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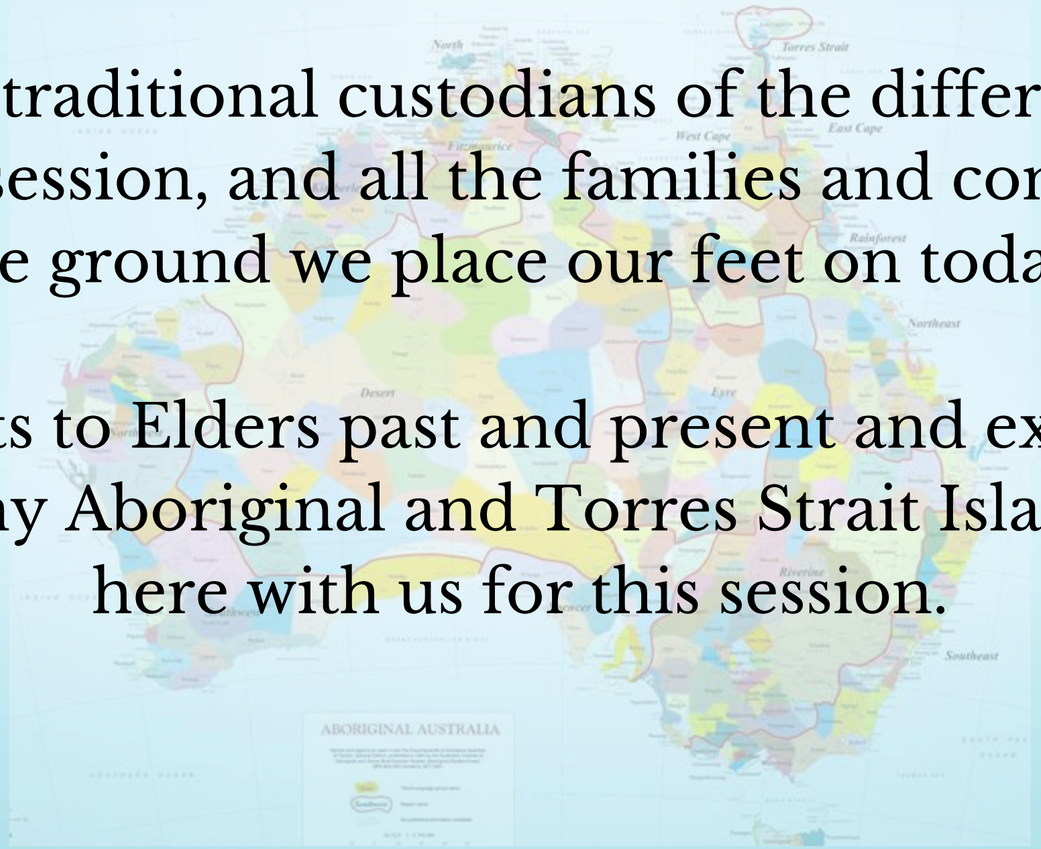
Intermediaries Working with Mental Health in Justice Settings

Acknowledgement of Country



We acknowledge the traditional custodians of the different lands we are each located on during this session, and all the families and communities with links to the ground we place our feet on today.

We pay our respects to Elders past and present and extend that deep and genuine respect to any Aboriginal and Torres Strait Islander peoples present here with us for this session.

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Before we begin...

- We would appreciate people keeping their cameras on unless you need to stretch or grab a drink etc
- We will use the chat function or may ask you to unmute
- There will be breaks across the two days of training
- Please let us know if the breaks are hitting the mark

Introductions

Who we are...

LUCY

Intermediary
ACT Intermediary Program
Clinical Psychologist

SARAH

Senior Intermediary
ACT Intermediary Program

LAURA

Director
ACT Intermediary Program

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Course content

- Consider different perspectives on what constitutes mental health and mental ill-health
- Discuss some prevalent psychiatric diagnoses from the ICD-11 and DSM-5 and their impact upon communication
- Consider diagnostic labels and the use of language in engagements
- Explore the fundamental nature of emotional co-regulation and self-regulation to mental health and communication
- Consider some perspectives of people diagnosed or impacted upon by mental health conditions
- Discuss the main groups of psychiatric medication and their impact upon communication

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Course content

- Consider complex presentations: co-morbidity, concurrent mental health conditions, addiction issues and/or learning difficulties/disabilities, and ‘personality disorders’
- Consider how to address safeguarding concerns in relation to mental health
- Explore approaches to assessing the impact of mental ill-health and emotional dysregulation on communication
- Consider how assessment findings and recommendations can be written up for adjustments to support effective participation
- Explore a range of case studies of witnesses with mental health issues

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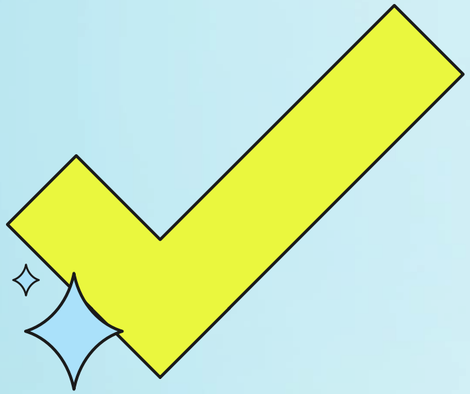
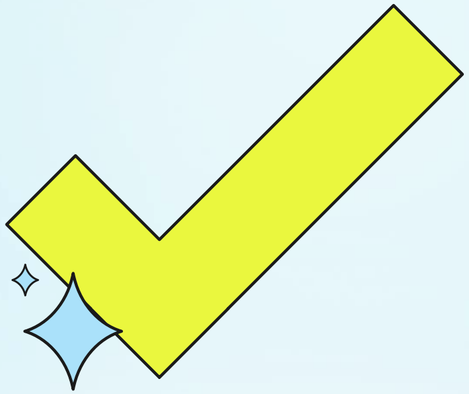
Course objectives



Objective 1

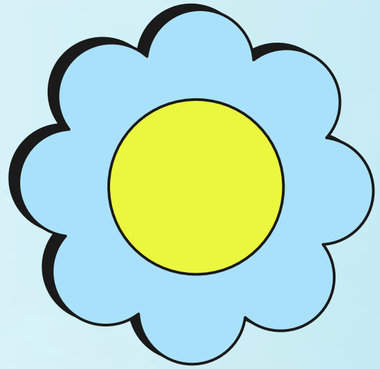
Build participants' knowledge and understanding in:

- Mental health
- Impact of mental health on communication



Objective 2

Build participants' confidence in working with vulnerable witnesses whose communication is impacted by mental health



Please note!

The course will not, in itself, equip participants to take on mental health referrals

Agenda: Day 1

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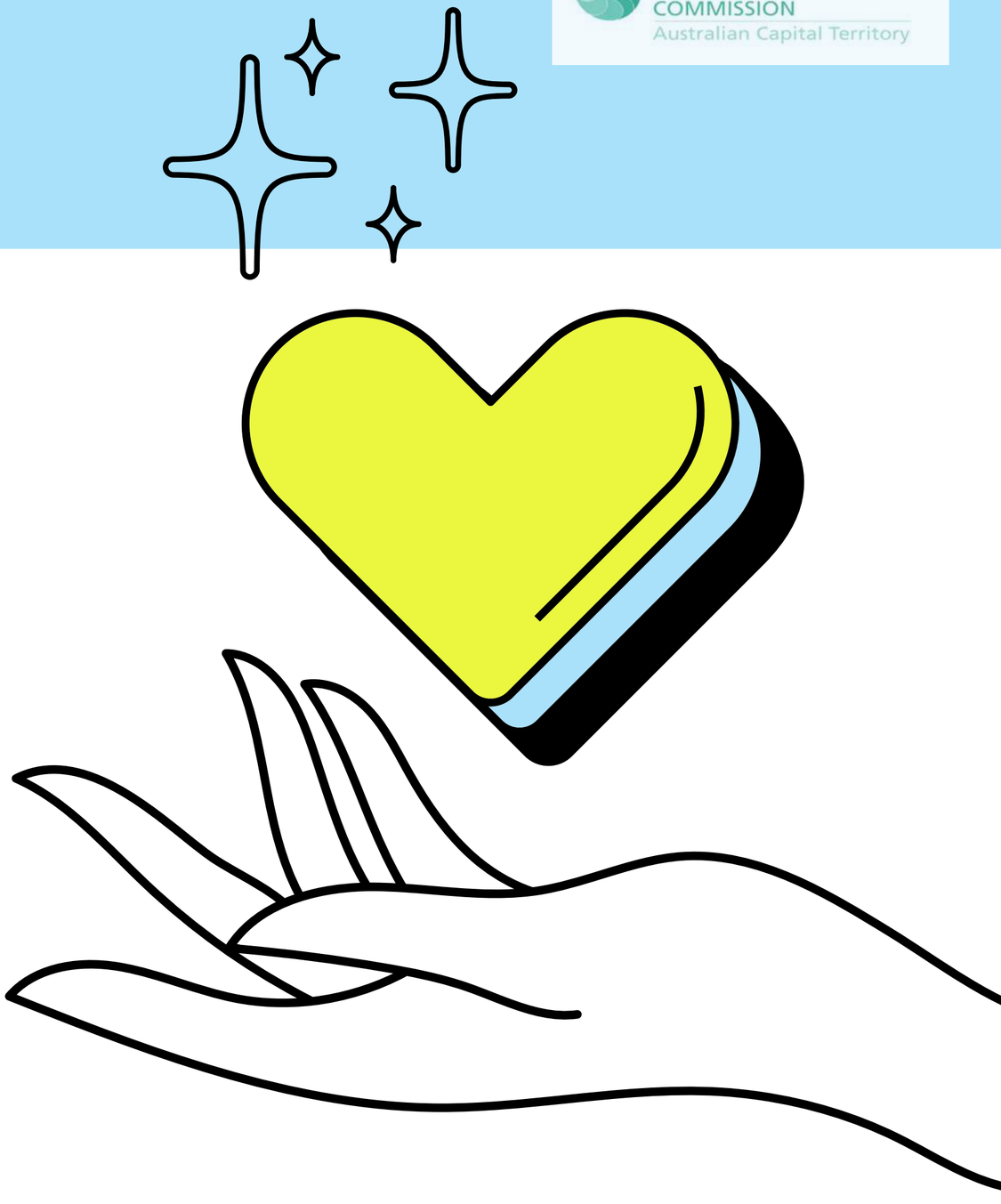
- Explore theories, literature, science and perspectives relating to mental health
- Consider diagnostic frameworks for mental disorders
- The impact of mental illness and medication on communication
- Approaches to regulation and useful intermediary resources
- Case studies and breakout rooms



Agenda: Day 2

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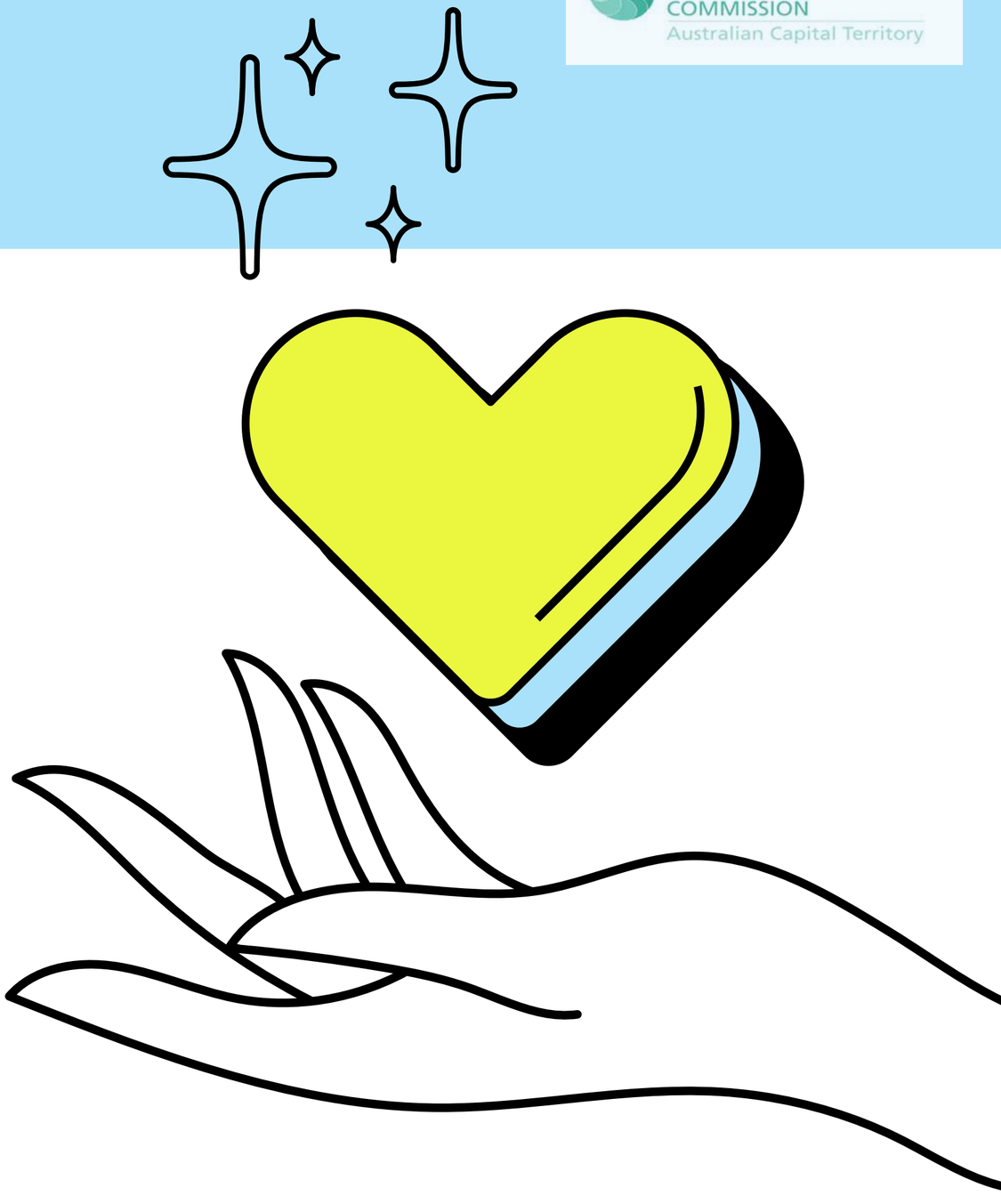
- Legislation about mental health
- Assessment considerations and recommendations
- Case studies and breakout rooms
- Intermediary court reports
- Working with witnesses at court
- Vicarious trauma and self-care



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Please be aware...

Challenging material

We all have direct and/or indirect experience of mental ill-health and distress

Respectful discussion

It's important we navigate conversations with respect and sensitivity

Practice self care

Let's take care of ourselves and each other throughout and beyond the two sessions

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Jurisdictional differences

Program structure

- 24-hour services
- Program Administrators
- In-house (8) and panel intermediaries (15)
- Social work, speech pathology, psychology, occupational therapy, other
- Officers of the Court
- Service provision commenced in 2020

Service eligibility

- Police, lawyer and court referrals
- Prescribed categories
- Children and young people
- Adults with communication difficulties
- At court, articulated in legislation
- No diagnoses required

Allocations and appointments

- In-house intermediaries attend all matters within business hours
- Panel intermediaries engaged for police referrals after hours and on weekends
- Legislation focuses on criminal matters
- Intermediaries have been appointed in civil matters

Intermediary practice

- Communication assessments completed prior to police interview, lawyer consultation and court
- Verbal recommendations at police interview
- Court reports
- A younger Program than others

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Terms in this session

Witness

May refer to a complainant, similar act witness or defendant

Accused person

For the purposes of this training, this term means a ‘defendant’

Communication difficulty

Examples only in legislation
‘A mental or physical disability that impedes speech’

Police interview

Evidence-in-chief interview
Achieving Best Evidence (ABE)
Suspect interview

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A note on language

Person-first language

The disability, condition, or neurotype is not considered part of the individual's identity

e.g. person with depression

e.g. person with autism

Identity-first language

The person's disability or neurotype is considered an inherent part of their identity

e.g. depressed person

e.g. autistic person

A note on language

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Identity-first language

The person's disability or neurotype is considered an inherent part of their identity

e.g. depressed person

e.g. autistic person

During this training we will use the current preferred language for different neurotypes and conditions according to recent literature, but acknowledge individual preferences. When referring to an individual, use their preferred language.

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What is Mental Health?

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We are going to explore the identified course context in some depth

As such, this training will not be a deep dive into neurodiversity. However, this is not to ignore or minimise the impact of neurodivergence on mental health or communication.

Mental health vs mental illness

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- Mental health includes emotional, psychological, and social wellbeing
- We all have mental health, but not everyone will have mental illness
- You don’t need to have a mental disorder to have poor mental health
- The impacts of mental illness may be short or long term, and range with respect to severity of impact
- Many mental health challenges are not mental disorders
  - For example, low self-esteem, perfectionism, panic attacks, sense of dread, avoidant coping style, poor body image, difficulty concentrating, intolerance of uncertainty

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Flourishing

MENTAL HEALTH
HIGH

MENTAL ILLNESS
HIGH

MENTAL ILLNESS
LOW

LOW
MENTAL HEALTH

Languishing

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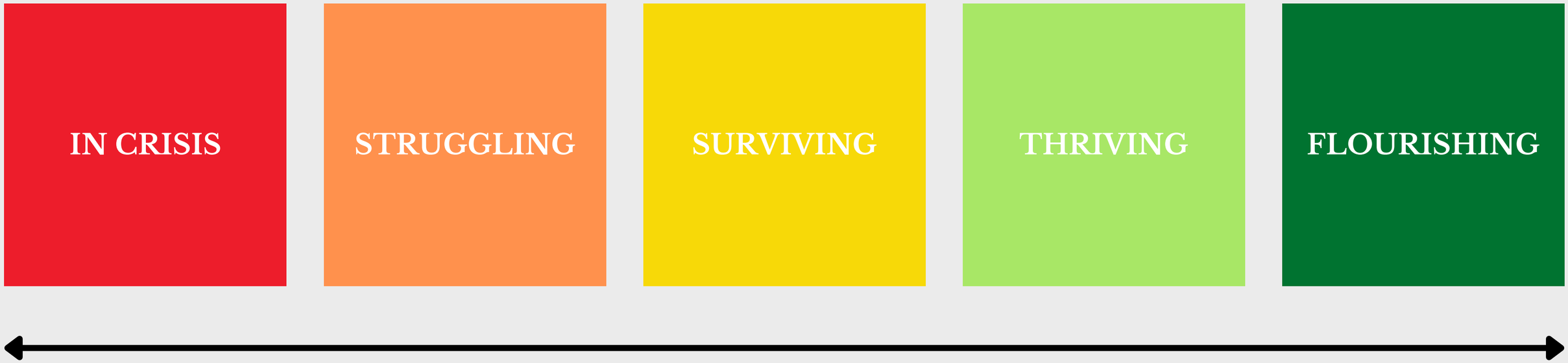
Mental Health Continuum

Looks less at symptoms, and more on social and occupational functioning



Where does mental illness come from?

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A number of different theories exist:

- Biological / Medical model
- Evolutionary psychology theories
- Behavioural model
- Attachment theory
- Sociocultural models
- Biopsychosocial model

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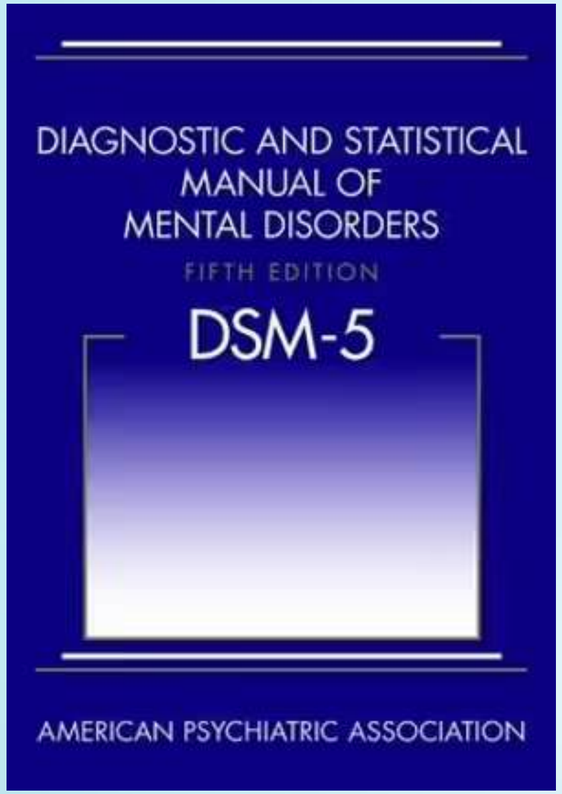
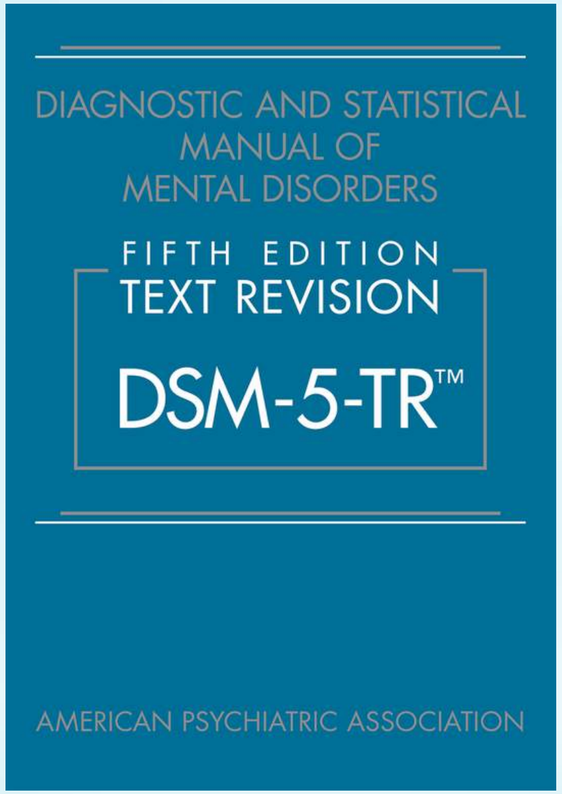
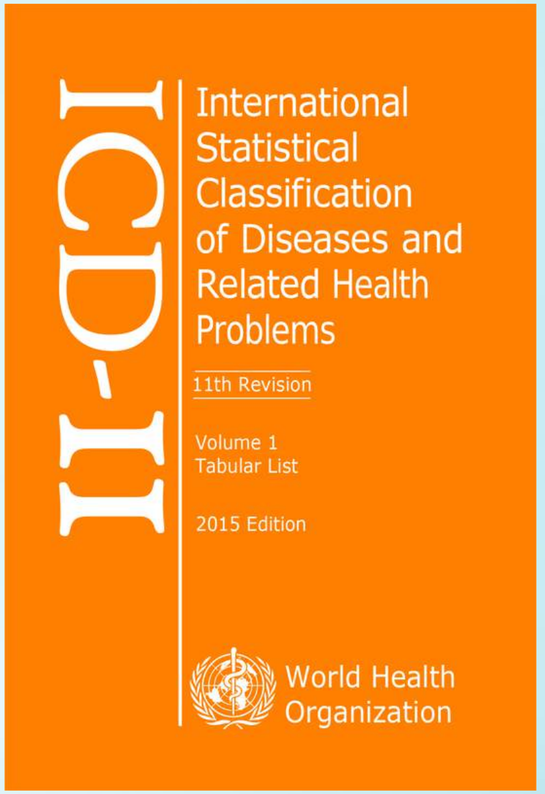




Diagnostic and Statistical Manual of Mental Disorders (DSM)



International Classification of Diseases (ICD)

What is anxiety?

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- Not all ‘anxiety’ is a mental illness
- Anxiety can refer to apprehension, tension, worry, rumination, nervousness, panic, dread
- Four components of anxiety:
  - Physical symptoms (sweat, nausea, heart rate increase)
  - Emotional response (e.g. dread, apprehension)
  - Behavioural response (avoidance, escape)
  - Cognitive response (images or thoughts of the feared thing, catastrophising bad outcomes)

Anxiety Disorders

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- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety
- Panic Disorder
- Agoraphobia
- Generalised Anxiety Disorder

Anxiety Disorders

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Impacts on communication:

- May avoid eye contact
- May be jittery/fidgety
- Strong fear of negative evaluation (in children, may seem like not wanting to mess up)
- Might avoid drawing attention to self (e.g. speak softly, physically withdraw)
- Might try and seek reassurance
- Might want to check things multiple times

Depressive Episode (DSM-5-TR)

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1. Five or more of the following:

- Depressed mood
- Diminished interest in activities
- Significant weight loss/gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness, or excessive/inappropriate guilt
- Difficulty concentrating, or indecisiveness
- Recurrent thoughts or death, or recurrent suicidal thoughts

Note: Must occur most days for at least two weeks, must include either depressed mood or diminished interest, symptoms must cause distress or impairment, and symptoms must not be due to another cause

Depressive Episode (DSM-5-TR)

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Impacts on communication:

- Difficulties concentrating
- Slower processing speed
- Low motivation
- Difficulty making decisions
- May appear disinterested, withdrawn, or even oppositional

Psychosis

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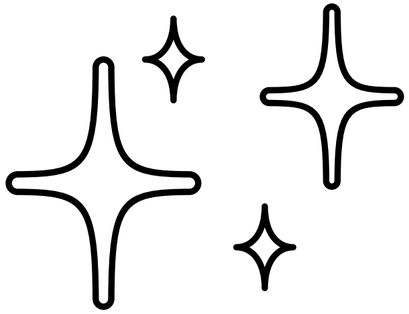
Note: Psychosis is a symptom, not a mental health disorder itself. People can experience psychosis for many reasons. Psychosis does not mean they have schizophrenia.

- Psychosis = loss of contact with reality
- Psychosis is common in schizophrenia, severe depression, and bipolar disorder
- BUT it can also be induced by substances (both illicit and medications), brain injury, malnutrition, and dementia



What is psychosis?

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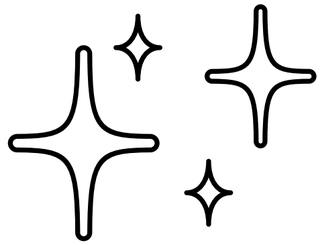
Hallucinations

Hallucinations can be:

- **Visual** (seeing things that aren't there)
- **Auditory** (hearing voices, hearing things)
- **Tactile** (feeling things, believe being touched)
- **Olfactory** (smelling things that aren't there)

Delusions

False beliefs that are perceived as real. Must be considered abnormal in the individual's social context.



What is psychosis?

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Hallucinations

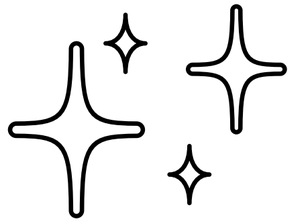
Delusions

Disorganised thinking

Racing thoughts, topic changes, distractibility, tangential thinking, word salad, attention difficulties, not orientated to time/place

Abnormal motor behaviours

Repetitive movements, movements without purpose, agitation, or catatonia



What is psychosis?

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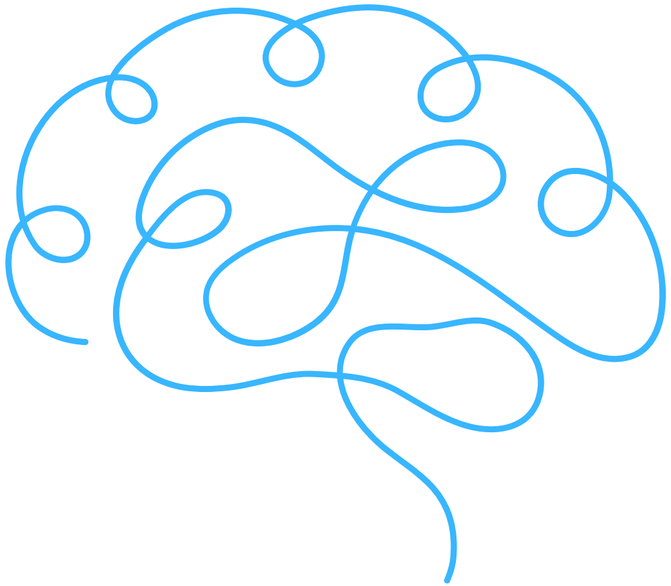
Common types of delusions:

- **Paranoid delusions** (of being hurt)
- **Grandiose delusions** (being special e.g. a prophet)
- **Delusions of control** (my actions are being controlled)
- **Thought insertion** (my thoughts are inserted by an external force, or people can listen in)
- **Thought broadcasting** (my thoughts are being broadcast aloud)
- **Delusions of reference** (external events have special meaning to the individual)



Disorganised thinking

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Note: these symptoms can are seen across a variety of conditions

- **Poverty of Speech** (inability to speak)
- **Thought Blocking** (mind suddenly blank. May abruptly stop speaking)
- **Circumstantiality** (detour but then comes back to topic)
- **Tangentiality** (switch to a related topic)
- **Derailment** (switch to an unrelated topic)
- **Clang speech** (grouping works based on similar sounds)
- **Echolalia** (repeating the words just spoken by another person)
- **Neologisms** (made up words or phrases)


Psychosis Film
From a UK healthcare provider
Share
Watch on YouTube

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Psychotic symptoms (and a person's insight into them) are exacerbated by stress

A witness may not be in active psychosis at the start of an interview, but can enter psychosis during the course of an interview or questioning

A person in active psychosis is unlikely to be participate effectively in evidence-gathering settings

PTSD

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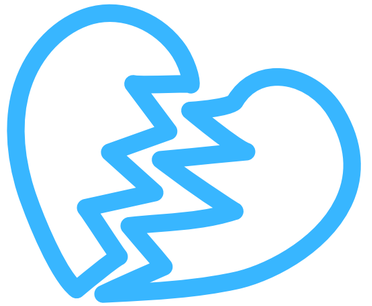
- **Exposure to actual or threatened death, serious injury, or sexual violence**

- **Intrusion symptoms**
  - e.g. memories, dreams, dissociative reactions like flashbacks, intense distress are reminders/triggers, intense physiological reactions



- **Avoidance of things associated with the traumatic event/s**
  - Mental avoidance or physical avoidance (people, places etc)

- **Changes in beliefs, cognition, activities, or mood**
  - e.g. trouble remembering the event, cognitive distortions (e.g. ‘no one can be trusted’), blaming themselves, persistent negative emotions (e.g. shame, anger), withdrawal from activities, detachment, inability to experience positive emotions

PTSD

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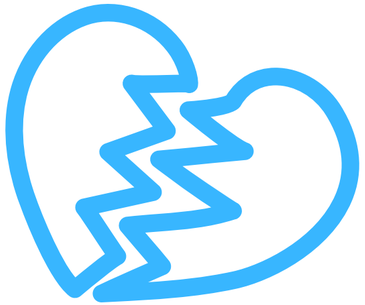
- **Changes in emotional arousal or reactivity**
  - e.g. irritability, recklessness, self-destructive behaviours, hypervigilance, startle response, problems concentrating, sleep issues
- **Need to experience for at least 1 month**
- **Associated with significant distress or functional impairment**
- **Not due to medications, substances, or medical conditions**



Tip: Ask the witness if they are comfortable sharing their triggers, so you can help to avoid them unnecessarily. Triggers can be anything (objects, words, smells, colours).
Note, some people do not know their triggers.

PTSD

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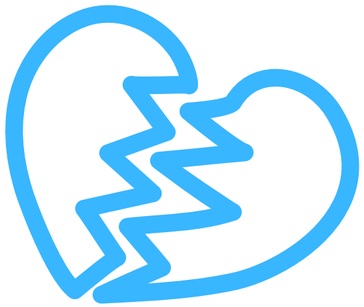
Impacts on communication:

- May dissociate or become highly distressed when discussing their evidence
- May experience depersonalisation (feeling detached from body) or derealisation (world is dreamlike or distorted)
- Potential mistrust of professionals
- Poor attention, concentration, hypervigilance



Schizophrenia

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A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

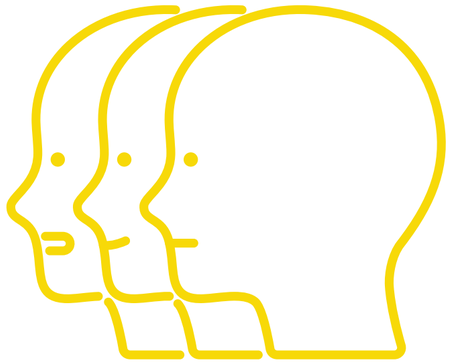
- Delusions
- Hallucinations
- Disorganized speech (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behaviour
- Negative symptoms (i.e., diminished emotional expression or avolition)

B. Significant change in functioning

C. At least 6 months

D. Not better explained by depressive or bipolar disorder with psychotic features

E. Not due to substances or medical condition



Schizophrenia

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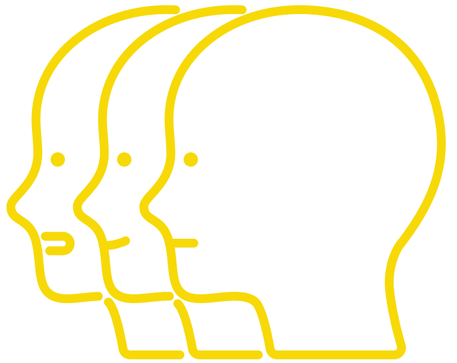
Impacts on communication:

- Hallucinations can impact ability to attend to questions/activities
- Delusions can impact willingness to engage in interviews or activities
- Issues with confusion
- Disorganised thinking (e.g. going on tangents, unrelated responses)



Personality Disorders

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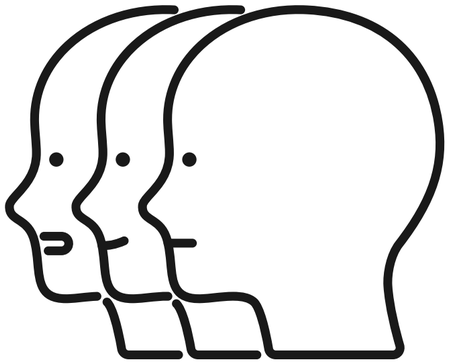
- Personality disorders are long-term patterns of behaviour, impulse control, emotional responses, relating to other people, and inner experiences that differ significantly from the norm
- Often the symptoms cause the individual significant distress
- Often linked to adverse childhood experiences
- Personality disorders are common - 5 to 10%
- Usually recognisable from adolescence/early adulthood
- **Note: State does not equal trait!**



Personality Disorders

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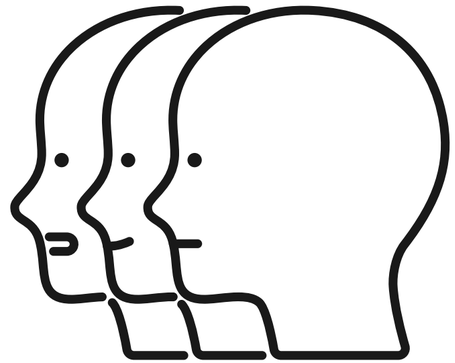
Borderline Personality Disorder

- **Changing emotions, strong emotions**
  - Can lead to using self-harm and other maladaptive methods to regulate distress
- **Relationship difficulties**
  - Intense fear of abandonment, very sensitive to signs of rejection and criticism from others
  - Often a pattern of rocky relationships
- **Problems with identity and sense of self**
  - Abruptly shifting values, goals, friendships
  - Can feel hollow or empty inside
  - May sometimes feeling like nothing is real
- **Impulsive and self-destructive behaviours**
  - e.g. binge eating, spending, gambling



Addiction Issues

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- Substance use alone does not equate to a mental disorder
- Addiction to substances = substance use disorder (inability to control use of drugs or medicines, prescribed or not prescribed)

<u>Things to consider for communication</u>:

- Is the individual intoxicated or affected at the time of engagement?
- Are they in a withdrawal state?
- Fear of judgement by others if being questioned about events which occurred when they were impacted by alcohol or other drug use
- Substance use may lead to psychosis (drug induced psychosis)

Bipolar Disorders

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- **Bipolar I Disorder**
  - Includes at least one manic episode
  - May or may not include depressive episodes
- **Bipolar II Disorder**
  - At least one hypomanic episode and at least one depressive episode
  - There have never been a manic episode
- **Cyclothymic Disorder**
  - Criteria for a major depressive, manic, or hypomanic episode have never been met

Bipolar Disorders

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Impacts on communication:

- If during a manic or hypomanic episode - may be more talkative, urgency of speech
- Racing thoughts
- Highly distractible
- Preference for goal-orientated tasks

Dissociative Identity Disorder (DID)

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A. Two or more distinct personality states (accompanied by alterations in affect, behaviours, consciousness, memory, perception, cognition, and/or sensory motor functioning)

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting

C. Significant distress or impairment

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures)

Dissociative Identity Disorder (DID)

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- Some individuals report they become observers of their own speech and actions with a personality takes over, whereas others do not recall the time spent in a different personality state
- Often the alternate personality states cannot even be directly observed by outsiders
- Some individuals report hearing multiple concurrent thought streams at the same time
- Strong emotions or thoughts or behaviours may suddenly materialise, without the person feeling control or ownership over them (often reported as bizarre or unwanted by the individual)
- Attitudes, preferences (e.g. about food, sexuality) can suddenly shift, and the person can feel like they are ‘not mine’ or ‘not under my control’
- Some individuals will have different personalities with different names, handwriting, accents etc - this is the minority of DID cases

Dissociative Identity Disorder (DID)

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Impacts on communication:

- Significant memory issues (dissociative amnesia)
- Hallucinations are common in DID
- Some people can recall events that happen to an alternate personality, whereas others cannot
- May experience a shift or change during the interview itself

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See you in 20 minutes!

Comorbidity

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Comorbidity (co-occuring disorders) are the **norm**

- Up to 80% of individuals with one anxiety disorder meet criteria for another anxiety disorder
- 72% of individuals with Major Depressive Disorder (depression) will also meet criteria for another DSM disorder
- 85% of individuals with depression will also report anxiety symptoms
- 40% of individuals with substance use disorders have a comorbid mental disorder
- 28% of those with a chronic physical disorder also have a mental disorder
- 58% of individuals with an affective disorder will have a comorbid anxiety disorder

Prevalence of mental illness and mental disorders

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- 1 in 5 adults will experience a mental disorder
- 1 in 7 children/teens will experience a mental disorder
- 1 in 12 (8.5%) has a diagnosable substance use disorder
- 1 in 24 (4.1%) has a serious mental disorder
- Anxiety disorders are the most common (17% of Australians)

Sources: American Psychiatric Association (2022) & Australian Institute of Health and Welfare (2024)

Prevalence of mental illness and mental disorders

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The most common mental illnesses among **children/teens** are:

- Attention deficit hyperactivity disorder (7%)
- Anxiety disorders (7%)
- Major depressive disorder (3%)
- Conduct disorder (2%)

Sources: American Psychiatric Association (2022) & Australian Institute of Health and Welfare (2024)

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Figure 2: Types of serious illness by age and sex, 2009 to 2021

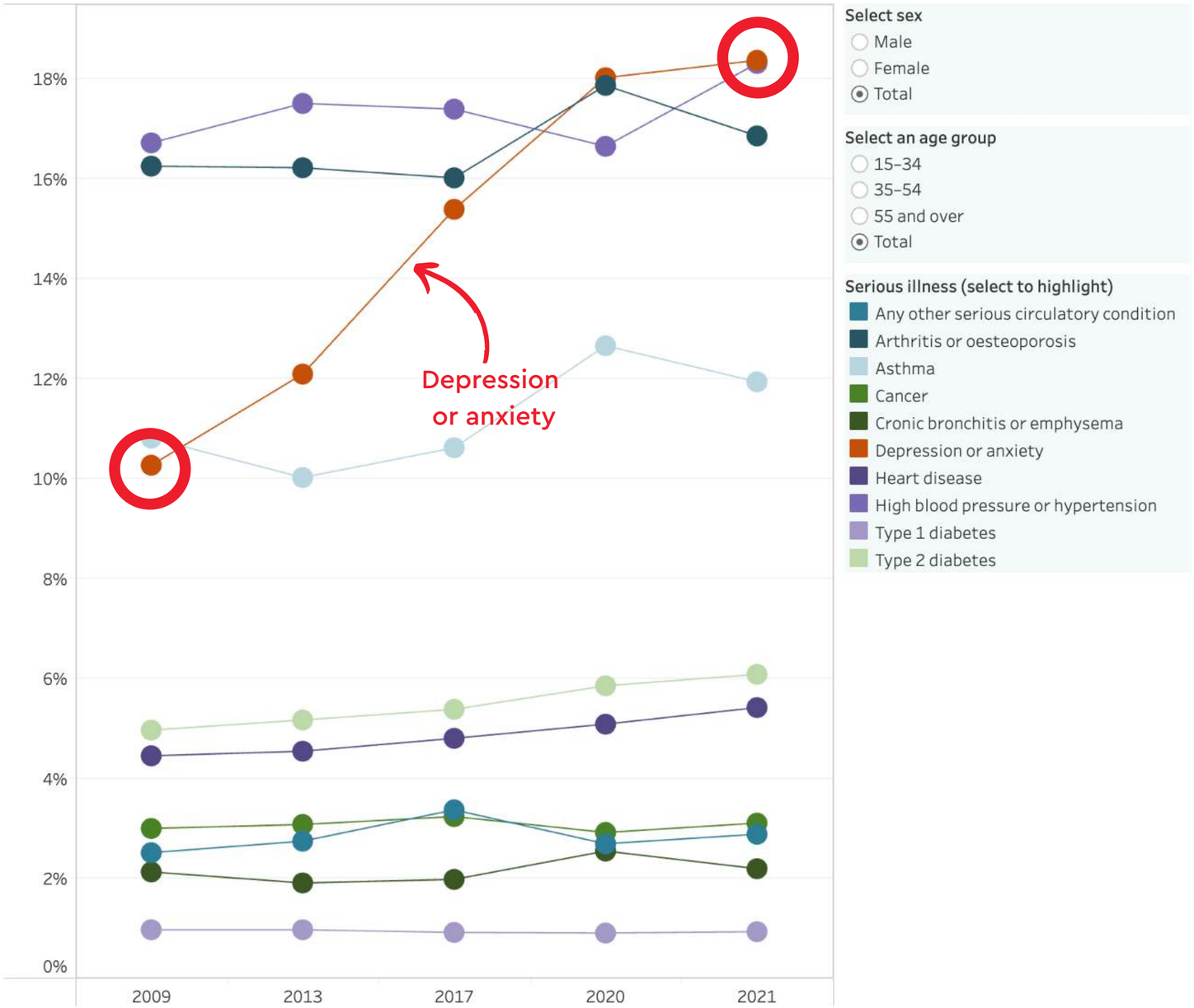

Figure 2: Estimated proportion of Australians reporting serious illnesses, by sex and age group, 2009–2021.

2009 2021

https://www.aihw.gov.au/mental-health

Source: Household, Income and Labour Dynamics in Australia Survey 2021

- **Rates of mental illness are rising!**
- Young women aged 15-34 are the fastest growing cohort
- Mental illness is more common among younger people compared to older adults
- 59% of Australian reported employment difficulties due to a mental condition
- Rates are higher for First Nations people, LGBTIQA+ people, and disabled people

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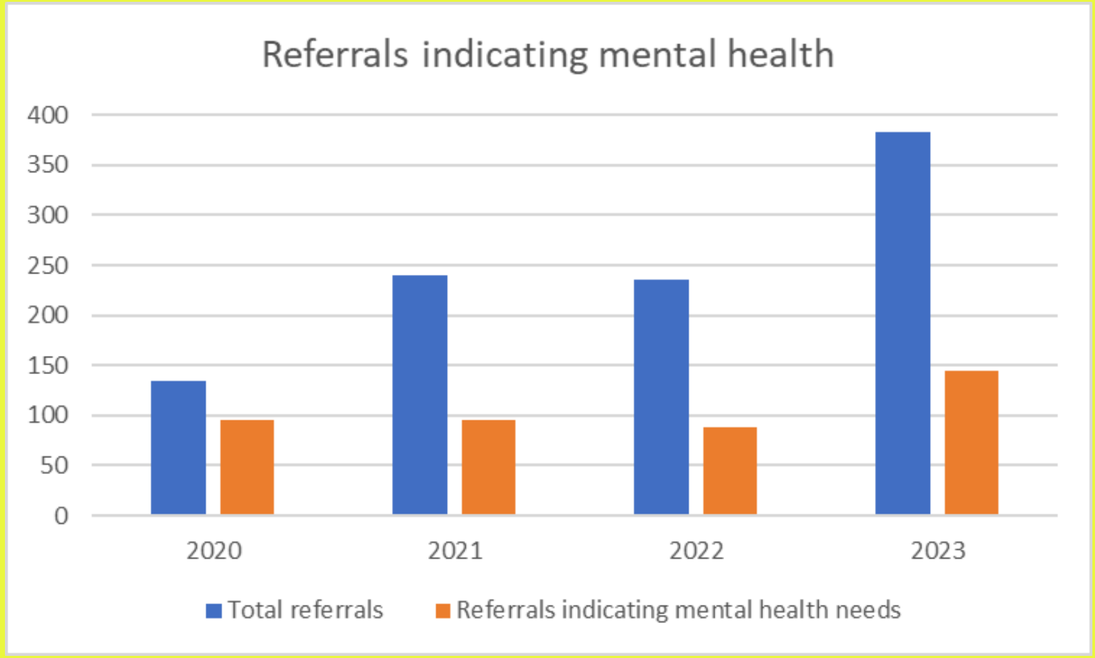
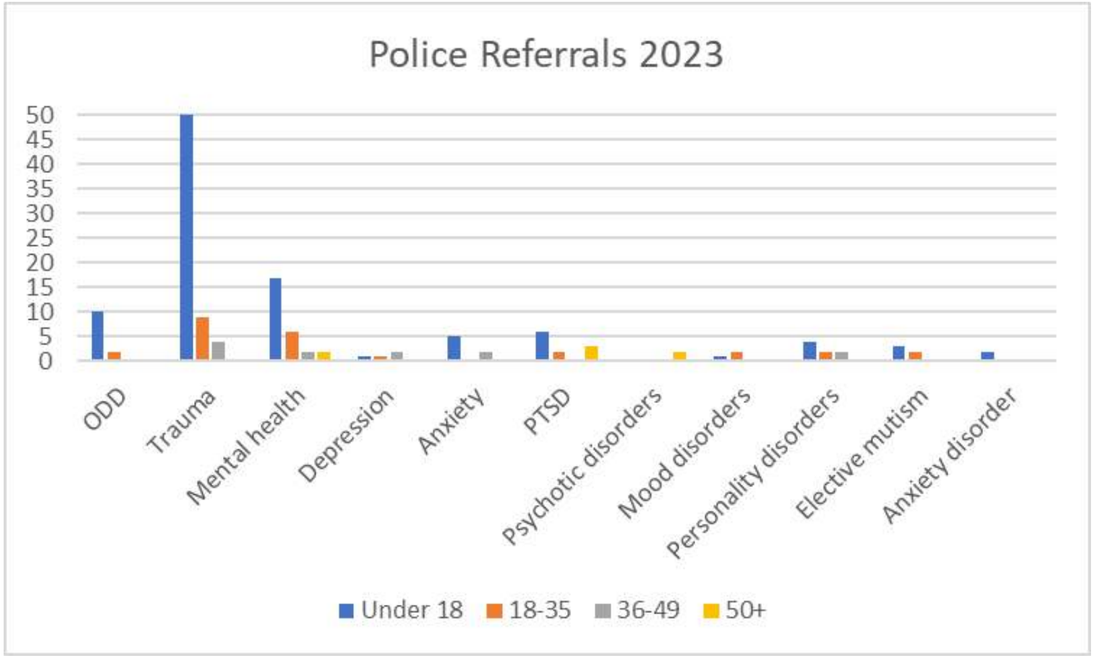
Some ACT police referral statistics





- As indicated on referral form and/or advised during a witness engagement
- No formal diagnosis required
- Young age aside, trauma as a standalone communication need is the most prevalent
  For context, the ACT has a current estimated resident population of 469,194

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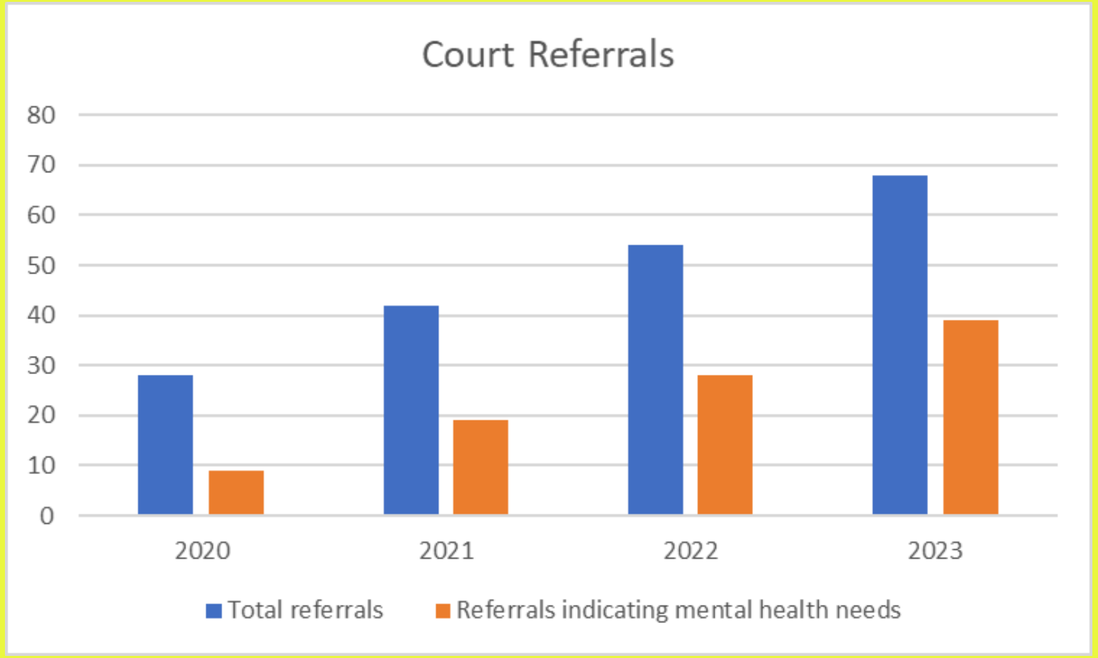
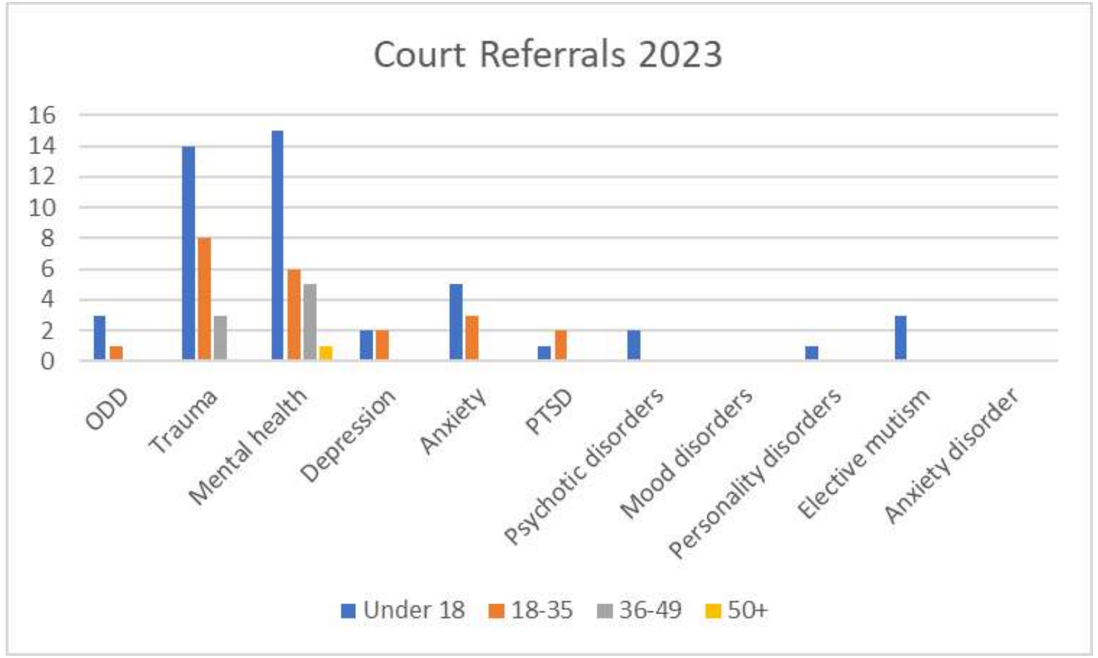
Some ACT court referral statistics





- As indicated on referral form and/or advised during a witness engagement
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Diagnostic Labels

Reasons for a diagnosis

- **Self awareness** - how and why the mind works the way it does, and what environments will best support success
- **Understanding from others** - feeling understood by their family, friends, teachers, employers, therapists, police officers, and intermediaries
- **Access to funding and supports** - accommodations in the workplace, at school, from government funding, etc
- **Sense of belonging** - being connected to other people with similar experiences, challenges, or neurotype
- **Self-advocacy -** advocating for needs, rights and accommodations that are necessary to flourish
- **Validation of experiences** - e.g. reframing from 'I am lazy' to 'I am depressed' and can provide a sense of **hope and relief**
- **Directs interventions and recommendations**

Reasons against a diagnosis

- Labels can **overgeneralise an individual's unique experience** - not every person with a diagnosis will meet every criterion under the criteria
- Some individuals **dislike or disagree with the diagnosis**
- Diagnoses can be **incorrect** or lead professionals to make **incorrect assumptions about a person's capacity**
- **Symptoms can change significantly over time** - individuals can improve their functioning or level of distress, yet labels can stick with a person for life
- Certain diagnoses **can attract stigma** and be seen as less treatable and more difficult to work with. Some diagnoses are **excluded from services**
- Mental health diagnoses are **subjective** and there can be differences in assessment and option among professionals
- **Wrong diagnosis can lead to wrong treatment/intervention**

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Lived experience perspectives of diagnosis

Being given a diagnosis is like being given a kick in the teeth. They're not saying that there's something wrong with your liver, but that something is wrong with you. (Anon)

I was told I had a disease. I was beginning to undergo that radically dehumanising and devaluing transformation…from being Pat Deegan to being 'a schizophrenic'. (Pat Deegan)

I prefer my illness having a name because it makes me feel less lonely, and I know that there are other people experiencing my kind of misery. And that people live through my illness and make a meaningful existence with it. (Karin Falk)

Quotes taken from Understanding Psychosis and Schizophrenia

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Impact on Communication

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Depression

- Difficulties concentrating
- Slower processing speed
- Low motivation
- Difficulty making decisions
- May appear disinterested, withdrawn, or even oppositional

PTSD / Trauma

- May dissociate or become highly distressed discussing their evidence
- May experience depersonalisation (feeling detached from body) or derealisation (world is dreamlike or distorted)
- Potential mistrust of professionals
- Poor attention, concentration, hypervigilance

Anxiety

- May avoid eye contact
- May be jittery/fidgety
- Strong fear of negative evaluation (in children, may seem like not wanting to mess up)
- Might avoid drawing attention to self (e.g. speak softy, physically withdraw)
- Might try and seek reassurance
- Might want to check things multiple times

Schizophrenia

- Hallucinations can impact ability to attend to questions / activities
- Delusions can impact willingness to engage in interviews / activities
- Issues with confusion
- Disorganised thinking (e.g. going on tangents, unrelated responses)

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Bipolar

- If during a manic or hypomanic episode: may be more talkative, urgency of speech
- Racing thoughts
- Highly distractible
- Preference for goal-orientated tasks

Dissociative Identity Disorder

- Significant memory issues (dissociative amnesia)
- Hallucinations common in DID
- Some people can recall events that happens to an alternate personality, whereas others cannot
- May experience a shift during the interview itself

ADHD

- Difficulties maintaining attention/focus - may need more breaks
- May experience urgency of speech
- May become frustrated when there are perceived 'blockers' to doing activity of choice (you might think they need a break, but they want to get it over with)
- Time blindness
- Difficulties awaiting turn in conversation
- Distractible

Autism

- Difficulties modulating voice (may not appear distressed or dysregulated when they are)
- May have internal social rules (e.g. talking to strangers is not appropriate) - be clear on your role
- May take comments/questions literally
- Preference for specific questions rather than free narrative questions
- Difficulties with double negatives and idioms
- Masking - can drain energy to maintain, or be seen as positive by the individual

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Tops tips for dissociation

Understand triggers and stressors	The individual is an expert of their own triggers and stressors Be comfortable exploring this or asking about this in different ways
Developing a plan	Check the individual is comfortable with any proposed approach to working through dissociation Consider what will occur during breaks
Grounding and focus	‘Grounding’ techniques 5 senses - what can you see, hear, feel, smell, taste? Focused sight techniques - focus on and describe something in the room Bringing an individual ‘back to the moment’ - fresh air, touching something cold
Support people	Consider how a support person may be engaged appropriately to assist an individual’s emotional regulation and effective participation
Tactile prompts	Sometimes a tactile prompt (for example, touching someone’s shoulder) can bring an individual back to the present space

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Indicators to be mindful of

- No speech or limited speech
- Staring
- Teariness or crying
- Comprehension difficulties
- Responds inappropriately or inconsistently
- Focusing or ruminating on, or disproportionate responses to irrelevant points
- Repetition of ideas
- Fidgeting and body cues (for example, finger drumming, clenched fists or jaw, restlessness, posture shifting)
- Attention span - may be limited, distractibility, tangentiality
- Issues with recall
- Masking strategies and cognitive load
- Focus on ‘saying the right thing’
- Pace of speech - may be rapid, or slower
- Lethargy
- Overexcitement or overstimulation

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Regulating the Nervous System

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Self-regulation

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Self-regulation is our ability to regulate our emotional and physiological state

Regulated = relaxed, calm, in control, think clearly

Dysregulated = fight/flight/freeze

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Arousal

DYSREGULATED

FIGHT / FLIGHT

Hyperarousal

Anxious, overwhelmed, angry, upset,

REGULATED

Window of Tolerance

DYSREGULATED

Hypoarousal

FREEZE

Shut down, numb, passive, dissociate

Co-regulation

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Co-regulation means **assisting another person** to regulate **their** emotional and physiological state

Provide a **structured** and **predicable** environment. Signpost activities and changes, and provide clear expectations.

Maintain a calm and warm demeanour. Consider your tone of voice, facial expressions, speed of speech, body stance.

Introduce regulation activities where required - e.g. deep breathing, 5 senses exercise, sensory items.

Remember: The best regulation activity is one the person has already practiced. So ask them what works for them!

Regulation activities

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Some exercises to help calm the nervous system:

- **Finger breathing**
  - Trace around your hand, breathing in as you go up each finger, and out as you go down each finger, then swap hands

- **Shape breathing**
  - Draw a shape, use your finger to trace it as you breathe in on one side, out on the side, repeat until the shape is complete)

- **Colour counting**
  - e.g. List 10 red things you see

- Use **sensory objects and focus items**

Regulation activities

- **Play mental distraction games**
  - e.g. List 10 pizza toppings
  - List 5 movies starting with ‘A’

- **Grounding exercises**
  - e.g. Identify 5 things you can see, 4 things you can hear, 3 things you can touch, 2 things you can smell, and 1 thing you can taste

- **Rhythmic repetitive activities**
  - e.g. Drumming, passing a ball back and forth, skipping

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Useful resources

YouTube

Calm

BREATHE RELAX

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Useful resources

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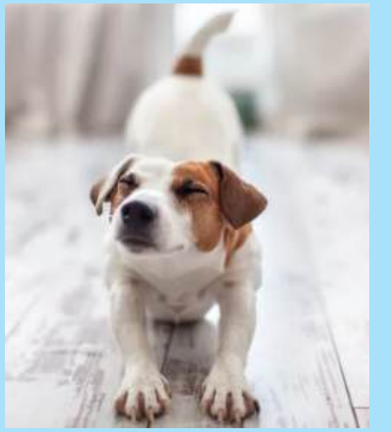

Quick break

Let’s return in 10 minutes

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Medication

Psychiatric Medications

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Anti-depressants

(Not just used for depression!)

Anxiolytics

Anti-psychotics

Stimulants & ADHD meds

Sedatives

Common side effects

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Anti-depressants

Headache, nausea, dizziness

Anxiolytics

Depressive effects: drowsiness, memory impairments, decreased reaction times

Anti-psychotics

Sedative effects, movement effects. Long term use can lead to 'cognitive dulling' and metabolic syndrome.

Stimulants & ADHD meds

Headaches, feeling jittery, decreased appetite, gastrointestinal symptoms

Sedatives

Sleepiness, drowsiness, difficulty concentrating, brain fog, fatigue

Impact of medication on communication

Need to consider:

- Is this a new medication for the person?
- Is their use acute/short-term or chronic/long-term?
- Does the witness have insight into their unique side-effects?
- When did they take the medication last?
    - Next-day effects
    - Comedown effects
- Have they stopped abruptly?
    - Discontinuation symptoms

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Time for some Case Studies!

Autism

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- **Social, language and communication characteristics**
  - Differences in social communication (e.g. talk passionately about their special interests, tendency to not engage in small talk, intonation/inflection)
  - Differences in nonverbal communication (e.g. reduced eye contact, gestures)
  - Relationships and friends understood/observed differently

- **Behaviours and interests**
  - Stimming behaviours, preference for routines and sameness, special interests (SPINs)
  - Logical, categorical, repetitive

- **Sensory characteristics**
  - Hyper or hyporeactive to stimuli

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Case study 1
Sally (17)

Let's discuss

Communication needs

Autism (level 1), severe anxiety, post-traumatic stress disorder

Court

- Complainant in a sexual assault matter
- Intermediary not involved in police interview
- 8 hours of interview to replay at court
- Will give evidence from the courtroom

Observations

- Communication impacted by defence lawyer 'watching' her and questioning her
- Yelling - insults, swearing
- Unfamiliar with court processes, questioning style, question forms and topics -> frustration, disengagement

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Outcomes for Sally

Location of individuals	Discussion about location of support people (friend in gallery and support service near to her) to be clearly visible and available for Sally, and visibility of Sally to the intermediary
Strategies for watching police interview	Colouring in and doodling Discussion with Sally about her location during proceedings (in courtroom versus remote witness suite)
Strategies for questioning	Discussion about conveying communication rules, including about behaviour at court Colouring in and doodling Sensory items Access to motivational sentence from psychologist Increased breaks and implementation of questioning schedule
Breaks	Sensory Den (people invited in by Sally) - colouring in, Play-Doh, food, games (Uno), supersize weighted blanket, music, tissues
Other notes	Intermediary recommendation about Sally typing responses was not agreed to Parties' response to recommendations and interventions given's Sally's age Length of police interview and questioning 'Fight' response and stakeholders' reactions to this

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Sally's questioning schedule

	Questioning	Morning tea	Questioning	Lunch	Questioning	Concluding remarks
Days 3 - 7	10:00am – 10:20am 10:30am – 10:50am 11:00am – 11:20am	11:20am – 11:40am	11:40am – 12:00pm 12:10pm – 12:30pm 12:40pm – 1:00pm	1:00pm – 2:15pm	2:15pm – 2:35pm 2:45pm – 3:05pm 3:15pm – 3:35pm 3:45pm – 4:05pm	4:15pm – 4:30pm

Learning disorders

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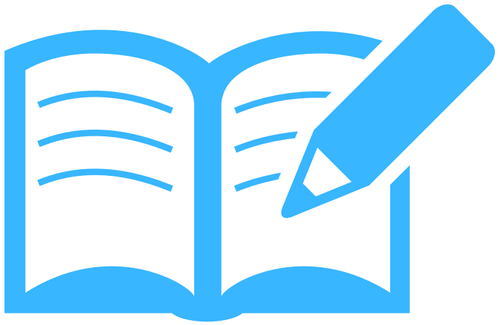
A. Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:

- Inaccurate or slow and effortful word reading
- Difficulty understanding the meaning of what is read
- Difficulties with spelling
- Difficulties with written expression
- Difficulties mastering number sense, number facts, or calculation
- Difficulties with mathematical reasoning



The learning disorder can be:

- with impairment in reading
- with impairment in writing
- with impairment in maths

Dyslexia = problems with accurate or fluent word recognition, poor decoding, and poor spelling
Dyscalculia = problems processing numerical information, learning arithmetic facts, and performing accurate or fluent calculations

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Case study 2
Tom (49)

Let's discuss

Communication needs

Dyslexia, major depressive disorder, post traumatic stress disorder, previous knee and pelvis surgery, upcoming hip replacement (experiences discomfort if sitting for extended periods)

Court

- Complainant in a sexual assault matter
- Occupation: Works in the legal profession
- Intermediary not involved in police interview
- 4 hours of interview to replay at court

Observations and findings

Tom advises that in stressful situations, he may experience:

- Slurred and/or unclear speech
- Loss of concentration and 'zoning out' of conversation
- Shaking hands
- Flashes appearing in front of his eyes
- Impacts to his ability to hear what is being said or occurring around him
- Difficulties with short term memory and interpreting spoken and written information
- Sudden bursts of annoyance at others

Some of his current strategies include:

- A registered therapy dog
- Subjective Units of Distress Scale (SUDS) scale to rate current emotional state

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Outcomes for Tom

Tom's existing strategies implemented	Luna, the registered therapy dog, was permitted at court! Use of the SUDS scale - moving from a resource in Tom's brain to something for use at court
Strategies for watching police interview and questioning	Breaks every hour to avoid physical discomfort (and to allow for emotional regulation) Use of court provided focus and emotion regulation items
Breaks	Tom and Luna went for walks Tom spent time with a family member and an appointed support person
Interventions related to	Signposting Multipart questions Breaks to support emotional state and physical comfort
Other notes	Parties' response to recommendations and interventions given Tom's age and profession Tom's response to recommendations and interventions Balance between what was observed and what Tom advised during assessment 'Fight' response and stakeholders' reactions to this

10	Highest distress/fear/anxiety/ discomfort that you have ever felt
9	Extremely anxious/distressed
8	Very anxious/distressed, can't concentrate
7	Quite anxious/distressed, interfering with performance
6	
5	Moderate anxiety/distress, uncomfortable, but can continue to perform
4	
3	Mild anxiety/distress, no interference with performance
2	Minimal anxiety/distress
1	Alert and awake, concentrating well
0	Totally relaxed

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Questions?

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See you for Day 2!

Get in touch via:
intermediaryprogram@act.gov.au