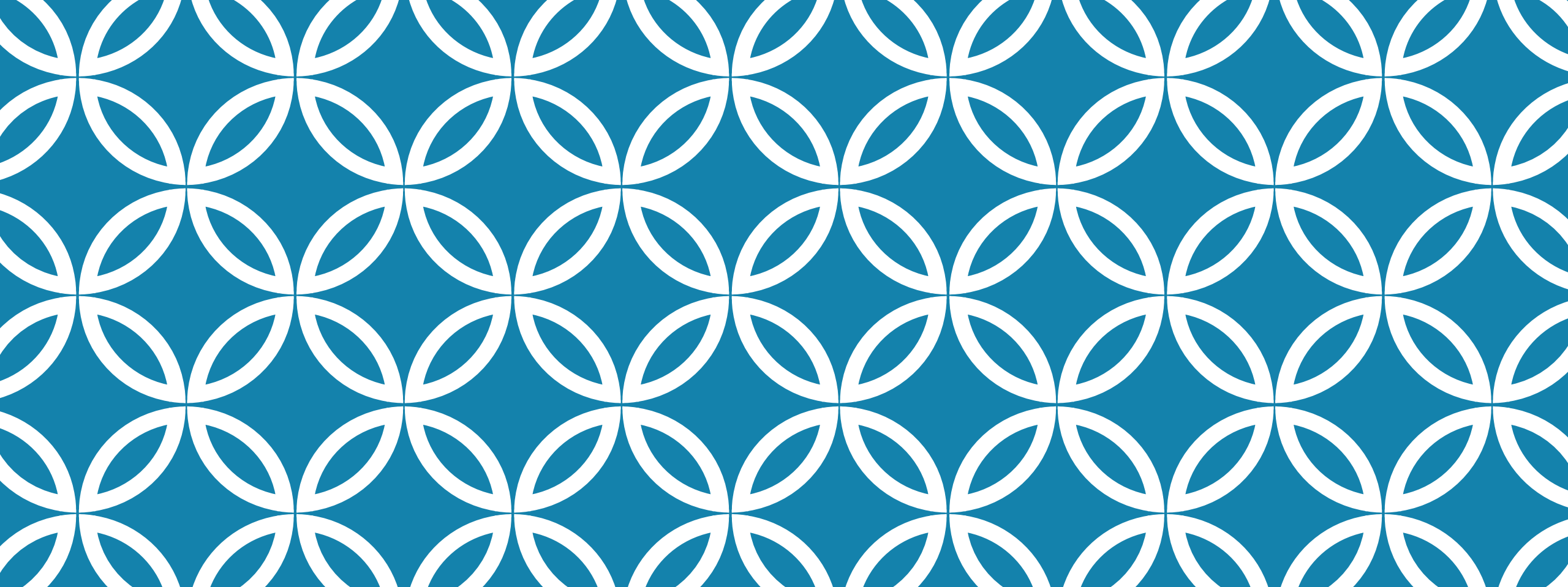


# CIT Training

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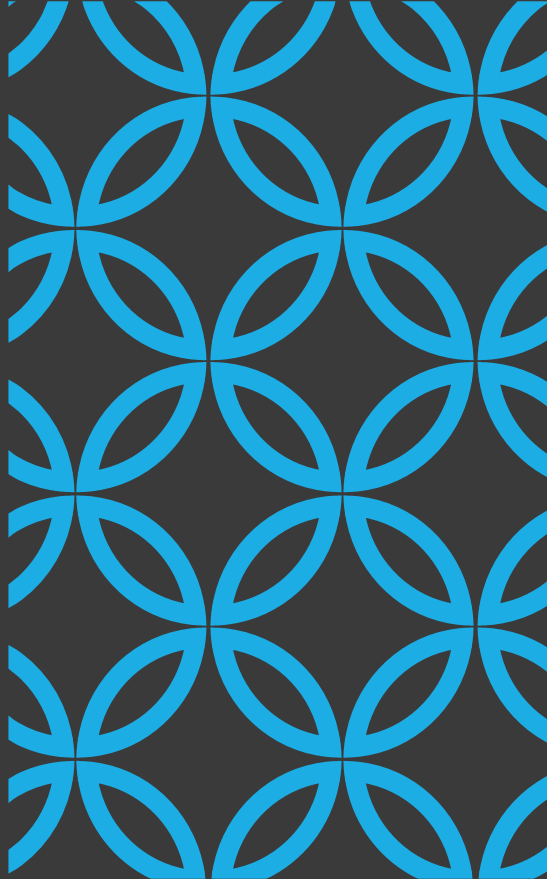
Day 2

May 23, 2023



# QPR: QUESTION, PERSUADE, REFER

Sarah Gaer, MA  
Suicide Prevention & Trauma Response  
Consultant  
QPR Master Trainer



## WHAT TO EXPECT

---

Overview of Suicide and Risk

Learn how to ask someone about suicidal intensity

Learn how to persuade them to get the support that they need

Learn how to refer them to resources

Identify Resources available

Consider the importance of self care

# TRAINING EXPECTATIONS: SUICIDE IS A SENSITIVE TOPIC

1

Please be sensitive to the experiences of others

2

Please be willing to reconsider your beliefs

3

Please take care of yourself: If you need a break, take it but please come back.

4

Please do not throw objects at your trainer.

# FOR ATTEMPT & LOSS SURVIVORS:

THANK YOU FOR BEING HERE!

## Activation of Memories

- Tyranny of Hindsight
- Challenging of current coping mechanisms:  
Anger, denial

# PREFERRED LANGUAGE

Suicidal thoughts vs Suicidal Intensity

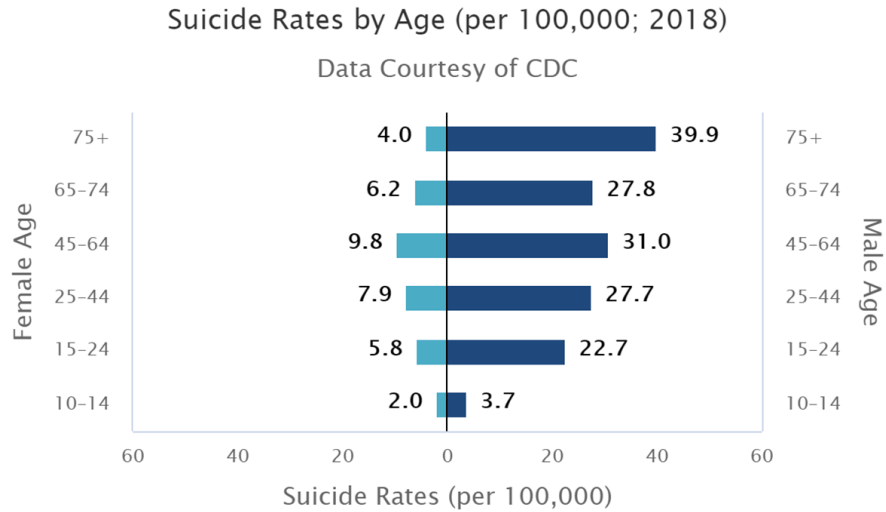
Committed, Completed vs died by suicide

Successful vs Failed

Serious vs level of lethality

Attention seeking vs Attention needing

# SUICIDE RATES BY AGE & GENDER



White men are at the highest risk – making up nearly 70% of all suicides

Men in the Middle Years are highest risk age/gender

Black women are lowest risk demographic

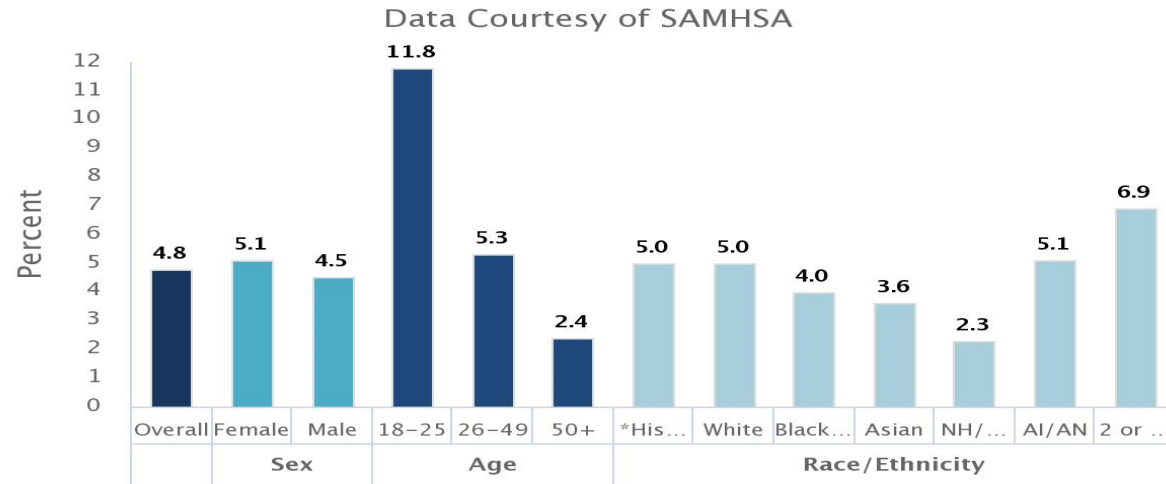
For children: Black male children are the highest risk

Recent years there have been spikes in suicide deaths among LatinX men and attempts among LatinX female youth

Nearly 1/2 of all transgender people will make a suicide attempt at some time during their lifespan

# AND RESEARCH INDICATES THESE NUMBERS ARE ON THE RISE.....

Past Year Prevalence of Suicidal Thoughts Among U.S. Adults (2019)

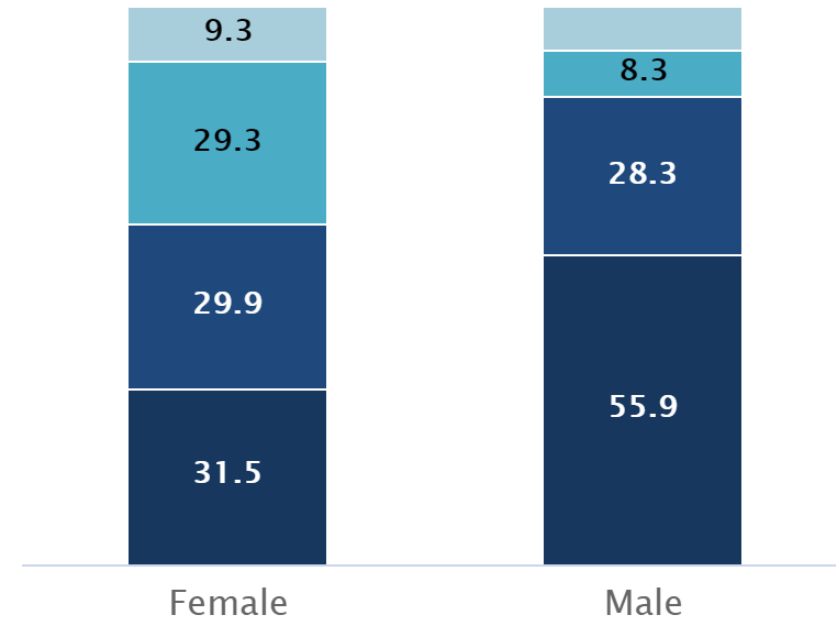


# WHAT EXPLAINS THE DISCREPANCY?

**Access to lethal means!**

Percentage of Suicide Deaths by Method in the United States (2018)

Data Courtesy of CDC





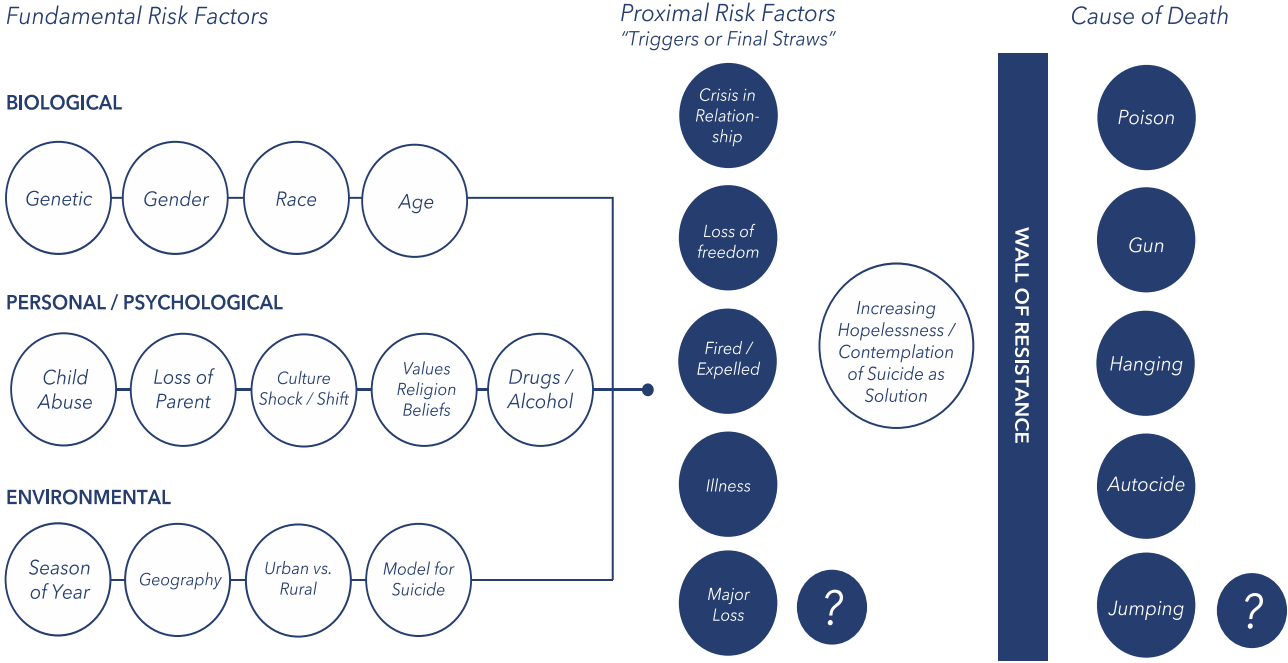
**MOST IMPORTANT  
THING I AM  
GOING TO  
SAY . . . . .**

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Suicide is a multi-factorial event. It is almost never caused by only one thing or event.

# SUICIDE AS A MULTI-FACTORIAL EVENT

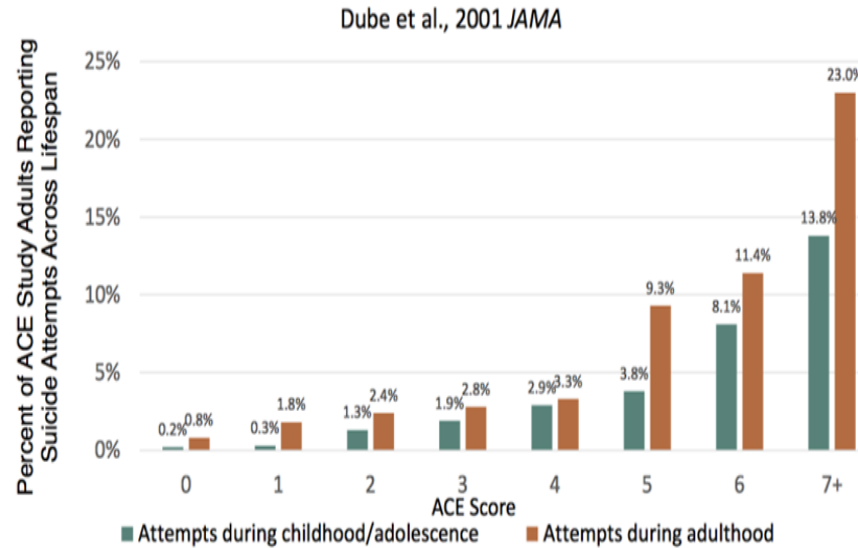
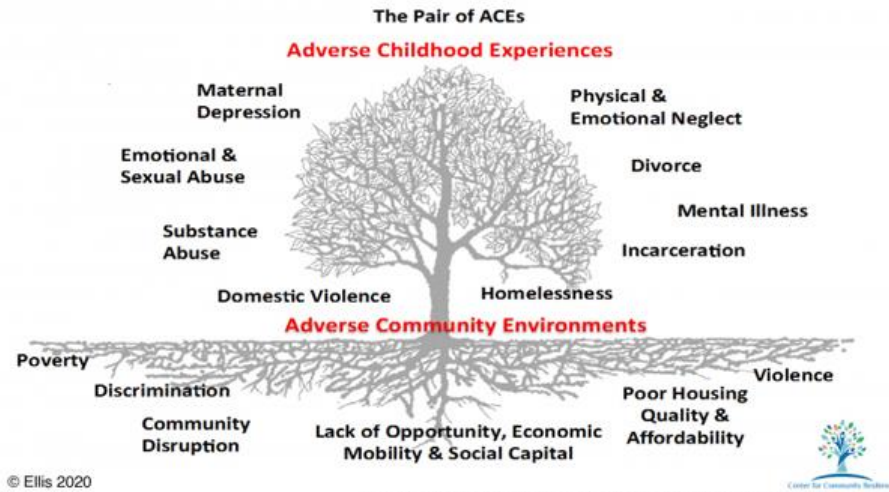
## The Many Paths to Suicide



# INVISIBLE RISK:

# EXPERIENCES

# ADVERSE CHILDHOOD



# QPR: WHAT DOES IT STAND FOR?

Q =  
Question

P =  
Persuade

R =  
Refer



# QPR

QPR is not intended to be a form of counseling or treatment.

QPR is intended to offer hope through positive action.

# SUICIDE: MYTHS AND FACTS


- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

How can I help? Ask the question.

## MYTHS AND FACTS (CONT)

- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.
- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction..
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question.



# SUICIDE CLUES & WARNING SIGNS

The more clues and signs observed,  
the greater the risk.

Take all signs seriously.



## DIRECT VERBAL CLUES

- “I’ve decided to kill myself.”
- “I wish I were dead.”
- “I’m going to commit suicide.”
- “I’m going to end it all.”
- “If (such and such) doesn’t happen, I’ll kill myself.”



## INDIRECT VERBAL CLUES

- “I’m tired of life, I just can’t go on.”
- “My family would be better off without me.”
- “Who cares if I’m dead anyway.”
- “I just want out.”
- “I won’t be around much longer.”
- “Pretty soon you won’t have to worry about me.”



## BEHAVIORAL CLUES

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability



## SITUATIONAL CLUES

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor or teacher
- Fear of becoming a burden to others



# TIPS FOR ASKING THE SUICIDE QUESTION

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; QPR Card, phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it!





## Q: QUESTION

### Less Direct Approach:

- “Have you been unhappy lately?  
Have you been very unhappy lately?  
Have you been so very unhappy lately that you’ve  
been  
thinking about ending your life?”
- “Do you ever wish you could go to sleep and never  
wake  
up?”

## Q: QUESTION

### Direct Approach:

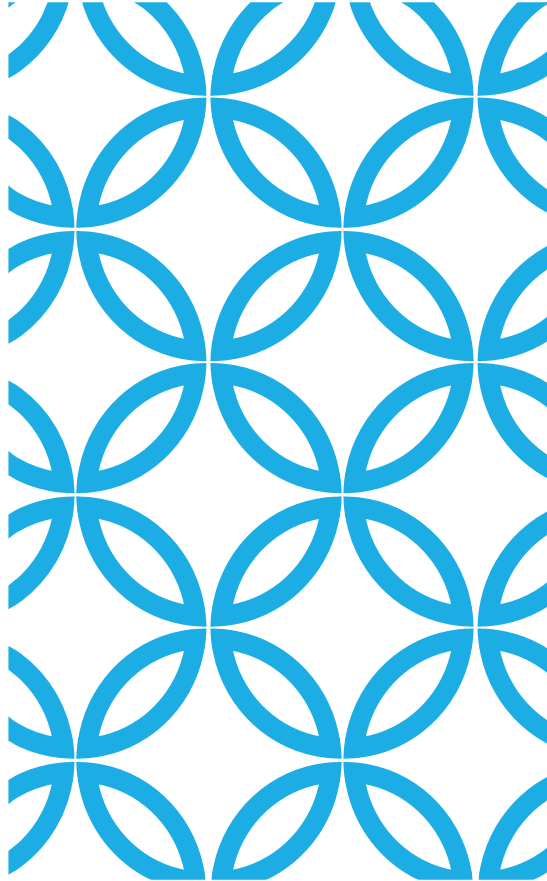
- “You know, when people are as upset as you seem to be, they sometimes wish they were dead. I’m wondering if you’re feeling that way, too?”
  - “You seem really upset; I wonder if you’re thinking about suicide?”
  - “Are you thinking about killing yourself?”
- \* Note: If you cannot ask the question, find someone who can!



## Q: QUESTION

### How NOT to ask the suicide question:

- “You’re not thinking of killing yourself, are you?”
- “You wouldn’t do anything stupid would you?”
- “Suicide is a dumb idea. Surely, you’re not thinking about suicide?”



## KEY POINT!

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If someone says they are suicidal, NEVER leave them alone!



## P:PERSUADE

### How to Persuade someone to stay alive

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

## P: PERSUADE

### **Then Ask:**

- “Will you go with me to get help?”
- “Will you let me help you get help?”
- “Will you promise me not to kill yourself until we’ve found some help?”

YOUR WILLINGNESS TO LISTEN AND TO HELP  
CAN REKINDLE HOPE AND MAKE ALL THE  
DIFFERENCE.

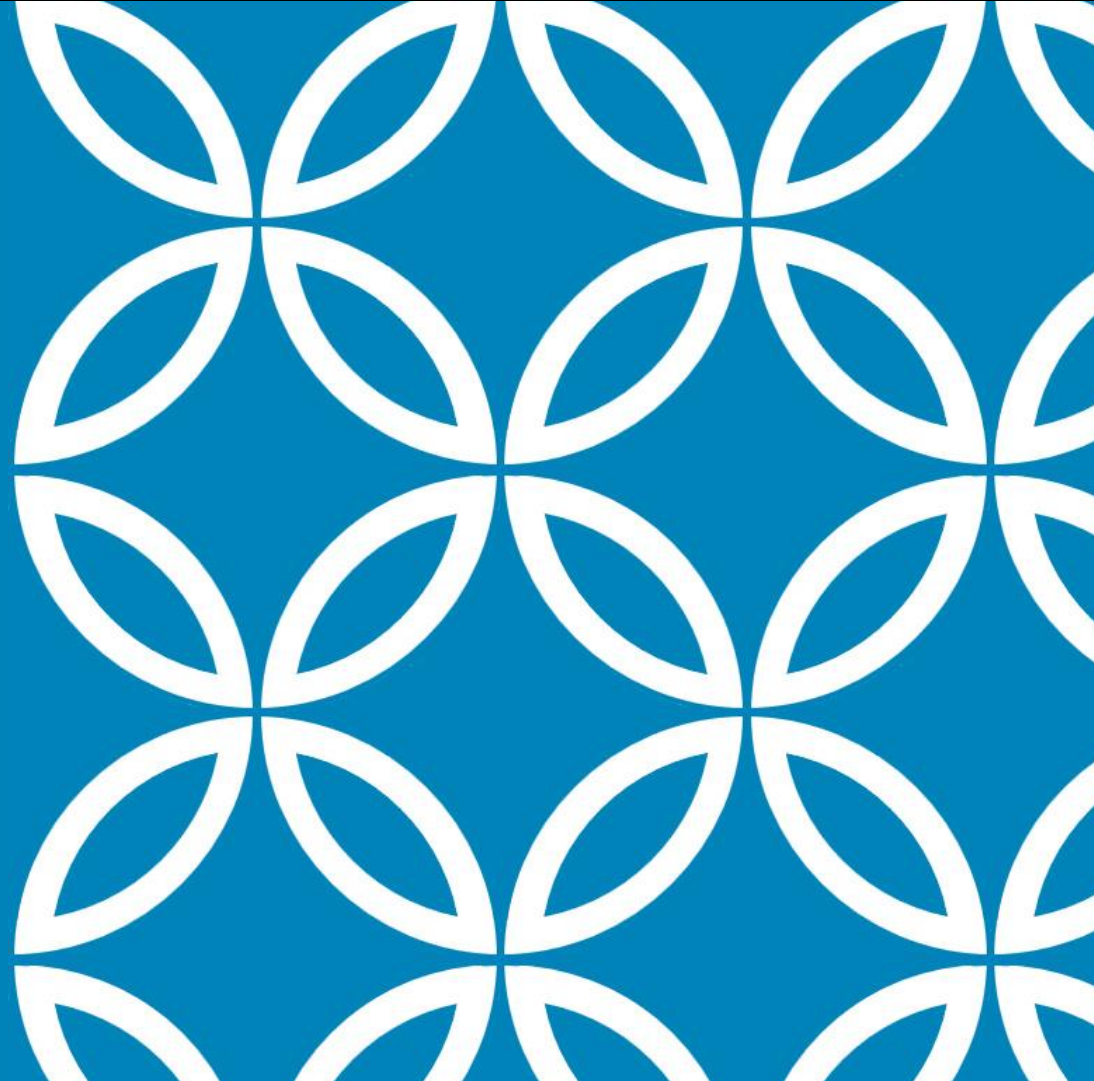
## R: REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

## REMEMBER

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Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.



## FOR EFFECTIVE QPR

Say: “I want you to live,” or “I’m on your side...we’ll get through this.”

Get Others Involved. Ask the person who else might help.  
Family? Friends? Brothers?  
Sisters? Pastors? Priest? Rabbi?  
Bishop? Physician?

## FOR EFFECTIVE QPR (CONT)

Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.

Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

# REMEMBER

**WHEN YOU APPLY QPR, YOU PLANT THE  
SEEDS OF HOPE. HOPE HELPS PREVENT  
SUICIDE.**



## RESOURCES:

National Suicide Prevention Lifeline: 1-800-273-TALK

Text Line: 741741

[suicidepreventionlifeline.org](https://suicidepreventionlifeline.org)

Trevor Project (LGBTQ) <https://thetrevorproject.org>

Hey Sam – Youth – 24years of age. Peer Support Text  
Line 9am-9pm 1-877-832-0890

# Wall of Resistance to Suicide

## *Protective Factors*

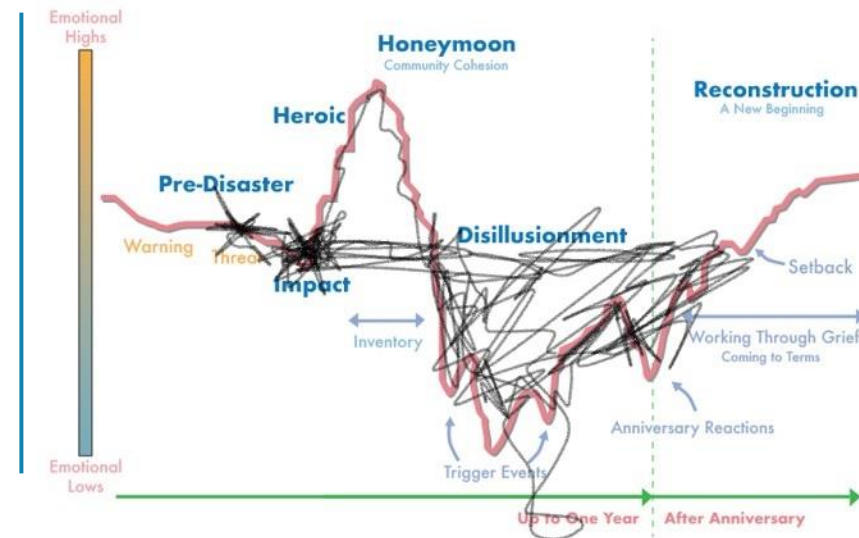
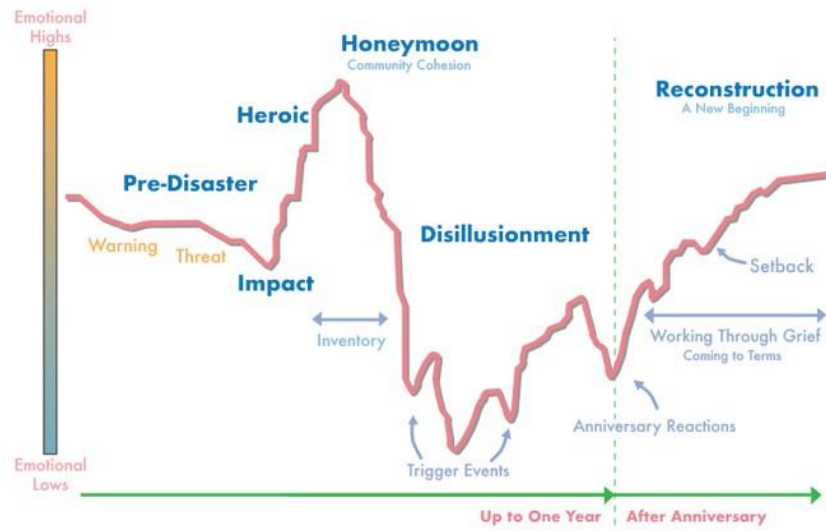
COUNSELOR / THERAPIST	DUTY TO OTHERS	GATEKEEPER AVAILABLE	
GOOD HEALTH	MEDICATION COMPLIANCE	SUPPORT OF SIGNIFICANT OTHER(S)	
JOB SECURITY / JOB SKILLS	RESPONSIBILITY FOR CHILDREN	FEAR	
DIFFICULT ACCESS	A SENSE OF HOPE	POSITIVE SELF-ESTEEM	
PET(S)	RELIGIOUS PROHIBITION	CALM ENVIRONMENT	AA or NA
BEST FRIENDS	SAFETY AGREEMENT	TREATMENT AVAILABILITY	
SOBRIETY			

## SELF CARE AS A NECESSITY

Interacting with someone who is potential experiencing suicidal intensity can be frightening, frustrating, exhausting and very sad.

It is extremely important that you create your own support system.

And pay special attention to your body and personal needs. Exercise, healthy eating & social connection



COVID 19

Community/Global Soul  
Exhaustion

# SOUL CARE

Culture

Art

Nature

Meaning

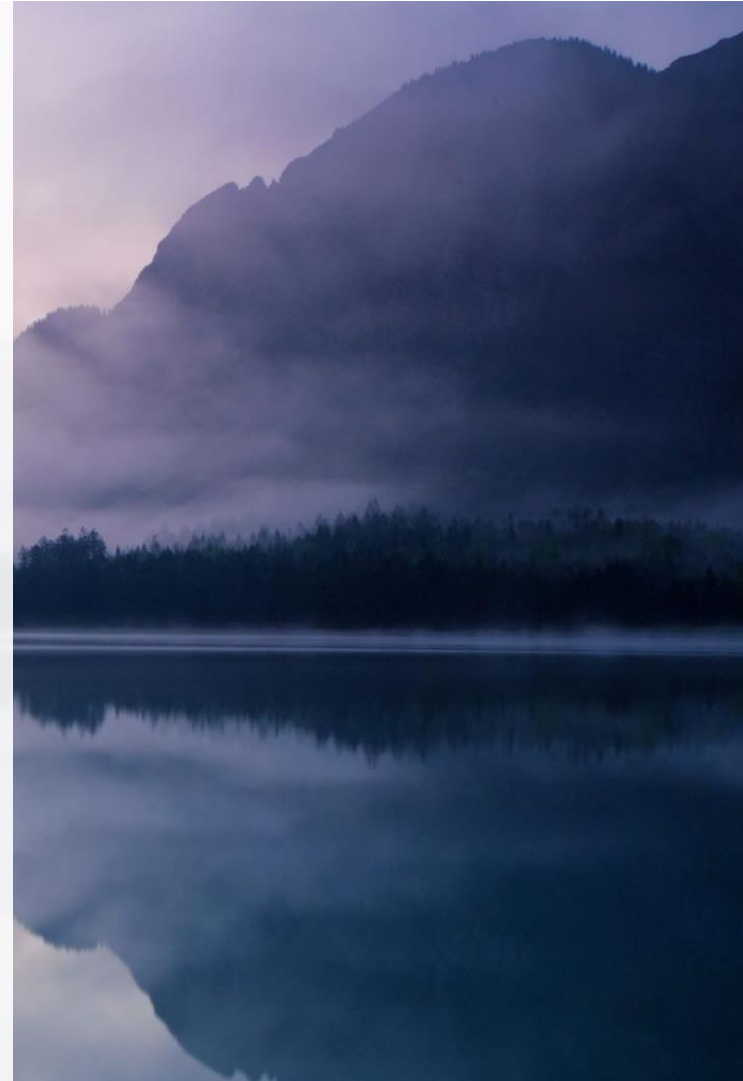
Joy

Friendship

Creativity

Self-  
expression

Spirituality



Twitter: @SarahGaer

Facebook: Sarah Gaer

LinkedIn: Sarah Gaer

Email: [Sarahgaer@gmail.com](mailto:Sarahgaer@gmail.com)

Books – available on Amazon

**Suicide Prevention &  
Postvention:**

The Price

Guts, Grit & The Grind – Series  
1-4

**Adverse Childhood  
Experiences Children's Book:**  
Good Night Grace



*SarahGaer.com*

# QUESTIONS



# Presentation #2

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9:30am- 10:00am

## **Youth in Crisis**

Hallie-Beth Hollister – MCI Program Manager

Danielle McBain, Senior Family Partner

Behavioral Health Network, Inc

# YMCI & CIT

Youth Mobile Crisis Intervention

# AGENDA

Overview

Staff at YMCI

Approaches

Spectrum of Youth Levels of Care

Contact Information

# OVERVIEW

Community Behavioral Health Center (CBHC) is the umbrella over urgent access and crisis teams in Massachusetts; 25 launched as of 2023

Crisis is now referred to as MCI (Mobile Crisis Intervention) that is broken into 2 teams - Youth MCI (YMCI) and Adult MCI (AMCI)

YMCI works with individuals 20 and under; no matter the insurance (or lack thereof). AMCI can work with 18-20 as well due to them being in a transitional age group

Mobile team- go to homes, provider offices, schools, etc.

At BHN, can be seen at 417 Liberty St. Springfield, MA and 77 Mill St. Westfield, MA. as well

## STAFF AT YMCI

YMCI Clinician	Family Partner	YMCI Mentor	Youth Services Coordinator
<ul style="list-style-type: none"> <li>-Dispatches to assessments in a team</li> <li>-Determines disposition and next steps for the youth/caregiver and family</li> <li>-Up-to-date on services available for youth to offer</li> </ul>	<ul style="list-style-type: none"> <li>-Dispatches to assessments with YMCI Clinicians and supports caregiver</li> <li>-Follow-ups with caregiver, supporting, empowering, and connecting caregiver with their own providers</li> <li>-Can dispatch to assist caregivers in crisis situations with youth in place of assessments (when appropriate)</li> </ul>	<ul style="list-style-type: none"> <li>-Dispatches to assessments with YMCI Clinicians and supports youth</li> <li>-Can dispatch to crisis situations for youth in place of assessments (as appropriate)</li> <li>-Follow-ups with youth to assist with skills and techniques</li> </ul>	<ul style="list-style-type: none"> <li>-Completes referrals</li> <li>-Connects with providers, including schools</li> <li>-Assisting in connecting providers with providers, creating communication and meetings</li> <li>-Up-to-date on providers and waitlists</li> </ul>



Assessments

Team approach that responds to a crisis situation, discusses presenting and precipitating events, and determines disposition through risk and protective factors.

Some risk and protective factors looked at include:

Risk	Protective
Suicidal Ideation (SI)	Family/Natural Supports
Self-Injurious Behaviors (Bx)	Providers
History of SI/attempts	Positive Coping Skills
Homicidal Ideation (HI)	Future Oriented/Goals
Aggressive/assaultive Bx	Core values/beliefs
History of HI/Assaults	Ambivalence towards dying
Hallucinations	Help-seeking
Other	Other

Support

- Following assessment, team can conduct follow-ups for 7 days; can be done in-person, telehealth, or via phone
- Family Partners and YMCI Mentors support and connect in the community with youth/caregiver
- Youth Services Coordinator can connect with school/providers and put in referrals for providers



## COMMUNITY APPROACH

Goal of crisis is to ensure safety and assist in keeping youth in the community

- Recidivism rate higher after being placed at a higher level of care
- Possible trauma from going to a higher level of care
- Long-term benefit of working with youth in their natural setting with community supports

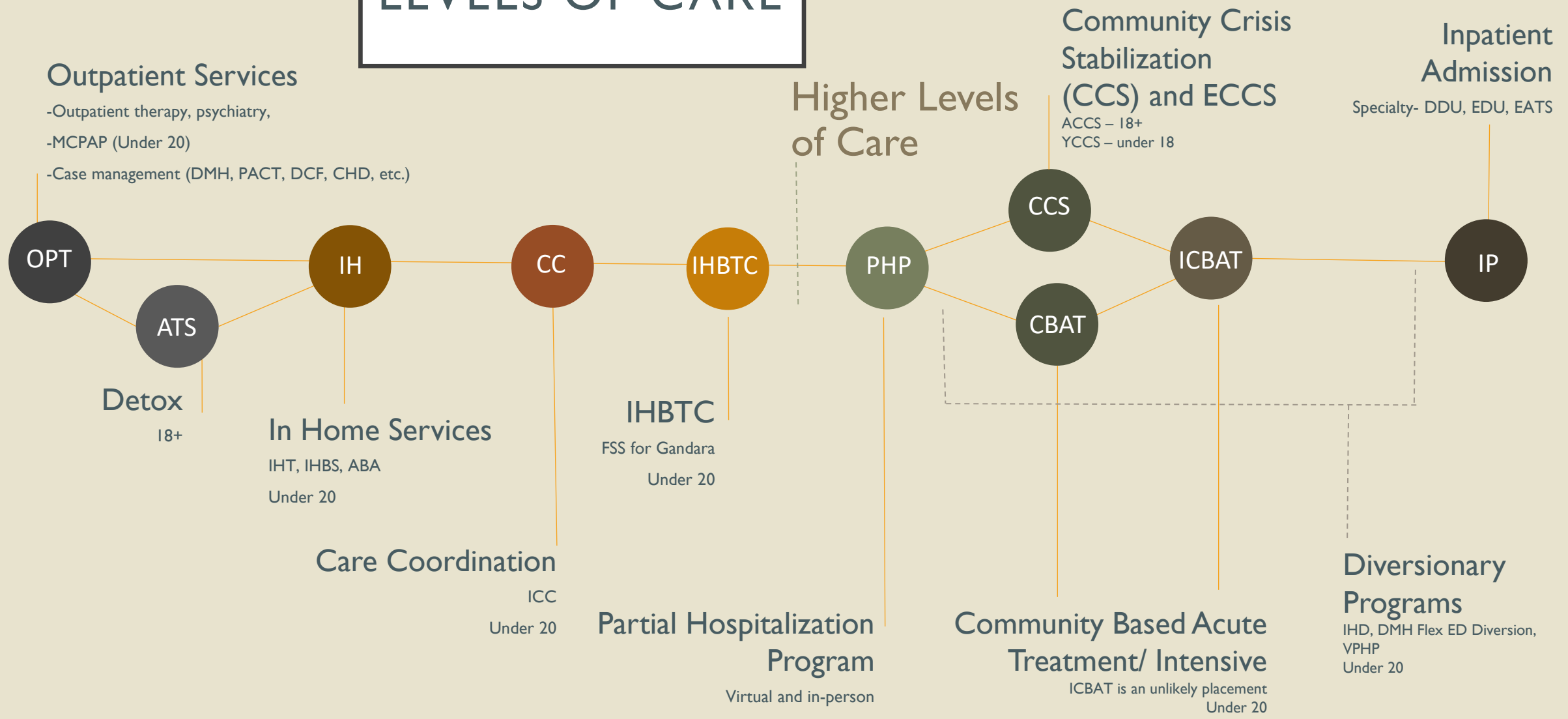
Push for an overall community approach and avoid Emergency Departments (ED)

- Possible trauma from being in the ED
- Separate ED crisis team – possibility of discharge with no follow-ups and no community supports
  - If it is safe to do so, do **not** send youth to the ED and instead have crisis respond to enable continued work with the family in the community during their crisis

What can we do?

- Work with diversion programs
- Continue to increase follow-ups from our crisis team
- Police drop-off at crisis site
- Utilize crisis mobile response rather than ambulance to the ED
  - Coming onsite or having us come to the location (home, provider office, etc.)

# LEVELS OF CARE



# THANK YOU

Ziana Dillon, YMCI Team Lead – [Ziana.Dillon@bhninc.org](mailto:Ziana.Dillon@bhninc.org); 413-218-5845

Danielle McBain, YMCI Senior Family Partner – [Danielle.McBain@bhninc.org](mailto:Danielle.McBain@bhninc.org); 413-657-0534

# Presentation #3

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**10:00am – 11:00am**

**MA Youth Diversion Program - Diversion Learning Lab**

**Jamaal Tartt, MS.**

**Diversion Coordinator - Gandara**

# MA Youth Diversion Program Diversion Learning Lab



**Gándara Center**  
*Culturally Sensitive Care*



# AGENDA

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Welcome & Introductions

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Program Development History

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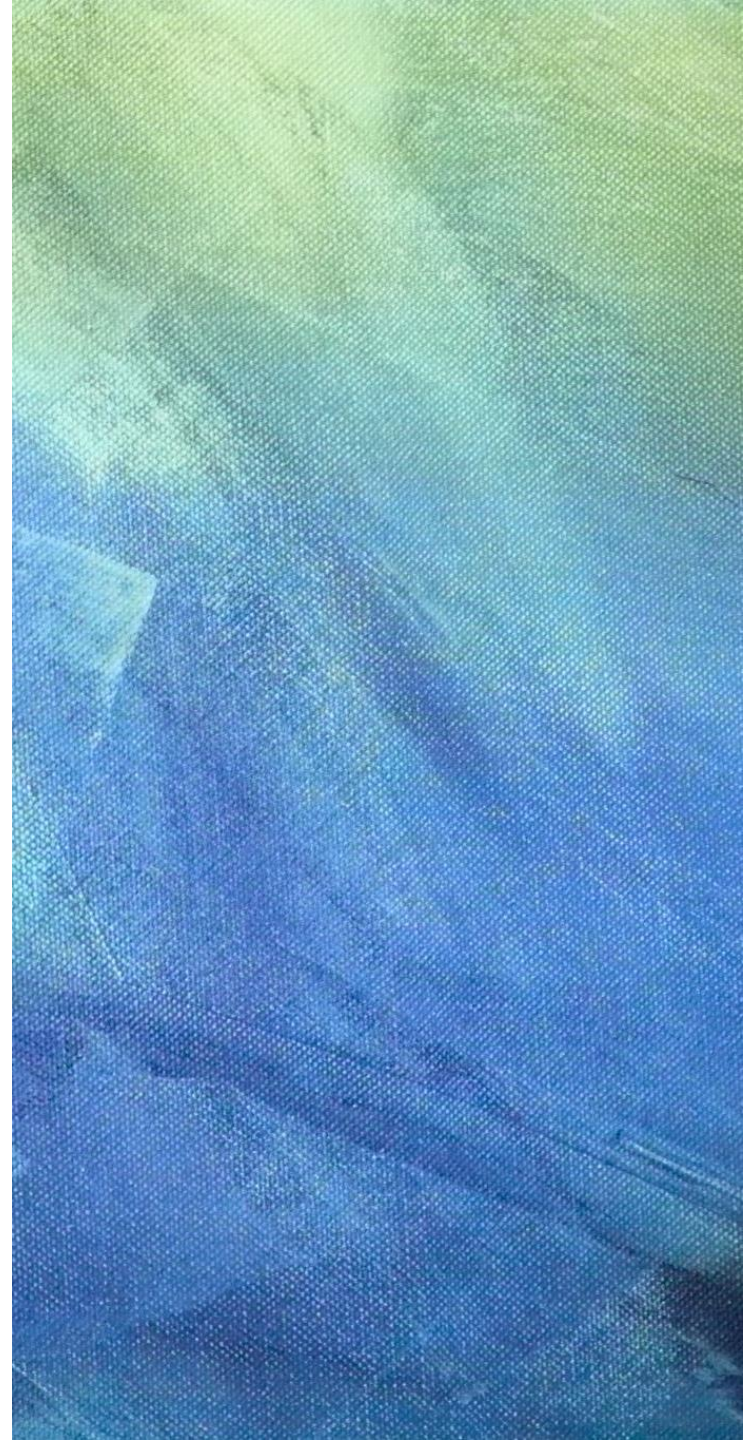
MYDP Goals and Process

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Referrals

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Q&A



# MYDP

- The 2019 legislative report recommended the state launch a *statewide diversion learning lab* across three pilot sites, with the goals of:

The 2019 legislative report recommended the state launch a *statewide diversion learning lab* across three pilot sites, with the goals of:

- Improving communication and coordination of diversion across the state;

- Improving the quality and consistency of diversion work by developing common infrastructure, policies and procedures; and

- Testing and refining the statewide diversion model.

**DIVERSION  
LEARNING LAB  
SITES**

NFI Middlesex  
County

FSMV Essex county

Family Continuity  
Worcester County

Gandara Center  
Hampden

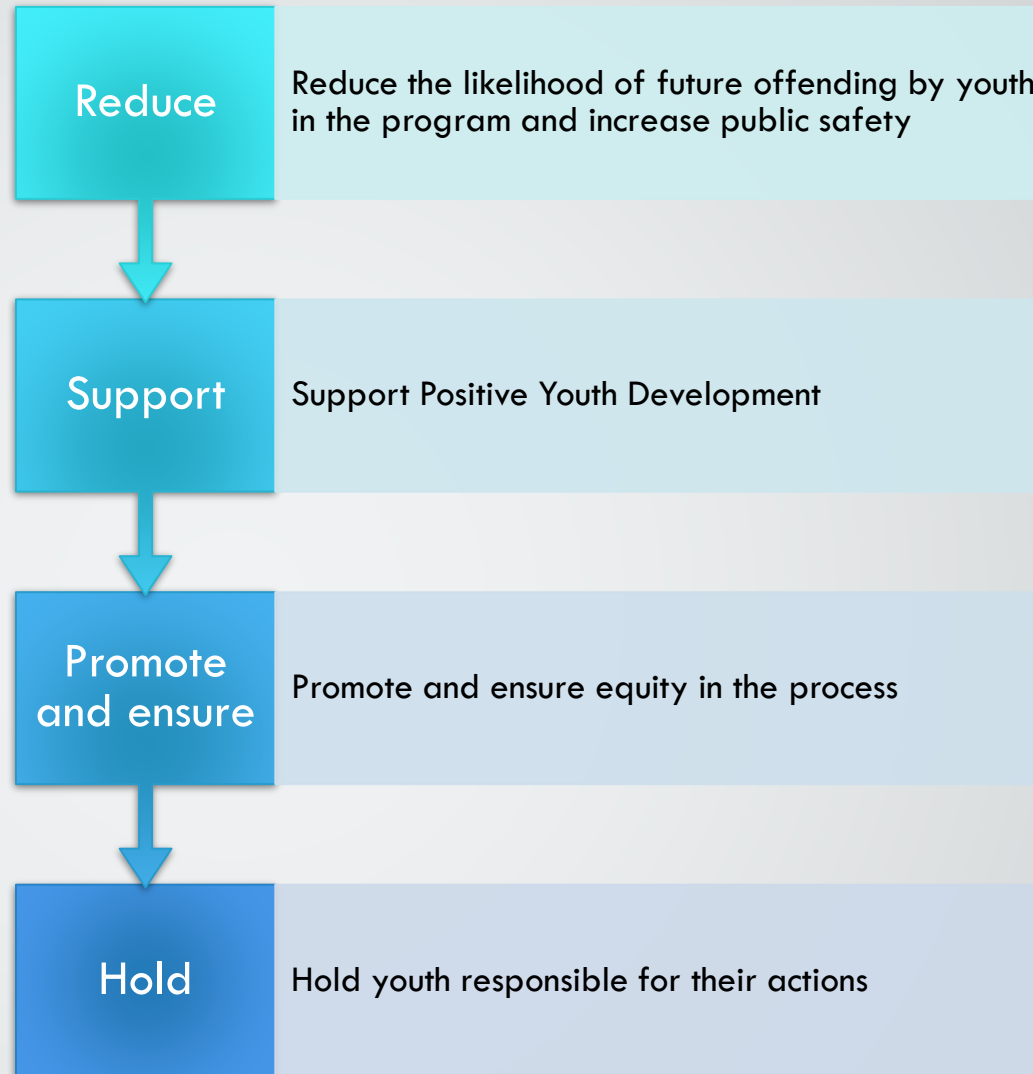
Old Colony YMCA  
Plymouth



# **MYDP GOALS & PROCESS**

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## PROGRAM GOALS



# Who are *Referrers* & Who Should They Refer?

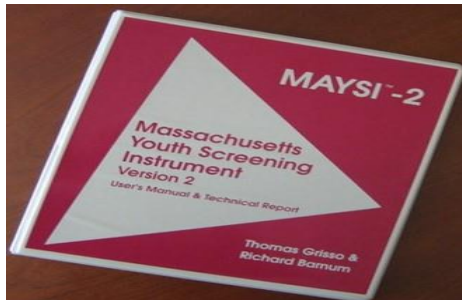
- **Police, Clerk Magistrates, District Attorneys & Judges** each can refer youth to the Learning Lab in their jurisdiction.
- Youth can be referred for **any juvenile delinquency case the referrer considers appropriate**, *in accordance with any legal limitations or requirements, including M.G.L. c.119 § 54A*
- Referrers are strongly urged to **refer lower-level** offenses, as well as any cases where a youth's **unmet needs** may be driving the delinquent behavior (e.g. behavioral health, educational supports, etc.)

# INTAKE PROCESS

**YLS/CMI Screener & MAYSI-2** (evidence-based tools –)

**Interviews** with youth & guardian/caregiver

Coordinators and youth **build a diversion agreement and case plan**



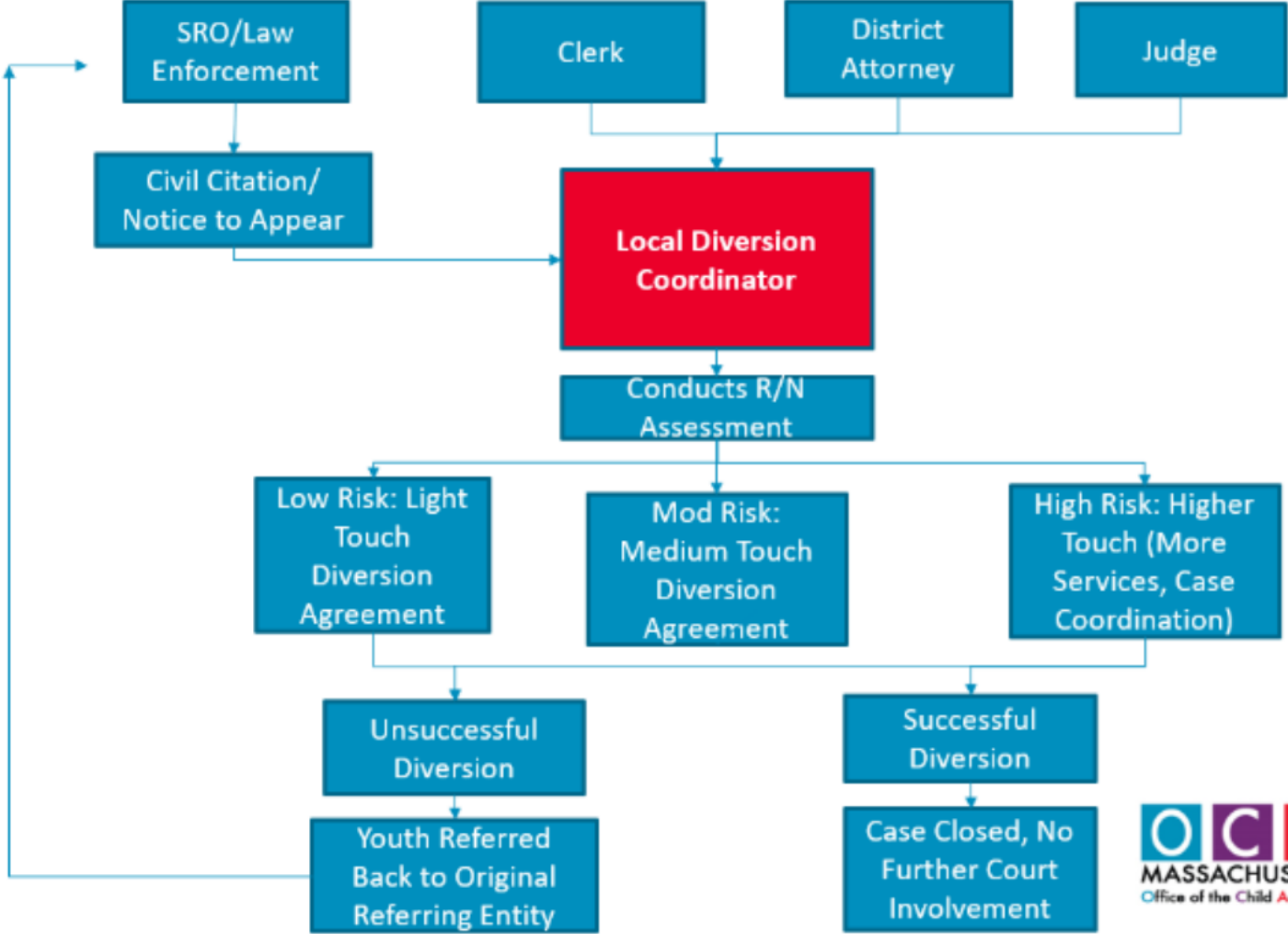
**Mental  
Health  
Screening**

**YLS/CMI:SRV Need**

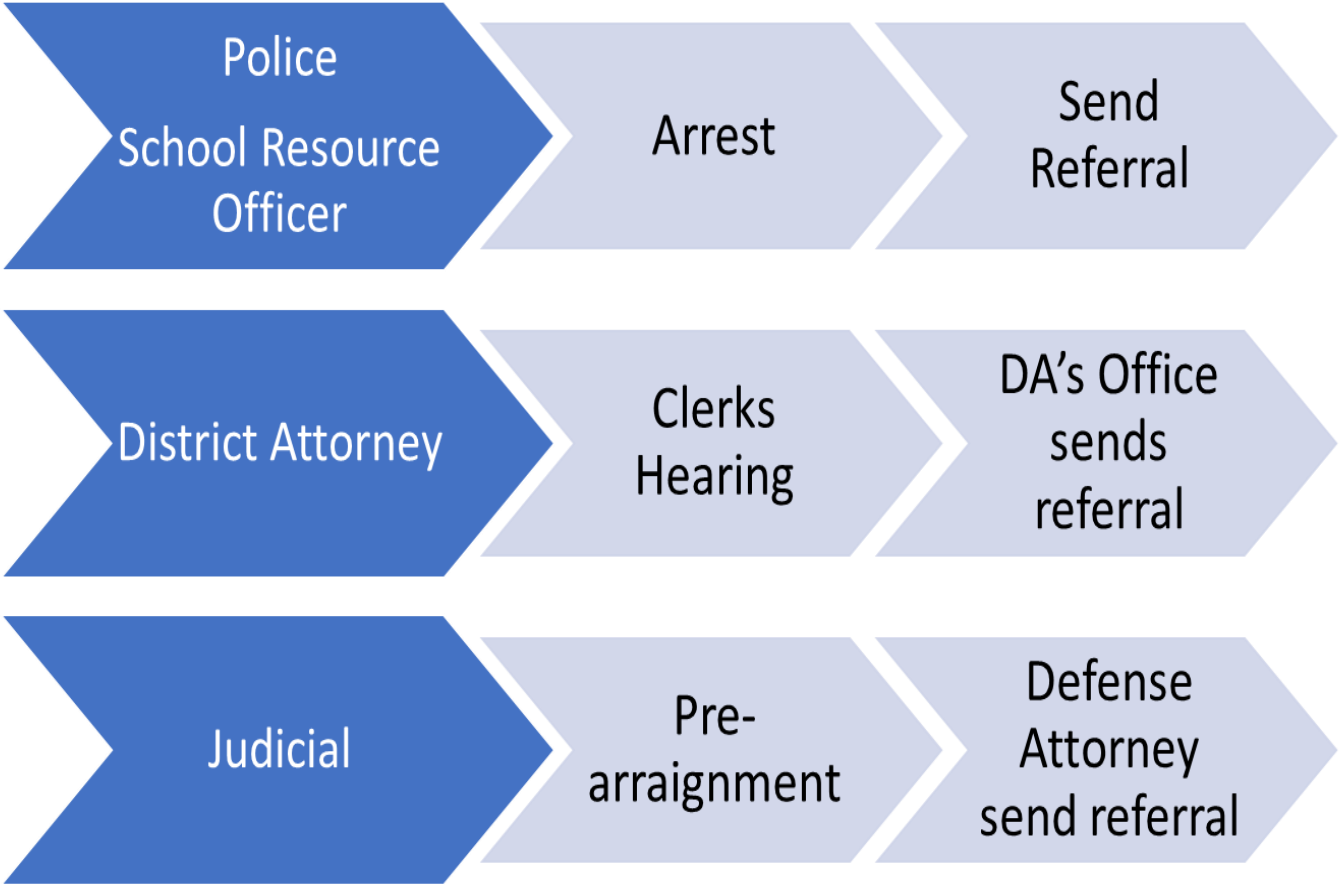
**Areas:**

- Family Circumstances/Parenting
- School/Employment
- Peer Relations
- Substance Abuse

Decision-makers would have option to refer youth to local Diversion Coordinator rather than proceeding further in process



# MYDP REFERRAL PROCESS



## Referral for Police, Clerks, District Attorneys, Judges

Police, Clerk Magistrates, District Attorneys, and Judges can refer youth to Massachusetts' Youth Diversion Program by securely sending this completed form (to the best of their ability) by email to the Diversion Coordinator.

*Refers can divert any youth they think would benefit from the program and that they are legally allowed to divert. Referrers are strongly encouraged to divert the following youth in particular: youth with first offenses, youth with low level offenses, youth with higher needs and/or complex cases whose unmet needs might be driving delinquent behavior.*

### Youth Contact Information

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_

Gender at Birth: \_\_\_\_\_ Identifying Gender: \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_ Language preferred: \_\_\_\_\_ DOB: \_\_\_\_\_

### Parent/Guardian Contact Information

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_

Does this person have physical and/or legal custody?  Yes  No

### Referral Contact Information

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

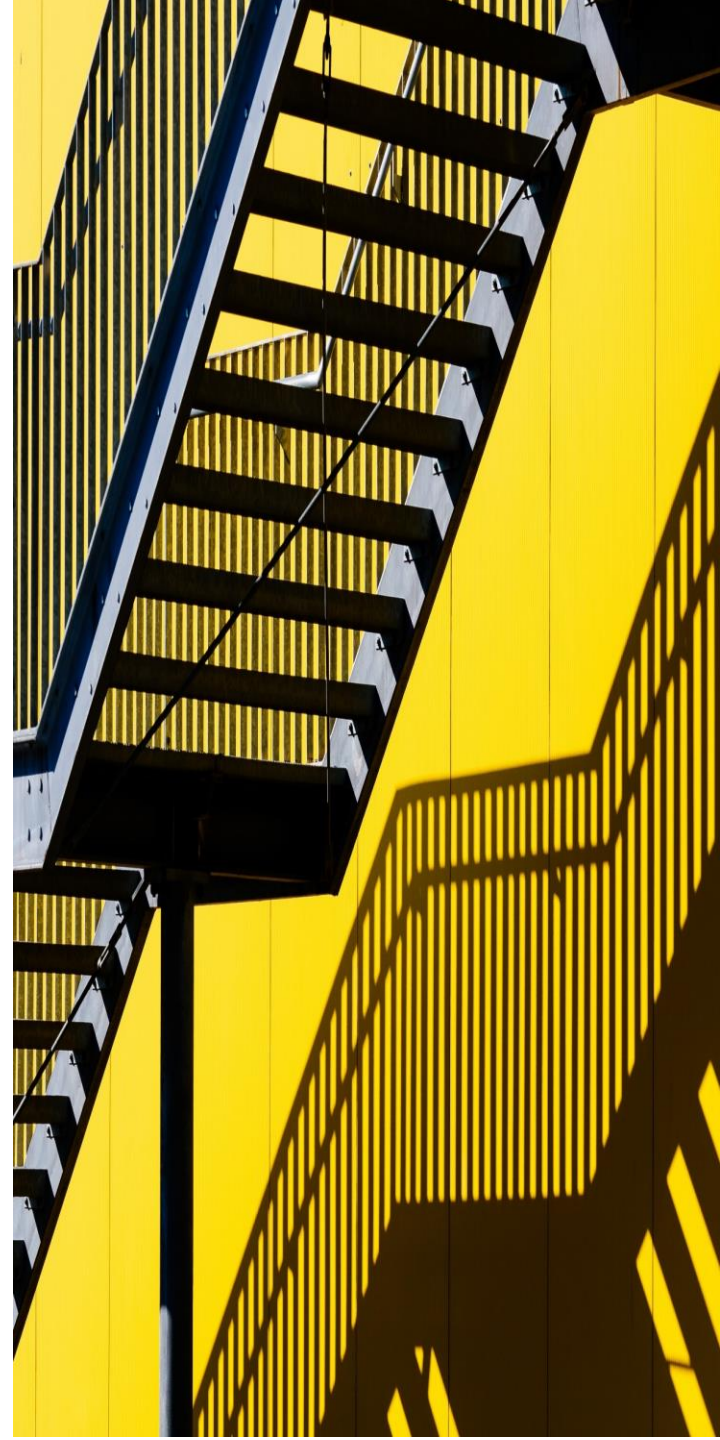
E-mail Address: \_\_\_\_\_ Agency/Department: \_\_\_\_\_

Referrer Role: Police Officer  Clerk Magistrate  (Assistant) District Attorney  Judicial

(check one)

# REFERRAL FORM

What to Expect after Referral





ONGOING  
MONITORING &  
ACTIVE CASE  
MANAGEMENT

**Connect** youth with local services based on need

Work with youth & families to **address challenges and barriers to success**

**Incidental money has been budgeted** to cover bus passes or any other barriers to services, etc.

Youth's without health insurance- will be serviced by community partners, or in house. **Health insurance is not needed for our programming.**



## DIVERSION COMPLETION

Youth who are **making progress/complete agreement requirements** are successful

Youth who are **not making progress or are re-arrested** are referred back to the original referrer for decision about how to proceed

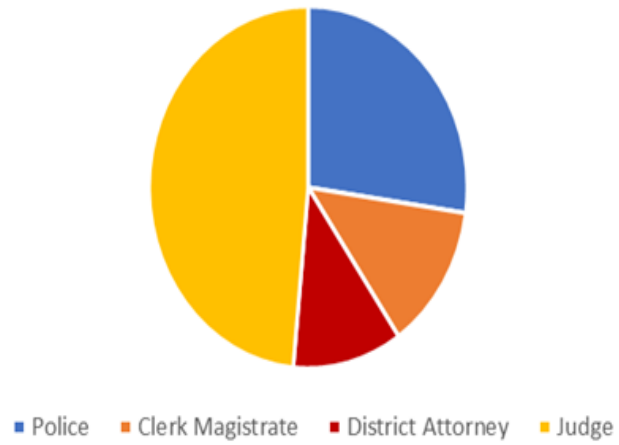
**Communication** with original referrer regarding the success of youth

## AN EXAMPLE.....

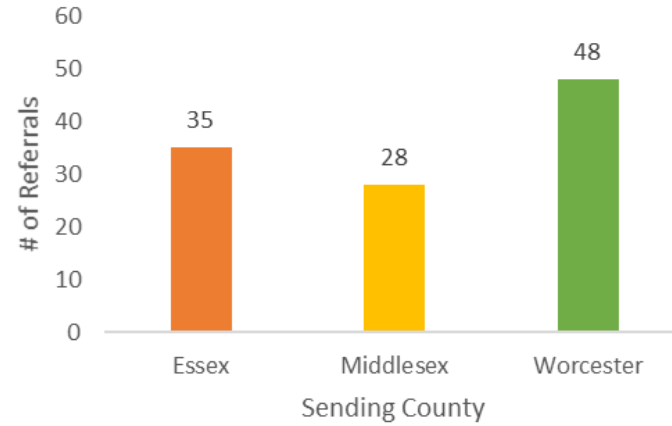
A Youth was diverted on Assault and Battery charges by the court. The Youth was assessed and needed support in Personality/ Behavior. The young person that rarely left her home and struggled to complete basic care for herself. She had a diagnosis of Depression but was not participating in therapy. With the work of her Diversion Coordinator, she began going outside and taking walks. She agreed to go to the Registry of Motor Vehicles with much cajoling from her coordinator. She obtained her identification in pursuit of applying for MassHealth Services. She was able to apply for healthcare and is seeking support in other areas. She has built connections at the FRC that she can utilize after her Diversion plan is completed.

# DATA

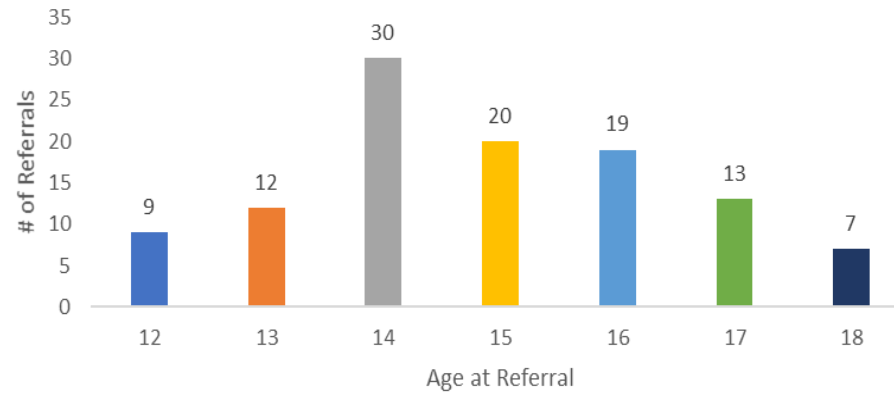
Referrals by Referral Point  
(All-Time)



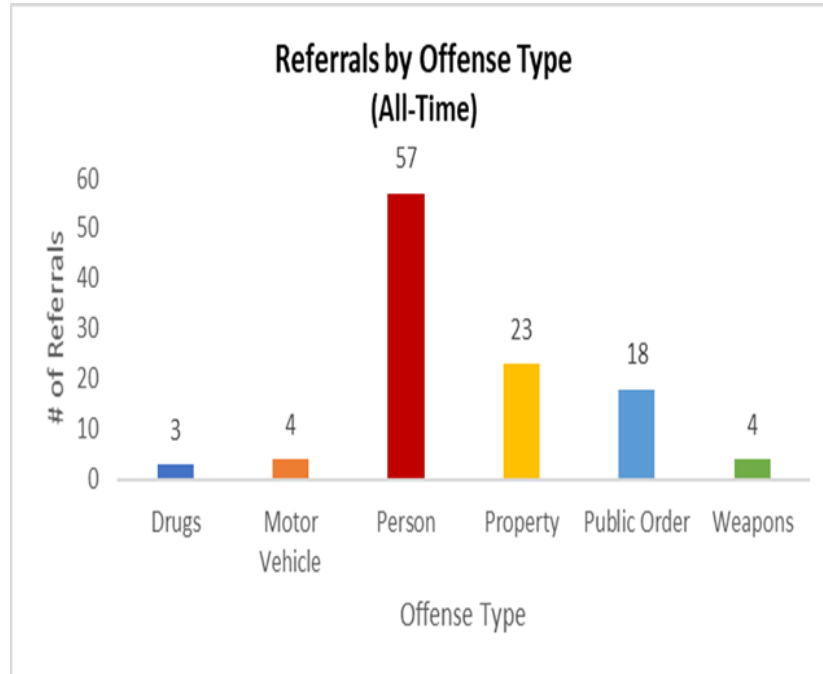
Referrals by Sending County  
(All-Time)



Referrals by Age at Referral  
(All-Time)



# COMMON CHARGES



## Appendix D – Youth ineligible for diversion under M.G.L.

Ineligible Judicial Diversion:

A child otherwise eligible for diversion pursuant to this section shall not be eligible for diversion if the child is indicted as a youthful offender

or if the child is charged with a violation of 1 or more of the offenses enumerated in the second sentence of section 70C of chapter 277:

chapter 90 § 22F, Habitual Traffic Offender	adoption, guardianship, custody or care; permit; application; bond	chapter 268 § 1, Perjury
chapter 90 § 24, Driving while under influence of intoxicating liquor, etc.; second and subsequent offenses; punishment; treatment programs; reckless and unauthorized driving; failure to stop after collision	chapter 119 § 39, Abandonment of infant under age of ten	chapter 268 § 2, Subornation of perjury
chapter 90 § 24D, Probation of persons convicted of driving under the influence;	chapter 119 § 51A, Reporting of suspected abuse or neglect; mandated reporters	chapter 268 § 3, Attempt to procure another to commit perjury
chapter 90 § 24G, Homicide by motor vehicle; punishment	chapter 119 § 51E, Reports of injured children; files; confidentiality; penalties	chapter 268 § 6, False reports or testimony before state departments, board or commissioner; false entries in company books or statements; aiders or abettors
chapter 90 § 24L, Serious bodily injury by motor vehicle while under influence of intoxicating substance	chapter 119 § 51F, Central registry of information; confidentiality; penalties	chapter 268 § 6A, False written reports by public officers or employees
chapter 90 § 24N, Suspension of operator's license upon issuance of complaint	chapter 119 § 55, Delinquent children; summoning of parent or guardian	chapter 268 § 6B, Process servers; false statements; penalty
chapter 90B § sections 8, Operation while under influence of intoxicating liquor or narcotics, etc.; breath or blood testing; water skiing	chapter 119 § 63, Inducing or abetting delinquency of child	chapter 268 § 8B, Compulsion or coercion to refuse appointment or promotion
chapter 90B § 8A, Operation of a vessel while under the influence of controlled substances causing serious bodily injury	chapter 119 § 63A, Delinquent children; aiding and abetting violation of juvenile court order; concealing or harboring child	chapter 268 § 13, Corrupting or attempting to corrupt masters, auditors, jurors, arbitrators, umpires or referees
chapter 90B § 8B, Operation of a vessel under the influence of a controlled substance causing death	chapter 119A, CHILD SUPPORT ENFORCEMENT	chapter 268 § 13A, Picketing court, judge, juror, witness or court officer
chapter 119 § 34, Transportation of children in patrol wagons	chapter 209, HUSBAND AND WIFE	chapter 268 § 13B, Intimidation of witnesses, jurors and persons furnishing information in connection with criminal proceedings
chapter 119 § 36, Bringing child into commonwealth with view to	chapter 209A, ABUSE PREVENTION	chapter 268 § 13C, Disruption of court proceedings
	chapter 265, CRIMES AGAINST THE PERSON	chapter 268 § 14, Receipt of gift by juror, arbitrator, umpire, referee, master or auditor
	chapter 266 § 25, Larceny by stealing; punishment; victim sixty-five or older; minimum sentence for repeat offenders	



# DYS VICTIM WITNESS UNIT

- Consultation
- Contact Victim
- Inform of rights
- Restorative Justice

# INFORMATION SHARING & CONFIDENTIALITY

## When Can Personal Information Be Shared?

- 1) To Coordinate Services and Treatment with an External Partner
  - 2) To Communicate with Referrers About the Status of the Case
  - 3) In Response to Requests from Potential Referrers regarding a Youth's Previous Participation in Diversion
  - 4) To Protect the Safety of the Youth and/or the Community:
- ✓ *If youth/family reveal any information about the offense they have been accused of – including accepting responsibility – will not be held against them in future legal/disciplinary proceedings*
  - ✓ *Additionally, personal information obtained throughout the diversion program will not be used against the youth in other delinquent and criminal matters.*



## **GÁNDARA CENTER SERVICES**

Substance Use & Recovery Services

Outpatient & Inpatient Services

Community & Prevention

Juvenile Detention Alternatives Initiative  
Meeting (JDAI)

Family Resource Center Of Springfield  
& Holyoke

And More....

# Contact Information

- **Local Pilot Site:**

Gándara Center

152 Center Street, Chicopee, Ma 01013

**Contact Person:**

Jamaal Tartt

Diversion Coordinator

Email: [jtartt@gandaracenter.org](mailto:jtartt@gandaracenter.org)

Phone: 860-573-9698



*Questions or  
Comments?*



# Presentation # 4

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11:00am-12:00pm

**Runaway Assistance Program, Children & Families**

Fran Cameron

&

Jean Rogers

Center for Human Development

# Families & Crises



# What you hear from parents--- This Kid--

“Won’t take their meds!”

“Always threatens to run away”

“Won’t listen, Rude, Swears at me!”

“Won’t stop fighting with little sister”

“Stays out till all hours with who  
knows who”



# What you hear from youth

“They hate all my friends and never let me do anything with anyone”

“my mom treats me like I’m 5”

“All the other kids get treated better, why should I be locked in 24/7?”

# Can you arrest? NO!



- Youth in the home or just back from being gone are NOT on the run, officers can NOT remove from home.
- Youth can not be removed for being “defiant or difficult”.
- Not taking meds, acting like a teen or breaking curfew are not criminal offenses.
- CRA warrant is a call to court, NOT arrest

**HOWEVER....**

## You can still offer help:

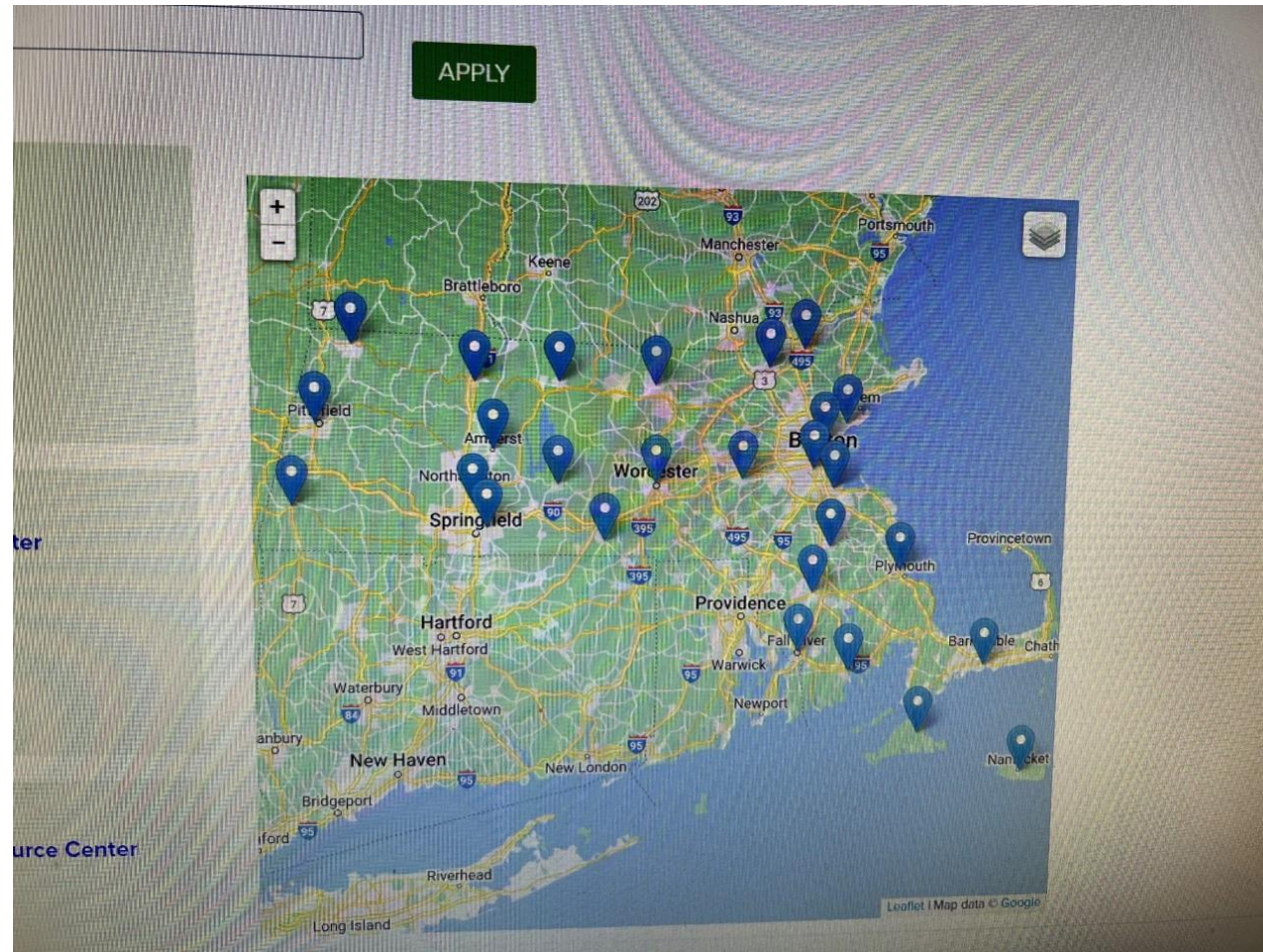
- If a parent is concerned about mental health, the crisis team (EMH) is more appropriate than police response. Mobile crisis will go to family, ER or site open 24/7.
- Anyone can call 211 at any time in 140 languages for referrals to counseling, detox, and other family issues.
- Parent/guardian can go to Juvenile court when open to consult on a CRA petition.
- Parent/youth can contact Safety Zone for community based support services.
- Parent/guardian can call DCF and sign up for services. 1-800-792-5200.



# 211 and Family Resource Centers

- Ma211 is the family 911.
- 211 can be called from any phone in Commonwealth, 24/7 and in 140 languages
- Family Resource Centers (FRCs) are locations that provide community connections, support and problem solving to anyone in their area.
- FRCs have access to everything from bus passes to fuel assistance signups to parenting groups to school uniforms and food handouts.

# FRCMA.org





- Talking to distressed families takes time, so encourage all parties to breathe. Remember, this issue has likely been simmering long before the 911 call and won't be rectified in 5 minutes.
- Having handouts for 211, Safety Zone, Crisis team or Family Resource Centers seems small, but has impact
- You may be at a home several times before a family acts on information given.
- In cases of abuse, neglect, exploitation or a refusal to parent, a 51a report IS necessary.

# Tips for Parents/Guardians when filing runaway reports



- Know your child! Who do they hang out with? Where? Which friends drive?
- Have several current photos.
- Keep medication list handy.
- Think in advance if you want the PD to post on social media @ your missing teen.
- Have a plan for youth's return. Alternate family member/friend to use for a respite.
- What are we missing?

# Community Runaway Youth

- Definition: Youth not currently open with DCF or DYS with an active missing person/runaway report

## Steps:

1. Contact guardian and attempt to return to family.
2. If unsuccessful, call 211.
3. 211 will ask a few questions and provide nearest crisis/EMH center.
4. Drive youth to crisis/EMH center, introduce youth to staff.
5. Say goodbye and go. Simple, easy and quick!

# What happens with these youth?

- Youth who are brought to crisis/EMH are seen by a clinician to screen for hospitalization or respite. If not hospital level of care....
- Clinician & youth meets with CHD worker to review situation and brainstorm
- CHD worker identifies foster home/group home and transports youth there and to court in AM.
- Youth meets with court staff and attorney.
- Attempts are made at each step to release to family with community based services. Fail? DCF steps in.

# SAFETY ZONE

## 14 to 17 years old



- Self Referral
- 24/7 Support
- Free
- Confidential
- Stabilize family and Youth
- Prevention Services
- Family Support

413-781-6556

## When you find a runaway teen...from DCF

- Call DCF Hotline 1-800-792-5200 to report a youth was found and is ready to be picked up.
- When speaking with DCF, use firm language – this youth is waiting, how long until arrival?
- DCF MUST come for youth in their legal custody OR from ANY placement.
- Group home or foster parent says youth is no longer a client!?

**DCF must come to pick up.**



# Sexual or Employment Exploitation

- If you have ANY suspicions or evidence that a youth has been exploited sexually or on the job, a 51a is required. Call 1- 800-792-5200.
- Say EXPLOITED youth during report.
- You don't have to be certain, suspicions ok.
- DCF has multidisciplinary teams to investigate
- Sexual Exploitation of youth is real & it's here
- Employment exploitation less with teens, but possible. Same reporting process.

# Under Arrest, under 14

- 14-18 under arrest, contact Overnight Arrest – DYS at 617-474-8179
- Youth under 14 can be charged, but not held in secure facilities.
- Not bail eligible, release to family or designated adult with court appearance in AM preferred.
- These situations are challenging and will require multiple calls to DCF, family, Probation.
- CHD will help navigate the process and seek to release or locate safe placement.
- CHD can place in foster home, if non-violent offense.
- Younger youth with violent charges require mental health assessments.

- Best practice for all youth:
  1. Seeking a MH assessment for youth
  2. Involving DCF for a 51a on any parent that refuses to pick up a youth who should be released.
- Call 24/7 to CHD for help in stuck or confusing situations

413-781-6556



One number reaches ALL CHD  
programs

413-781-6556

Call at any time & Share this  
number with families.

We will figure it out!

# Presentation # 5

1:00-2:00pm

**Hampden County Sheriff's Department**

**Karen Donelson, *Forensic Mental Health Clinician***

# HAMPDEN COUNTY SHERIFF'S DEPARTMENT OVERVIEW OF MENTAL HEALTH & PROGRAMS

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*Karen Donelson, Forensic Mental Health Clinician*

# OVERVIEW

- Hampden County sites/counts
  - ESU/MHU/STU
  - Effects of Criminal Justice Reform
  - Specialized Programs at HCSD
  - Stonybrook Stabilization Center (Section 35)
  - Suicide Prevention & Intervention
  - **NEW** HCSD Emotional Support Division
-

# FOUR SECURE SITES OF HCSD

- Main Institution
    - Ludlow MA
  - Women's Correctional Center
    - Chicopee MA (regional jail – from Worcester West)
  - Western Massachusetts Recovery & Wellness Center
    - Springfield MA (Local, DOC step-down & Federal step-down)
  - Stonybrook Stabilization Treatment Center
    - Ludlow MA
-

# OPEN MENTAL HEALTH CASES

*JAILS REALLY ARE THE NEW HOSPITALS...*

Facility	# in Custody	Open w/ MHS	Percentage w/ MHS
Main Instituion	693	433	62.48%
WCC	163	98	60.12%
WMRWC	56	28	50%
SSTC	108	57	52.78%
<b>TOTALS</b>	<b>912</b>	<b>559</b>	<b>61.29%</b>

*\*\*These numbers are a very specific example of why we need Crisis Intervention Teams in our police departments and correctional facilities.\*\**

**Cook County Jail, in Chicago, is the largest single-site jail in the United States. Because so many people with mental illness pass through their custody, Cook County Jail can also be considered the largest mental-health facility in the nation.**

# EVALUATION & STABILIZATION UNIT

- The **ESU** (Evaluation & Stabilization Unit) is a maximum security inpatient treatment unit for individuals living with a mental illness that are in need of further evaluation and stabilization.
- We have one of the 2 ESU's in the state, the other is in Middlesex County.
- This is a regional program and patients can be admitted from the following counties for stabilization then returned to their county:
  - Worcester
  - Hampden
  - Hampshire
  - Berkshire
  - Franklin



This is a 15 bed inpatient unit w/ 2 restraint beds available.  
There are an additional 16 beds on the top-tier to utilize for respites and step-down patients.

# ESU LEVEL SYSTEM & ADMISSIONS

- Level I w/ 1:1 observation
- Level I
- Level II
- Level III
- Step-down
- Respite

## Reasons for Admission:

- Thoughts to harm others or oneself.
- Attempts to harm others or oneself.
- Struggling to manage in current housing unit.
- Increase in symptoms
- Medication evaluations
- Bizarre behavior



# EVALUATION & STABILIZATION PROGRAM

- This is a program that we utilize at WCC and SSTC as there is no specific unit, currently, set aside at these facilities to have an ESU.
  - SSTC does have a MHU and they house ESP clients in the same area as well as 3 other areas if needed.
  - WCC does not have a MHU but does have 2 ESP beds in their STU.
- The ESP program follows the same leveling system that we follow on the ESU.

# MENTAL HEALTH UNIT

- The MHU is a medium security housing unit designed to provide enhanced treatment for individuals living with a mental illness.
- Mental Health Staff utilize, and encourage all staff to utilize, a Trauma Informed approach. With this approach, we treat all individuals with the assumption that they have experienced some type of trauma without needing to know the details of their past.
- A Trauma informed practice is being firm, fair and consistent.

# MENTAL HEALTH UNIT (MI)

- HCSD MHU has the capacity to house 31 inmates with serious and persistent mental illness; usually requiring a DMH level of care.
- These inmates have historically showed struggles with managing in general population.
- Additional mental health staff available, groups being run daily and a correctional caseworker to maintain help with legal issues.
- This unit is run like a general population unit in terms of privileges.



# SECURE TREATMENT UNIT (WCC)

- This unit houses multiple classifications:
    - Protective Custody
    - Discipline (in place of restrictive housing)
    - ESP Admissions (2 beds)
    - RISK (awaiting assessment on suicide precautions)
  - This unit offers additional support and treatment for the women who are housed here.
    - Additionally, this unit houses Federal inmates for up to 90 days for discipline out of FCI Danbury.
-

# CRIMINAL JUSTICE REFORM

- CJR in its entirety is **237** pages long.
  - Enacted into law on April 13, 2018 by Governor Charlie Baker.
  - Most of the changes went into effect on January 1, 2019, other portions became effective in April 2019.
  - Purpose was to create a more modern and fair Criminal Justice System in the Commonwealth.
  - Laws provide for a **strong emphasis on rehabilitation, reintegration, and public safety.**
-

# CRIMINAL JUSTICE REFORM

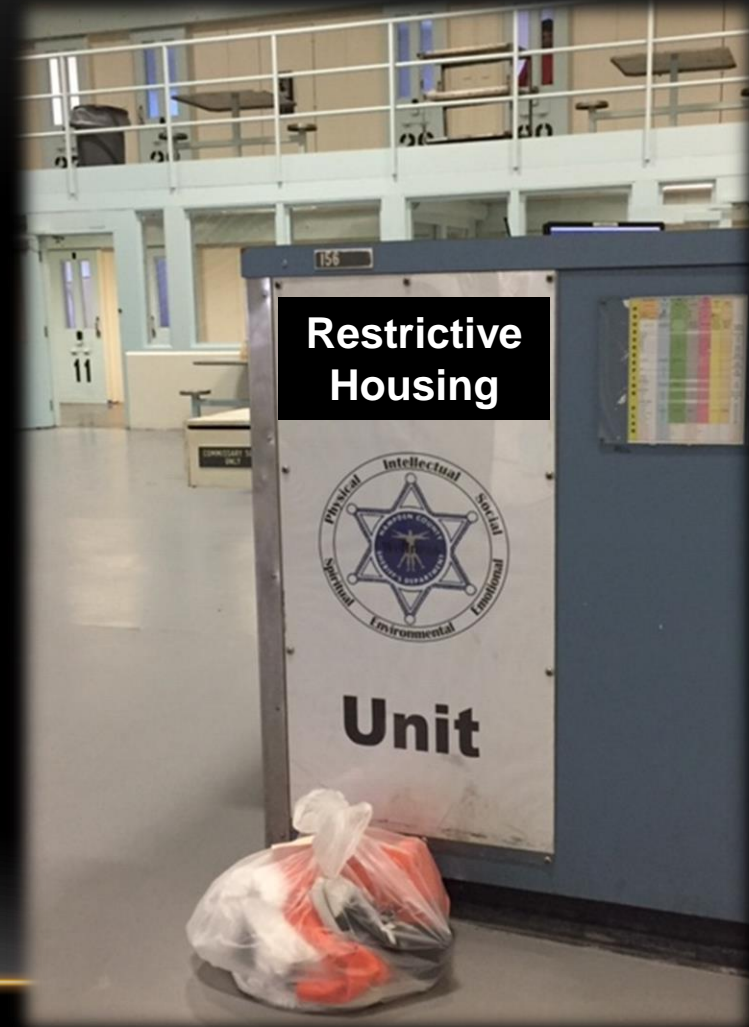
*HOW IT AFFECTED CORRECTIONS FROM MENTAL HEALTH STANDPOINT...*

- Restrictive Housing – Serious Mental Illness
- Transgender Rights
- Youthful Offenders



# CJ Reform – RH – Serious Mental Illness

- All inmates are screened by a qualified Health Professional for **Serious Mental Illness (SMI)**.
- If RH is found to be **clinically contraindicated**, then, based on the qualified Mental Health Professional's clinical judgment, alternate housing would be recommended.
- Mental Health Service staff are utilizing the JMS alert **MHCI** to indicate if there is a contraindication related to moving an inmate to C1/C2 due to Mental Health related issues.



## Restrictive Housing

# CJ Reform – RH – Serious Mental Illness

A **Serious Mental Illness (SMI)** is a current or recent diagnosis by a Qualified Mental Health Professional of one or more of the following disorders:

- (1) schizophrenia and other psychotic disorders;
- (2) major depressive disorders and all types of bipolar disorders;
- (3) a neurodevelopmental disorder, dementia or other cognitive disorder;
- (4) any disorder characterized by breaks with reality or perceptions of reality;
- (5) all types of anxiety, trauma and stressor related disorders;
- (6) severe personality disorders; or,
- (7) a finding by a Qualified Mental Health Professional that the inmate is at **serious risk of substantially deteriorating mentally or emotionally** while confined in Restrictive Housing, or **already has so deteriorated while confined in Restrictive Housing**, such that diversion or removal is deemed to be clinically appropriate by a Qualified Mental Health Professional.

# Restrictive Housing

An inmate with an **SMI must not be** placed in Restrictive Housing unless it is determined that the inmate's retention in general population poses an unacceptable risk:

- (1) to the safety of others;
- (2) of damage or destruction of property; or
- (3) to the operation of the Correctional Facility.

**A Placement Review (MH Certification) must be completed within 72 hrs. if it is determined that an inmate with an SMI is to be placed in RH.**

**The Sheriff or a designee certifies in writing:**

- (1) the reason why the inmate may not be safely held in GP;
- (2) that there is no available placement in an STU or SAU;
- (3) that efforts are being undertaken to find appropriate housing and the status of those efforts; and
- (4) the anticipated time frame for resolution.

The Placement Review must be conducted every 72hrs. thereafter while more appropriate housing can be located.

# Restrictive Housing

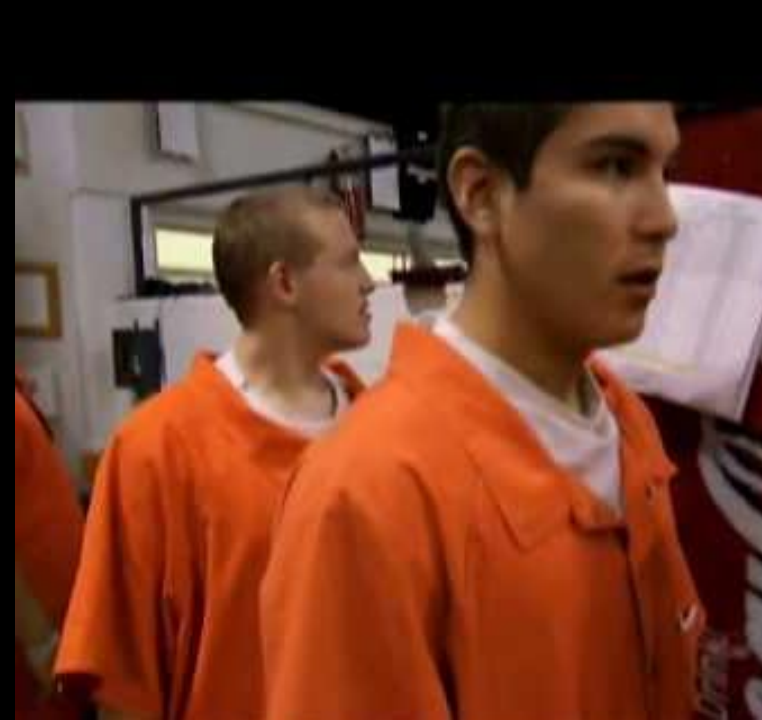
- A Qualified Mental Health Professional **must announce and make daily rounds** in every Restrictive Housing Unit.
- Can conduct out-of-cell meeting with an inmate if, in the clinician's professional judgment, confidentiality is warranted.



# YOUTHFUL OFFENDERS

**Youthful Offender** is a person who is subject to an adult or juvenile sentence for having committed, while between the ages of 14 and 18, an offense against a law of the Commonwealth which, if he were an adult, would be punishable by imprisonment in the State Prison, and:

- (a) Has previously been committed to the Department of Youth Services; or
- (b) Has committed an offense which involves the infliction or threat of serious bodily harm in violation of law.



# YOUTHFUL OFFENDERS

CJR places a priority on Juvenile or Youthful Offender's pathways into the Juvenile Justice System.

## Goal:

To reduce the likelihood of recidivism by addressing the unique issues associated with Juvenile or Youthful Offenders including emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, family violence, household substance abuse, household mental illness, parental absence, and household member incarceration.



# YOUTHFUL OFFENDER UNIT

MAGIC PROGRAM

## Mission

To promote and encourage youth towards their next steps in personal development through a supportive, relational program that helps interrupt beliefs, attitudes, habits, and behaviors supportive of a criminal lifestyle in favor of productive and positive futures.

- **Meaningful**
- **Accomplishments**
- **Gain**
- **Increased**
- **Character**

*“Your thoughts determine your actions.”*

# CRIMINAL JUSTICE REFORM (CJR) LAWS

One positive change to the Criminal Justice Reform Laws is the creation of a Special Committee to study the **Prevention of Suicide among Correction Officers in Correctional Facilities.**



# ALL-INCLUSIVE SUPPORT SERVICES

As an AISS member, the client will be assigned a caseworker.

The caseworker will work with the client to help them meet their goals.

Some of the ways AISS can help the client includes:

- ID and license assistance
- Job search assistance
- Education
- Employment
- Health insurance
- SNAP (Food stamps)
- Housing search assistance
- Accessing substance abuse and mental health treatment
- Counseling
- Meeting requirements for DCF, probation or parole
- Credit and banking assistance
- Sealing criminal record
- Free cell phone (must meet eligibility requirements)



# OUTPATIENT MENTAL HEALTH SERVICES

- Mental Health Clinician work outpatient within the facilities conducting:
  - Emergency assessments
  - Non-emergency assessments
  - Follow-up assessments
  - Treatment Planning
- Each facility is assigned clinicians based on caseload size and acuity:
  - MI – 9 clinicians assigned
  - WCC – 2 clinicians assigned w/ 1 floater
  - WMRWC – 1 floating clinician assigned
  - SSTC – 3 clinicians assigned

# OPIOID TREATMENT PROGRAM & MEDICALLY ASSISTED TREATMENT

- Methadone was delivered to York Street Jail (Springfield, MA) daily via Providence Hospital staff to treat opioid addiction; this practice began in the late 1980's and continued through the early 90's
- Methadone – for pregnant women, 1993
- Buprenorphine – Main Institution, 2007
- Vivitrol – HCSD participated in a study, Project New Hope, with Yale University, 2011
- Vivitrol MAT Pilot – Western Massachusetts Correctional Alcohol Center, Springfield, MA, 2013
- Opioid Treatment Program (OTP), offering Buprenorphine (Subutex), Methadone, and Naltrexone (Vivitrol) – September 1, 2019

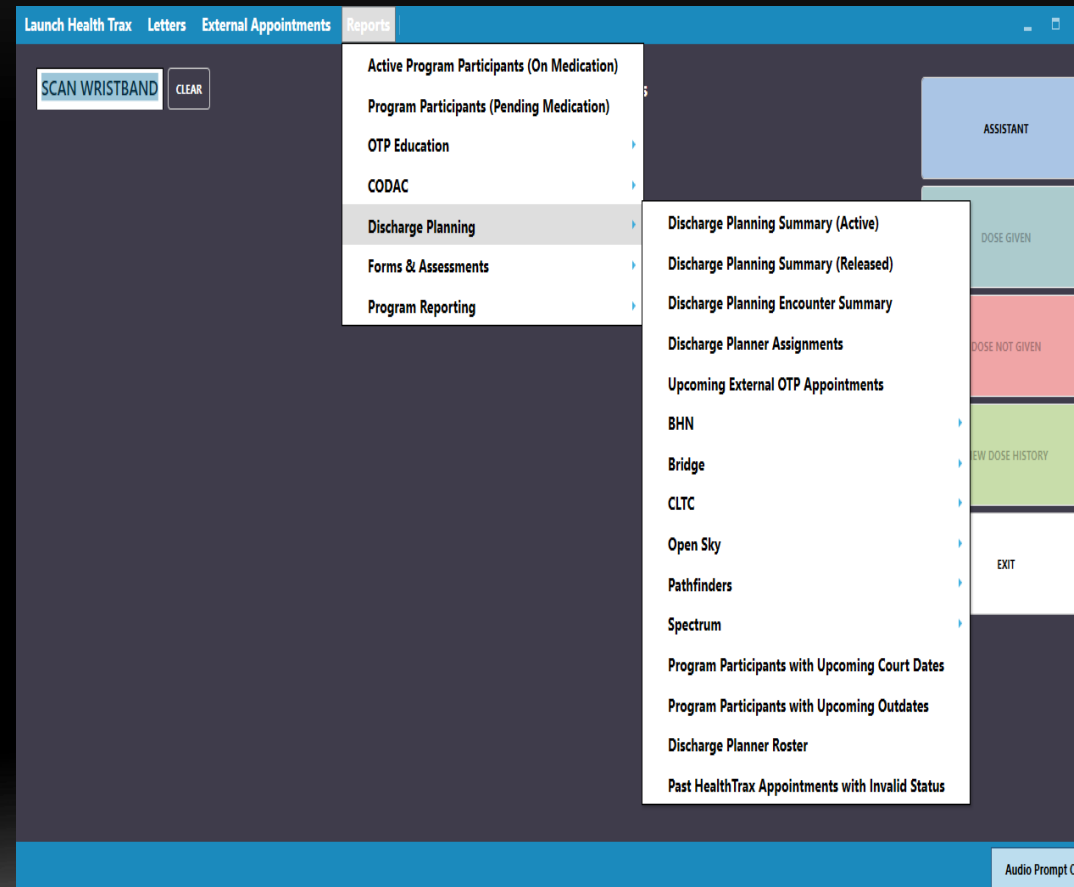
# HCSD AND COMMUNITY PARTNERS

- HCSD is contracted with CODAC Behavioral Health, an awarded service provider that began operating an OTP in the Rhode Island DOC in 2016
  - CODAC staff work hand-in-hand with Hampden County staff to ensure that patients receive the proper care
- BHN
  - Continuation – Seen within 5-7 days of intake
  - Induction – After being seen by a CODAC Clinician client is referred to CODAC Provider; Discharge Planner meets within 5 days before the Provider meeting
  - Pre-Trial & Sentenced on OTP – Seen within 5 days before court, within 5 days after if return from court (pre-trial)
- Bridge
  - Works with clients in their last six months of incarceration
  - Bi-weekly check-ins; weekly in the month before release

# KEEPING TRACK WITH OTP ASSISTANT

Home grown internal database created to keep track of:

- Dosing
- Appointments
- Referrals
- Upcoming items due (forms/assessments)
- Outside appointments upon release
- Statistics



**Re-entry planning starts at day 1 of incarceration or commitment at HCSD!**

# SUICIDE PREVENTION & INTERVENTION

- Suicide Prevention Committee
  - 8 hour suicide prevention training for incoming academies
  - 1 hour initial suicide prevention training for all new staff
  - Ongoing annual trainings in suicide prevention for all staff employed by HCSD
  - Currently building a Crisis Intervention Team
-

# SUICIDE PREVENTION AT HCSD

- It is the policy of the Hampden County Sheriff's Department to effectively monitor all inmates for the potential for self-harm and suicidal behavior.
- All staff are trained in warning signs, major risk factors and mental health referrals; coupled with their experience and knowledge of inmate behavior.
- This combination can have a positive impact on reducing these incidents.

# SAFETY PRECAUTIONS

## SUICIDE PREVENTION/INTERVENTION



Restraint Bed/Suicide Resistant Cell



Safety Smock/Blanket

### Restrictive Housing –

Remain RISK or Admit to ESU

Partially Clear w/ re-evaluation every 24 hours until disposition is reached

Clear Precautions

# STONYBROOK STABILIZATION TREATMENT CENTER

## SECTION 35

- Section 35 is a Massachusetts law that allows a qualified person to request a court order requiring someone to be civilly committed and treated involuntarily for an alcohol or substance use disorder.
  - Who is considered a qualified person?
    - Police Officer
    - Physician
    - Spouse
    - Blood relative
    - Guardian
    - Court Official
  - The petitioner must go to the local court and file a written petition or affidavit for an order of commitment. Petitions may be filed at any District or Juvenile Court.



# STONYBROOK STABILIZATION TREATMENT CENTER

- Criteria to meet for a Section 35 civil commitment
  - The person must have an alcohol or substance use disorder; and
  - There is a likelihood of serious harm to self or others as a result of their substance use disorder. If both criteria are met, the person will be involuntarily committed. A judge should order a commitment under Section 35 only when less restrictive alternatives are unavailable.
- The statute states the commitment may be up to, but not exceed 90 days. The commitment may be less than the 90 days depending on the individual's clinical needs and if they cease to meet the criteria for likelihood of serious harm to themselves.



<https://www.mass.gov/service-details/section-35-the-process>

# STONYBROOK STABILIZATION TREATMENT CENTER

- Levels of Care at SSTC
  - Acute Treatment Services
    - Up to 10 days
    - Detox phase
    - Groups/classes
    - Assessment completed from Mental Health, Medical, and Counseling Staff to determine need for services while in programming
  - Clinical Stabilization/ Support Services
    - Once cleared from ATS, up to 90 days
    - Medically Stable
    - Discharge planning/referrals
    - Groups/classes
    - Counseling



# EMOTIONAL SUPPORT DIVISION

- In addition to Molly, there are 4 other Emotional Support Animals that are assigned to different areas of the Department (Training, Medical, Security, and Mental Health)
- Pet Therapy started in October 2020 at the Main Institution with individuals classified to Mental Health Unit/Admitted to Inpatient level of care.
- Clients are provided with the opportunity to have individual treatment sessions with Molly when completing a mental health evaluation.
- Animal Assisted Treatment Caseload: Individualized Caseload for individuals open for mental health services to work towards completing treatment goals.
- Roles of Emotional Support Animals include:
  - Providing a therapeutic environment for the inmates at all HCSD facilities
  - Giving the staff of HCSD the ability to interact with Therapy Dogs
  - Provide additional programming to clients at SSTC
  - Provide community outreach at schools, hospitals, nursing homes, etc.



*Molly (6 y/o yellow lab): Joined the mental health department in July 2020 and is currently working at SSTC.*

Any Questions???



## Contact Information

*Amber Beauchemin, M.A.*

Forensic Mental Health Clinician

*Restrictive Housing*

Regional CIT Instructor for MSA

Hampden County Sheriff's Department

413-858-0732

[amber.beauchemin@SDH.state.ma.us](mailto:amber.beauchemin@SDH.state.ma.us)

# Presentation # 6

2:00-3:00pm

**DMH Community Services**

Brian Parsons -DMH CM



# DMH Community Services

EOHHS

DEPARTMENT OF MENTAL HEALTH

MARCH 2023

# Fact:

- ▶ There are an estimated 36,000 individuals in Western Mass identified as long term, seriously mentally ill adults. The estimated population of Western Mass is 151,000.

# Mental Health Treatment: Inpatient Setting

Inpatient – Community hospitals, Continuing Care Hospitalization, Civil or Forensic commitments

Does not necessarily need to be a DMH client to receive inpatient care, can be an access point to DMH services

# Mental Health Treatment: Community Settings

- ▶ Crisis stabilization units/Respite
- ▶ Day programs/ partial hospitalization
- ▶ Outpatient clinics for medication and therapy
- ▶ Other select programs and services:
  - ▶ PREP
  - ▶ Star Lite clubhouse
  - ▶ Northampton Recovery Center
  - ▶ Community Support Program (CSP)
  - ▶ Wildflower Alliance/peer support

**Can all be potential access points to DMH services**

# Community DMH Services

- ▶ DMH Case Management: referral, access to programs, care coordination
- ▶ Adult Community Clinical Services (ACCS)
  - ▶ Wrap around services based on individual needs
  - ▶ includes group home (GLEs) and shared living settings
- ▶ Programs of Assertive Community Treatment (mobile interdisciplinary teams): PACT
  - ▶ Wrap around services
  - ▶ Multidisciplinary team for each client

# Other DMH-Funded and affiliated Services

- ▶ Community respite programs
- ▶ Homeless programs – include Eliot Homeless Outreach Services, Shelter Plus Care, and other housing subsidies.
- ▶ Clubhouse employment supports (Lighthouse, Forum, Odyssey, Starlight, Berkshire Pathways, Green River House)
- ▶ Recovery Learning Communities-Peer Supports  
(i.e. Wildflower Alliance)

# WM Adult Community Services: Number of Service Recipients (2018)

In community, set up via “catchment area”:

- ▶ Springfield: 730 (477 ACCS)
- ▶ Holyoke/Chicopee: 462 (300 ACCS)
- ▶ Westfield: 298 (216 ACCS)
- ▶ Hampshire: 287 (200 ACCS)
- ▶ Franklin/N. Quabbin: 270 (187 ACCS)
- ▶ Berkshire: 394 (305 ACCS)

# Eligibility/Service Authorization

- ▶ Service Authorization forms available on DMH website
- ▶ Adult WM receives at least 700 applications a year; about 50% are found eligible (per 2018 data)
- ▶ Serious and persistent mental illness
- ▶ Not head injury, intellectual disability, medical disorder
- ▶ Needs not met elsewhere (ex: VA)

# What happens if a DMH client declines services?

- ▶ Steps taken to engage, if appropriate
- ▶ Close out services, if that is what the client determines or unable to make contact
- ▶ Resume services if the client changes their mind and reapplies. An individual who decides to accept services within a year of the initial application does not need to reapply

# DMH Values

- ▶ Recovery
- ▶ Person Centered Approaches
- ▶ Trauma Informed Care
- ▶ Voluntary Treatment
- ▶ Least Restrictive Environment/Community
- ▶ Wellness and independence

# Questions and Answers

▶ Contact Information:

**Heather Martin (interim)** 413-587-6233 (Hampshire)

[Anne.Martineau@massmail.state.ma.us](mailto:Anne.Martineau@massmail.state.ma.us)

**Christine Fowle** (413) 587-6448 (Westfield)

[Christine.Fowle@massmail.state.ma.us](mailto:Christine.Fowle@massmail.state.ma.us)

**Jennifer Dugan** (413) 452-2310 (Springfield)

[Jennifer.Dugan@massmail.state.ma.us](mailto:Jennifer.Dugan@massmail.state.ma.us)

**Chris Haley** (413)-395-2014 (Berkshires)

[Chris.Haley@massmail.state.ma.us](mailto:Chris.Haley@massmail.state.ma.us)

**Dan Sontag** (413) 772-5600 (Greenfield)

[Dan.Sontag@massmail.state.ma.us](mailto:Dan.Sontag@massmail.state.ma.us)

**Tracy Harris** (413) 452-2376 (Holyoke/Chicopee)

[Tracy.Harris@massmail.state.ma.us](mailto:Tracy.Harris@massmail.state.ma.us)

# Presentation # 7

3:00-4:00pm

**National Alliance on Mental Illness (NAMI): In Our own  
Voice - Lived Experience Perspective**

End of Day 2

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