Western MA CIT
PARTNERSHIP, DEPENDABILITY,
COMMUNITY & SERVICE

Welcome

CIT TRAINING

JULY 18TH – 22ND, 2022

Opening Remarks

- Welcome
- Ground Rules
- Introductions – Person- Role-System Introductions
- Presentations
- Evaluations

Crisis Intervention Team (CIT) Overview

Hallie-Beth Hollister, M.Ed., Program Manager, BHN Crisis Services & Carl Girouard, BHN Police Consultant, CIT-TTAC.

July 18, 2022 - 8:30am-9:30am

What is CIT?

- The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.

- **C**risis **I**ntervention **T**eams: Local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises

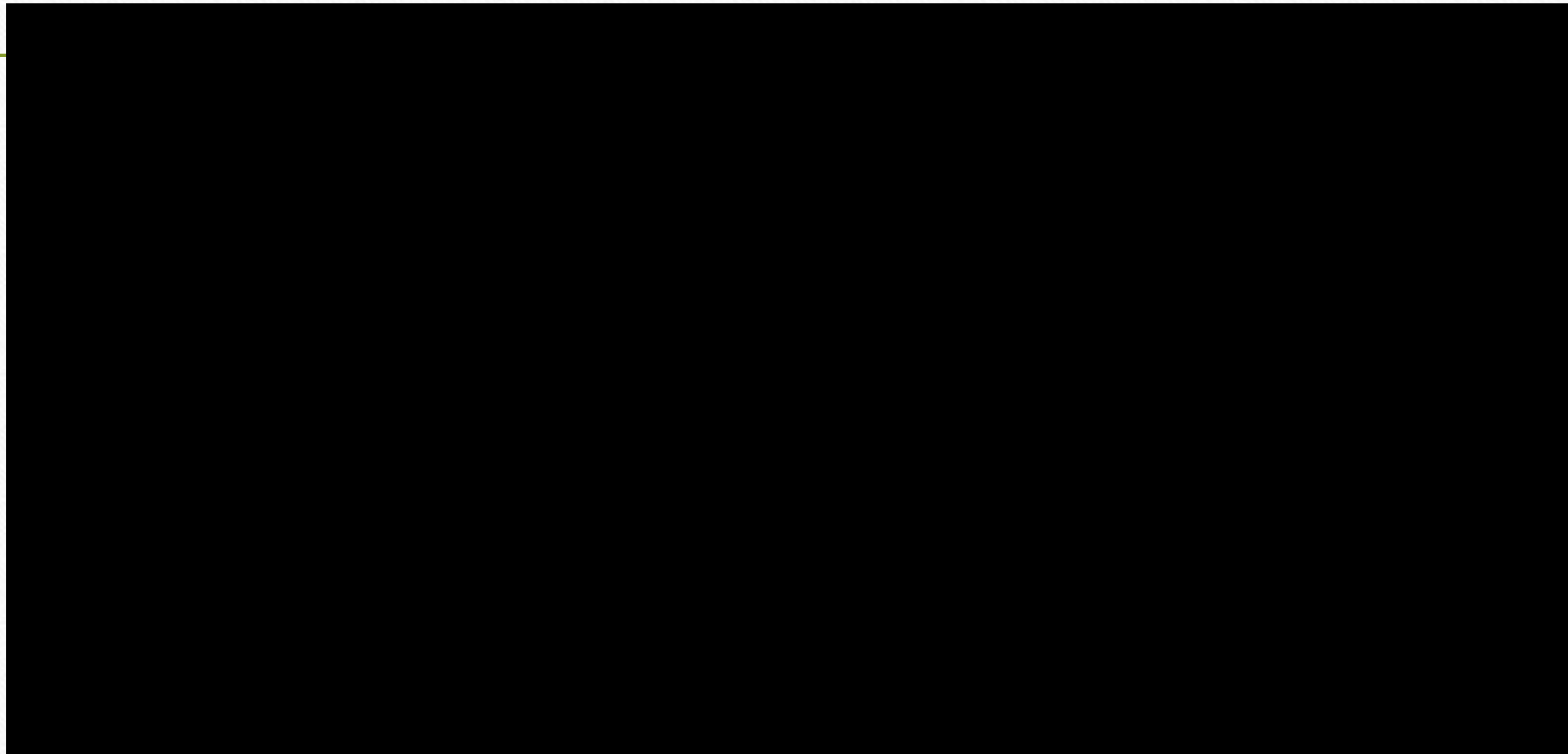
History of CIT

- First CIT program was established in Memphis in 1988.
- Established after the aftermath and public outcry of a 1987 incident when Memphis PD shot and killed a 27 year old man with a mental illness.
- Memphis Police Department teamed up with NAMI, the city, MH consumers, MH Professionals, University of Memphis, and the University of Tennessee to develop.
- Often referred to as "The Memphis Model"
- Now utilized throughout the U.S. and internationally

Why collaborate?

- "Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers. Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them." – *Police-Mental Health Collaborations : A Framework. Bureau of Justice Assistance & Council of State Governments Justice Center*

The Origins of CIT



- https://www.youtube.com/watch?v=y99kODtyVhk&t=11s 10:10

BHN Western Massachusetts CIT – Training & Technical Assistance Center (CIT-TTAC)

- Started in 2013 and funded through DMH Jail/Arrest Diversion grant.
- BHN provides 6 full 40 CIT hour trainings per year.
- Also provided are 8 hour CIT Dispatcher Training, 8 hour Youth Focused CIT, roll call trainings & Mental Health First Aid.
- Technical assistance to involved PD's which includes: hot case reviews, consultation, collaborative programs and assistance in starting and maintaining CIT Programs in their cities/towns.
- BHN CIT-TTAC team includes Assistant Program Director, Program Clinician, Police Consultants, Certified Peer Specialist and Administrative Staff.
- 865 officers trained in CIT, 80 in Youth-Focused CIT & 189 in CIT Dispatcher to date (05/09/22mber

What are the “Core Elements” of CIT?

- Partnerships:
  - Advocacy Community
  - Mental Health Community
    - NAMI
    - Stakeholders Meetings
    - Statewide conference
  - Law Enforcement Community

CIT Implementation

- Training and CIT Policy are first steps
- Training of Dispatch
- Having a skilled, trained first responder available to respond immediately
- Having a mentality of helping, with an awareness for safety.
- More than a training!
- A police department needs a CIT Coordinator, Mental Health Coordinator and team of officers.
- Working with community stakeholders and MH partners
- Stakeholder meetings and evaluation
- Continued collaboration

Why is CIT training necessary?

- Law enforcement, especially the dispatchers, are often the **first responders** for persons in mental health crises
- Available 24/7
- High response to an “Emotionally Disturbed Persons” call or “mental disturbance” call
- Decrease officer injury, increase safety
- Reduces stigma
- Redirect Individuals with Mental Illness from the Judicial System to the Behavioral Health Care System

BHN CIT-TTAC involved Law Enforcement Agencies

- Amherst*, Belchertown, Chicopee, East Longmeadow, Easthampton, Fitchburg*, Granby, Great Barrington, Greenfield*, Hampshire County Corrections, Hampden, Hatfield, Holyoke*, Longmeadow, Ludlow, Northampton, South Hadley, Southbridge, Springfield*, Springfield College, UMass Amherst, Ware*, West Springfield, Westfield, Wilbraham

Thank You

- Please complete evaluation.

- https://www.youtube.com/watch?v=anxhlthj_ZQ

Presentation # 2

9:30am – 11:00am Suicide Prevention, Nicola Howe, MSW, CIT Coordinator, BHN – Crisis Emergency Services

NON-SUICIDAL SELF-INJURY AND SUICIDE: THEORY, RESEARCH, AND ASSESSMENT

WHAT IS NON-SUICIDAL SELF-INJURY

- The act of deliberately harming oneself.

- What behaviors constitute non-suicidal self-injury?

- Cutting
- Burning
- Scratching
- Tattooing
- Biting

Piercing

Head banging

Erasing

Digging at wounds

NON-SUICIDAL SELF-INJURY

What are some reasons people engage in non-suicidal self-injury?

- Discharge stress
- To penetrate numbness
- To punish themselves
- To achieve some other aim such as an adrenalin rush, control actions of others, express one's self, or as a distraction.
- Slight contagion effect.

For the most part, self-injurious acts are not an attempt at suicide

NON-SUICIDAL SELF-INJURY: SIGNS AND SYMPTOMS

- Scares (burns cuts), fresh cuts, scratches, bruises or other wounds,
- Keeping sharp objects on hand,
- Wearing long sleeves, pants even in hot weather,
- Claiming to have frequent accidents resulting in cuts/bruises,
- Hidden razors or other sharp objects,
- Often in need of first aid materials frequently.
- Broken bones
- Spending a great deal of time alone
- Difficulties with interpersonal relationships
- Emotional instability
- Impulsiveness and unpredictability
- Depressed mood
- Irritability
- Frequent thoughts of helplessness, hopelessness, or worthlessness

CO-OCCURRING DISORDERS

Non-suicidal self-injury is a symptom

- Borderline personality disorder
- Major depressive disorder
- Anxiety disorders
- Eating disorders
- Trauma
- Post-traumatic stress disorder
- Substance use disorders
- Dissociation and dissociative disorders
- Autism spectrum disorders

POSSIBLE EFFECTS OF SELF-INJURY

- Permanent scars
- Disfigurement
- Worsening feelings of shame, guilt, low self-esteem
- Depression regarding the inability to stop self-injuring despite the consequences
- Stress of providing many reasons for injuries
- Social isolation
- Stress of having to hide the self-abuse from others
- Infected wounds
- Substance use and abuse to self-medicate
- Failure to address reasons behind the self-injury
- Long-standing problems cause decreased enjoyment in other areas of life
- Anxiety that someone will discover the self-mutilation
- Death

STATISTICS

It’s estimated 1%-4% of adults self-injure

Prevalence of chronic self-harm occurs in approximately 1% of the adult population.

Self-harm rates in adolescents are especially high, with about 15% of adolescents reporting self-injury behavior.

College students have the highest number of reported self-injury, ranging about 17%-35%.

Those between the ages of 20-29 have the largest hospitalization rate for self-harm.

Self-harm rates are almost equal among genders

NON-SUICIDAL SELF-INJURY: WHAT MIGHT BE HELPFUL?

Have a conversation about the relief it really provides.

- How long does it last? What if there were other things that could provide similar stress relief?

Harm Reduction

- What techniques are available to reduce harm?

You cannot stop the behavior – so do not try! It is a means of coping that is probably well established and needs a replacement before it can be stopped.

- Any good you can identify in self-harming?

SUICIDE

- **Suicide** is death caused by injuring oneself with the intent to die.
- Death caused by self-directed violence with an intent to die
- Is preventable
- Is manageable
- 10th leading cause of death in the US in 2017
- Suicide is a permanent solution to a temporary problem; or the "only irreversible choice.“
- It is the result of a person unable to see any other solutions to the problems that are consuming him/her.
- Suicidal people do not want to die, they want their problems to end.
-

NATIONAL SUICIDE STATISTICS - 2020

- According to the Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports, in 2020:
  - Suicide was the twelfth leading cause of death overall in the United States, claiming the lives of over 45,900 people.
  - Suicide was the second leading cause of death among individuals between the ages of 10-14 and 25-34 , the third leading cause of death among individuals between the ages of 15-24, and the fourth leading cause of death among individuals between the ages of 35 and 44.
  - There were nearly two times as many suicides (45,979) in the United States as there were homicides (24,576).

NATIONAL SUICIDE STATISTICS CONT…

- Across the period, age-adjusted rates for firearm-related suicide in males were higher than for all other suicide means (Figure 5). The rate decreased from 11.0 per 100,000 in 2000 to 10.3 in 2006 and then increased to 12.5 in 2020.
- The rate for suffocation-related suicide nearly doubled from 2000 (3.4) to 2019 (6.6) and then decreased to 6.1 in 2020.
- The rate for poisoning-related suicide increased from 2.1 in 2000 to 2.3 in 2010 and then decreased to 1.7 in 2020.
- The difference in rates for firearm-related suicide and suffocation-related suicide narrowed over the period, from more than 3 times higher for firearms in 2000 (11.0 compared with 3.4) to 2 times higher in 2020 (12.5 compared with 6.1).

* www.suicidology.org

MASSACHUSETTS STATISTICS - 2020

- Based on preliminary death data, there were 642 suicides in 2019 and 615 suicides in 2020. These numbers represent a decline in suicides for Massachusetts, which had been rising for several years and peaked in 2018 with 725 suicides.
- Nationally, suicide rates declined by 2.1% in 2019, but Massachusetts was one of only five states to see a statistically significant decline in suicides between 2018 and 2019.2
- Between January 2019 and February 2020, Massachusetts averaged 54 suicide deaths per month. Between March and December of 2020, Massachusetts averaged 51 suicide deaths per month, indicating that suicide deaths continued to decline despite an increase in overall poor mental health during the COVID-19 pandemic.
- Despite recent increases in suicide-related ED visits among female youth, there has not yet been a corresponding increase in suicide deaths among this group. In 2019, there were 19 suicides among females age 0-24, and in 2020, there were 20 suicides, which are in line with what has been observed in previous years and a slight decrease from what was seen in 2018 (N=22)

**MA Department of Public Health*

PAD in United States

California- (End of Life Option Act; approved in 2015, in effect from 2016)

Colorado - (End of Life Options Act; 2016)

District of Columbia - (D.C. Death with Dignity Act; 2016/2017)

Hawaii - (Our Care, Our Choice Act; 2018/2019)

Maine - (Death with Dignity Act; 2019)

New Jersey - (Aid in Dying for the Terminally Ill Act; 2019)

New Mexico - (Elizabeth Whitefield End of Life Options Act; 2021)

Oregon - (Death with Dignity Act; 1994/1997)

Vermont - (Patient Choice and Control at the End of Life Act; 2013)

Washington - (Death with Dignity Act; 2008)

In MA- General Laws Part II, Title II, Chapter 201D Section 12 – Suicide or Mercy Killing

Section 12. Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one's own life other than to permit the natural process of dying.

TERMS associated w/Death

- **Advance Directive**
  This is a general term describing two kinds of legal documents [See Living Will and Durable Powers of Attorney]. Such documents allow a person to give instructions about future medical care in case they are unable to participate in medical decisions due to serious illness or incapacity. Each state has its own regulations concerning the use of advance directives. Find yours here.
- **Assisted Death**
  This is also know as "physician-assisted suicide", "physician-assisted dying" or "aid in dying" and is legal the US states of Oregon and Washington. It permits mentally competent, terminally-ill adult patients to request a prescription for life-ending medication from their physician. The Oregon and Washington laws mandate that the medication must be self-administered.
- **Autonomy**
  This is the exercise of self determination and choice among alternatives, based on the individual's values and beliefs.
- **Double Effect**
  This is the doctrine established by St. Thomas Aquinas in the 13th century in which an action that has two effects—one that is intended and positive and one that is foreseen but negative—is ethically acceptable if the actor intends only the positive effect. The doctrine is often used to describe the impact of administering high doses of morphine or terminal sedation—treatments intended to relieve suffering but that often hasten death. Since the intention is comfort care, this is not considered euthanasia and is legal and generally practiced throughout the United States and around the world—generally in private and without publicity.

TERMS associated w/Death

- **Continuum of Care**
  This relates to a course of therapy during which a patient's needs for comfort care and symptom relief is managed comprehensively and seamlessly. Hospice provides a continuum of care to terminally-ill patients, and aid-in-dying is assumed as the option of last resort at the end of that continuum.
- **Coma**
  The National Institute of Neurological Disorders and Stroke defines coma as "a profound or deep state of unconsciousness. An individual in a state of coma is alive but unable to move or respond to his or her environment." Comas can result from chronic illness or severe injury/trauma.
- **Comfort Care**
  This medical specialty, also referred to as palliative care, is often associated with hospice; however, it can also be used independently and alongside curative treatments. Palliative care is available in every state, appropriate for anyone at any stage of life suffering with a debilitating illness–terminal or not–and focuses on pain management and providing comfort.
- **DNR / DNI**
  DNR/DNI stands for Do Not Resuscitate/Do Not Intubate and is a specific physician order. Do Not Resuscitate means that in the event of cardiac arrest, no CPR or electric shock will be performed to re-start the heart. Do Not Intubate means that no breathing tube will be placed in the throat in the event of breathing difficulty or respiratory arrest.

TERMS associated w/Death

- **Durable Power of Attorney**
  This is a document appointing a surrogate to make medical decisions in the event that an individual becomes unable to make those decisions on their own. It is also sometimes referred to as a "health care proxy."
- **Futile Measures**
  This generally refers to the medical care of patients in which the care will have little or no effect on the patient's outcome or prognosis.
- ***Guardian Ad Litem***
  A Latin term for a court-appointed representative who makes decisions in a legal proceeding on behalf of a minor or an incompetent or otherwise impaired person.
- **Hospice**
  Hospice is an organization or institution that provides comfort (a.k.a. palliative) care for dying individuals when medical treatment is no longer expected to cure the disease or prolong life. Hospice sometimes also applies to an insurance benefit that pays the costs of comfort care usually at home for patients with a prognosis or life expectancy of six months or less.
- **Intent**
  This is a concept used to draw a moral distinction between aid-in-dying and other acts/omissions that cause death—such as terminal sedation and withdrawing life-sustaining therapy. "Intent" assumes the ability to draw a clear distinction between *knowledge* of a certain outcome and an *intention* to produce that outcome.

TERMS associated w/Death

- **Life-Sustaining Treatment**
  This is any treatment, the discontinuation of which would result in death. Such treatments include technological interventions like dialysis and ventilators. They also include such simpler treatments as feeding tubes and antibiotics.
- **Living Will**
  A “living will” is a type of advance directive containing instructions about future medical treatment in the event the individual is unable to communicate specific wishes due to illness or injury. Each state has its own regulations concerning the use of living wills.
- **Minimally Conscious**
  This state was described in the February 12, 2002 edition of *Neurology* as qualitatively distinct from coma and vegetative states. For example, patients who are “minimally conscious” are impaired but have some capabilities, such as the ability to reach for and grasp objects, track moving objects, locate sounds, and process and respond to words. Patients may inconsistently verbalize or gesture to communicate, and patients may regain full consciousness. However, minimal consciousness may also be permanent.
- **Palliative Care**
  This medical specialty is often associated with hospice; however, it can also be used independently and alongside curative treatments. Palliative care is available in every state, appropriate for anyone at any stage of life suffering with a debilitating illness–terminal or not–and focuses on pain management and providing comfort. [See also comfort care]

RISK AND PROTECTIVE FACTORS FOR SUICIDE

Risk factors are variables strongly associated with suicide. Risk factors do not *cause suicide*.

Protective factors are behaviors, characteristics, and other variables found to offset risk factors of suicide and precipitants of suicidal behavior. They contribute to feeling that life is worth living.

RISK FACTORS

Several conditions act as short-term risk factors:

- a sense of being a burden, helpless, not belonging, instability, agitation, panic, anxiety; relational conflict, aggression, and violence.

Impulsivity is linked to suicide risk because it makes it more likely that individuals will take on behaviors that increase the capability for lethal self-harm.

RISK FACTORS FOR SUICIDE

A past suicide attempt and alcohol use are such strong risk factors that they almost qualify as "predictors" of suicide. They are present in many completed and attempted suicides. Other common risk factors are:

- Adult white male, Native American, veterans,
- Poor coping, problem-solving, help-seeking
- Intimate partner conflict, social isolation
- Family history of suicide, mental disorder or *substance abuse
- Family violence, including physical or sexual abuse
- Firearms in the home or otherwise accessible
- Legal charges, financial problems, incarceration
- Physical illness and disability
- Academic failure

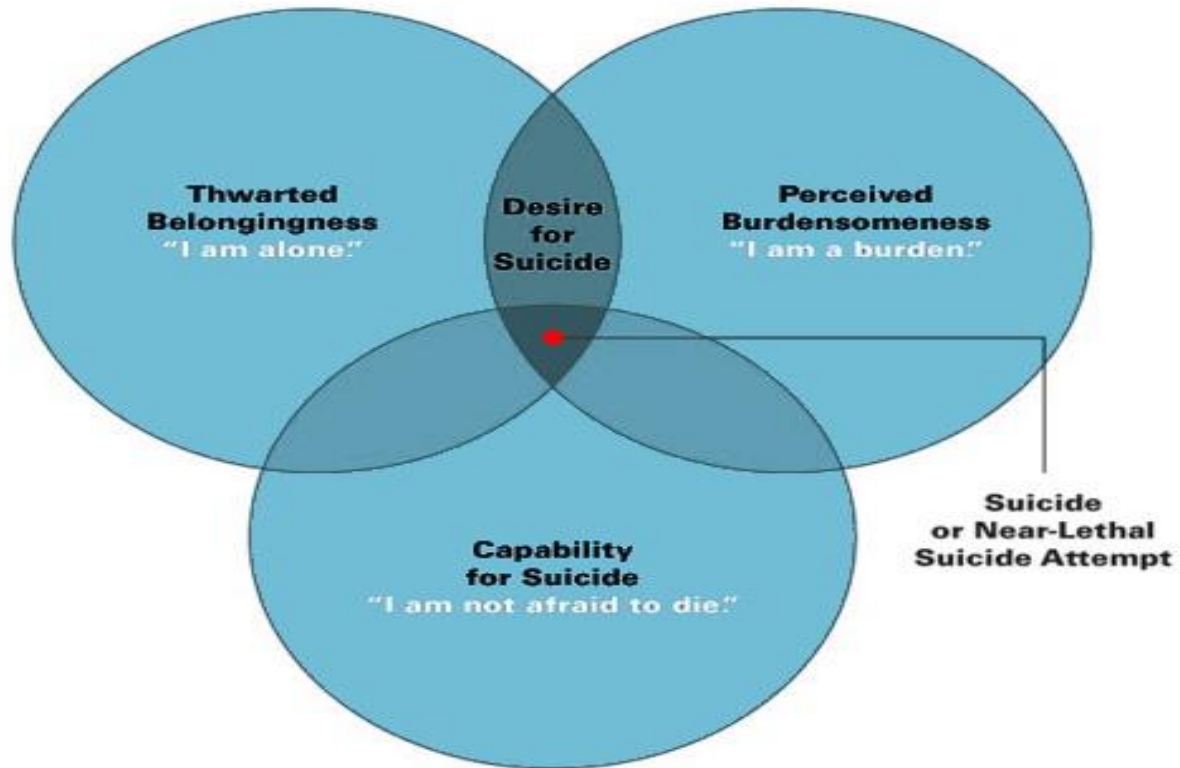
PROTECTIVE FACTORS

The main protective factors for suicide:

- Strong family, social ties, support sources
- Optimism, resilience, life satisfaction, emotional stability
- Strong self-esteem, sense of self-worth
- Good problem-solving, coping skills, and willingness to seek help
- Religiosity, spirituality
- No firearms in household
- No alcohol or drug use
- Trusting relationship with provider
- Employment
- Childrearing responsibilities

Social support is a strong protective factor because it increases self-esteem and self-efficacy.

SUICIDE MODEL – THOMAS JOINER



DANGER/WARNING SIGNS - IS PATH WARM

I Ideation

S Substance Abuse

P Purposelessness

A Anxiety

T Trapped

H Hopelessness

W Withdrawal

A Anger

R Recklessness

M Mood Change

DANGER/WARNING SIGNS

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide
- Talking about feeling hopeless, trapped, burden
- Increased use of alcohol
- Citing a doable plan specifying how and when
- Giving away valued possessions (e.g., pets, CDs, books, tools, money, etc.)
- Talking about seeking revenge
- Loss of interest
- Sleeping changes
- Making unexpected visits or calls to family members or friends
- Settling up affairs, making a will, dictating funeral arrangements

ASKING THE TOUGH QUESTIONS…

Screening is the basic technique for finding suicide risk factors. It involves simple direct questioning. It requires training but not clinical skill or judgment. It does not evaluate or estimate an individual's level of suicide risk.

Screening questions must be direct:

- Have you ever thought about killing yourself?
- Are you thinking about it right now?
- Do you have a plan on how to kill yourself?
- Do you have the means to carry out this plan?
- Have you tried out or rehearsed your plan?
- Have you ever attempted suicide?

CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: ____________ Clinician: ____________ Date: ________ Time: ________

Section A (*Patient*):

Rank Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

Rank	
____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind,* ***not*** *stress,* ***not*** *physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: ____________
____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: ____________
____	3) RATE AGITATION (*emotional urgency; feeling that you need to take action;* ***not*** *irritation;* ***not*** *annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: ____________
____	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: ____________
____	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: ____________
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will *not* kill self) 1 2 3 4 5 :Extremely high risk (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**

2) How much is being suicidal related to thoughts and feeling about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: ____________

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Section B (*Clinician*):

Y N Suicide ideation — Describe: ____________
- Frequency — ____ per day ____ per week ____ per month
- Duration — ____ seconds ____ minutes ____ hours

Y N Suicide plan — When: ____________ Where: ____________ How: ____________ Access to means Y N How: ____________ Access to means Y N

Y N Suicide preparation — Describe: ____________

Y N Suicide rehearsal — Describe: ____________

Y N History of suicidal behaviors
- Single attempt — Describe: ____________
- Multiple attempts — Describe: ____________

Y N Impulsivity — Describe: ____________

Y N Substance abuse — Describe: ____________

Y N Significant loss — Describe: ____________

Y N Relationship problems — Describe: ____________

Y N Burden to others — Describe: ____________

Y N Health/pain problems — Describe: ____________

Y N Sleep problems — Describe: ____________

Y N Legal/financial issues — Describe: ____________

Y N Shame — Describe: ____________

Section C (*Clinician*): **TREATMENT PLAN**

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☐	
2				
3				

YES ____ NO ____ Patient understands and concurs with treatment plan?

YES ____ NO ____ Patient at imminent danger of suicide (hospitalization indicated)?

Patient Signature ____ Date ____ Clinican Signature ____ Date ____

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Ask Suicide-Screening Questions

NIMH TOOLKIT

Suicide Risk **Screening Tool**

Ask the patient:

1. In the past few weeks, have you wished you were dead?	❍ Yes	❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?	❍ Yes	❍ No
3. In the past week, have you been having thoughts about killing yourself?	❍ Yes	❍ No
4. Have you ever tried to kill yourself?	❍ Yes	❍ No

If yes, how? ______________________________

____

____

When? ______________________________

____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now?	❍ Yes	❍ No

If yes, please describe: ______________________________

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = acute positive screen (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

MORE IN DEPTH RISK ASSESSMENT

All consuming versus fleeting thoughts

How specific is the plan?

Recent attempt

- Rescue factor
- Insight into the severity situation/attempt
- Believed it would result in death
- Feelings about being alive
- Mitigating risk (identifying risk/protective factors)

WHAT IMPACTS COMMUNICATION?

Development of emotions/responses

- Anxiety, defensiveness, actions, calming

Nonverbal and paraverbal communication

- Personal space, body language, tone, volume, cadence

Integrated experience – understanding our own anxiety, frustration, counter transference

BARRIERS TO TREATMENT

Discussion – why don't people get help???

Connecting with Crisis

Final Thoughts/ Open forum

RESOURCES

American Association of Suicidology

Center for Disease Control and Prevention (CDC).

Joiner, Thomas (2006). *Why people die by suicide.*

Massachusetts Department of Public Health

- www.mass.gov

Substance Abuse and Mental Health Services Administration.

THANK YOU!

Presentation # 3

11:00am – 12:00pm **NAMI 101 – National Alliance on Mental Health Overview** – Tim Burton, Criminal Justice Diversion Project Coordinator

NAMI Massachusetts

an overview

Tim Burton

Criminal Justice Diversion Project Coordinator

About NAMI Massachusetts

National Alliance on Mental Illness (NAMI) of Massachusetts is a nonprofit grassroots organization that was founded in 1982

We work to improve the quality of life for people dealing with mental health symptoms and their families through advocacy, education, and support

NAMI Massachusetts is part of a 3-tiered network

NAMI national

NAMI state orgs

NAMI affiliates

There are 17 local affiliates in our state

What We Do

advocacy

We advocate at the state level and bolster local advocacy efforts

education

We provide educational programs for people dealing with mental health symptoms and their supporters, as well as community members

support

We offer support groups for people dealing with mental health symptoms and their supporters

NAMI & CIT

CIT has expanded to over 2,700 communities -- supported by NAMI affiliates and NAMI state organizations across the country .

NAMI's role is to share the real experiences of people who have interacted with police -- to underscore how impactful a
CIT-trained officer can be.

Criminal Justice Diversion Project

at NAMI Massachusetts

About the Criminal Justice Diversion Project (CJDP)

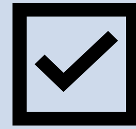
The Criminal Justice Diversion Project (CJDP) at NAMI Massachusetts aims to prevent the unnecessary arrest and detention of people dealing with mental health symptoms.

The CJDP has been facilitating training, technical assistance, and collaboration across the mental health and criminal justice systems since 2012.

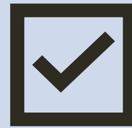
What Do We Mean By "**Diversion**"?

Diversion is an alternative to and enhancement of the criminal justice system's response to behavioral health issues.

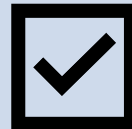
Criminal justice diversion…



recognizes the needs of the person and the community



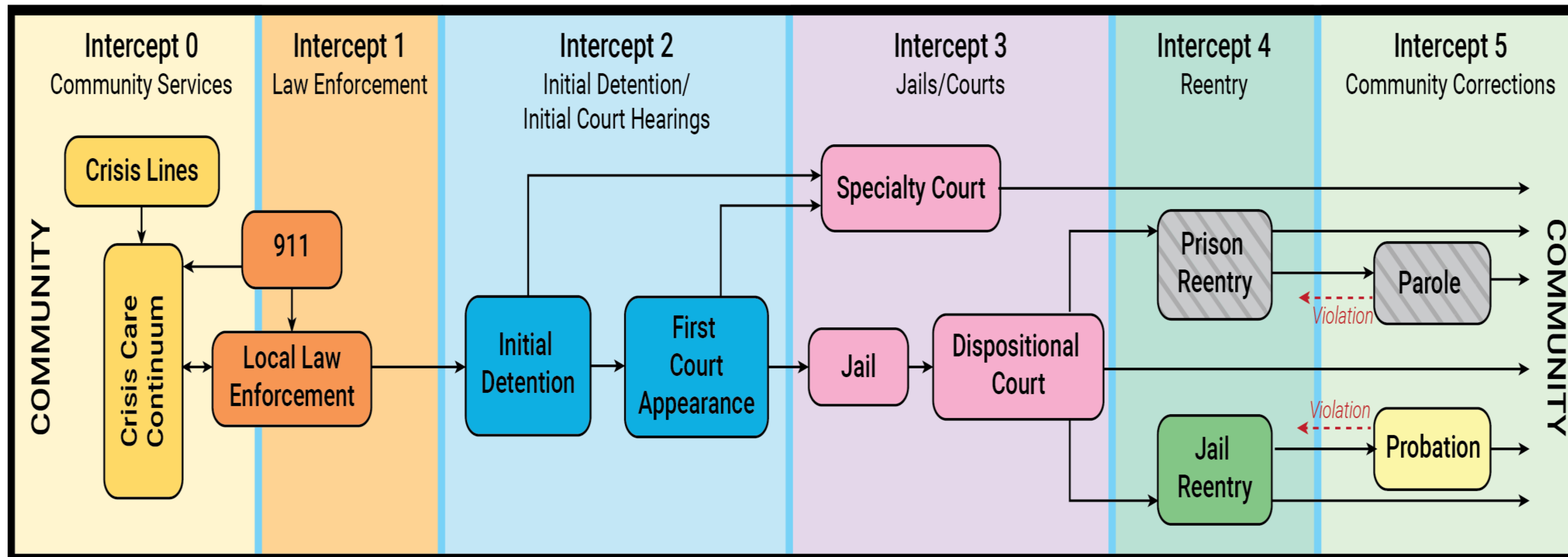
emphasizes the effectiveness of treatment and support



provides better outcomes at lower cost - for the person, their family, the individual officer, and for the community

Sequential Intercept Model

The Sequential Intercept Model identifies how people dealing with mental health symptoms enter and progress through the criminal justice system.



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Each point - or intercept - in the model represents an opportunity to divert someone from the criminal justice system and instead into treatment.

Obstacles to Diversion

Lack of integrated data and communication structure

Legal impediments to information sharing between agencies

Insurance rules and other regulatory burdens on systems of care

Bureaucratic delays, resource limitations, redundancies and system inefficiencies

Political, public, systematic and organizational stigma misunderstandings and indifference

Crisis Resolution Checklist

Know community resources and programs beforehand

Know the criteria for utilization of the resources

Know the resource's availability (time, place, capability, etc.)

Know the best "fit" for addressing the person's needs

Know the next step for care after the crisis - for the person you're interacting with, their family, and you

How Can CJDP Help You

For local police departments and other public safety entities, we can…

Offer information about criminal justice system diversion and crisis response

Facilitate and provide training, guidance and technical support

For people experiencing mental health symptoms who are interacting with the criminal justice system and their families, we can provide information, referral, and support

For individual officers and other first responders, we can offer confidential support and assistance

Contact the Criminal Justice Diversion Project

Tim Burton, Coordinator
Criminal Justice Diversion Project

To learn more about the work of the CJDP and criminal justice system diversion:

www.namimass.org/nami-mass-criminal-justice-diversion-project/

Compass Helpline
at NAMI Massachusetts

About the Compass Helpline

We are available Monday through Friday, 9 am to 5 pm

Anyone can reach out to Compass

We welcome inquiries by phone, email, and postal mail

Our goal is to help get people to the next best step

About the Compass Helpline

Compass is staffed by people who have first-hand experience navigating the mental health system	We provide information, ideas, and resources to help people navigate the mental health system and related systems of care
Some people contact us just once, while others reach out again when their situation changes or new challenges arise	We are not a support line, but we do try to provide warmth, validation, and compassion to all users

What We Can Help With

finding peer or family support

accessing mental health treatment or providers

answers to basic questions about systems and rights

resources for housing, work, transportation, insurance, the legal system, education, benefits, etc.

How Compass Can Help You

Share our contact info with someone you've interacted with. Compass can offer them resources and support.

Reach out on behalf of someone you've interacted with. Compass can help you identify resources and support for them.

Reach out for yourself, your family, or your friends. Compass is a confidential source of information and resources.

Contact Compass

contact Compass

Monday - Friday, 9 am - 5 pm

Questions?

Presentation # 4

1:00-2:00pm

The Family Perspective

Amanda Pappas, Care Coordinator, BHN Intensive Care Coordination Program

Presentation # 5

2:00-3:00pm

Special Consideration with a Veteran Population, Department of Veterans Affairs (VA Services)

Kate Nye, LICSW
Suicide Prevention Coordinator

&

Melissa Barillaro, LICSW
Social Worker
Veterans Justice Outreach

United States
Department of Veterans Affairs

Special Considerations for Veteran Population

Central Western Massachusetts
VA Healthcare System

Kate Nye, LICSW
Suicide Prevention Coordinator

Melissa Barillaro, LICSW
Social Worker
Veterans Justice Outreach

First Responders Training

Why We are Here

War may be hell…but home ain’t exactly heaven, either. When a Soldier comes home from war, he finds it hard…

adapted from “A gentle reminder to keep your life in perspective. “

CPT Alison L. Crane, RN, MS
Mental Health Nurse Observer-Trainer
7302nd Medical Training Support Battalion

…to listen to his son whine about being bored.

...to keep a straight face when people complain about potholes.

…to be tolerant of people who complain about the hassle of getting ready for work.

…to be understanding when a co-worker complains about a bad night's sleep.

…to control his panic when his wife tells him he needs to drive slower.

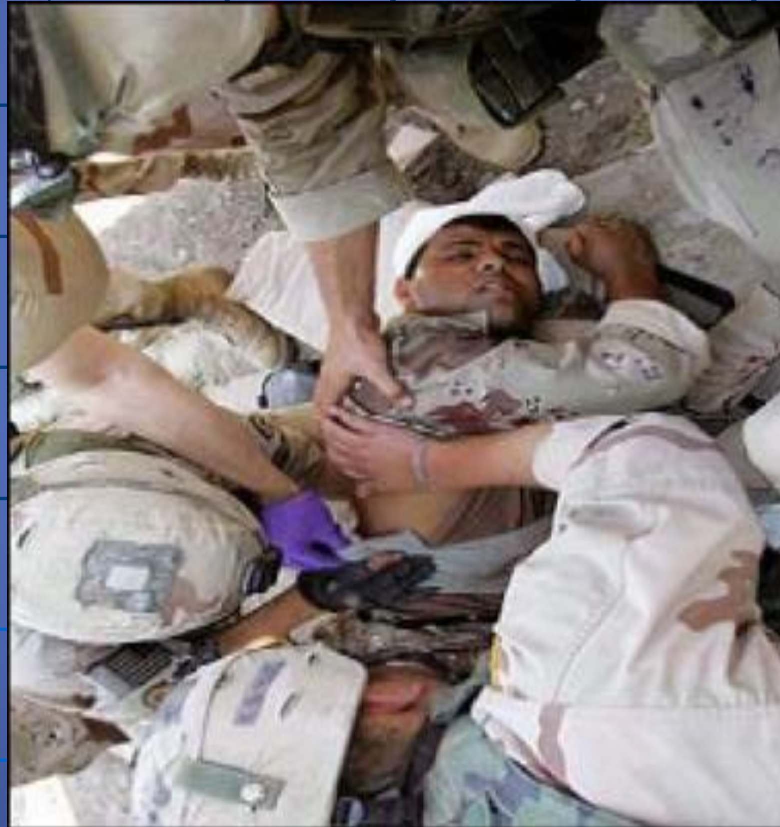
…to be silent when people pray to God for a new car.

…to be compassionate when a businessman expresses a fear of flying.

…to not laugh when anxious parents say they're afraid to send their kids off to summer camp.

…to not ridicule someone who complains about hot weather.

…to control his rage when a colleague gripes about his coffee being cold.



…to remain calm when his daughter complains about having to walk the dog.

…to be civil to people who complain about their jobs.

...to just walk away when someone says they only get two weeks of vacation a year.

…to be happy for a friend’s new hot tub.

…to be forgiving when someone says how hard it is to have a new baby in the house.

What is a Veteran?

A Veteran is someone who, at one point in their life wrote a blank check made payable to the United States of America for an amount of up to and including their life.

American Veteran
Your Neighbor
Across The USA

July 4 1776

Pay to the Order of United States Of America $ ANY PRICE

Up To And Including, "MY LIFE" .... Dollars

For To keep America Free

American Veteran

⑆0123456789⑆ ⑈987654321⑈

HISTORY OF RECENT CONFLICTS

- World War II (1941-1945)
- Korean War (1950-1953)
- Vietnam (1961-1975)
- Grenada (1983)
- Panama (1989)
- First Gulf War/Desert Storm (1990-91)
- Somalia (1993)
- Bosnia(1993-1995)
- Kosovo (1998-1999)
- Operation Enduring Freedom/OEF (2001-present)
- Operation Iraqi Freedom (2003-2011)

How to spot a veteran

OEF/OIF Facts

- 2.7 million military personnel have been deployed since the War in Afghanistan began in late 2001.
- 89 % are men, 11% are women
- 43% screened positive for PTSD, MDD, or Alcohol Use Disorder
- 2000 - 2017: > 379,000 suffer from some form of closed-head injury

Justice Involved Veterans

- In 2018 – 180,000 incarcerated Veterans in MA
  - -SUD was #1 factor for arrest
  - -Symptoms of PTSD was #2 factor for arrest (anger/irritability)
- Veterans are more likely to be sentenced for violent offences

Combat Exposure and Substance Use

- Alcohol abuse doubles following combat deployment (Jacobson et al 2008)
- Greater combat exposure is associated with greater substance abuse
- Reserve & Guard personnel had higher rate of new onset alcohol abuse post deployment than active-duty personnel

Readjustment

Combat Zone

Home

Military vs. Civilian life

- Predictability vs. variation
- Following orders vs. making decisions
- Expectations of unit vs. expectations of family
- Mission orientation vs. every person for themselves
- Shared experience/camaraderie vs. no one understands

Adjustment

The stresses and effects of combat on behavioral health are fairly well documented. PTSD, Traumatic Brain Injury, and general readjustment issues sometimes manifest themselves in Veterans as crisis encounters with law enforcement or first responders.

The community's response to this crisis can have a major impact on the Veteran, the Veteran's family, and the community itself.

PTSD-Clinical Criteria

*Trauma-experiencing or witnessing life threatening event

*Symptoms lasting more than a few months and interfering in life:

A) Re-experiencing
B) Avoidance
C) Hypervigilance
D) Disconnection

Symptoms of PTSD

- **Re-experiencing the event**
  - nightmares
  - flashbacks
- **Avoidance**
  - Crowds
  - people, places, things that remind you of the event
  - thinking about or talking about event
- **Negative changes in beliefs and feelings**
  - difficulty connecting with others
  - loss of interest in enjoyable activities
  - difficulty recalling important parts of the traumatic event
  - impending doom
- **Hyperarousal**
  - sleep challenges
  - trouble concentrating
  - easily startled
  - Hypervigilance/over interpret things as threats

PTSD Veteran Stats

- **Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF)**: 11-20% who served in OIF or OEF have PTSD in a given year.
- **Gulf War (Desert Storm)**: 12% have PTSD in a given year.
- **Vietnam War**: 15% (late 1980s study, estimated more likely to be 30%)

TBI in Veterans

- TBI represents ~ 22% of confirmed injuries in Iraq/Afghanistan War veterans.
- Many veterans have experienced multiple TBI’s due to chronic exposure to blasts
- As many as 50% to 60% of veterans with chronic blast exposure have significant hearing loss or tinnitus (“ringing” in the ears) (Lew, et al. 2007)

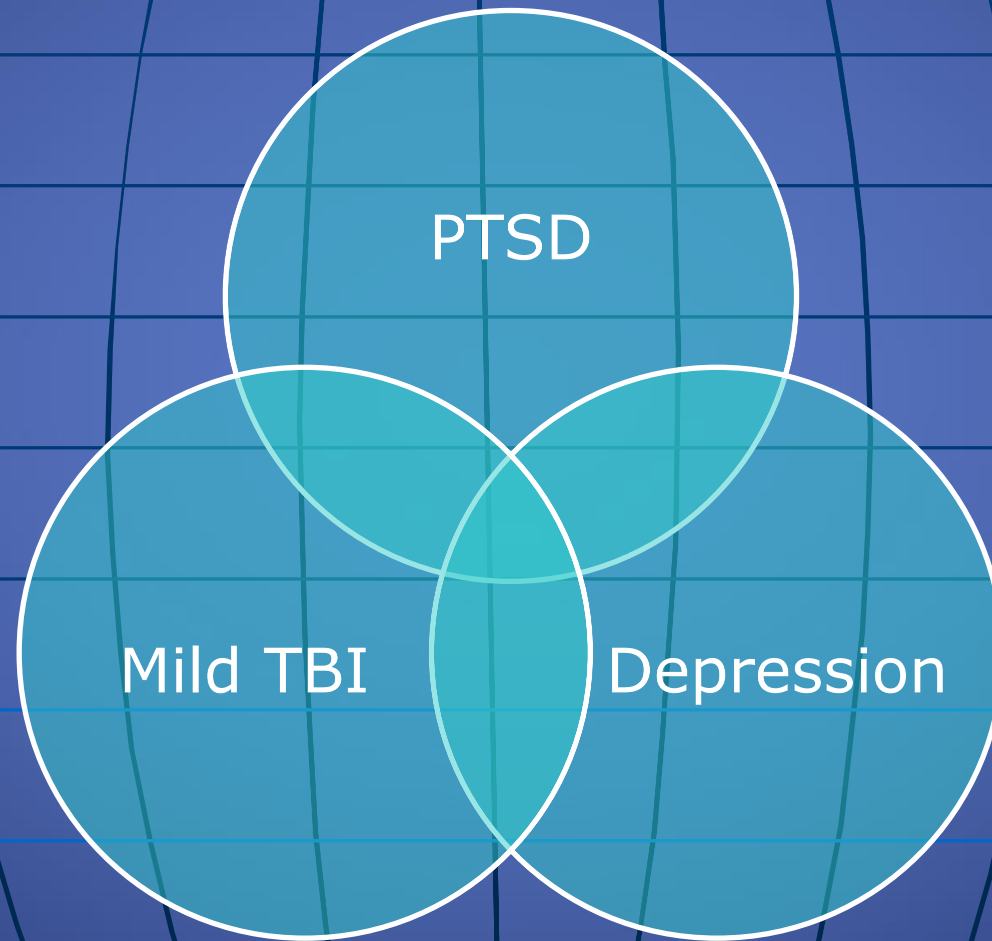
Behaviors We May See

- Risky behaviors to get the adrenaline rush
- Speeding/Erratic driving/road rage/avoidance driving/non-defensive driving
- Panic while in traffic
- Violent Behavior (Rage)/Domestic Violence/Child abuse
- Addictions (work, drugs, alcohol, food, adrenaline, sexual behavior)
  - Combat exposure increases the likelihood of substance use
- Withdrawal, isolation, intolerance of others
- Complain of headaches, chronic pain, forgetfulness
- Emotional dysregulation/Impulsive

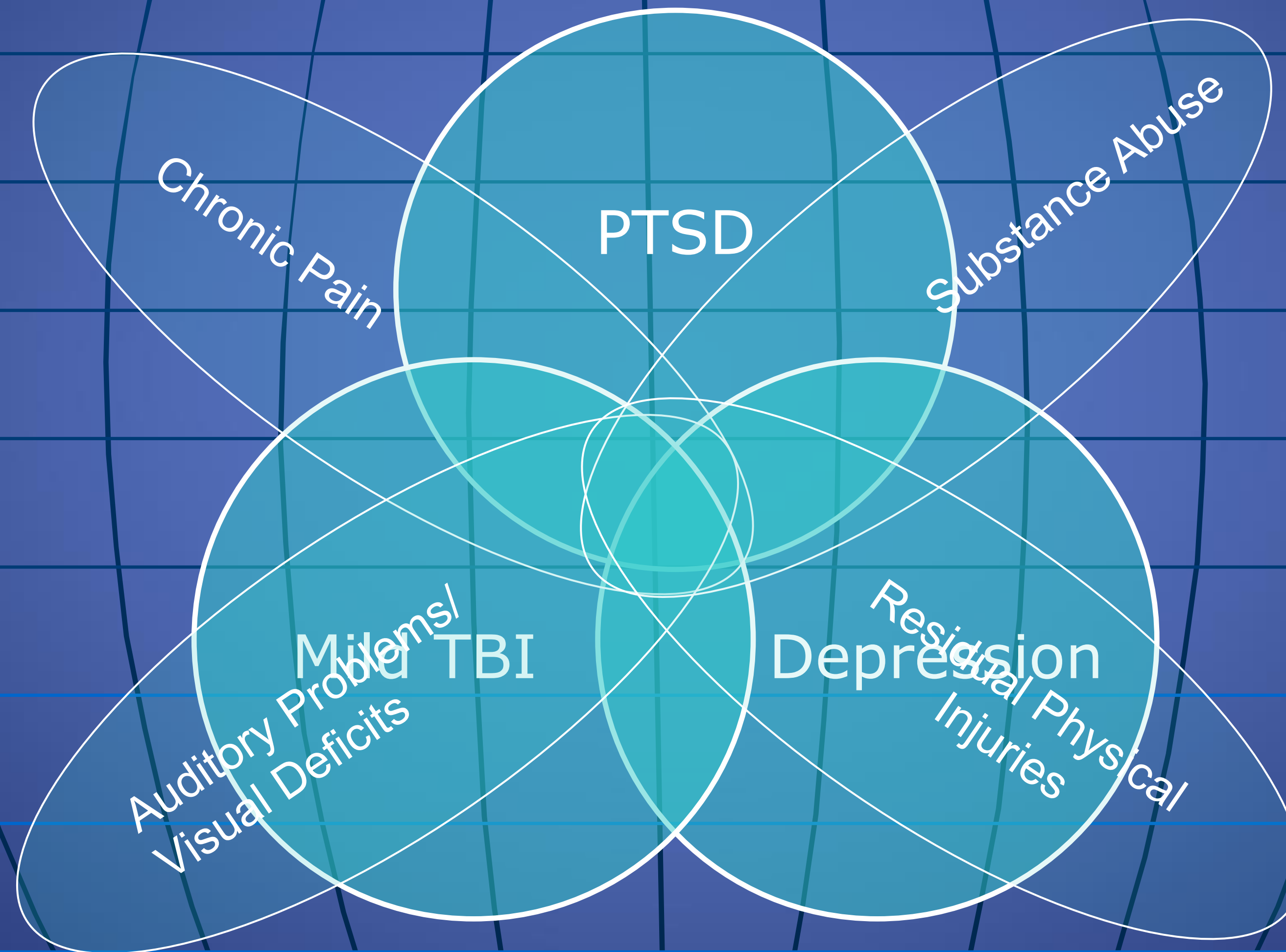
Domestic Violence

- Higher rate of domestic violence in military compared to civilian counterpart
- DV increases with subsequent deployments and with longer deployments
- DV increased by 33% from 2006-2011 in Army families
- June 2018: VA commits $17 million to expand IPV assistance program

Difficulties with diagnoses and/or treatment



Further contributing factors



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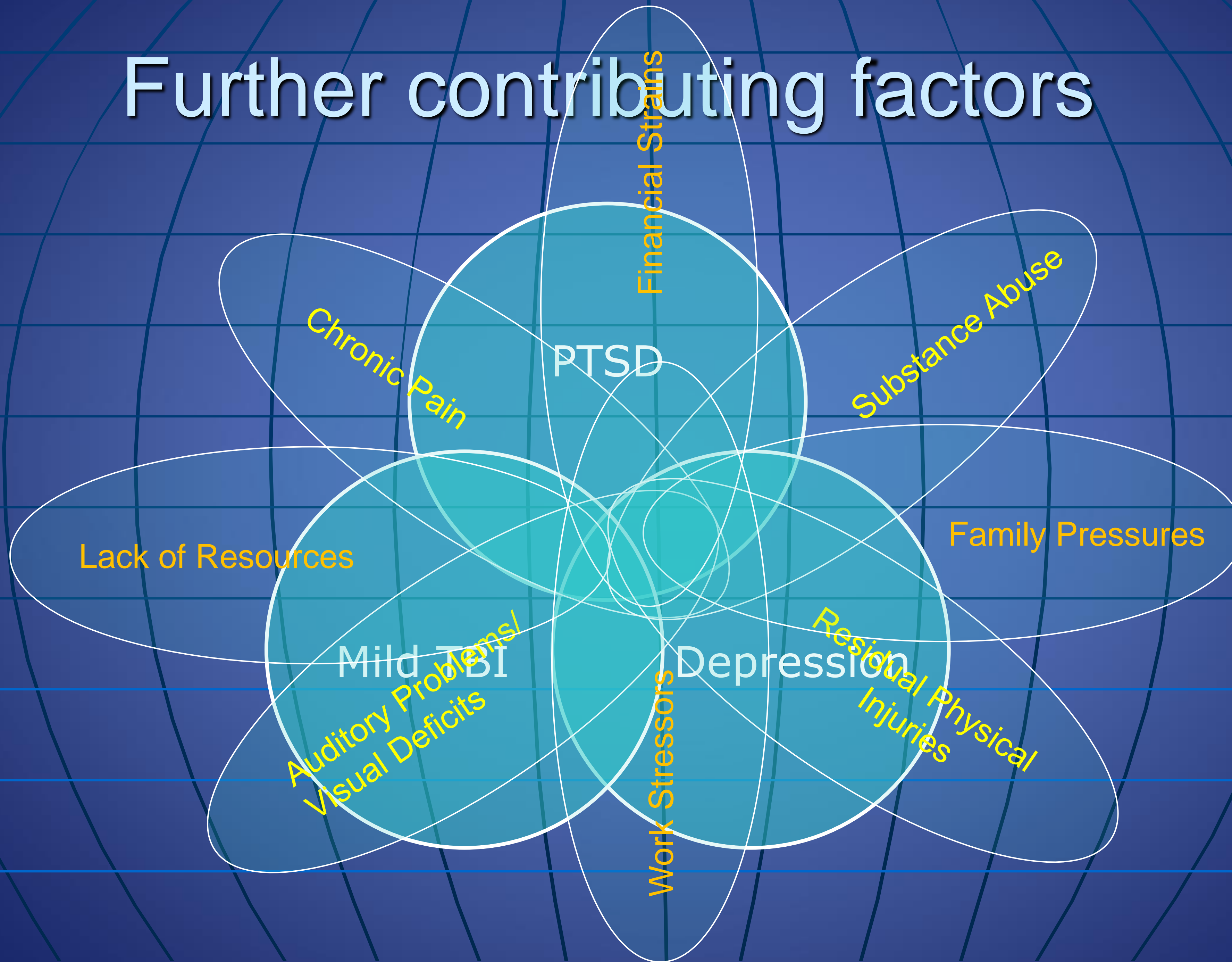


Veterans Crisis Line:
Call, Chat, or Text

Facts about Veterans and Suicide

- **13.9%** of all deaths by suicide among U.S. adults were Veterans (2019)
- Veterans are more likely than the general population to use **firearms** as a means for suicide
- On average, **17.2** Veterans die by suicide every day in the US. **6.8** of these Veterans are engaged in VHA care, **10.4** are not.
- **25%** of Veteran suicides have a history of previous suicide attempts

Warning Signs of Suicide

- Hopelessness
- Rage, anger, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug abuse
- Withdrawing from friends, family, and society
- Anxiety, agitation, inability to sleep, or sleeping all the time
- Dramatic changes in mood
- Perceiving no reason for living, no sense of purpose in life

Tips for Working with Veterans: “The best negotiator is a good listener”

- *Ask if Veteran (“Have you served in the US Military?”)*
- *Be RESPECTFUL*
- *Establish rapport/TRUST*
- *Express appreciation for their service*
- *Active listening skills*
- *Softer/slower voice/be careful of tone/avoid sarcasm*
- *Stay calm*
- *Ask open-ended questions (“what, how, when – avoid why”)*
- *Effective Pauses*
- *Re-state/recap what they have said (“tell me if I’m understanding you correctly”)*
- *Validate their feelings*
- *Watch physical demeanor/body language (sit if they are sitting, don’t intimidate)*
- *Be sincere – they will recognize BS/insincerity*

De-escalation Techniques to employ

- When interacting with those who may be experiencing psychiatric symptoms and/or are conditioned to be impulsive, reactive, ready to defend, consider:
  - Non verbal awareness (eg. body posture)
  - Verbal cues (eg. tone of voice)
  - Personal Space
  - Environment (lower lights, radio)

Techniques to employ (cont.)

- Other considerations:
  - Clarification ("good dentist technique")
  - Simple 1-step instructions
  - Stay calm/supportive
  - Grounding *…Get them in the here and now…(Where were you heading? Do you know what street you are on now?)*
  - Breathing
  - Walk together/Get to sit down
  - Avoid threats, intimidation, judgement
  - Active listening / Open-ended questioning

Communication Cautions

- Overreacting
- Power Struggles
- False promises
- Threats

Veterans Justice Outreach Initiative

"The purpose of the VJO Initiative is to avoid unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible Veterans in contact with the criminal justice system have access to:

VHA mental health and substance abuse services when clinically indicated , and other VA services and benefits as appropriate."

Department of Veteran Affairs, April 30, 2009, Under Secretary for Health's Information Letter

A Justice-Involved Veteran is:

- In contact with local law enforcement
- In custody at a local jail, either pretrial or serving a sentence
- Involved in adjudication or monitoring by a court

The VJO Provides:

- Direct outreach, assessment, and case management
- Assistance with eligibility determination, enrollment
- Referral to both VA and non-VA services upon release
- Connection to services for homeless vets

The VJO Also provides:

- Information and education to courts, attorneys and law enforcement about veterans' issues and services

Expected VJO Outcomes

- Reduce recidivism
- Stabilize behavior
- Reduce court/jail costs
- Save a life

VA Eligibility

- *Eligibility determination is based on each individual's service. We encourage all Veterans to apply for VA services.*

Also important to know about:

- Western Mass Veterans Treatment Court (for Vets with or without records who need intensive, long term probation. We are looking for high risk, high needs clients)

The Valor/Brave Act (for Vets with no record who are getting pretrial probation)

Central Western Massachusetts Department of Veterans Affairs Intimate Partner Violence Assistance Program

Our mission is to implement a comprehensive person-centered, recovery-oriented assistance program for Veterans, their families and Caregivers and VHA employees who use or experience intimate partner violence (IPV).

VA IPV Resources

- IPV Coordinators
- Link to community-based support groups
- Link to community-based advocacy and legal services
- Referral to and coordination with other VA treatment providers
- Connection to domestic violence shelters and services
- Homeless Services
- Interventions and treatment for Veterans who use violence in their intimate relationships

Christine Dunn, LICSW
Intimate Partner Violence Program Coordinator
Phone: 413-557-0627
Email: Christine.Dunn2@va.gov

Domestic Violence National Hotline
Call **800-799-SAFE (7233)**
TTY **800-787-3224**

Jane Doe Inc.
The Massachusetts Coalition Against Domestic Violence:
Website: **janedoe.org**
Email: **info@janedoe.org**
Call: **617-248-0922**

VA | U.S. Department of Veterans Affairs
Veterans Health Administration

Vet Center

What are Vet Centers?

Vet Centers are community-based counseling centers, providing social and psychological services including professional readjustment counseling to eligible Veterans and active-duty service members, to include members of the National Guard and Reserve components and their families.

Services Include
Individual & Group Counseling
Therapeutic Recreation & Activities
Family & Couples Counseling
Evidence-Based Treatment
Bereavement Counseling

Who is eligible?

Veterans and active-duty service members who:

- Have served on active military duty in any combat theater or area of hostility;
- Experienced a military sexual trauma (MST)
- Provided direct emergent medical care or mortuary services to the casualties of war, while serving on active duty, or
- Served as a member of an unmanned aerial vehicle crew that provided direct support to operations in a combat zone or area of hostility

What makes Vet Centers unique?

Non-traditional hours (including evenings and weekends), services without time limitation and at no charge. Individuals do not need to be enrolled in VA Healthcare Services, do not need a disability rating or service connection and can access Vet Center services regardless of discharge character.

Worcester Vet Center
bruce.ware@va.gov
508-753-7902

Springfield Vet Center
bryan.doe@va.gov
413-737-5167

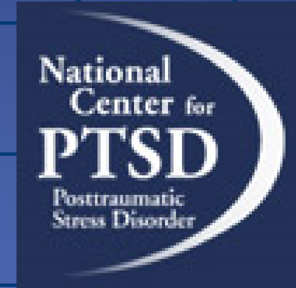
@VAVetCenters

www.vetcenter.va.gov
877- WAR-VETS (927-8387)

Scan QR Code
Find your local
Vet Center

On-Line Resources

- National Center for Posttraumatic Stress Disorder (www.ncptsd.va.gov)



- Veterans Justice Outreach (www.va.gov/HOMELESS/VJO.asp)

- NcPTSD Police Officer Toolkit (https://www.ptsd.va.gov/professional/toolkits/police/index.asp)

Questions

Human & Civil Rights

3-4pm

Nicola Howe, MSW

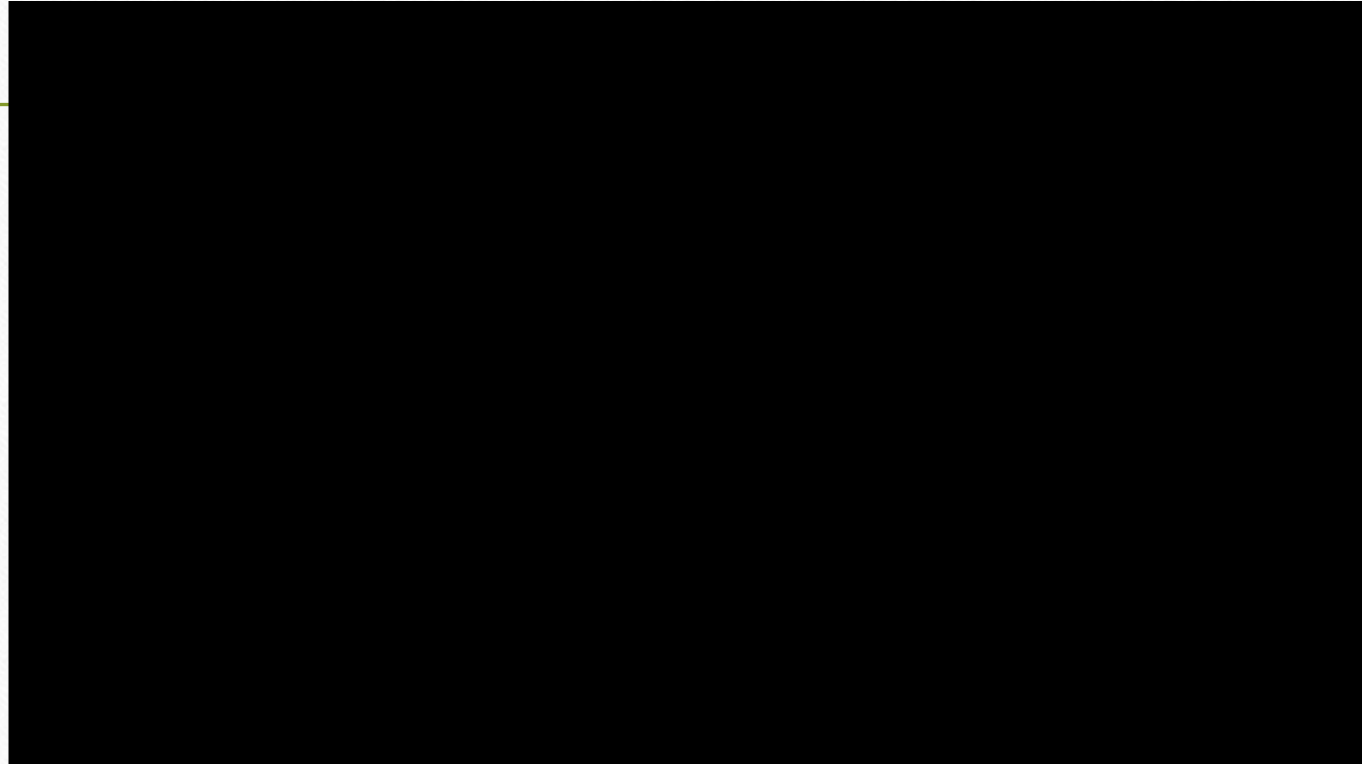
CIT-TTAC Coordinator

Objectives

By the end of this presentations, participants will be able to:

- Explain human rights, civil rights and civil liberties.
- Have some knowledge of rights of the mentally challenged, disabled communities and addiction population.
- Identify Laws regarding the mentally challenged, disabled communities and addiction population.

The Story of Human Rights



Group Discussion

- In your own words – what are Human Rights?
- Now that you have viewed this video, **how** did your first answer about what Human Rights have changed ?
- What would you add to your personal definition of Human Rights?

What are Human Rights?

- The **Universal Declaration of Human Rights (UDHR),** adopted by the UN General Assembly in 1948, was the first legal document to set out the fundamental human rights to be universally protected.
- The UNDR 30 articles provide the principles and building blocks of current and future human rights conventions, treaties and other legal instruments.

What are Human Rights?

- Human rights are rights we have simply because we exist as human beings - they are not granted by any state.
- These universal rights are **inherent** to us all, regardless of nationality, sex, national or ethnic origin, color, religion, language, or any other status.
- They range from the most fundamental - the right to life - to those that make life worth living, such as the rights to food, education, work, health, and liberty.

What are Human Rights

- Universality
- Inalienable
- Indivisible
- Interdependent

States Obligations regarding "Rights"

- The obligation to **respect** means that States must refrain from interfering with or curtailing the enjoyment of human rights.
- The obligation to **protect** requires States to protect individuals and groups against human rights abuses.
- The obligation to **fulfill** means that States must take positive action to facilitate the enjoyment of basic human rights.

What is a Civil Right?

- **Civil rights**, guarantees of equal social opportunities and equal protection under the law, regardless of race, religion, or other personal characteristics.
- Eg. of civil rights include the right to vote, the right to a fair trial, the right to government services, the right to a public education, and the right to use public facilities. Civil rights are an essential component of democracy; when individuals are being denied opportunities to participate in political society, they are being denied their civil rights.

What are civil liberties?

Civil liberties are basic freedoms and rights that are guaranteed either by the Bill of Rights in the Constitution or by interpretations of those rights by the legislature or courts. **Civil liberties in the U.S. include all of the following rights:**

- Free speech
- Privacy
- Right to remain silent
- Right to be free from unreasonable searches
- Right to a fair trial
- Right to marry
- Right to vote

UNHCR Declaration on the Rights of Mentally Ill Persons

- 1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.
- 2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.
- 3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.
- 4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

UNHCR Declaration on the Rights of Mentally Ill Persons

- 5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.
- 6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.
- 7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

What is a Civil Right?

The Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, religion, sex or national origin. Provisions of this civil rights act forbade discrimination on the basis of sex, as well as, race in hiring, promoting, and firing. The Act prohibited discrimination in public accommodations and federally funded programs. It also strengthened the enforcement of voting rights and the desegregation of schools.

Rights for People With Mental Illness & DD/ID

- Liberty and autonomy
- Protection from seclusion and restraint
- Community inclusion
- Access to Services and Privacy

Rights for People With Mental Illness

Liberty and autonomy

- People living with mental health conditions have the right to make decisions about their lives, including their treatment.
- They should be assumed competent to make their own decisions, and a refusal of any type of treatment should not be considered evidence that a person is incompetent.
- Preferences should be observed. In rare cases where an individual is considered an imminent danger to self or others, he or she has the right to due process, adequate representation, and appeals should there be civil commitment or involuntary treatment procedures.

Rights for People With Mental Illness

Protection from seclusion and restraint

- People living with mental health conditions have the right to be free from all abuses, including the practices of seclusion and restraint.
- Shackling, physical restraints, chemical restraints, and seclusion are among the practices used in schools and treatment facilities and throughout the criminal justice system.
- Seclusion and restraint also play a role in many interactions with law enforcement, where some estimate about half of those killed by police officers has a mental illness.

Rights for People With Mental Illness

- **Community inclusion**
- People living with mental health conditions have the right to live and fully participate in their communities of choice.
- From denying someone an apartment to kicking kids out of schools, discrimination against people living with mental health conditions often occurs in areas like housing, employment, and education.
- Community inclusion

Rights for People With Mental Illness

Access to Services and Privacy

- People living with mental health conditions have the right to receive the services they want, how and where they want them, with full explanation of insurance benefits, treatment options, and side effects.
- Insurance plans - providing coverage for mental health related services comparable to those offered for physical health services.
- Choices in both services and providers with access to necessary and effective treatment options.
- Informed consent and culturally and linguistically competent services empower people to make the best decisions for their health and well-being

Rights for People With Mental Illness

Privacy

- People living with mental health conditions have the right to privacy and to manage who can see their healthcare information.
  - This includes controlling who sees their health information and the ability to access and supplement their mental health records.
- Health plans and providers should provide information about privacy and confidentiality protocols.

Laws to be considered

- Important laws that involve community inclusion include the Americans with Disabilities Act (ADA), Rehabilitation Act, Individuals with Disabilities in Education Act (IDEA), the Affordable Care Act (ACA), the Mental Health Parity and Addition Equity Act (MHPAEA) the Health Insurance Portability and Accountability Act (HIPAA) and state duty-to-warn laws, Civil Rights of Institutionalized Persons Act, Individuals with Disabilities Education Act.

End of Presentation

- Recap
- Evaluation
- Thank You