

DAY 4 – CIT TRAINING



8:00-9:00am

Psychological Trauma – Amber Robinson-Green, PsyD, DFP (Designated Forensic Psychologist), Adult Court Clinic

9:00-10:00am

Mental Health in Elders – Jenny Cox, Director – Behavioral Health, Baystate Medical Center

10am- 10:30am

CIT Officer - IOOV

10:30am- 12:00pm

ALEC – Autism and law Enforcement Education Coalition – Captain V. Caputo

Psychological Trauma



AMBER ROBINSON GREEN, PSYD, DFP

**LICENSED PSYCHOLOGIST
DESIGNATED FORENSIC PSYCHOLOGIST**

The Basics - We know this!



- Trauma –damage to the mind - an emotional response – to a distressing event or events. Trauma is person specific and can occur when stress level exceeds person’s ability to cope and integrate the emotions associated with traumatic event. Sense of helplessness in the face of one’s emotional and physical safety/wellbeing.

i.e. - witnessing a terrible event, being the victim of interpersonal violence, natural disasters, car accidents and injury, loss of a loved one, public humiliation.....other ideas ???

Studies have shown that interpersonal trauma can be more damaging than natural disasters etc. WHY???

Prevalence of trauma



Who here has experienced an event that they consider to be traumatic?

The majority of Americans – 70% - of people experience an event or events that would be considered traumatic.

Risk factors – men, youth, history of prior trauma (sexual trauma), occupation (military, police), history of childhood conduct disorder, familial psychiatric history, personal characteristics such as extroversion, high crime neighborhoods

Complex Trauma



Complex Trauma describes children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect.

- Needs are not fulfilled, attachments are not formed
- Life is seen as unpredictable
- World is not a safe place – survival, me vs. the world
- Early attachment pioneers / Bowlby and Ainsworth – Blame the mother

* handout - New Yorker article

Racial Trauma



- Racial trauma or race-based traumatic stress, is the cumulative effects of racism on an individual's mental and physical health.
- Racial discrimination and race-based violence, can cause anxiety, avoidance, depression, suicidal ideation and PTSD, whether
 - overt (assaults, threats, slurs),
 - covert (crossing the street when a young Black male is walking towards you) or
 - institutional (difficulty accessing benefits like housing or education).
This is true whether there is one incident or ongoing discrimination.
- Racial trauma can compound stress reactions to other forms of trauma
- Racial differences exist in rates of trauma exposure

Everybody is different



Severity and type of trauma,
interpersonal trauma vs.
accidental – sense of betrayal

One time event or chronic
underlying mental health
condition

May not meet diagnostic
classification for PTSD but....

Many other psychological
problems can occur, depression,
panic disorder, other anxiety
disorders. Not just PTSD!

How Does Trauma Affect You?



Adverse Childhood Experiences


BRFSS Adverse Childhood Experience (ACE) Module

Prologue: I'd like to ask you some questions about events that happened during your childhood. This information will allow us to better understand problems that may occur early in life, and may help others in the future. This is a sensitive topic and some people may feel uncomfortable with these questions. At the end of this section, I will give you a phone number for an organization that can provide information and referral for these issues. Please keep in mind that you can ask me to skip any question you do not want to answer. All questions refer to the time period before you were 18 years of age. Now, looking back before you were 18 years of age---

- 1) Did you live with anyone who was depressed, mentally ill, or suicidal?
- 2) Did you live with anyone who was a problem drinker or alcoholic?
- 3) Did you live with anyone who used illegal street drugs or who abused prescription medications?
- 4) Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?
- 5) Were your parents separated or divorced?
- 6) How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?
- 7) Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking. Would you say—
- 8) How often did a parent or adult in your home ever swear at you, insult you, or put you down?
- 9) How often did anyone at least 5 years older than you or an adult, ever touch you sexually?
- 10) How often did anyone at least 5 years older than you or an adult, try to make you touch sexually?
- 11) How often did anyone at least 5 years older than you or an adult, force you to have sex?

Key concept underlying the study is that stressful or traumatic childhood experiences lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality.

* Handout – ACES



The more categories of trauma experienced in childhood, the more likely one experiences the following.....

- adolescent health
- teen pregnancy
- smoking
- alcohol abuse
- illicit drug abuse
- problem sexual behavior
- mental health problems
- risk of revictimization
- lack of stability of relationships
- poor performance in the workforce



**These behaviors lead to increased risk for heart disease, Chronic Lung disease, Liver disease, Suicide, Injuries-HIV and STDs
Diabetes**

Law Enforcement Work is Dangerous



Are you allowed to feel the pain?



Vicarious trauma



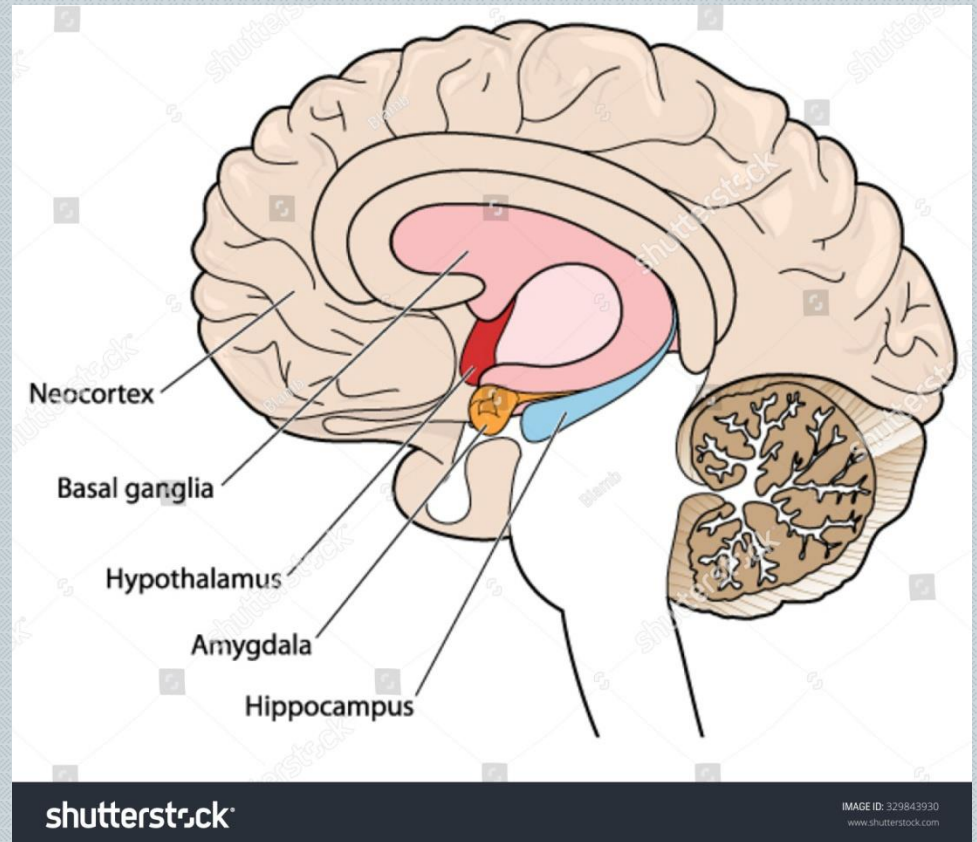
- **Work-related trauma exposure following:**
 - listening to individual clients recount their victimization
 - looking at videos or images of exploitation and abuse
 - reviewing case files
 - hearing about or responding to the aftermath of violence and other traumatic events day after day
 - responding to mass violence incidents
- Ongoing vicarious trauma can change a person's worldview
- Secondary traumatic stress (STS): behaviors and emotions that often result from knowing about another's trauma and the stress resulting from helping, or wanting to help.

Neurological Response to Threat



Humans have an automatic response to threat that is common to all animals

Threat is processed in the lower, primitive part of the brain – amygdala which is a part of limbic system



Fight Flight Freeze



- When a threat occurs, the reptilian brain makes an immediate decision whether to fight, flee, or freeze.
- The reptilian brain learns from prior threats and over generalizes to keep you safe.
- ***Training and life experience can override these automatic impulses.***



Biological Perspectives



In PTSD multiple neurobiological systems are dysregulated and maladaptive

Brain Regions (prefrontal cortex, amygdala, hippocampus, dorsal raphe nucleus, locus coeruleus) In child brain - disruption to actual cognitive development

Neurotransmitter/
Neurohormonal System
(Noradrenergic, Serotonergic,
Hypothalamic-Pituitary-
Adrenal axis (HPA axis))

PTSD symptoms/criteria



- **Stressor/s**
- **Intrusive symptoms**
(Nightmares, flashbacks, thoughts, intense or prolonged distress after exposure to traumatic reminders, physiologic reactivity after exposure to trauma-related stimuli)
- **Avoidance - Persistent effortful avoidance of trauma-related stimulus**
- **Dissociation**
(Depersonalization - experience of being an outside observer of or detached from oneself and Derealization - experience of unreality, distance, or distortion)
- **Negative alterations in cognitions and mood**
- **Alterations in arousal and reactivity**
(Trouble sleeping, Irritability, Reckless or self-destructive behavior Exaggerated startle response, Poor concentration)

What have you seen in your work?

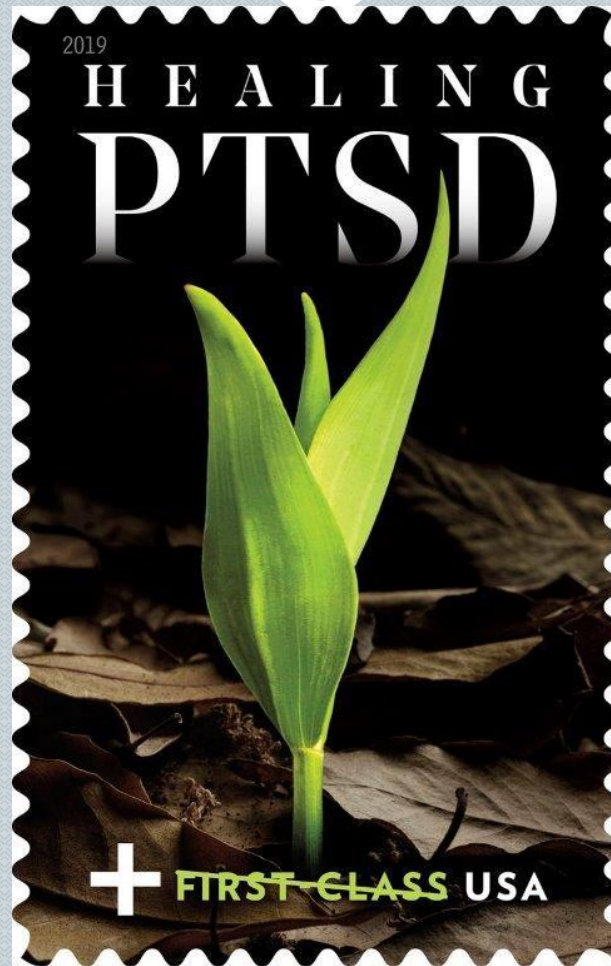


Resilience and hope



- Medications, therapy, meditation, exercise, hobbies and on and on
- If you believe a coworker might be experiencing negative reactions to trauma, consider—
 - reaching out and talking to them individually about the impact of the work;
 - helping them establish a consistent work-to-home transition that creates an important boundary and safe place outside the workplace;
 - encouraging them to attend to the basics—sleep, healthy eating, hygiene, and exercise;
 - supporting connections with family, friends, and coworkers;
 - referring them to organizational supports such as a peer support team, employee assistance program, or chaplain;

More awareness and dialogue



End of Presentation



- Question and Answers

PRESENTATION #2

9:00-10:00 am

Mental Health in Elders

Jenny Cox, Director – Behavioral
Health, Baystate Medical Center

Mental Health Issues in Older Adults



JENNIFER COX, LICSW

BAYSTATE HEALTH

EMAIL:

JENNIFER.COX@BAYSTATEHEALTH.ORG

TEL: 413-794-8308

Mental Illness vs. Cognitive Impairment



- After about age 70 (sometimes earlier) what looks like mental illness is often really a neurological problem with psychiatric symptoms
- Older adults are more likely than other populations to experience psychiatric symptoms related to
 - Delirium
 - Medication interactions
 - Confusion or agitation related to infection or medical condition
 - Dementia (many different types, some with hallucinations and delusions)
 - Increased anxiety and fear due to confusion or memory problems

Living with cognitive impairment



- Dementia is not just a “memory problem”. Domains that are affected
 - Sensory/motor input
 - Problem solving, sequencing and sorting
 - Wayfinding and navigation
 - Facial recognition
 - Incorrect (delusional) beliefs about themselves or their situation
 - Errors in judgement
 - Ability to predict consequences of actions or solve multi-step problems

It's all in your approach



- Never contradict or “reorient” a confused older adult
- Ask for permission to enter personal space
- Use a supportive stance with room
- Join with and validate the older adult’s experience
- Engage in emotional mirroring even when it doesn’t make sense
- Try and reach a collaborative solution
- “therapeutic fibbing” is fine
- Utilize the hand-over-hand technique when possible

Communication strategies



- Ensure you engage eye contact first, using the person's name
- Speak slowly and eliminate unnecessary words and phrases – pause longer between words and sentences than you think you need to
- Ask failure-free questions, and provide information when you can. Don't use open ended questions or ask someone to explain a situation
- Try and use a gentle tone of voice, even when a person is extremely agitated. Keep in mind that most aggressive behavior in older adults is rooted in fear.



- Questions

- Thank you

PRESENTATION # 3

10:30am- 12:00pm

**ALEC – Autism and law Enforcement
Education Coalition**

Sgt. M. Lyman,
Chicopee Police Department

Presentation # 5

1:00pm - 2:00pm

Department of Developmental Services (DDS)



DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

CIT PRESENTATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AND
ACQUIRED BRAIN INJURY

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

The Department's mission is to create, in partnership with others, innovative and genuine opportunities for individuals with intellectual and developmental disabilities to participate fully in their communities and meaningfully engage as valued members.

DDS works with adults to connect them with an array of employment and day program supports, community living and other residential aid, and family support.

DDS works with children to provide family support and supplement educational services through specialized programs.

Services are individualized and planned using a person-centered approach.

Information above from DDS website : <https://www.mass.gov/orgs/departments-of-developmental-services>



THINGS TO BE MINDFUL OF:

- Someone's disability may not be visible. Diagnoses like ASD, Deafness or hard of hearing, processing disorders, etc. are not visible to the eye.
- Example: Someone diagnosed with echolalia will repeat the things that have been said to them. This may be interpreted as offensive or noncompliant
- Some physical disabilities may limit someone's movement and may not be able to do what other bodies can.
- Brain Injuries vary and can have different symptoms presented.
- Escalation of a situation- recognition that if police are involved the situation has reached a difficult level
- Working with other professionals involved- looking for cues

DIFFERENCES IN POPULATIONS SERVED

- Processing difficulties: Frontal lobe function- Executive functioning difficulties
- Intellectual/Developmental and Brain Injury differences
- Differences in service models offered to populations served
- Intersection of disability-mental health-substance abuse
 - Co-occurring illnesses
- Guardianship/Legally Competent Person
- Service limitations

RESOURCES FOR ASSISTANCE

Springfield Westfield Area Office- 436 Dwight St. Suite 205 Springfield MA 01103


Area Director- Elaine Baillargeon 413-784-1339

Central West Eligibility Department: 140 High St, Suite 30, Springfield MA 01105

Phone number: 413205-0940

Central West Risk Manager: Adam Holst, 140 High St., Suite 30, Springfield MA 01105

Phone number: 413-205-0950



MORE RESOURCES

- Brain Injury Association of Massachusetts(BIAMA): <http://www.biama.org/>
- Department of Developmental Services(DDS): <https://www.mass.gov/orgs/departement-of-developmental-services>
- State Head Injury Program(SHIP): <https://www.mass.gov/service-details/statewide-head-injury-program-ship>
- MASS Advocates Standing Strong (self advocacy group): <https://www.wearemass.org/>

Presentation # 5

2:00pm - 3:00 pm

Mobile Crisis Intervention & Community Behavioral Health Centers

BHN & CSO

Mobile Crisis Intervention & Community Behavioral Health Centers

Hallie-Beth Hollister
Clinical Program Director
BHN YMCI & LE Programs

Leanne Hadsel,
Co-Response Clinician Supervisor
Clinical & Support Options

Mobile Crisis Intervention

- Preferred service delivery method
 - Homes, residential programs, schools, treatment programs, providers offices, doctors offices, police stations, places of employment, etc.
 - Higher comfort level in familiar environment, opportunity for family interaction and safety planning, less stigmatizing, opportunity for clinical observation
 - Stabilization in place whenever possible
 - Mobile Response times
 - Staff Safety Considerations
- Collaboration with Co-Response

Mobile Crisis Intervention

- Designated Youth & Adult Mobile Crisis Intervention teams
 - Masters level Telephonic Triage Clinicians
 - Multidisciplinary teams deploying partnered response
 - Adult teams are comprised of Masters & Bachelor Level Clinicians and Certified Peer Specialists
 - Youth teams are comprised of Masters & Bachelor Level Clinicians and Family Partners

Hospital Based Crisis Teams

- Decoupling of Hospital and Community Teams
- Hospitals diverting to CBHC/MCI
- Importance of ED Diversion
 - Helps ED's focus on medical needs of community
 - Helps lower hospitalization rates
 - Exposure considerations
 - Time & resource of transport and ED visit with lack of benefit
 - Process of referral to crisis in ED
 - Repeated account of crisis
- Notification to ED
 - May help avoid discharge by doctor without referring to crisis
 - Information sharing ensures more informed disposition
 - Helps ED personnel best treat the patient

MCI & Police intersection/collaboration

- MCI may call police for:
 - Assistance with executing Section 12 for transport to ED for containment while awaiting psychiatric placement
 - Assistance with executing Section 12 for transport to ED for safety while awaiting crisis assessment
 - Assistance with a person who cannot be de-escalated by crisis staff or a person who has a history of violence , destroying property, engaging in criminal activity
 - Enforcement of Rogers Order
 - Duty to Warn/Tarasoff
 - Guidance around responding to neighborhoods with recent violent activity

MCI & Police intersection/collaboration

- Police may call the 24/7 MCI # to:
 - request Crisis Assessment due to risk issues
 - Significant self harm, suicidal thoughts, active suicide attempt, interrupted suicide preparation, homicidal/violent threats seeming to be related to psychiatric condition, person cannot care for self related to psychiatric condition
 - request resource information for Substance Use treatment, Mental Health treatment, social services
 - request assistance for someone they are encountering
 - request telephonic assistance with filling out a section 12 or request in person consult for section 12 if unclear

Section 12

- Section 12

A). Mental Illness: For purposes of admission to an inpatient facility under Section 12, “Mental Illness” means a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life. Symptoms caused solely by alcohol or drug intake, organic brain damage or intellectual disability do not constitute a serious mental illness. Specify evidence including behavior and symptoms:

B). Likelihood of Serious Harm (check all categories that apply):

- (1) Substantial risk of physical harm to the person himself/herself as manifested by evidence of threats of, or attempts at suicide or serious bodily harm; and/or
- (2) Substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; and/or
- (3) Very substantial risk of physical impairment or injury to the person himself/herself as manifested by evidence that such person’s judgment is so affected that he/she is unable to protect himself/herself in the community and the reasonable provision of his/her protection is not available in the community.

Specify evidence including behavior and symptoms:

Section 12 cont.

- Section 12 cont'd

3). Applicant Certification (check all applicable boxes)

- a. I am a: Licensed Physician or Nurse Practitioner (GL. Ch 112 §80i) Qualified (i.e. Licensed) Psychologist Qualified (i.e. Licensed and Certified) Psychiatric Nurse Mental Health Clinical Specialist Police Officer Licensed Independent Clinical Social Worker (LICSW)
- b. I have OR I have not personally examined this person. If not, why?

-
- c. I have consulted with either the receiving facility or emergency screening program.
- d. I have not so consulted because _____

Applicant's name (not patient):
(print) _____

Phone: _____

Address: _____ City/Town _____ State _____

Applicant's signature: _____ Date: _____ Time: _____

NOTE: Parts 1) through 3), above, must be completed to apply for involuntary hospitalization.

	Clinical Support Options	Ashburnham, Gardner, Hubbardston, Templeton, Westminster, and Winchendon
Western	Clinical Support Options	Amherst, Chesterfield, Cummington, Easthampton, Florence, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, and Worthington Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Millers Falls, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Turners Falls, Warwick, Wendell, and Whately
	Behavioral Health Network	Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Indian Orchard, Longmeadow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, and Wilbraham
	Center for Human Development	Belchertown, Bondsville, Chicopee, Granby, Holyoke, Ludlow, Monson, Palmer, South Hadley, Southampton, Thorndike, Three Rivers, and Ware
	The Brien Center	Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesboro, Lee, Lenox, Monroe, Monterey, Mount Washington, New Ashford, New Marlboro, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, and Windsor

Crisis

Programs



Individuals may request crisis services on their own or they can be referred by family members, medical providers, schools, state agencies, law enforcement, etc. **Crisis services are available to all individuals regardless of insurance or ability to pay.**

- Crisis assessment and support by a clinician on location (home, school, clinical office, ED, etc.).
- Development of a Crisis Management Plan.
- Psychiatric consultation and urgent psychopharmacology intervention as needed.
- Referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

CSO is a Certified Community Behavioral Health Clinic and provides a full range of behavioral health and substance abuse services through a network of six licensed outpatient sites. Four of our sites (Northampton, Greenfield, Athol, and Gardner) are state-designated **Community Behavioral Health Centers** (CBHCs), providing open access to outpatient, urgent, and emergency behavioral health care.

NORTHAMPTON / HAMPSHIRE COUNTY

24 Hours/Day, 365 Days/Year
Adult & Youth Crisis Intervention
413.586.5555

GREENFIELD / FRANKLIN COUNTY

24 Hours/Day, 365 Days/Year
Adult & Youth Crisis Intervention
413.774.5411

ATHOL / NORTH QUABBIN

24 Hours/Day, 365 Days/Year
Adult & Youth Crisis Intervention
978.249.3141

GREATER GARDNER / NORTH COUNTY

24 Hours/Day, 365 Days/Year
Adult & Youth Crisis Intervention
978.488.8888

Outpatient Services include:

- Urgent Outpatient assessment and treatment
- Diagnostic evaluations
- Therapy for children, adolescents and adults
- Child and Adult Psychiatry
- Sexual abuse and trauma treatment for survivors and their families
- Treatment for depression, anxiety, PTSD and general adjustment disorders
- Group Therapy
- Structured Outpatient Addiction Programs
- Case Consultation and collaboration
- Medication management
- Intensive Outpatient Programs
- Psychological testing and assessment





417 Liberty Street, Springfield, MA 01104

77 Mill Street, Westfield, MA 01085



- **BHN Mobile Crisis Intervention**
- **24/7 Crisis Line 413-733-6661**
 - RAP Drop off
 - Police Drop Off
 - Dedicated Police Line 413-417-6511
 - Mobile Response Triage & Dispatch
 - MCI Available 24 hours a day, 7 days a week
 - Shift supervisors in house and on call
 - On campus access to The Living Room
 - Telephonic Triage including de-escalation, brief risk assessment
 - Phone consultation, phone support
- **Central Intake 413-301-WELL (413-301-9355)**
 - Detox Admissions, Urgent Care & Access center
 - On site assessments/walk ins accepted (call ahead preferred)

BHN CBHC Services



Services for Youth and Adults

Crisis Services, Urgent Care Same-day support & **Therapy**

Navigation Support: Help with insurance, housing food, etc.

Access to: Peer Specialists, Care Coordination, Psychiatry Services, Skill-Building Workshops

Monday - Friday, 8 am - 8 pm
Saturday & Sunday, 9 am - 5 pm

Helpful Information

- Section 18a, regarding assessment of persons in police custody
 - Youth
 - Adults
- Roger's Order
 - Order in place by court mandate, medication is administered and managed by others
 - Refusal of 3 consecutive doses of prescribed antipsychotic medication
 - Criteria generally includes history of negative symptoms often to include aggression
 - Enforced by crisis implementing an involuntary admission, held at ED for safety and containment



Thank you!