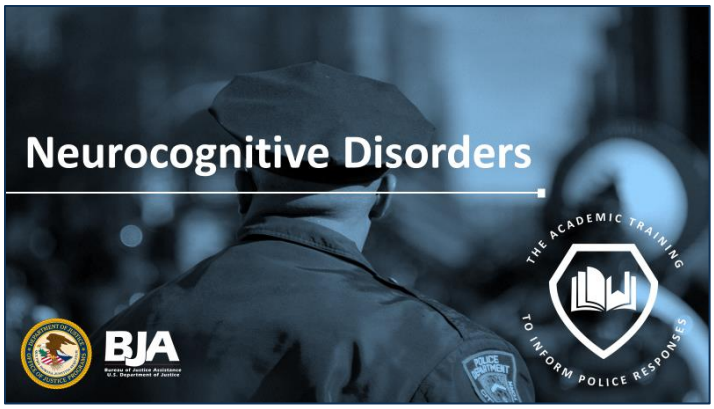


SLIDE 10.1

TITLE SLIDE

NEUROCOGNITIVE DISORDERS

Time: 50 minutes

Slides: 20

Purpose: This module introduces participants to neurocognitive disorders and the symptoms and behaviors associated with these disorders.

Instructor:

This module should be co-taught by a mental health practitioner who has expertise in working with people living with neurocognitive disorders and a law enforcement co-instructor who has been trained in crisis response and intervention. It may also be helpful to have those with lived experience as co-instructors.

Learning Objectives:

Upon completing this module, participants should be able to:

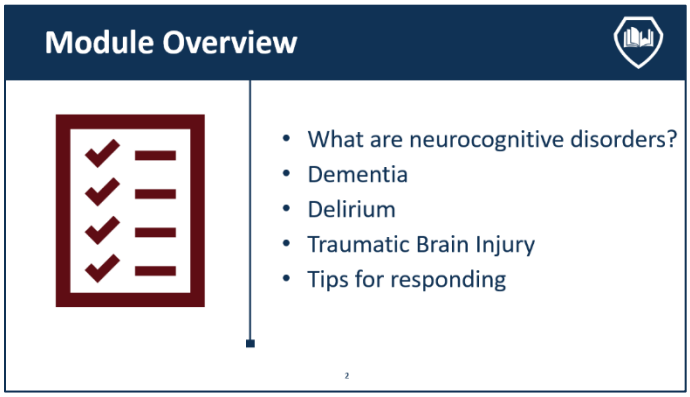
1. Explain the effects of dementia;
2. Describe the symptoms associated with Alzheimer's disease;
3. Describe the symptoms of traumatic brain injury;
4. Describe the symptoms of delirium; and
5. Identify appropriate responses to incidents involving individuals living with neurocognitive disorders.

Activities:

- Optional Video Activity: "Alzheimer's Disease" (3:14) https://www.youtube.com/watch?v=Eq_Er-tqPsA
- Optional Case Scenario

Additional Materials:

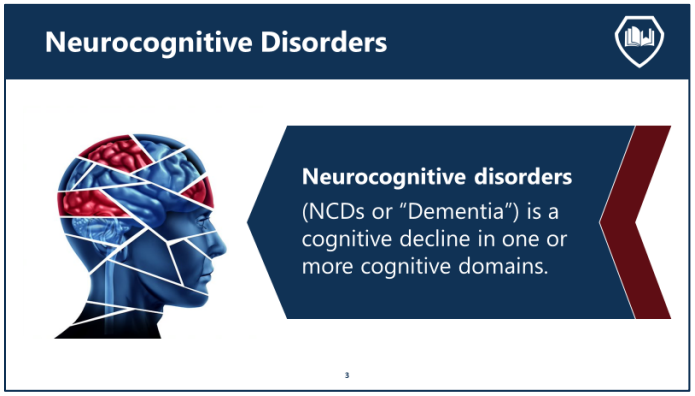
- Handout: International Association of Chiefs of Police, IACP's Alzheimer's Initiatives



SLIDE 10.2
MODULE OVERVIEW

Trainer Note: Briefly highlight what topics will be discussed during this module. Use the content note below to support this discussion.

People living with neurocognitive disorders may encounter law enforcement for a variety of reasons, including wandering (missing person), aggressive behavior, exploitation, alcohol or substance withdrawal, victimization, etc. It is important for officers to better understand the signs and symptoms of these disorders and how they can affect behavior so that they can respond in a manner that will help to either de-escalate and/or manage the situation and to find an appropriate resolution.



SLIDE 10.3 NEUROCOGNITIVE DISORDERS

T N

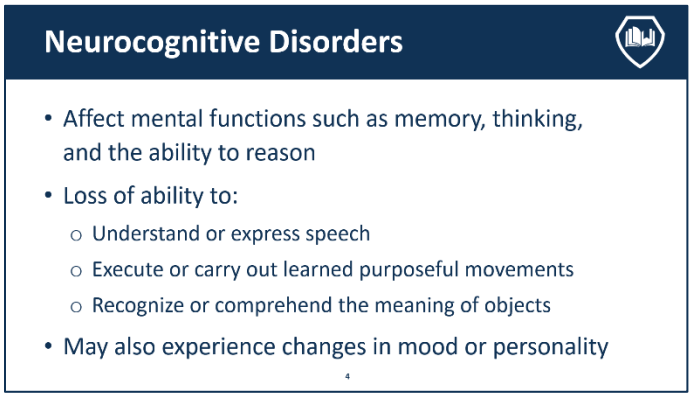
Trainer Note: Briefly cover the definition on the slide. Use the content below for additional reference.

C N

Neurocognitive disorders, known as Dementia, are a group of conditions that frequently lead to impaired mental function that is severe enough to interfere with a person's independence and daily life.

Make a note to the participants that Dementia is not a natural part of aging. As people age, there may be some decline in memory, but aging in and of itself does not mean a person will develop dementia.

Neurocognitive disorders are diagnosed as mild or major disorders based on the severity of symptoms. While anxiety, mood, and psychotic disorders (covered in Understanding Mental Health Conditions and Mental Illness) can also affect cognitive and memory functions, these are not considered neurocognitive disorders, because the loss of cognitive function is not the primary symptom. Additionally, developmental disabilities are different from neurocognitive disorders because they are typically developed at birth or early in life (i.e., before the age of 22), rather than occurring at any age. Neurocognitive disorders most commonly occur in older adults, but they can affect younger people as well. People living with mental health conditions and IDD may also have neurocognitive disorders (i.e., co-occurring conditions).

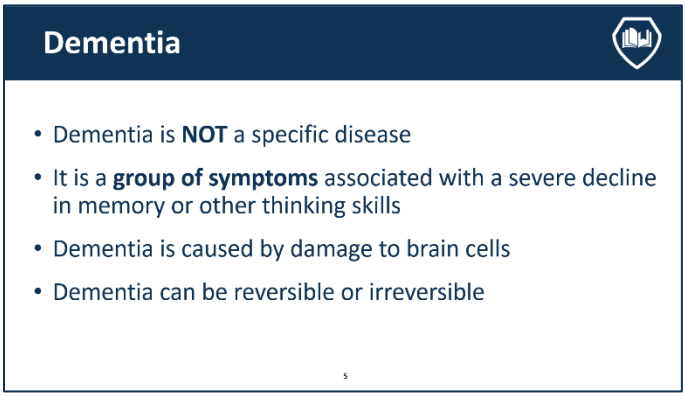


SLIDE 10.4 NEUROCOGNITIVE DISORDERS

TN **Trainer Note:** Highlight each point on the slide using the content note as a reference point. Highlight that this information is relevant to first responders because people with neurocognitive disorders may experience difficulties communicating and understanding those who try to communicate with them. Their disorder can also make them act impulsively due to mood or personality changes. This will be discussed further in the module.

CN **Content Note:** People living with neurocognitive disorders may appear very passive or become paranoid. Older people living with dementia, including Alzheimer's (a type of dementia), begin to lose the ability to express themselves with words. Their ability to communicate is diminished. They can also lose the ability to remember how to do simple activities like shaving, buttoning shirts, etc. They can also forget their loved ones' faces and other people they have known for years.

NOTE: If you think you are developing dementia when you forget simple things easily, you are not. This usually is a sign that you are distracted, not paying attention, and/or not focused. A distinction to make between dementia and mere forgetfulness: "It is one thing to forget where your keys are; it is another to forget what your keys are used for." This ties to the sub-bullet on the slide: "Loss of ability to recognize or comprehend the meaning of objects."



SLIDE 10.5
DEMENTIA

Trainer Note: Briefly cover each point on the slide using the content below for reference. Emphasize that dementia is not a specific disease; it refers to a group of symptoms. There are several conditions that can cause dementia, including Alzheimer's disease, Lewy Body dementia, Parkinson's disease, vascular dementia, Huntington's Disease, and frontotemporal dementia, to name a few.

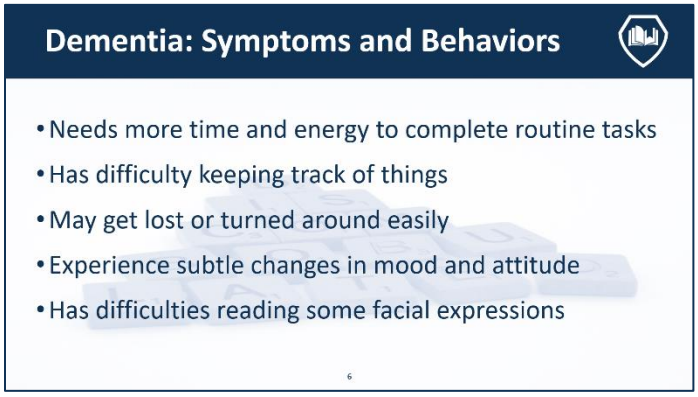
Let participants know that the decline in memory and thinking skills can be severe enough to reduce a person's ability to perform everyday activities.

Symptoms of dementia can be reversible or progressive and irreversible. Still, damage to the brain caused by dementia may interfere with the ability of brain cells to communicate with each other. Potentially reversible dementia symptoms include those caused by depression, stroke, traumatic brain injury, certain medications, alcohol use, and even bladder infections. Irreversible and progressive dementias include Alzheimer's disease, vascular dementia, Lewy body dementia, and frontotemporal dementia.

Sources:

Alzheimer's Association, n.d., "What is Dementia?" https://www.alz.org/alzheimers-dementia/what-is-dementia.

Alzheimer's Association, n.d., "Types of Dementia," https://alz.org/alzheimers-dementia/what-is-dementia/types-of-dementia.

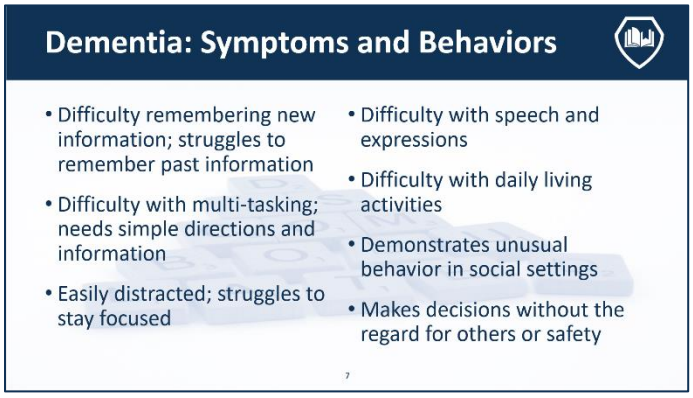


SLIDE 10.6
DEMENTIA: SYMPTOMS AND BEHAVIORS

Trainer Note: Highlight each of the symptoms and behaviors associated with dementia on the slide. Do not read each bullet but summarize the symptoms and behaviors. Use the below content note as a reference. Explain how understanding these symptoms and behaviors can help determine effective responses.

Content Note: A person living with dementia will exhibit a host of symptoms and behaviors as reflected on the slide. Because dementia affects memory and thinking, you can see that several of the symptoms are related to a person's ability to carry out certain tasks and their mood and behaviors.

Difficulties reading social cues and facial expressions are significant symptoms to notice. For example, people living with dementia may not understand the seriousness of the situation when law enforcement is present, because they forget what a police uniform means. As a result, they may not follow directions well or may become argumentative.



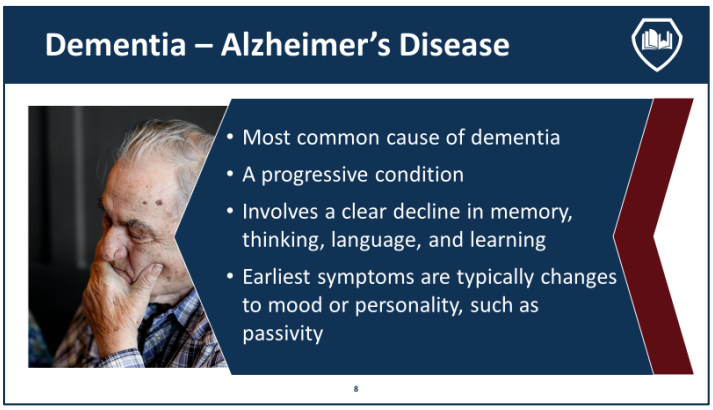
SLIDE 10.7
DEMENTIA: SYMPTOMS AND BEHAVIORS

TN

Trainer Note: Continue highlighting each symptom and behavior on the slide. Use examples from your own clinical experience when appropriate. Note that individuals may have one or more of these symptoms but may not be experiencing dementia. These symptoms may also be associated with other conditions or may just indicate that a person is easily distracted or upset. However, if an individual is experiencing several of these symptoms and has a diminished ability to perform daily living activities, they may have some form of dementia.

Emphasize the impact of dementia on memory in terms of diminished short-term memory and one's ability to remember key things like their address, phone number, and names of family members. Also, discuss how a person living with dementia may be easily distracted, requiring simple directions and repetition.

Highlight that recognizing these symptoms can help officers determine effective responses and minimize the possibility of escalation.



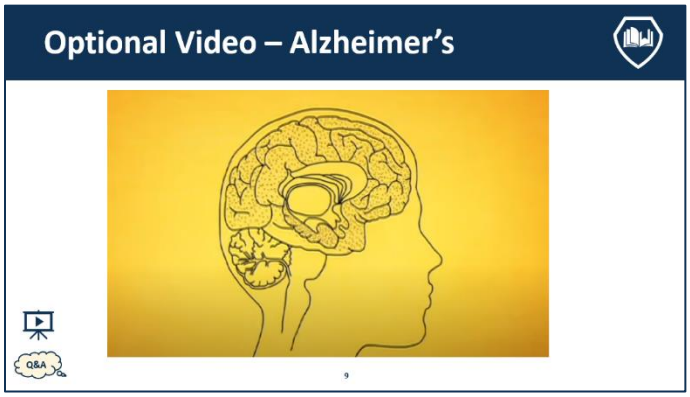
SLIDE 10.8
DEMENTIA – ALZHEIMER'S DISEASE

Trainer Note: Cover the symptoms and warning signs of Alzheimer's on the slide. Use examples from your clinical experience when appropriate. Make note that, because Alzheimer's is a type of dementia, many of the symptoms and behaviors are the same as what was discussed in the previous slides.

Content Note: Alzheimer's disease is characterized by a progressive decline in thinking/reasoning, memory, behavior, and social skills that disrupts a person's ability to function on their own. Alzheimer's disease tends to develop slowly and gradually worsen over several years. Eventually, Alzheimer's disease affects most areas of the brain. Memory, thinking, judgment, language, problem-solving, personality, and movement can all be affected by the disease.

There are stages of Alzheimer's ranging from mild to severe, however, it does cause death, as opposed to other forms of dementia. Alzheimer's is a fatal form of dementia. There is no treatment that cures Alzheimer's disease or alters the disease process in the brain. As noted earlier, Alzheimer's disease is irreversible and progressive. Some medications may help reduce or control some symptoms, especially in mild to moderate cases.

Source: Mayo Clinic Staff, June 26, 2021, "Alzheimer's Disease," Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/symptoms-causes/syc-20350447.



SLIDE 10.9
OPTIONAL VIDEO – ALZHEIMER'S

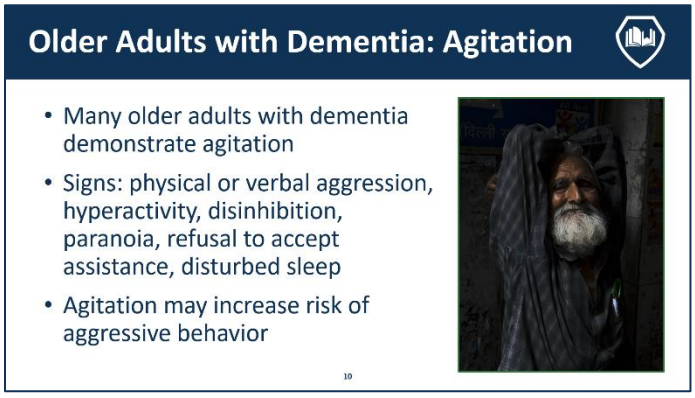
TN **Trainer Note:** If time allows, show the video "Understand Alzheimer's Disease in Three Minutes." Following the video, use the **Q&A** below to prompt a discussion on participants' experiences with people living with Alzheimer's disease and how those experiences may impact their responses to people with Alzheimer's. Consider writing the responses (What approaches have been helpful in their response?) on a board or flip chart. You can refer to this list when you show the Quick Tips slide (SLIDE 10.19) at the end of the module and compare the participant-generated list to the slide.

Optional Video Activity: "Understand Alzheimer's Disease in Three Minutes" (3:14)
https://www.youtube.com/watch?v=Eq_Er-tqPsA

This short, animated video presents an explanation of what Alzheimer's disease is and how it damages the brain over time, affecting memory, communication, problem-solving, emotions, and behavior.

Content Warning: This video discusses the progression of Alzheimer's disease from forgetfulness to death. It may cause some participants to experience an emotional response—particularly if they have a loved one with Alzheimer's. Be sure to inform participants about the content of the video before playing it. Allow those who would like to step out of the room during the video to do so.

Q&A **Debrief with the class and ask if they know someone living with Alzheimer's disease, and if they would share their experience. Also, ask if they have used their experiences to empathize or relate to someone when they are called to respond to a person living with Alzheimer's disease. What approaches have been helpful in their response?**



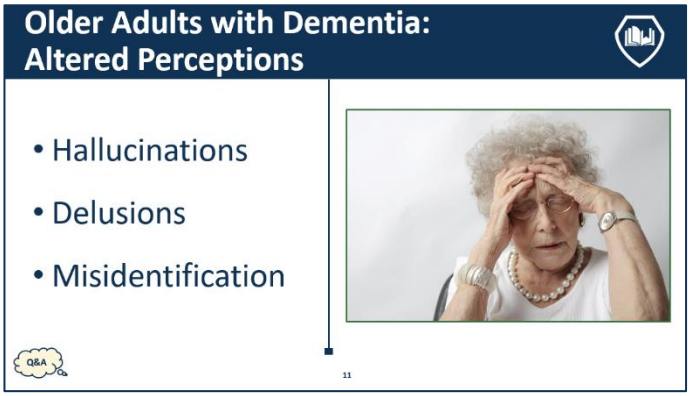
SLIDE 10.10
OLDER ADULTS WITH DEMENTIA: AGITATION

Trainer Note: Briefly cover each point on the slide. Use the content note to expand on the bullet points.

Point out that if a person with dementia does not know somebody, they can become agitated quickly. Their world is changing which may create even more fear. There may be a higher risk of aggressive behavior. Emphasize officer safety and civilian safety when responding, as well as being empathic and using de-escalation skills to help calm the individual. Additionally, officers should seek assistance from others who know the individual and whom the individual may recognize.

Content Note: Agitation is common in people living with dementia, no matter their age. However, most people living with dementia are over the age of 65. Agitation is seen in about 30% of all persons living with dementia and it is seen in about 80% of residents in nursing homes. Agitation may be caused by medical conditions, medications, exhaustion, acclimating to new surroundings, reduced personal capacity, and fear.

Source: Claudia Carrarini, Mirella Russo, Fedele Dono, Filomena Barbone, Marianna G. Rispoli, Laura Ferri, Martina Di Pietro et al., 2021, "Agitation and Dementia: Prevention and Treatment Strategies in Acute and Chronic Conditions," *Frontiers in Neurology 12*: 644317.



SLIDE 10.11

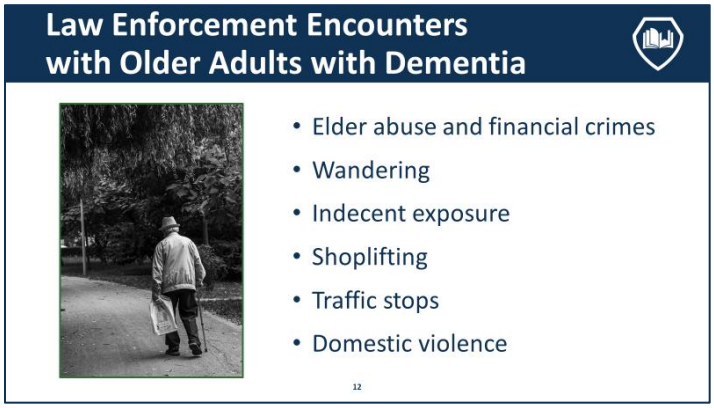
OLDER ADULTS WITH DEMENTIA: ALTERED PERCEPTIONS

Trainer Note: Briefly cover each point on the slide. Note that altered perceptions are common in dementia, no matter the age of the person. However, most people living with dementia are older adults. You can also reference the video on Alzheimer's that talked about the part of the brain that regulates mood and can cause these altered perceptions.

Ask the class if they remember what hallucinations and delusions are. What are the symptoms? Remind them they learned about these in the Introduction to Mental Health Conditions and Mental Illness module.

If the class participants struggle with remembering what hallucinations and delusions are, remind them of what they are and their symptoms, then share the rest of the information below:

- **Hallucinations** can affect all senses (including sight, sound, touch, taste, and smell), in which persons perceive a sensation in the absence of actual stimuli.
- **Delusions** create false fixed beliefs. These beliefs are often persecutory in nature, meaning they support negative thoughts or feelings towards others because of their religious or political beliefs, ethnic or racial origin, gender identity, and/or sexual orientation.
- **Misidentification** results in the inability to recognize self or others.



SLIDE 10.12
LAW ENFORCEMENT ENCOUNTERS WITH OLDER ADULTS WITH DEMENTIA

TN **Trainer Note:** Briefly cover the information on the slide. Emphasize that these are some common types of police encounters that may involve older adults living with dementia. Use the information below to discuss these encounters.

CN **Content Note:**

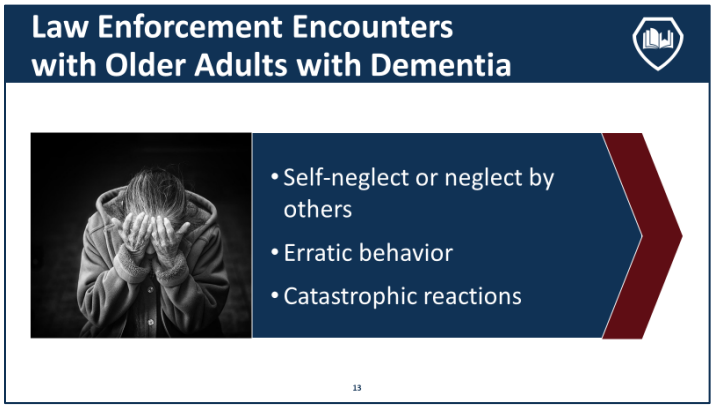
- **Elder abuse and financial crimes:** Older adults living with dementia can be easily manipulated and abused by family, caretakers, or strangers. Abuse can involve physical or emotional harm, financial exploitation, neglect, and/or abandonment. (Contact your local Adult Protective Services if you suspect abuse).
- **Wandering:** Older adults with dementia can become disoriented when engaged in routine activities. Wandering is a result of individuals being unable to recall familiar surroundings or routes and having problems with spatial orientation and problem-solving. Wandering situations are emergencies where immediate protective action is needed.
- **Indecent exposure:** Dementia can impact individuals' behavior, judgment, and reasoning. Reports of indecent exposure by older adults living with dementia can be common.
- **Shoplifting:** Reports of shoplifting by older adults living with dementia can be common. Officers should intervene with store personnel when managing these encounters.
- **Traffic stops:** Older adults living with dementia may experience difficulties when driving. Possible signs of dementia in these encounters may include slow or poor decisions in traffic, inappropriate speeds, and disoriented or distracted behavior.

- **Domestic violence:** Adults living with dementia who are experiencing delusions may engage in aggressive behavior with caretakers as a result of perceived persecution. When caretakers, often family, call 911 for help in managing behavior, officers must determine if domestic violence is the appropriate disposition based on officer discretion, standard operating procedure, and state laws.

Sources:

Administration for Community Living, January 31, 2019 [Last Modified], "What is Elder Abuse?" U.S. Department of Health and Human Services, https://acl.gov/programs/elder-justice/what-elder-abuse.

IACP National Law Enforcement Policy Center, April 2011, *Missing Persons with Alzheimer's Disease: Concepts and Issues Paper*, Alexandria, VA: IACP National Law Enforcement Policy Center, retrieved from https://www.theiacp.org/sites/default/files/all/a/AlzheimersPaper.pdf.



SLIDE 10.13

LAW ENFORCEMENT ENCOUNTERS WITH OLDER ADULTS WITH DEMENTIA (continued)

TN

Trainer Note: Briefly cover the points on the slide. Emphasize that these are some of the main types of calls that officers are asked to respond to involving older adults living with dementia.

CN

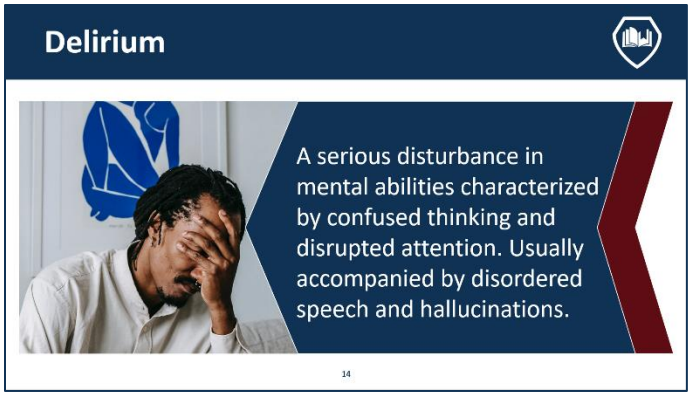
Content Note:

- **Self-neglect** refers to the inability or failure of a person to perform essential self-care tasks in areas such as food, water, hygiene, medication, living environment, etc. This neglect creates a threat to the person's health and/or safety. It may be difficult to intervene in situations of personal care or hoarding. It is important for officers to remain supportive and connect with service agencies or service providers.
- **Erratic behavior**, such as quick agitation and aggression, wandering, and placing self at risk, can be a symptom of dementia**.** Officers should offer immediate assistance for reports of erratic behavior. Officers should contact service providers or seek medical evaluation and protective measures.
- **Catastrophic reactions** are an individual's overreaction to a situation that appears normal and non-threatening, but the individual may believe that something terrible has happened. Their reactions to the situation can include emotional outbursts and physical aggression. In these instances, it is important for officers to stay calm and use simple language.

Sources:

Esther Heerema, March 28, 2021 [Updated], "Catastrophic Reactions in People with Alzheimer's," *Verywell Health,* retrieved from https://www.verywellhealth.com/alzheimers-and-catastrophic-reactions-97606.

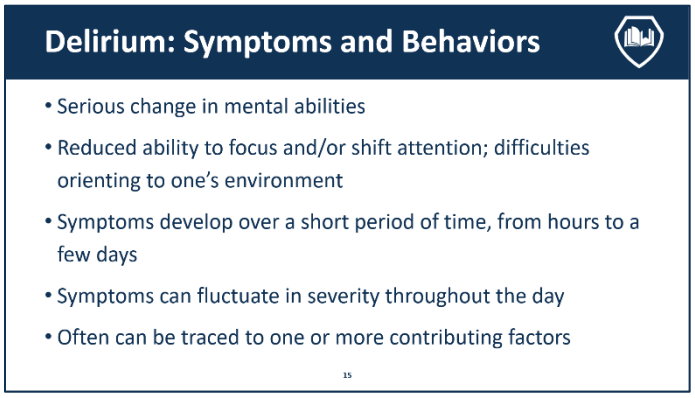
XinQi Dong, 2017, “Elder Self-Neglect: Research and Practice,” *Clinical Interventions in Aging 12*: 949–954.



SLIDE 10.14
DELIRIUM

Trainer Note: Introduce delirium using the definition on the slide. Note that delirium frequently occurs in people with dementia, but having episodes of delirium does not necessarily mean the person has dementia.

Source: Jahangir Moini, Justin Koenitzer, and Anthony LoGalbo, 2021, *Global Emergency of Mental Disorders*, London, UK: Elsevier: 450.



SLIDE 10.15
DELIRIUM: SYMPTOMS AND BEHAVIORS

TN **Trainer Note:** Highlight each of the signs and symptoms of delirium on the slide using the information below as a reference point. Be sure to note the difference between delirium and dementia.

CN **Content Note:** Delirium may lead to functional decline and risk of hospitalizations or institutional placements. Adults ages 65 or older who are hospitalized and experiencing delirium have three times the risk of being placed in a nursing home than adults who are hospitalized and are not experiencing delirium. Often symptoms of delirium can be traced to one or more contributing factors such as medical illness, changes in metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal. The symptoms of delirium can mimic symptoms of dementia. Once the underlying cause is treated or improves, the symptoms of delirium go away.

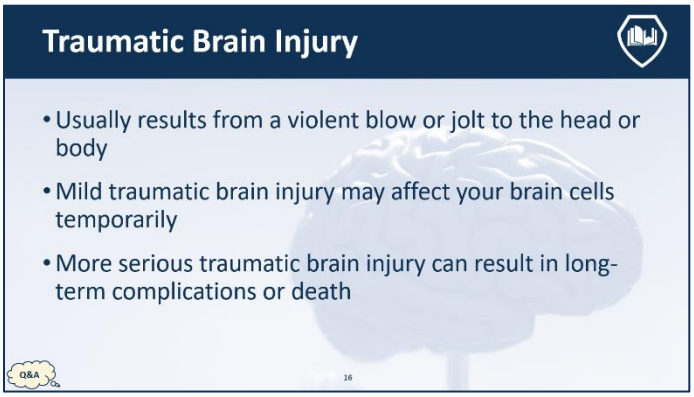
Delirium frequently occurs in people living with dementia but having episodes of delirium does not always mean a person has dementia. Some differences between the symptoms of delirium and dementia include:

- **Onset:** The onset of delirium typically occurs within a short amount of time, while dementia often begins with minor symptoms that worsen over time.
- **Attention:** Delirium significantly affects a person's ability to stay focused or maintain attention, while a person in the early stages of dementia generally remains alert.
- **Fluctuation:** Symptoms of delirium can fluctuate significantly and frequently throughout the day. Although people with dementia can have "better" or "worse" days, their memory and thinking skills are at a fairly consistent level during the course of the day.

Sources:

Deepti Kukreja, Ulf Günther, and Julius Popp, 2015, "Delirium in the Elderly: Current Problems with Increasing Geriatric Age," *Indian Journal of Medical Research 142*(6): 655–662.

Mayo Clinic Staff, September 1, 2020, "Delirium," Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/delirium/symptoms-causes/syc-20371386.



SLIDE 10.16 TRAUMATIC BRAIN INJURY

T N

Trainer Note: Cover the material on the slide, referencing the content note below as needed. Use the **Q&A** to prompt a discussion on the prevalence of traumatic brain injuries in certain groups.

Q&A

Ask participants what groups of people have a high prevalence of traumatic brain injuries. These injuries are often seen among veterans and athletes. For veterans, the shockwave or blast of an IED can cause a concussion. For athletes, the jolt of hitting their head on the ground or colliding with other athletes can cause concussions.

C N

Content Note: Traumatic brain injury (TBI) usually results from a violent blow or jolt to the head or body. A concussion is a mild TBI; repeated or severe concussions may result in more serious brain injury. An object that penetrates brain tissue, such as a bullet, can also cause traumatic brain injury.

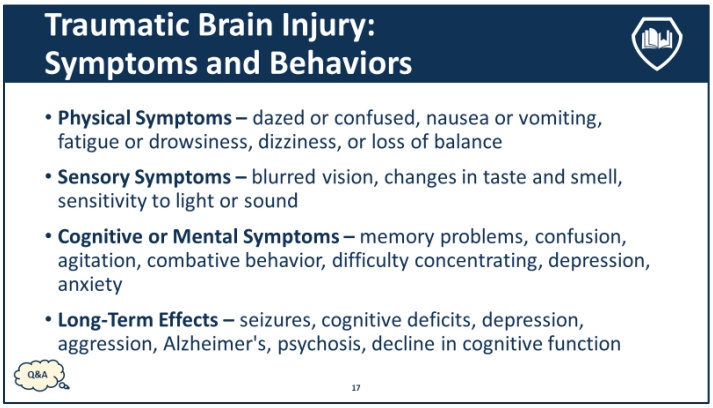
Mild TBIs may affect brain cells temporarily and is potentially reversible. More serious TBIs can result in bruising, torn tissue, bleeding, and other physical damage to the brain that may not be reversible. These injuries can result in long-term complications, such as dementia or even death.

A TBI will usually involve at least one of the following symptoms: loss of consciousness, post-traumatic amnesia, disorientation and confusion, neurological signs (e.g., new onset of seizures, marked worsening of a pre-existing seizure disorder), or a neurocognitive disorder that develops immediately after the occurrence of the TBI or immediately after recovery of consciousness and continues past the acute post-injury period.

Individuals with TBI frequently find loud noises challenging, have difficulty following conversations with many people at the same time, struggle to complete simple tasks (e.g., driving and grocery shopping), and may become easily overwhelmed when around too many stimuli. Simple tasks may require additional time and thought for an individual with a TBI.

If a person is having a strong reaction to sirens and lights on-scene, they may have a traumatic brain injury. If the person appears to have some of the symptoms described for a TBI, officers should ask the person if they have ever had a brain injury or ask family members if they are available.

For more information about TBI, see the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: https://www.cdc.gov/traumaticbraininjury/.



SLIDE 10.17
TRAUMATIC BRAIN INJURY: SYMPTOMS AND BEHAVIORS

Trainer Note: Refer to the symptoms on the slide, using the content note to expand upon the things officers may see on-scene. Note that some of these symptoms may appear immediately after a traumatic brain injury, while others may appear days or weeks later. Use the **Q&A** to prompt a discussion on participants' responses to people who had (or appeared to have) a TBI.

Ask participants if they have responded to a person with traumatic brain injury or if they know anyone who has suffered from one. If so, what have they noticed about their cognitive abilities and their behaviors? When responding to a person with TBI, what did you do that was helpful to the individual?

Content Note:

Physical symptoms:

- Loss of consciousness for a few seconds to a few minutes
- No loss of consciousness, but a state of being dazed, confused, or disoriented
- Headache
- Nausea or vomiting
- Fatigue or drowsiness
- Problems with speech
- Difficulty sleeping
- Sleeping more than usual
- Dizziness or loss of balance

Sensory symptoms:

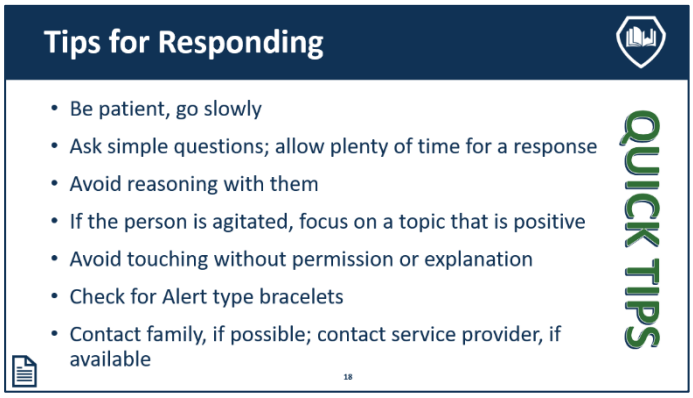
- Sensory problems, such as blurred vision, ringing in the ears, a bad taste in the mouth, or changes in the ability to smell
- Sensitivity to light or sound

Cognitive or mental symptoms:

- Memory or concentration problems
- Mood changes or mood swings
- Feeling depressed or anxious

Individuals with mild to moderate brain injury will show signs of improvement within the first six months of the injury. For people with moderate TBI, over the next two years, improvements may slow down or cease. People with mild to moderate brain injury will be able to regain many functions; however, they may still struggle with some memory issues, some physical symptoms, and some mood changes such as depression and anxiety.

Source: Mayo Clinic Staff, May 4, 2021, "Traumatic Brain Injury," Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.



SLIDE 10.18
TIPS FOR RESPONDING

TN **Trainer Note:** Explain to the participants that these are tips for responding to a person with dementia, Alzheimer's disease, TBI, and delirium.

Review the points on the slide. It is not necessary to discuss each point in-depth. If you created a participant generated list from the Q&A on slide 10.9, remember to display that in comparison to this QUICK TIPS slide. If the participant list is like the QUICK TIPS Slide, use this as a reinforcement tool that the participants have many of the skills already to respond to calls involving neurocognitive disorders.

Emphasize the importance of following agency policy.

CN **Content Note:** When asking questions, avoid or reframe open-ended questions. Open-ended questions are questions that require the person responding to choose from an unlimited or unrestricted set of options and produce a spontaneous answer. For a person with dementia, this might be difficult. To reframe an open-ended question, consider suggesting an answer and allowing the person to respond and/or asking a question in a way that allows for a "yes" or "no" answer.

A person with dementia may sometimes lose the ability to use complex reasoning and process information logically. If you ask questions or give directions that require a person with dementia to reason something out or think logically, you may be asking the person to do something that is impossible for them to do. Keep things simple and concrete.

Source: Washington State Department of Social & Health Services, July 2007, *Dementia Care, Specialty Training: Basic Training for Managers and Caregivers*, Aging & Disability Services Administration, retrieved from https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/Dementia%20Training.pdf.

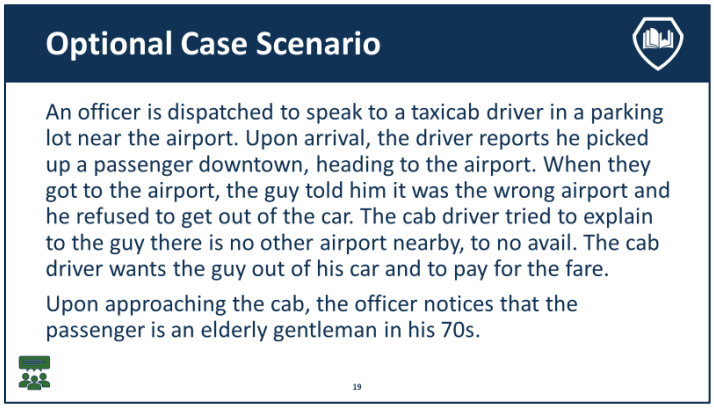
Handout: International Association of Chiefs of Police, IACP's Alzheimer's Initiatives, https://www.theiacp.org/sites/default/files/all/p-r/PostcardAlzDidYouKnow.pdf

Additional Resources:

International Association of Chiefs of Police, Alzheimer's Initiatives, https://www.theiacp.org/projects/alzheimers-initiatives

International Association of Chiefs of Police, Identifying and Responding to Elder Abuse: An Officer's Role, https://www.theiacp.org/elder-abuse

International Association of Chiefs of Police, Home Safe Initiative, https://www.theiacp.org/projects/home-safe



SLIDE 10.19 OPTIONAL CASE SCENARIO

Trainer Note: This is an optional case scenario. Depending on timing, you may choose to use this case scenario in one of two ways. These options are presented below.

Optional Activity: Case Scenario

Option 1: Use the scenario as a tabletop exercise and ask some of the questions listed below. You can add questions that you think would be helpful as the discussion unfolds:

1. What type of information do you want from the cab driver?
2. Upon approaching what observations will you make about the man in the cab?
3. What types of questions will you ask?
4. How might you determine he is impaired—perhaps has Alzheimer's?
5. If the person becomes agitated, how might you slow things down to de-escalate?
6. How might you communicate with him if he is having problems with memory?
7. As this unfolds, the gentleman also has a tough time with loud noises and the flashing lights of the patrol car, what might this indicate?
8. What type of resources are you thinking about?
9. What other information do you want to know?
10. How do you use body language to help the person feel safe?
11. What words might you use to encourage feelings of safety and cooperation?

Option 2: Complete the scenario with a live role-player. Officers can come up and interact with the role-player to practice some of the Tips for Responding. The script for the scenario and directions for the role player can be found below.

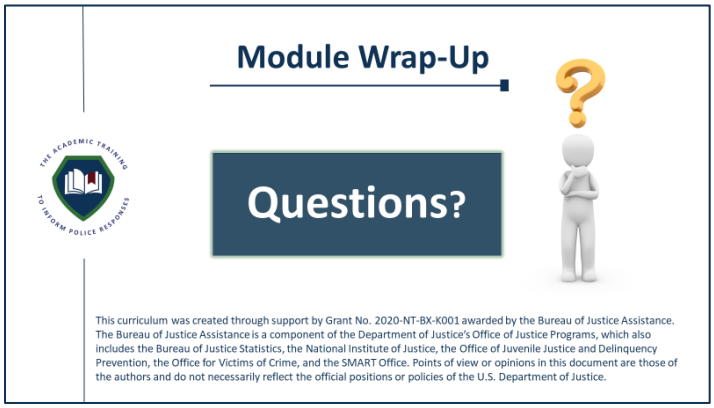
A taxi driver calls for help from law enforcement. He is stopped in a parking lot near the local airport with a passenger in the back of his car that will not pay for the ride or get out of the car. When the driver tries to reach in and pull him out, he gets combative.

Role Player Instructions:

You have Alzheimer's. You are trying to get home because you have been living in a home that is not your home. (You are living with your son and his wife, but you do not think that is your home.) You stay fixated that the cab brought you to the wrong airport to get home to your wife and that you want him to take you to the other airport. You have trouble remembering where your house is, you do not think the people you are living with are really your kids, they are just nice people, but strangers to you. You think your wife is waiting for you (although she has been dead for the last 5 years). You get agitated and upset. You do have identification on you.

Officer Information: [This is the only information the class receives]

An officer is dispatched to speak to a taxicab driver in a parking lot near the airport. Upon arrival, the driver reports he picked up a passenger downtown, heading to the airport. When they got to the airport, the guy told him it was the wrong airport and he refused to get out of the car. The cab driver tried to explain to the guy there is no other airport nearby, to no avail. The cab driver wants the guy out of his car and to pay for the fare. Upon approaching the cab, the officer notices that the passenger is an elderly gentleman in his 70s.



SLIDE 10.20
MODULE WRAP-UP

TN

Trainer Note: Use this as an opportunity for participants to ask questions before moving on to the next module.

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