Legal Counsel for the Elderly
- US Attorney’s Office for DC
- Adult Protective Services
- DC Coalition Against DV
- DC Forensic Nurse Examiners
- DV Unit - Superior Court
- Long-Term Care Ombudsmen
- Office of Attorney General for DC
- DC Dept on Disability Services - Incident Management & Enforcement Unit
- DC Dept of Insurance, Securities & Banking
- Age-Friendly DC
- Jewish Coalition Against Domestic Abuse
- Seabury Resources for Aging
- ElderSAFE Shelter
Support for our DC TROV Team

- **Funding:**
  - Office on Violence Against Women: ovw.doj.gov
  - DC Office of Victim Services & Justice Grants: ovsjg.dc.gov
  - Equal Justice Works through Elder Justice Initiative at the US Department of Justice Office for Victims of Crime: equaljusticeworks.org

- **Training & Support:**
  - National Clearinghouse on Abuse in Later Life: www.ncall.us

350+ Detectives Trained

- DC TROV Training Team
- Led by Detective Curtis Prince
- 8hr Basic + 4hr Advanced Elder Abuse Curriculum
- Every single detective on the force!

Allied Professionals Trained

- **Social Workers & Attorneys:**
  - Aging Services Network
  - Adult Protective Services
  - Victim Services
  - Legal Services
  - Health Care, Homelessness & Poverty
- **Prosecutors** — National Institute for the Prosecution of EA
- **Judges & Court Personnel** - DC 2016 Joint Judicial & Senior Managers Conference to 200 attendees including all DC judges & their staff.
**Legislative Advocacy**

- Financial Exploitation of Vulnerable Adults & Elderly Amendment Act
  - Helped to draft legislation
  - Testified as a panel
  - Presented on law to victim services, LE, aging network
- Wide-ranging implications for senior survivors in the District!
- UPOAA – June 2017 Hearing

**Needs & Prevalence Assessment**

- Conducted in 2015: Surveyed seniors and providers, gathered existing data, engaged partners + community orgs
- Goal: identify gaps in services & set priorities for new or enhanced services for older victims
- Data used to inform services for FY17 → hired Elder Justice Legal Fellow + Elder Abuse Housing Specialist
- Data also used for public outreach, media, legislative advocacy, and to inform the work of Age Friendly DC

**Scope & Impact**
How Prevalent in DC?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>10%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>8%</td>
</tr>
<tr>
<td>Financial</td>
<td>19%</td>
</tr>
<tr>
<td>Neglect</td>
<td>6%</td>
</tr>
</tbody>
</table>

How Many Reports Reach the Authorities Here in DC?

MPD Financial & Cyber Unit:
- 2014: 251 Direct to Unit + 5 APS Referrals
- 2015: 293 Direct to Unit + 7 APS Referrals

Adult Protective Services (APS)
Substantiated Elder Cases

- Physical: 69
- Criminal Neglect: 106
- Financial: 174

Source: NYS Elder Abuse Prevalence Study, Weill Cornell Medical College, NYC Department for the Aging (2011)
Unique Demographics & Vulnerabilities

- 70,568 residents 65+
- Race: 61% African American, 4% Hispanic
- 56% Live alone – higher than nat’l avg
- 60% Own home
- 38% Higher Ed – higher than nat’l avg
- Nation’s largest ratio of GLBT seniors
- Poverty: 1 in 4 seniors – highest in nation

Tougher Time Recovering

- Compared to younger wage earners.
- 1 in 10 → Medicaid after funds are stolen, moving out of community - to nursing homes.
- Elder abuse triples the risk of premature death and causes unnecessary illness, injury, and suffering. 
- The direct medical costs associated with violent injuries to older adults add $5.3 billion to the nation’s annual health expenditures. 

Disability & Dementia - Additional Vulnerabilities

- 47% of seniors with dementia experience abuse
  - Wigglesworth et al., Journal of the American Geriatric Society, 2010
- 14 million seniors have a disability
- Study of 200 women with disabilities:
  - 67% experienced physical abuse
  - 53% experienced sexual abuse over their lifetimes
- Study of 342 men with disabilities:
  - 55% of men experienced physical abuse
Elder Abuse or Domestic Violence?
Abuse in Later Life

Violence against older women is largely unaddressed because it exists in the margins between two fields: domestic violence & elder abuse.


Perpetrators of Domestic Violence Against Older Adults

But Who Would Do Something Like This?

76% of physical mistreatment of individuals 60+ is perpetrated by family:
• 57% by a partner
• 10% by children or grandchildren
• 9% by other family

By law, what does DC consider domestic violence?

- **Interpersonal Violence**
  - shares or has shared a mutual residence
  - or married or in a romantic relationship

- **Intimate Partner Violence**
  - is or was married, domestic partnership, or romantic relationship

- **Intrafamily Violence**
  - related by blood, adoption, legal custody, marriage, or domestic partnership
  - or has a child in common

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**Relationship Between Victim & Perpetrator**

Studies have consistently shown that the majority of elder abuse cases involve female victims with **spouses** as perpetrators.

Lane et al., (2013).

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**Relationship Between Victim & Perpetrator**

In the community, older victims of sexual abuse were violated most often by **spouses/partners**.


In facilities, employees responsible for care (43%) or other residents (41%) were most likely offenders.

Ongoing Abuse by a Spouse

Flying by the Seat of our Pants... What Can Go Wrong?

- Fall into trap of a charming abuser & are manipulated
- Offer marriage/couples/family counseling
- Minimize, blame, judge, silence victim
- Merely delay outcome with temporary “solutions”
- Victims don’t return for help
- Danger, injury, suffering, death

Relationship Between Victim & Perpetrator

- Adult children
  - Mental or physical disabilities?
  - History of power and control?
  - New pattern of abuse facilitated by health-related vulnerabilities?
  - Power of Attorney
  - Caregiving
  - Undue Influence
  - Translators
Heard These Excuses from Adult Children?

- “I was high – I didn’t know what I was doing” (substance abuse problem)
- “He treated me poorly when I was a child; he owes me” (learned behavior)
- “In my culture, elders share their resources” (culture)
- “You don’t know what it’s like to care for her” (caregiver stress)
- “She has abused me” (mutual abuse)
- “She’ll die soon anyway, and the money will be mine – why not take some now?” (feeling of entitlement)

Relationship Between Victim & Perpetrator

- Intimate Partner Violence
  - Long-Term Partners
  - New Relationships
  - Late onset abuse?
  - New health condition?
  - History of power & control?

Why?

- Greed
- Power/control

- Similar to the power and control dynamics used against younger victims of domestic violence.
- Similar strategies for professionals to investigate the case and to interact may be effective.

We are not talking about accidents, well-intended caregivers, persons with physical/mental health conditions who can’t control aggressive behavior. Abuse involves INTENT.
Family Dynamics

Adult Children as Abusers

Victim wants:
- Abuse to end but may want to have relationship
- To try to be a good parent
- To be perceived as a good parent

Victim may:
- Protect the adult child rather than self
- Recant or be reluctant to work with MPD

Challenges Victims Face

- Health concerns (victim & offender)
- Balancing safety & relationship
- Where to go? Lack of money & affordable housing
- Pressure from family & friends
- Fears of being:
  - Seriously injured or killed
  - Placed in a nursing home
  - Placed in a mental health facility
  - Under or over medicated
  - Without an interpreter
  - Deported
  - Outed
Family Dynamics: More Complex Than Meets the Eye

Later, Norman’s wife joined the conversation.

Criminal Neglect

- Neglect may be due to inaction or poor caregiving by caregivers who do not have the necessary skills or support
- OR neglect may be the crime of Criminal Negligence
  - knowingly, willfully or wanton + reckless or willful indifference
  - fails to discharge a duty to provide care & services necessary to maintain health that a reasonable person would deem essential
- Criminal neglect & financial abuse go hand-in-hand...

A Common Thread

- Money, money, monnnnnney!
- More likely to disclose financial concerns first.
  - Gauging your trustworthiness
  - Shame regarding sexual & other forms of physical abuse
- Have you encountered this at outreach events, etc.?
**Why is this happening?**

- 10,000 Americans turn 65 per day
- 70% of personal wealth in US held by seniors
- Access:
  - 1 in 3 seniors dies with dementia
  - Volume of data shared at medical institutions
  - Undue influence & caregivers
  - 90% SNF employ 1+ people who have committed 1+ crime. – HHS

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**Financial Exploitation**

- **UNDUE INFLUENCE**
  - Identity theft
  - Theft
  - Extortion
  - Fraud & deception
  - Abuse of legal authority (i.e., Power of Attorney)
  - Because not all older adults use the banking system, consider: cash, gold, jewelry, antiques, and **homes** as assets.

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**A Typical Case of MPD’s Financial & Cyber Unit...**

- Daughter calls 911 to report brother, Stan (age 45) may be abusing mom (age 68).
- Daughter saw fist marks but Mrs. J claims she fell.
- Mild Alzheimer's disease.
- Upstairs is immaculate but basement where Stan lives is a mess.
- Mrs. J was recently prescribed pain medication for a sprained wrist but the meds are gone and Ms. J does not remember where they went.
- Stan is his mother's POA.
- Stan hurts his mother when she won't sign over Social Security checks.
- Stan: no job, gambles, deep in debt.
These Cases Take a LOT of Resources/Time of MPD's Financial Fraud & Cyber Unit

- Checkbooks and registers
- Overdue or unpaid bills
- Bank statements of victim and suspect
- Tax records
- Receipts for purchases
- ATM transactions
- Surveillance footage at bank, ATMs
- Credit card statements
- Credit reports
- Data off computers
- Power of Attorney and other legal documents
- Medical records of victim
- Capacity evaluation of victim
- Mental health & substance abuse treatment records of suspect
- Employment records for suspect
- Toxicology screen for victim
- Prescription records of suspect and victim

MPD May See...

- Unusual and/or inconsistent transactions
- New debit card, credit card &/or increased activity
- Withdrawals over daily maximum limit
- Sudden insufficient funds
- Bounced checks and/or nonpayment for services
- Unusual credit or debit transactions
- New: Wired funds
- New: Internet banking
- Closed CDs, without regard to penalties
- New POA, account holder, change of address

Power of Attorney

- It's real!
- POA is granted by the senior
  - Senior must have capacity to grant
  - Can be immediate or "springing"
  - Specifies the activities for which the POA has authority
- POA has broad freedom to act in senior's shoes within scope of authority unless senior revokes
Abuse of Legal Authority

- **Power of Attorney**
  - Given by senior when they are of sound mind/ability to consent
  - Delegates authority to make health care and/or financial decisions to another

- **Guardianship**
  - Court order
  - Grants control over many aspects – medical, living arrangements, etc.

- **Conservatorship**
  - Court order
  - Grants control over financial affairs

Criminal Misuse of POA & Guardianship

- POA/guardianship is not a license to steal.
  - Just because a POA or guardianship was used does not make it a civil matter.

- Authorities:
  - Should determine if guardian or person with the POA spent victim’s money on themselves rather than to benefit victim.
  - Will need a copy of POA/guardianship documents.
  - Will check POA for gifting provision.
  - Will check for prior complaints or investigations involving either the victim or suspect.
Criminal Misuse of POA & Guardianship

- D.C. law requires all POAs to be signed & notarized.
- While D.C. has no prescribed form, it must contain specific statutory language at the top of the first page in all bold, capital letters.
- Must be recorded in the recorder of deeds office immediately prior to any documents being signed using that POA.
- Principal may revoke by recording a revocation instrument in the recorder of deeds office.

Consent as a Defense

- Valid consent is given: 1) freely 2) knowingly 3) voluntarily
- Must have capacity to understand consequences
- Consent is not valid when:
  - Obtained by undue influence, force, lies, coercion
  - Victim lacks capacity
- We shouldn’t take perpetrator’s claim of consent at face value
- We should always talk to the victim alone, away from suspect
- It’s helpful to document pattern of conduct and concerns expressed by others

Sexual Abuse as a Component of Domestic Violence

- 1 in 10 cases are 50+ seeking help from DC’s Sexual Assault Crisis Response
- Oldest victim 95+ (grandson)
Stalking

A DOJ study identified 663,660 cases of stalking among victims age 50 or over that had occurred during a 12-month period.

U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2012).

Recognizing Domestic Violence in Later Life When You See It

Victim Indicators

- Elder’s report – sometimes subtle
- Medication: over- or under-utilization
- Elder’s deviation from their typical behavior
- Bruises, black eyes, welts, lacerations, rope marks
- Injuries in various stages of healing
- Broken medical equipment (cane, glasses, hearing aide, etc.)
Suspect Indicators

- Provides conflicting explanations about the senior’s injuries
- Isolates older adult
- Controls and dominates the older adult
- Refuses to leave visitors with elder alone
- Portrays self as victim or the only caring person in older adult’s life
- May be charming and helpful toward professionals

Environmental Indicators

- Strong odors of urine and or feces
- Lack of food
- Locks outside of doors (to lock older individual in a room)
- Non-traditional restraints (belts, neckties near bed)
- Damage to home caused by abusive behavior

A Word About Dementia

- **Dementia:**
  - Group of symptoms, not a disease
  - Temporary dementias from: depression, medical conditions, trauma, lack of food, water, sleep, offender tactics, fatigue
  - Alzheimer’s Disease: 1 in 8 over 65; 1 in 2 over 85 (US)

- **Older adult’s account may be discounted:**
  - Not be able to accurately recount details
  - Be preyed upon by those who realize he/she may not be able to defend self or be believed
Other Limitations & Factors at Play

- Physical limitations
- Elders perceptions of those in authority
- English proficiency, deafness, use of assistive devices, inability to read or write
- Your own assumptions based on age, race, ethnic background or sexual identity
- Cultural traditions – learn as much as you can & respect them as much as possible
- Your gender – may influence seniors’ decision to disclose abuse to you

How Does DC Define, Penalize, and Provide Remedies for Crimes that Occur to Seniors?

“Criminal Abuse, Neglect, Financial Exploitation of Vulnerable Adults & the Elderly”: 22-930

Definition of a Vulnerable Adult:
- A person who is 18 years of age or older and
  - Has one or more physical or mental limitations that substantially impair the person’s ability to independently provide for his or her daily needs or safeguard his or her person, property, or legal interests.

Definition of Elderly:
- Anyone 65+ is now in protected class of “elderly” who have the same protections under existing laws as those which applied to “vulnerable adults” historically

Criminal Abuse
- Intentionally or knowingly inflicts or threatens pain
- Repeated or malicious statements that would be considered by a reasonable person to be harassing or threatening
- Imposes unreasonable confinement or involuntary seclusion

Criminal Negligence
- Knowingly, willfully or wanton + reckless or willful indifference
- Fails to discharge duty to provide care & services necessary to maintain health of vulnerable (all + condition impairing provision of own care)
- That a reasonable person would deem essential
Enhanced Penalty for Crimes Against Seniors: 22-3601

- The onus is on the defense to show evidence that the defendant didn't know the victim was a senior
- 1.5 x’s max fine & prison
- New law added financial exploitation to list of crimes eligible for senior enhancement!
- Financial exploitation is sometimes committed using undue influence (in those cases, could not previously be classified as theft).

New Law Defines Undue Influence

- “Undue influence” = mental, emotional, or physical coercion that
  - overcomes the free will or judgment of a vulnerable adult or elderly person and
  - causes the vulnerable adult or elderly person to act in a manner that is inconsistent with his or her financial, emotional, mental, or physical well-being.

New Law Provides New Remedies

- Adds Option of Civil Penalties:
  - Fine up to $5,000
  - Revocation of all permits, certificates, licenses issued by DC authorizing the person to provide services to vulnerable or elderly persons
  - A temporary or permanent injunction

- Empowers OAG to Stop the Bleeding - amends OAG Clarification & Elected Term Amendment Act of 2010 to:
  - Gives OAG investigatory and subpoena power
  - Allows OAG to move forward with civil actions
  - Allows OAG to seek injunctive relief for victim:
    - Temporary restraining order
    - Order to freeze offender’s assets
    - Order to temporarily freeze elderly victim's assets & appoint a receiver or conservator for those assets
## Protective Orders

<table>
<thead>
<tr>
<th>16-1031 - Protective Orders - Temporary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate endangerment, no need to have accused present, 14 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16-1004 - Hearing &amp; Final Order - Both parties present, judge can:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Require treatment/counseling</td>
</tr>
<tr>
<td>- Require abuser to vacate dwelling – regardless of who owns/rents</td>
</tr>
<tr>
<td>- Require relinquishment of firearms</td>
</tr>
<tr>
<td>- Award care of animal, regardless of ownership</td>
</tr>
</tbody>
</table>

## Understanding Clients’ Reactions to Trauma

### Why Does This Matter?

- Building Rapport
- Evidence Collection
- Testimony
- Solvability

**Big Picture:**
- DC MPD Victimization Study from Jan. 2002
- Of 401 victims surveyed, 13% were re-victimized within just 3 months
**Trauma 101**

General Factors:
- Threatening or dangerous experience
- Helplessness and lack of control
- Determined by the response to the event not the event itself = defined by the experience of the survivor
- Reoccurring traumatic experiences can lead to Post Traumatic Stress Disorder (PTSD)

*Understanding the Impact of Sexual Assault: The Nature of Traumatic Experience, Sandra L. Bloom, M.D. 2003.*

**Trauma 101**

- Well established that events occurring during and subsequent to the traumatic event can make a profound difference in how the victim experiences and interprets that event.
- “Traumatization occurs when both internal and external resources are inadequate to cope with external threat.”

*Understanding the Impact of Sexual Assault: The Nature of Traumatic Experience, Sandra L. Bloom, M.D. 2003.*

**What Causes Trauma**

- Military experience
- Surviving natural disasters
- Serious accidents
- Crimes?
  - Any crime
  - Trauma is a subjective determination
**Trauma Effects on the Brain**

**Two Phases**

1. The Initial Crisis
2. Long-term Stress Reaction


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**The Crisis Reaction: Phase I**

- Normal state of equilibrium
- Occasional Stressors
- Trauma disrupts the range of equilibrium
  - Acute
  - Chronic
  - Developmental

---

**Physical Reactions?**

- Increase in heart rate
- Hyperventilation, perspiration & physical agitation
- Heightened sensory perception
- Regurgitation or urination
Emotional Reactions?

- Parallels the Physical Response
- Shock, disbelief and/or denial

Most Common Responses?
- Fear
- Anger
- Others?

Trauma & the Brain

The Limbic System

1. Emotions
2. Memories
Frontal Lobe Cortex

- Stores Memories
- Involved in the logic process

The Amygdala

- Designed for protection
- Operates like a pass fail exam
- Is incapable of logic
- Unconscious; Activates the Autonomic Nervous System
- Determines the best response to a threat
- Is an automatic response to danger and not a conscious choice

The Hippocampus

- Associated with learning and memory
- Encodes and stores memories—stores traumatic memories differently
- Unconscious response to templates of danger
- Only requires 10 to 20% of overlap
- Signals danger to the amygdala which activates the flight, fight or freeze (tonic immobility)

Examples
Over-Generalized Signals of Danger

- Better for survival
- Emotionally can disrupt life
- Trauma victims can be more vulnerable to make false associations which interpret danger in an environment where none exist
- **This is not the same as invented memories!**

The Invisible Epidemic: Post-Traumatic Stress Disorder, Memory and the Brain, J. Douglas Bremner, M.D.

Trauma & Memory

- The ability to recall details of traumatic incident aren't the same in the acute crisis moment as they are 48 hrs (2 sleep cycles) later
- Sticky notes example

U.S. Department of Justice, Office of Justice Programs, National Institute of Justice The Research, Development, and Evaluation Agency of the U.S. Department of Justice Transcript "The Neurobiology of Sexual Assault" with Dr. Rebecca Campbell

Chronic Trauma & Memory Research

- Decreased size of hippocampus
- Hard time recalling the trauma
- But recall the physical & emotional feelings associated with the trauma
- Physiologically not able to simply ignore emotions in order to increase logical thinking
- Think of it as a broken leg

The Invisible Epidemic: Post-Traumatic Stress Disorder, Memory and the Brain, J. Douglas Bremner, M.D.
Chronic Trauma & Memory Research

1-868-641-4728

1-800-641-4028

- What just happened?
- Memory can slip away when it never had time to form.
- It takes a few hours for new experiences to complete the biochemical and electrical process that transforms them from short-term to long-term memories.
- Explains why victims often have trouble recalling events that occurred just before a car crash/crime or other severe trauma.
Long-Term Reaction: Phase 2

- Requires an experience that causes a traumatic response
- Requires the distressing event persistently be re-experienced
  - Actual
  - Imagined (as a result of common triggers)

Common Triggers

- Identification of assailant
- Sensing something similar to an awareness during the trauma
- News of actual or similar events
- Proximity to “life events”
- Hearings, trials, appeals, critical phases in the proceedings

Responses to Triggers

- Symbols of the event revert survivors back to the response they exerted at the event
- Avoidance of stimuli associated with event
- Avoidance of situations that cause recollection
Common Reactions

• Trying to make sense of their experience
• Self-blame/minimizing behavior

Complications

• Survivors often have an inability to recall important aspects of event
• Common to forget certain aspects
• Unawareness of behaviors during & after event
• Substance Abuse is a form of dissociation & avoidance
• Victims can’t put the crime into a timeline

*IACP, Sexual Assault Incident Report Guidelines, 2005*

Best practices to navigate case complications related to trauma
Have You Ever

<table>
<thead>
<tr>
<th>Gone running with headphones?</th>
<th>Gotten a ride from someone you did not know well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forgotten to lock your door?</td>
<td>Drank too much?</td>
</tr>
<tr>
<td>Driven with your car unlocked?</td>
<td>Accepted a drink from someone you did not know well?</td>
</tr>
<tr>
<td>Slept during a Metro ride (or had your eyes closed)?</td>
<td>Dressed up to look nice/sexy for someone?</td>
</tr>
<tr>
<td>Walked alone at night?</td>
<td>Flirted with someone?</td>
</tr>
<tr>
<td>Gone on a 1st date, without a group of friends?</td>
<td>Spent time alone with a date?</td>
</tr>
<tr>
<td>Went home with someone you did not know well?</td>
<td>Made a bad decision?</td>
</tr>
</tbody>
</table>

History of Victim Blaming

Start of victimology

- How theories of victimology and criminology integrated into investigations
- What we know now about the focus of an investigation shifting to offender behavior
- How does self victim blame impact a case?
- The only way to completely prevent rape is to prevent perpetration. Only a perpetrator chooses to commit sexual assault, nothing a victim does makes someone rape.

Alcohol & Assault

Alcohol & the Double Standard

- A victim who has been drinking is perceived as being more responsible for the assault.
- A perpetrator who has been drinking is perceived as being less responsible for the assault.
Alcohol & Assault

In 2000, study of 212 officers looked at responses to stories of sexual assault when alcohol is involved.

- The more intoxicated the complainant was perceived, the more negatively she was viewed by the officers and the more blame they assigned to her.

- Minimize the effects of our biases:
  - The factors related to the officers’ likelihood of charging the perpetrator involved assessment of credibility and likelihood that the perpetrator would be found guilty
  - Officers still assigned more blame to the perpetrator
  - Regardless of alcohol use, the officers did not discourage the victim from filing a report

Drug Facilitated Sexual Assault

Common ‘date rape’ drugs
- Rohypnol
- GHB (Gammahydroxybutyric Acid)

No conclusive statistics on use of drugs to facilitate sexual assault
- Dept. of Justice study of 144 patients administered a forensic exam, only 4.6% found traces of common date rape drugs
- Victims may remember very little
- Drugs often leave system within 72 hours; some leave the body in 8 hours
- Effects can mimic that of alcohol

MYTH
Rapes are falsely reported more often than other crimes.

REALITY
Only 2% - 8% of rapes are falsely reported, the same amount as any other serious crime.
**Challenging Factors**

What happens to a case when:
- The victim has a prior relationship with the perpetrator
- The victim used alcohol or drugs
- There is no visible evidence of injury
- The victim fails to label her sexual assault as rape
- The victim is not crying, upset, or hysterical
- The victim delays telling the police
- No forensic exam was obtained
- The victim is not perceived as credible (may be homeless, have a disability, or is a sex worker)
- The victim is not able to give a clear account of what happened
- Suspect is perceived as a 'nice' guy

**MYTH**
Someone who has been sexually assaulted will be very upset or hysterical and often never recovers from their rape.

**REALITY**
There is no normal reaction to being sexually assaulted, everyone reacts in their own way.

**Reactions to Sexual Assault**

A survivor may respond differently as time progresses
- May react immediately or delayed response
- Responses can be triggered later (even years later) by an association to the assault

**Resilience**
Positive capacity of people to cope with stress and adversity
- Can result in the individual “bouncing back” to a previous state of normal functioning
- Can produce a “steeling effect” and function better than expected
- Resilience is a process not an individual trait
Long-term Effects of Trauma

- shame
- hypervigilance
- self-blame
- denial—minimization—avoidance
- high levels of anxiety
- depression/lethargy
- unable to concentrate
- unable to continue in school
- social withdrawal
- isolation (perceived and actual)
- disrupted sleep patterns
- loss of friends & support
- sexual dysfunction
- hyper-sexuality
- substance abuse
- restricted affect (reduced ability to express emotion)
- eating disorders
- unable to trust/commit partners, friends
- fear
- suicidal ideation
- codependency on abusive relationships

Other Sexual Assault Myths

Other myths we combat:
- Having sex with someone who is “blacked out” is not rape.
- Consent is ongoing.

Challenges Regarding Prosecutorial Discretion
Combating these Challenges

- How we talk about sexual assault cases in the media
- Trauma-trained staff
- Utilizing experts
- SARTs
- Collaborations
- Other ideas?

In Your Role

☐ it is NOT your job
- to be your client’s therapist
- to fix all of her problems
- to tell her to leave her relationship or what to do

☐ it IS your job
- to show your client compassion
- to listen to your client
- to educate yourself on what your client may be going through

Talking to Survivors about Trauma

What not to do:

1. Do not judge the survivor
2. Never make promises that you can’t keep
3. Do not try to rationalize what happened
Talking to Survivors About Trauma

How to Make Referrals and What Happens When You Do

Who is Reporting to MPD or APS?

- Mandatory Reporters to APS or MPD: Conservators, guardians, licensed health pros & admins, LE and animal cruelty officers, bank/financial managers, social workers (exception of SA advocates)
Do DC Providers Know How to Report?

- 38% not familiar with DC’s EA reporting laws
- 34% do not know how to report EA
- 61% never made a report before
- 60% do not screen for EA
- 52% never received any training on EA
- 76% don’t display EA info, brochures, posters
- 44% didn’t know services available to older victims
- 57% felt training is most important support DC TROV can provide

Adult Protective Services

- Tasked with receiving reports & investigating.
- Then refers seniors to community organizations for services (house cleaning, health, etc.)
- Competent adults may refuse help.
- APS may enter w/police to remove incapacitated senior. But APS has no custodial authority – can’t take custody for any reason. Not equivalent to CPS.
- May petition court order for guardian or conservator
- Case closed within 90 days.
- Reports to licensing agency when licensed professional is abuser
- 24/7 APS intake: 202-541-3950

APS Gets Community Nonprofits, Volunteers, Agencies Involved:

- Cleaning, transport & food services
- Representative payee services
- Scheduling medical appointments
- Capacity assessments
- Counseling
- Temporary hotel stays w/ health aide
- Placement in LTC facilities
- Assistance w/ Medicaid Waiver Application
- Legal services - emergency orders, guardian, conservator

Network for Victim Recovery of DC (NVRDC)
**Prosecution**

- USAO can take criminal actions:
  - Criminal Abuse, Neglect, Financial Exploitation of Vulnerable Adults & the Elderly
  - Enhanced Penalty for Crimes Against Seniors

- OAG of DC can take civil actions:
  - Fine up to $5,000
  - Temporary/civil restraining order
  - Order to freeze offender’s and victim’s assets
  - Revoke all permits, certificates, licenses issued by DC authorizing the offender to provide services to vulnerable or elderly persons

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**Network for Victim Recovery of DC**

- Runs the District’s Sexual Assault Crisis Response
- Provides advocacy & legal representation to victims of all crimes
- All services free
- No time limit
- 202-742-1727

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**Legal Counsel for the Elderly**

- Legal Hotline – screens for abuse/exploitation
- Consumer Fraud & Financial Abuse Unit
- Landlord Tenant Project – assists in self-neglect cases & has 2 full-time hoarding social workers
- Ashley Morse & Tina Smith-Nelson take CPO cases from DC SAFE Listserv
- Public Benefits
- Wills & Powers of Attorney
- Senior Medicare Patrol
- Office of the D.C. Long-Term Care Ombudsman
**Long Term Care Ombudsmen**

Advocates for residents of facilities + those in home settings with a CNA

- Educates residents, families & communities on residents’ rights & quality care
- Collaborates on policy change to meet resident needs
- Receives & resolves complaints about care
- Ensures care is in accordance with DC & federal laws

202-434-2190

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**Long Term Care Ombudsmen**

- Are they the APS equivalent but in nursing homes?
- Confidentiality – no longer mandatory reporters
- Head of LTC Ombudsmen Mark Miller – discretion in egregious cases
- DC is unique:
  - LTC Ombudsmen is a federally mandated program, but states house program in different settings
  - CNAs in home settings & community residential facilities (group homes) also covered

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**Elder Abuse Shelter & Housing**

- **SOME’s Kuehner House for Abused & Neglected Elderly**
  - Waiting list with priority for APS referrals
  - Independent living / apartments
- **ElderSAFE**
  - In Rockville but accepts DC seniors
  - Must be nursing home eligible
- **District’s Alliance for Safe Housing**
  - Zaneta Greene, Community Housing Resource Specialist – Elder Advocacy
  - 202-290-2356 ext. 105 or zgrene@dashdc.org
Consider Non-Traditional Support Networks

Faith Affiliation by Age
- 65 years and older: 88%
- 50–64 years: 83%

"Religious affiliation is the most common form of organizational participation among older adults, with 50% reporting attending services weekly."

American Psychological Association, Older Adults’ Health & Age-Related Changes: Demographic, Economic, & Social Issues

Breaking Isolation is KEY to Preventing Abuse in Later Life

Questions?

Curtis Prince
MPD Financial & Cyber Crimes Unit
Curtis.Prince@dc.gov

Amy Mix
Legal Counsel for the Elderly
AMix@aarp.org

Merry O’Brien
Network for Victim Recovery of DC
Merry@nvrdc.org

Bridgette Stumpf
Network for Victim Recovery of DC
Bridgettte@nvrdc

Sheila Jones
Adult Protective Services
Sheila.Jones@dc.gov

Network for Victim Recovery of DC (NVRDC)