
Western MA CIT
PARTNERSHIP, DEPENDABILITY,
COMMUNITY & SERVICE

Welcome

CIT TRAINING

MARCH 27th – 31st, 2023

Opening Remarks

- Welcome
- Ground Rules
- Introductions – Person- Role-System Introductions
- Presentations
- Groups
- Evaluations
- Polling (Participants can vote at **slido.com** with **#2507601**

Crisis Intervention Team (CIT) Overview & Co-Response

Hallie-Beth Hollister, M.Ed., Program Manager, BHN Crisis Services, Carl Girouard, BHN Police Consultant, CIT-TTAC & Richard Winning, LICSW– Co-Response Supervisor, BHN.

March 27, 2023 - 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 training per year.
- Also provided are 8-hour CIT Dispatcher Training, 8-hour Youth Focused CIT, roll call training & Mental Health First Aid.
- Technical assistance to involved PDs 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.
- 1024 officers trained in CIT, 86 in Youth-Focused CIT, 46 MHFA & 60 in CIT Dispatcher to date (03/27/2023)

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

- BHN's Community Behavioral Health Center catchment area includes Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Indian Orchard, Longmeadow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, and Wilbraham.
- BHN/CIT-TTAC covers training for all Western Massachusetts Police Departments.

CO-RESPONSE

Consists of a clinician and their support staff that work directly with officers from the point of call to the point of conclusion.

OBJECTIVES:

- Objectives:

1. What is Co-Response?
2. Goals of Co-Response
3. Co-Response Model being used in WM
4. Police Departments with Co-Response
5. Future of Co-Response.

GOALS OF CO-RESPONSE

1. To intervene with officers to a variety of mental health and substance abuse calls.
2. To evaluate individuals contacted in this way for safety and limiting the need for transports to the hospital.
3. To provide opportunities and choices that reduce the need for arrest through the addition of treatment and services.
4. To provide follow ups with community members to reduce recidivism

HOW CAN CO-RESPONSE HELP

1. Co-responders training helps calm community members experiencing acute Psychiatric symptoms.
2. Co-responders work to secure community support reducing the need for police responses to individuals over time.
3. Co-responders can work as a bridge between law enforcement, the courts and the jail systems to guide away from incarceration and towards treatment.
4. Providing alternative options in the moment that reduce conflict for the responding officers.

WHAT CAN CO-RESPONSE ACCOMPLISH.

Co-Response has been shown to reduce the need to engage physically with those with psychiatric illness. Which saves community member lives but also the lives of responding officers.

Close to a quarter of people killed by police officers in the United States had a known mental health condition, and a November 2016 study in the *American Journal of Preventive Medicine* estimated that 20% to 50% of law enforcement fatalities involved an individual with a mental illness. https://www.apa.org/monitor/2021/07/emergency-responses

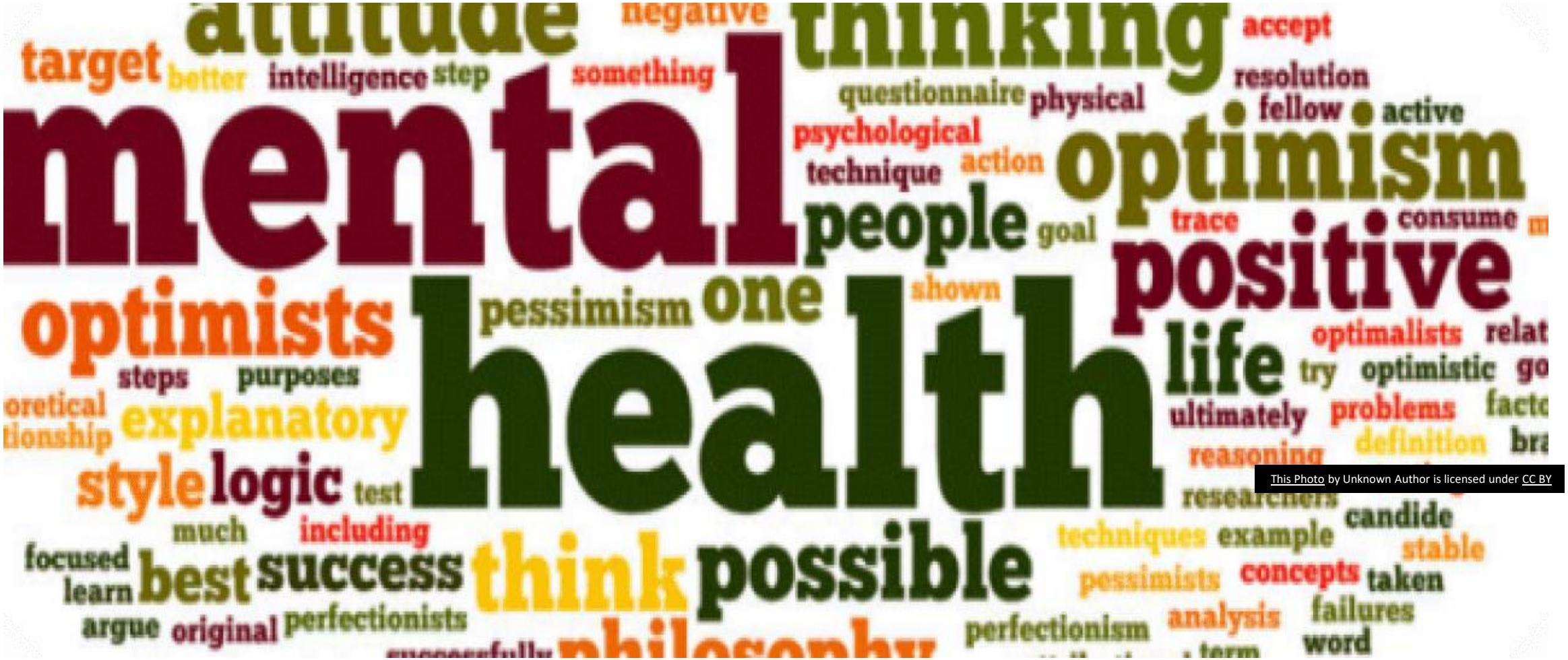
CO-RESPONSE MODEL TAKING SHAPE

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

Presentation # 2

Mental Health Disorders

Nicola Howe, MSW



BY: NICOLA HOWE, MSW
CIT-TTAC COORDINATOR – WESTERN MA CIT-TTAC

Objectives

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

- ❑Understand the signs and symptoms of serious mental health disorders.
- ❑Appreciate the role that stigma plays in preventing treatment, and that people do recover from mental illness.
- ❑Understand how different types of disorders affect behaviors.
- ❑Will understand what the CIT police officer's role is in encounters with people who have mental illnesses or are in crisis.
- ❑Dissect myths about people with mental illnesses.
- ❑Sensitized about concerns and types of victimization that individuals who have mental health and other conditions face.

Defining Mental Health and Mental Illness

Mental health refers to cognitive, behavioral, and emotional well-being. It is all about how people think, feel, and behave.

(Medical News Today, 2020)

Conversely, mental illnesses are health conditions involving changes in emotion, thinking, or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.

(Psychiatry.org, 2018).

Definitions of Mental Health

"Mental health influences how we think and feel about ourselves and others, and how we interpret events. It affects our capacity to learn, to communicate and to form, sustain and end relationships. It also influences our ability to cope with change, transition and life events, such as: having a baby, moving to a new house, experiencing bereavement"
Friedl, 2014

Signs and Symptoms of a serious Mental Health Disorder

What is a Sign? Clinician – Psychiatrist – Family member – Therapist – Medical Doctor

What is a Symptom? – Patient

The key difference between signs and symptoms is who observes the effect.

Symptoms can be remitting, chronic and relapsing.

Considerations when Working with Mental Health

Stigma

Presentations of diagnoses

Medical considerations

Using Person-Centered Language

Stigma - Exercise

What are some words we use to describe the symptoms of someone who is suffering from cancer?

What are some negative words we use to describe someone suffering with a mental health disorder?

Why are the two looked at differently?

Do you use these words? Regularly? Sometimes?

Do you think the stigma prevents someone from seeking help/treatment?

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What are some negative words we use to describe someone suffering with a mental health disorder?

ⓘ Start presenting to display the poll results on this slide.

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What are some words we use to describe someone who is suffering from cancer?

ⓘ Start presenting to display the poll results on this slide.

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Why are the two looked at differently?

ⓘ Start presenting to display the poll results on this slide.

Considerations When Working with Mental Health

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Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough.

ⓘ Start presenting to display the poll results on this slide.

Mental Health is too often ignored

- Currently:
- 1 in every 8 people in the world live with a mental disorder
- 1 in 5 people will experience mental health problems
- 1 in 6 workers are experiencing depression, anxiety or stress.
- 1 in 16 in General population have a serious mental illness

Myths vs Reality

Knowledge Check: Myths/Factual

Causes of Mental Health Disorders

- **Genetics**
- **Environment**
- **Childhood trauma**
- **Stressful events**
- **Negative thoughts**
- **Unhealthy habits**
- **Drugs and alcohol**
- **Brain chemistry / TBI**

Mood Disorders

Psychotic Disorders

Anxiety Disorders

Personality Disorders

Eating Disorders

Substance-Related Disorders

Neurocognitive Disorders

Autism Spectrum Disorders/Intellectual Disabilities

Trauma/Stressor-related Disorders

Co-Occurring Disorders

Describe your mood?

Mood Disorders:

General emotional state or mood is distorted or inconsistent with your circumstances and interferes with your ability to function. Can be extremely sad, empty or irritable (depressed), or have periods of depression alternating with being excessively happy (mania).

- **Major depressive disorder** — prolonged and persistent periods of extreme sadness
- **Bipolar disorder** — also called manic depression or bipolar affective disorder, depression that includes alternating times of depression and mania

Bipolar Disorder

Bipolar Disorders are groups of brain disorders that cause extreme fluctuation in a person's mood, energy, and ability to function.

An individual cannot be diagnosed with Bipolar Disorder until at least age 18

Bipolar I Disorder could include psychotic features and episodes of hypomania

Mania is defined as "a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently goal-directed behavior or energy*, lasting at least 1 week* and present most of the day, nearly every day".

Hypomania is defined as "a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting *at least 4 consecutive days* and present most of the day, nearly every day".

•.

Treatments for Bipolar Disorder

Types of Therapy:

- Cognitive Behavioral Therapy
- Family Therapy
- Psychoeducation
- Psychotherapy

Types of Medication:

- Anticonvulsants: Topiramate, Lamotrigine, Oxcarbazepine
- Antipsychotic: Risperidone, Haldol, Quetiapine
- SSRI -Fluoxetine

Depression

Depression is a mood disorder characterized by persistent sadness or loss of interest or pleasure in previously rewarding or enjoyable activities. The effects of depression can be long-lasting or recurrent and can dramatically affect a person's ability to function and live a rewarding life.

Included under depressive disorders:

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)

An individual must be experiencing five or more symptoms during the same two-week period to meet criteria for Major Depressive Disorder:

- Psycom.net, 2020

Black Dog/ Depression

Slowing the brain down?

Activity

Treatments for Depression

Types of therapy:

- Cognitive Behavioral Therapy (CBT)
- Behavioral Therapy
- Talk/psychotherapy

Types of medications:

- Selective Serotonin Reuptake Inhibitor (SSRI) –Sertraline, Fluoxetine, Escitalopram
- Antidepressant –Amitriptyline, Mirtazapine, Bupropion
- Antipsychotic –Aripiprazole

Medical Treatment:

- Electroconvulsive Therapy (ECT)

Psychotic Disorders:

A person's personality is severely confused, and that person loses touch with reality. When a psychotic episode occurs, a person becomes unsure about what is real and what isn't real and usually experiences hallucinations, delusions, off-the-wall behavior, chaotic speech, and incoherence.

Examples:

Schizophrenia - The most common psychotic disorder. Patients with this condition experience changes in behavior, delusions, and hallucinations that last longer than six months. Those diagnosed with this type of disorder often show a decline in social function, school, and work.

Schizoaffective Disorder

Patients with schizoaffective disorder have symptoms of both a mood disorder, such as depression and schizophrenia.

Psychotic Disorders:

Brief Psychotic Disorder

When a patient has only short, sudden episodes of psychotic behavior, the condition is diagnosed as brief psychotic disorder. These episodes are typically a response to a stressful situation and usually last less than a month.

Delusional Disorder

Patients that have false, fixed beliefs involving real-life situations that could be true, such as having a disease or being conspired against, are diagnosed with delusional disorder. These delusions persist for at least one month.

Treatments for Psychotic Disorders

Treatment is usually lifelong and often involves a combination of medication, therapy, and coordinated specialty care services.

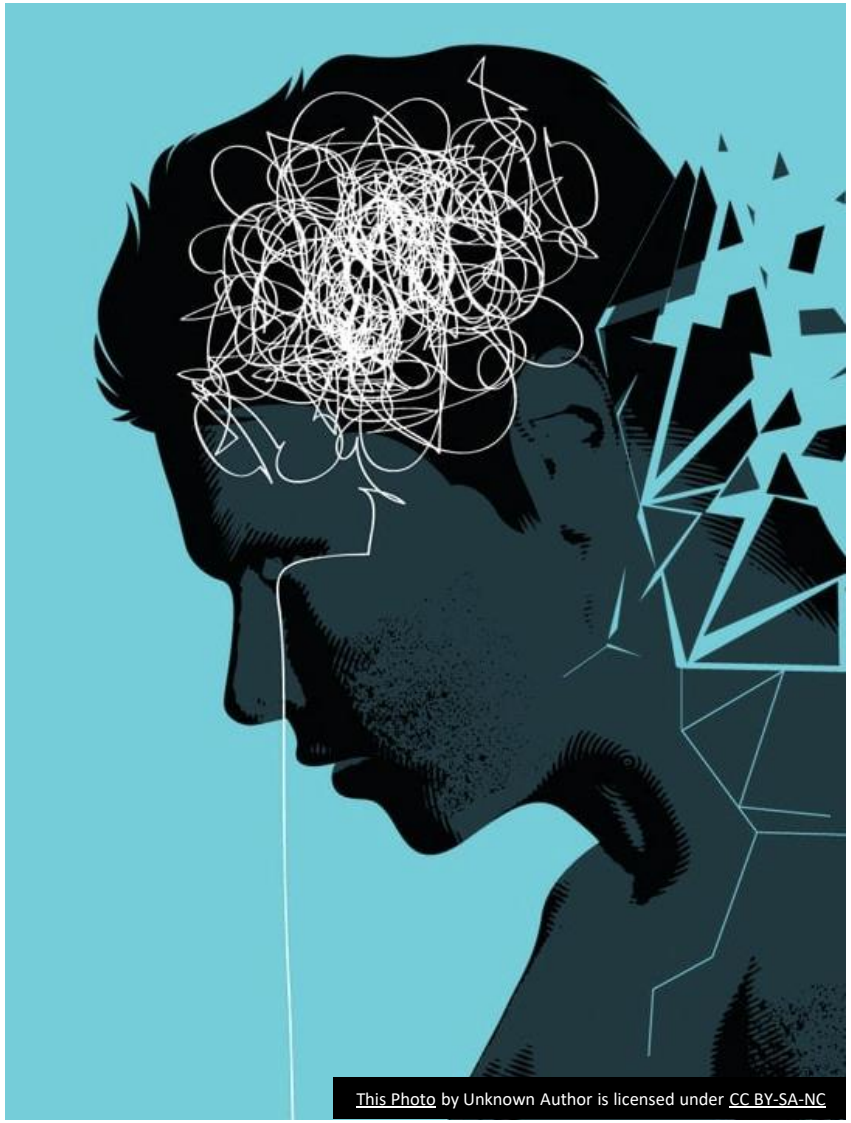
Types of Therapy:

- Support Groups
- Rehabilitation
- Cognitive Therapy
- Psychoeducation
- Family Therapy
- Behavior Therapy
- Group Psychotherapy

Types of Medications:

- Antipsychotic: Olanzapine, Risperidone, Haldol, Perphenazine, Clozapine
- Anti-tremor –Benztropine

https://youtu.be/Kzce8OtJMus



Anxiety

The term anxiety refers to feelings of worry, nervousness, apprehension, or fear commonly experienced by people when faced with something they view as challenging.

Anxiety Disorders

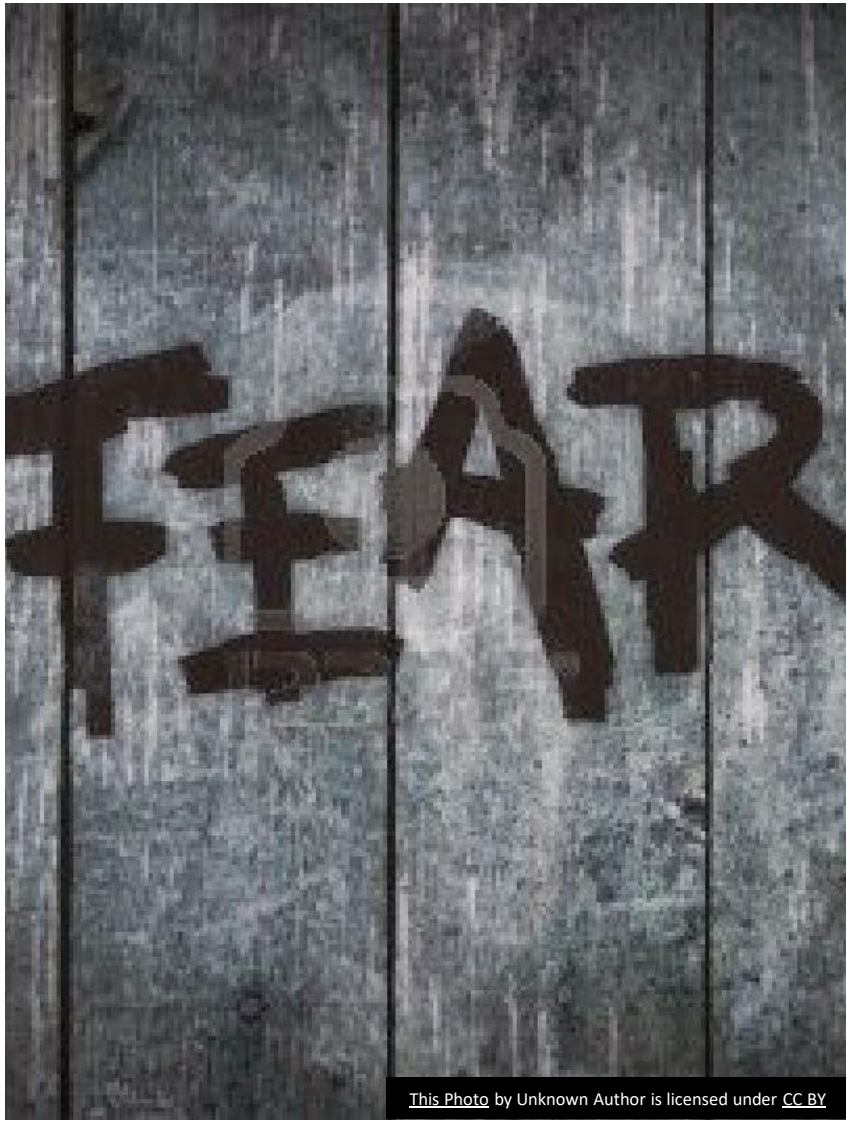
Classified when anxiety, fear, or nervousness does not go away and inhibits daily living activities.

Types of Anxiety Disorders:

- **Generalized Anxiety Disorder (GAD):** excessive anxiety or worry, most days for at least 6 months. Symptoms include feeling restless, easily fatigued, difficulty concentrating, forgetfulness, irritability, difficulty sleeping.
- **Panic Disorder**: Recurrent unexpected panic attacks; classified by periods of intense fear that come on quickly and can include heart palpitations, sweating, shaking, shortness of breath, feelings of impending doom, feeling of being out of control
- **Phobia-Related Disorders**: an intense fear or aversion to specific objects or situations
  - Common phobias: agoraphobia, social anxiety disorder, separation anxiety; “specific phobias” to things such as flying, blood, heights, etc.

Fear

- Fear is one of the most powerful emotions it can have a very strong effect on our minds and body for example, if we are caught in a dangerous situation or if we are being attacked.
- Fear is something that we consider is a bad thing and makes us make bad decisions.
- Fear Is also a good thing because It is the response to our survival, which keeps us safe and alive.



FEAR

Anxiety and adrenalin are connected to the feeling of fear. If we were not able to feel fear, we would be killed by a tiger when we were cavemen, but fear keeps us from doing dangerous things. Fear makes us think before we take action.

Fear is not reasonable when it keeps us from doing what we want or following our dreams. It gets in our way and stop us from taking action

The Psychology of Fear

Treatments for Anxiety

Self-care:

- Reduce caffeine intake
- Avoid alcohol and smoking
- Exercise and healthy diet
- Relaxation techniques

Types of therapy:

- Cognitive Behavioral Therapy (CBT)
- Meditation
- Psychotherapy

Types of medication:

- SSRI –Fluoxetine, Escitalopram, Sertraline, Citalopram, Paroxetin
- Anxiolytic –Diazepam, Buspirone
- Antidepressant –Imipramine, Duloxetine, Venlafaxine
- Sedative –Lorazepam, Clonazepam

Personality Disorder

Personality Disorders

Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

Changes in how a person feels and distorted beliefs about other people can lead to odd behavior, which can be distressing and may upset others.

Common features include:

- being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger
- avoiding other people and feeling empty and emotionally disconnected
- difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people
- odd behavior
- difficulty maintaining stable and close relationships, especially with partners, children and professional carers
- sometimes, periods of losing contact with reality

Personality Disorders

Cluster A : Paranoid personality disorder, Schizoid personality disorder; Schizotypal personality disorder

Cluster B: Antisocial personality disorder, Borderline personality disorder, Histrionic personality disorder, Narcissistic personality disorder

Cluster C: Avoidant personality disorder, Dependent personality disorder, Obsessive compulsive personality disorder

Treatments for Personality Disorders

- Psychotherapy
- Cognitive Behavioral Therapy
- Medications: Antidepressants (citalopram, duloxetine) , Mood stabilizers (Olanzapine, Abilify, Latuda), Anti-Psychotic Medications (clozapine, Haldol, quetiapine), Anti-Anxiety (buspirone, Benzodiazepines, Hydroxyzine)
- Hospital and Residential Treatment programs
- Coping and support within family and community

Related Definitions

Delusions –fixed beliefs that are not amenable to change in light of conflicting evidence. May take on a variety of themes: persecutory, delusions of reference, erotomanic, grandiose, jealous, nihilistic, and somatic are the most common.

Hallucinations –perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control.

Catatonia –a marked psychomotor disturbance that may involve decreased motor activity, decreased engagement during interview or physical examination, or excessive or peculiar motor activity.

Other Commonly Encountered Diagnoses

Post-Traumatic Stress Disorder: classified by exposure to actual or threatened death, serious injury, or sexual violence by means of witnessing, directly experiencing, learning that it occurred to a friend or family member in a violent or accidental way, or extreme or repeated exposure to the aversive details of the event . Intrusion symptoms include distressing dreams, reactions, and dissociative reactions or physiological cues to internal or external cues that symbolize the event.

Neurocognitive Disorders: Commonly include delirium, dementia, or Alzheimer's Diagnoses, marked by behavioral disturbances, inability to verbally communicate, and are frequently degenerative.

Autism Spectrum Disorder: characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interactions; and skills in developing, maintaining, and understanding relationships.

- Presentations can range significantly in communication ability, behaviors, and independent functioning.

Commonly-Encountered Diagnoses (continued)

Attention-Deficit Hyperactivity Disorder (ADHD): A persistent pattern of inattention and/or hyperactivity that interferes with functioning or development. Examples of inattention include wandering off-task, lacking persistence, having difficulty sustaining focus, and being disorganized which is not due to defiance or lack of comprehension. ADHD begins in childhood and several symptoms must exist between the ages of 6 and 12 to meet the full criteria.

Substance-Related Disorders include ten different separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, and tobacco. Disorders are classified when substances produce such an intense activation of the reward system that normal activities may be neglected.

Co-Occurring Disorders

- This is any combination of two or more substance use disorders and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
- No specific combinations of mental and substance use disorders are defined uniquely as co-occurring disorders.
- People with Substance Use Disorders are at particular risk for developing one or more primary conditions or chronic diseases. The coexistence of both a mental illness and a substance use disorder, known as a Co-Occurring Disorder, is common among people in medication-assisted treatment (MAT).
- People with mental illness are more likely to experience a substance use disorder than those not affected by a mental illness. According to SAMHSA's 2018 National Survey on Drug Use and Health, approximately 9.2 million adults in the United States have a co-occurring disorder.

Police Intercept with Mental Illness

- The police officer is not expected to be a clinician;
- Observation of behaviors (signs or symptoms reported to you)
- What is obviously different about the person's behavior?
- How are they dressed? What is the content of their thoughts (symptoms)?
- Are they talking about things that the officer cannot perceive or are nonsensical (delusions/ hallucinations)?
- What is their mood like (signs – observe (affect) or symptoms)?
- Concern about suicide or violence?
- Substance use present?
- Are there cultural considerations?

What not to do……

Presentation #3

Kathy Picard – Lived Experience

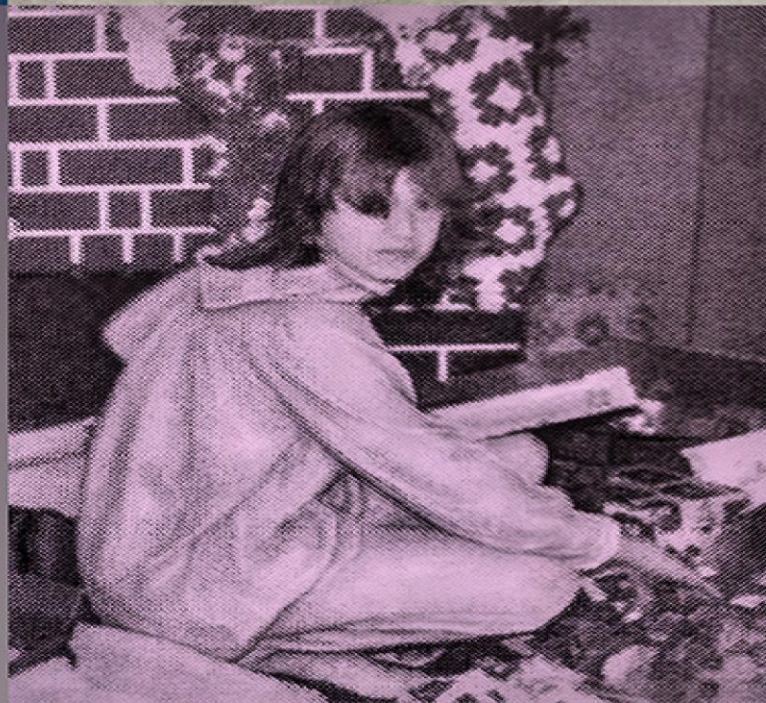
11am-12pm

Let's RAISE the BAR...

AND
PROTECT
ALL OF OUR
CHILDREN FROM
SEXUAL ABUSE.

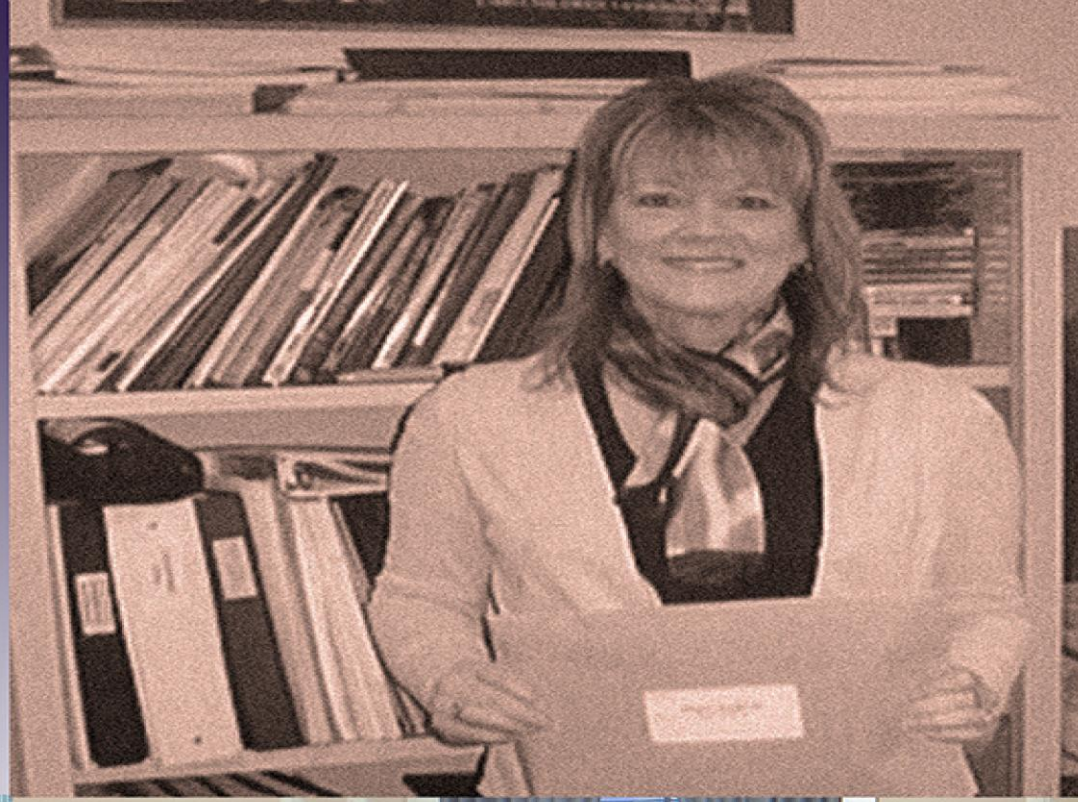
Kathy J. Picard

My Personal Story



With help, hope, and the necessary tools to heal.

Advocacy and Beyond



The William Pynchon Award

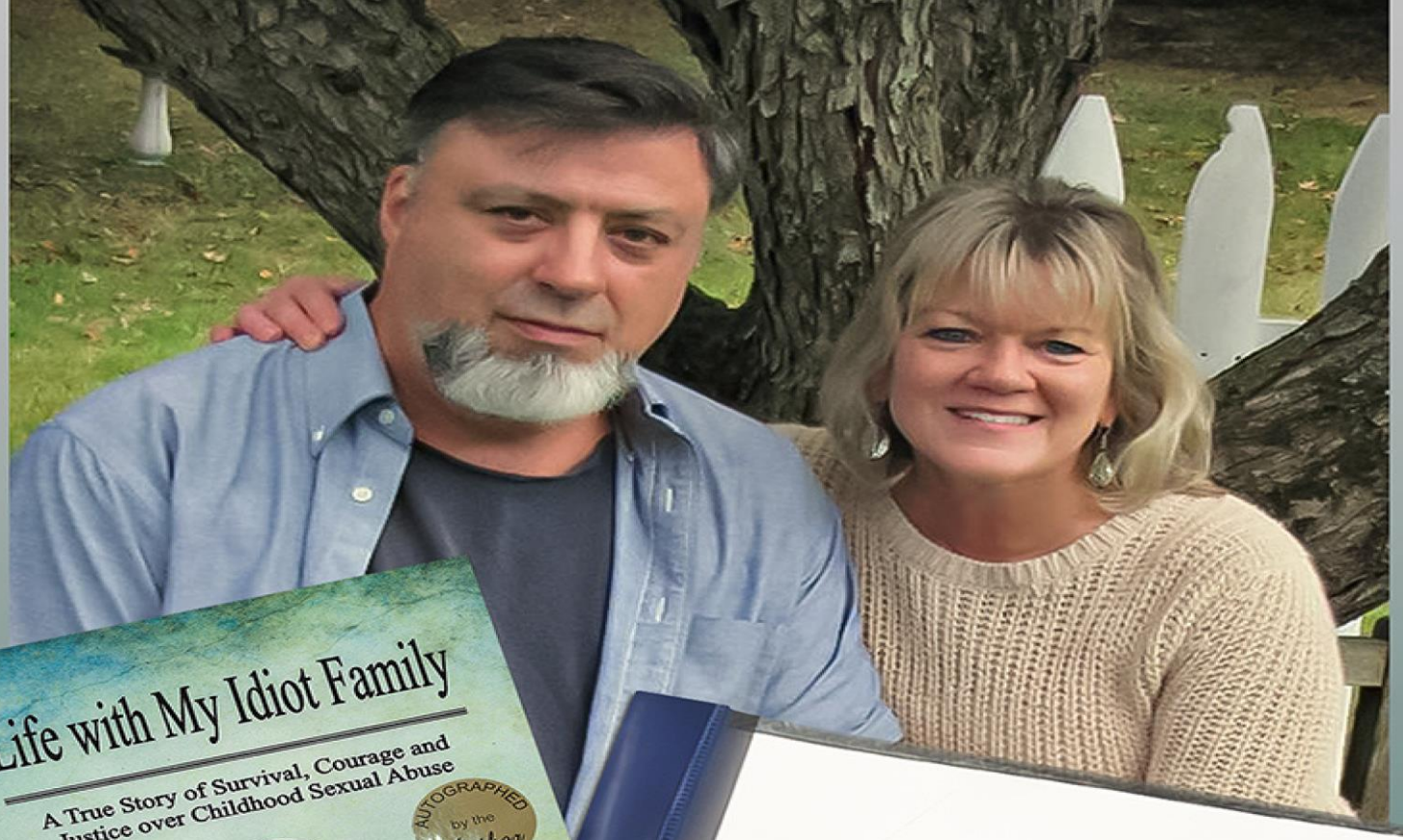
ENOUGH
CHILD SEXUAL ABUSE

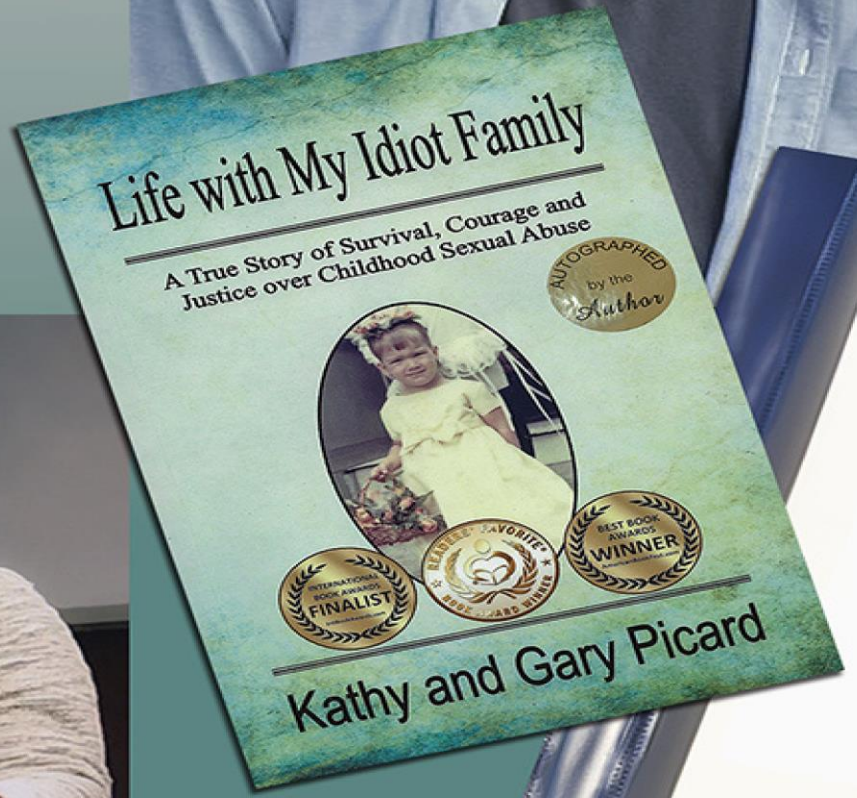
MassKids
Massachusetts Citizens for Children

Childhelp®

A Fight for Justice

Finding My Voice





THE GIRL NEXT DOOR

Based on the Book, "Life With My Idiot Family"
by Kathy and Gary Picard

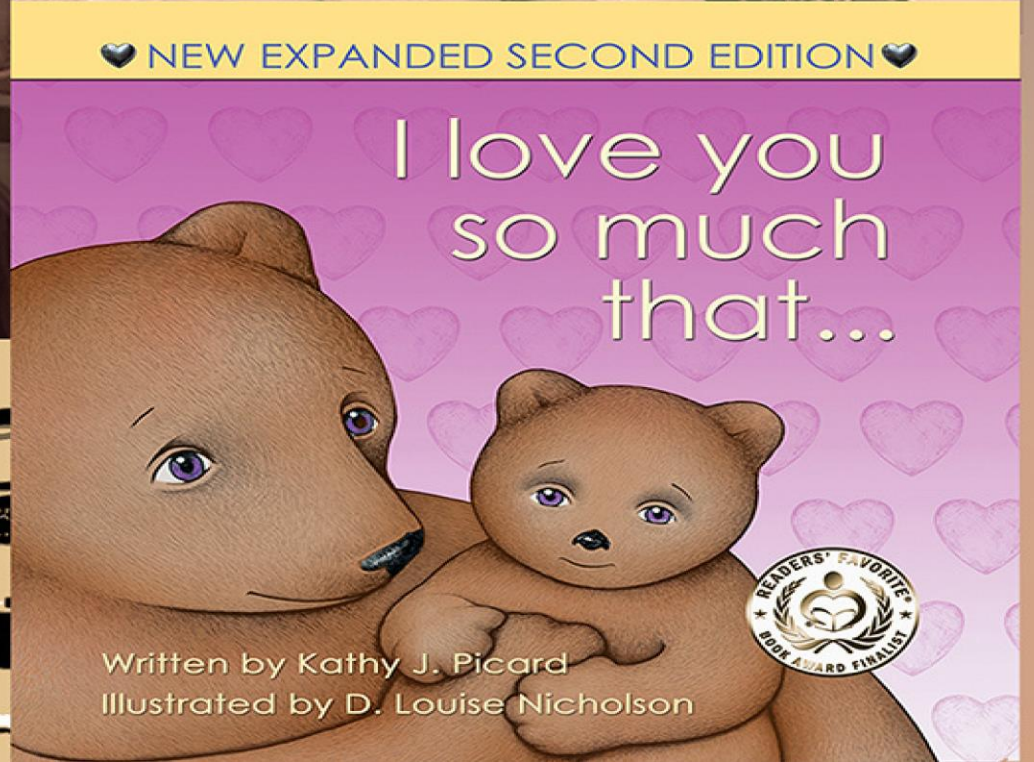
Screenplay by

GARY PICARD and VALERIE UTTON

New Resources

NEW EXPANDED SECOND EDITION

I love you so much that...



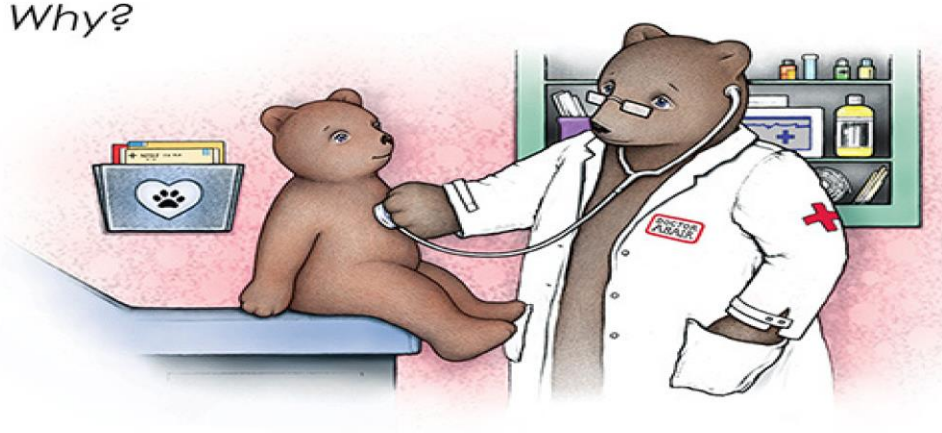
Written by Kathy J. Picard
Illustrated by D. Louise Nicholson

READERS' FAVORITE BOOK AWARD FINALIST

I love you and want you to be safe
so much that

I want you to
keep your private parts private.

Why?

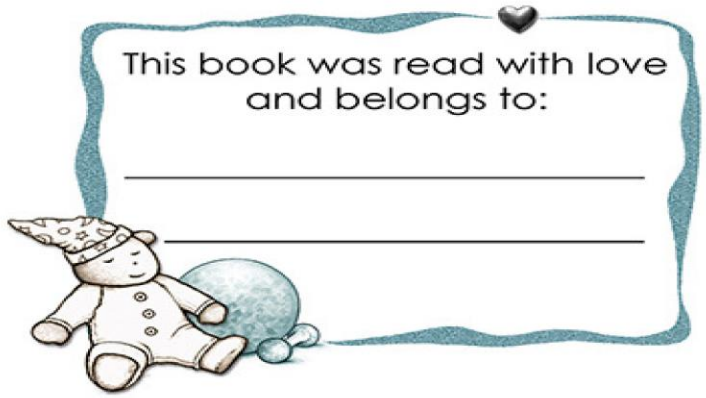


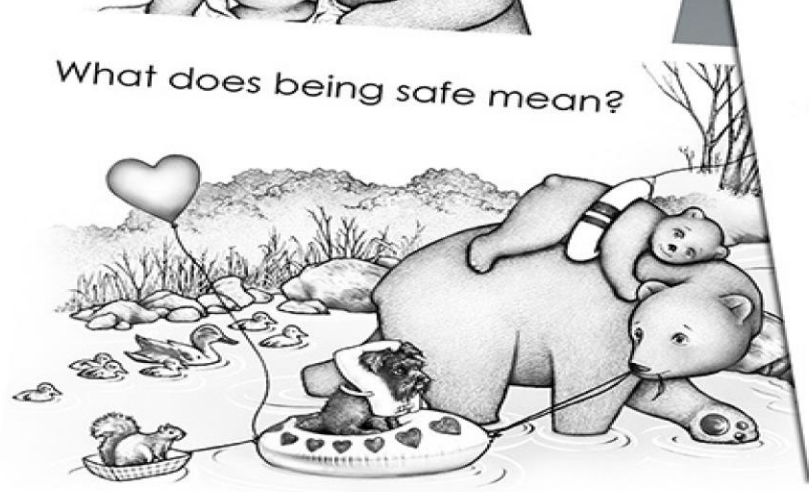
Because private means we don't show or share them with other people.

Is there a time when it's okay for someone to see your private parts?

Early Prevention

A Life Lesson





Q & A:

All Questions Welcome!

This heartfelt project is dedicated in loving memory of
Danny Croteau and Molly Bish.

One person can make a difference in the life of
a child, and by doing so makes the world
a safer place for us all.

Thank you on behalf of children everywhere

Kathy J. Picard

413.575.4674

Kathychildadvocate@gmail.com

Presentation # 4

1:00-2:00pm

The Family Perspective

Amanda Pappas, Care Coordinator, BHN Intensive Care Coordination Program

Presentation # 5

2:00-3:00 pm

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

Jeffrey McCarthy, Psy.D.
Western Massachusetts Outpatient Mental Health CBOC Program Manager
Chair, Disruptive Behavior Committee (DBC)
VA Central Western Massachusetts Healthcare System

Special Considerations for Veteran Population

Central Western Massachusetts
VA Healthcare System

First Responders Training

Why We are Here

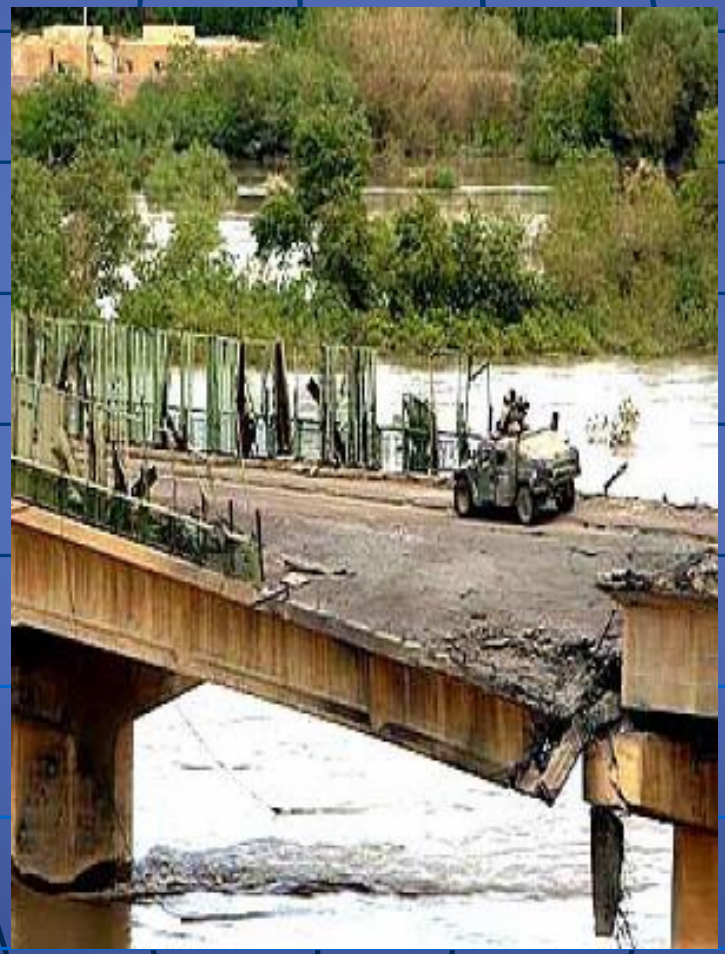
War may be hell…but home ain't exactly heaven, either. When a Soldier comes home from war, he finds it hard…

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.

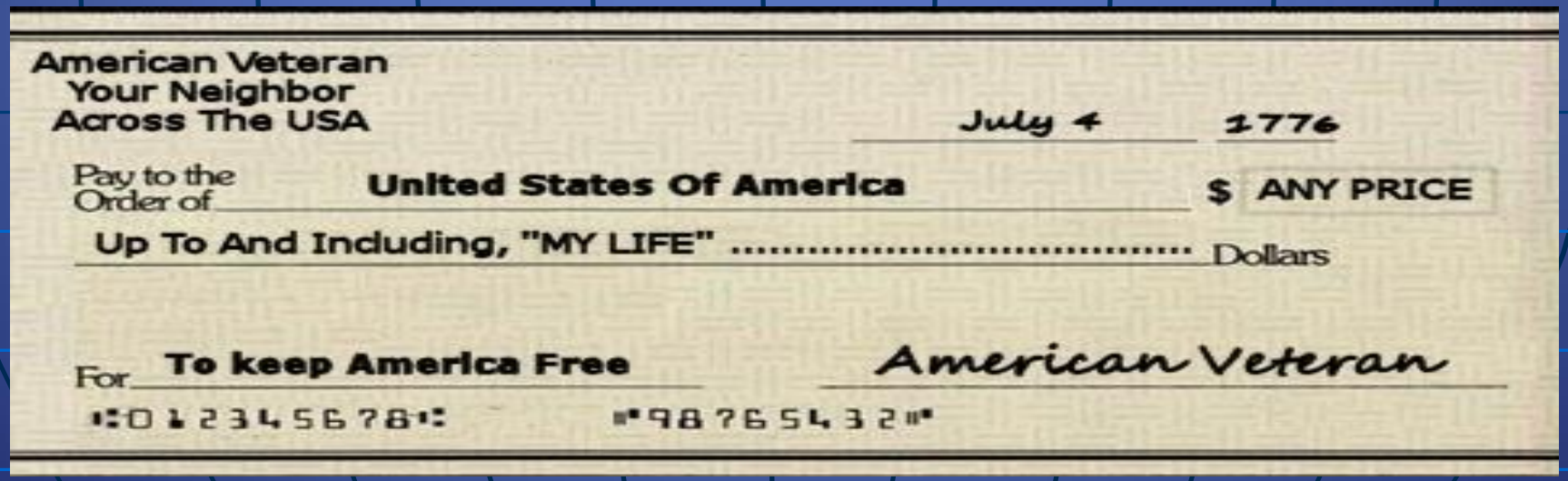
…to just walk away when someone says they only get two weeks of vacation a year.

…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.

Who 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.



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

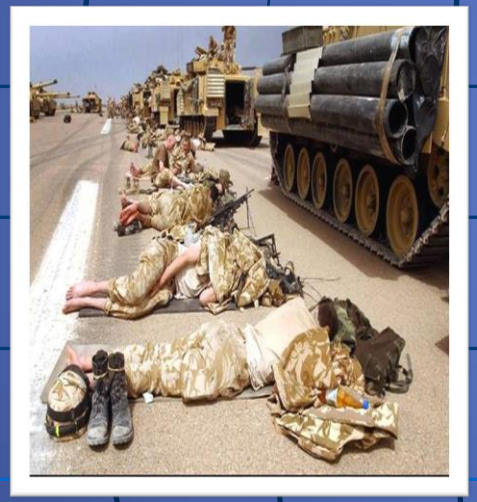
- In 2018 – 180,000 incarcerated Veterans in MA
  - -SUD was #1 factor for arrest
  - -Symptoms of PTSD was #2 factor for arrest (anger/irritability)
- Veterans are more likely to be sentenced for violent offences

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)

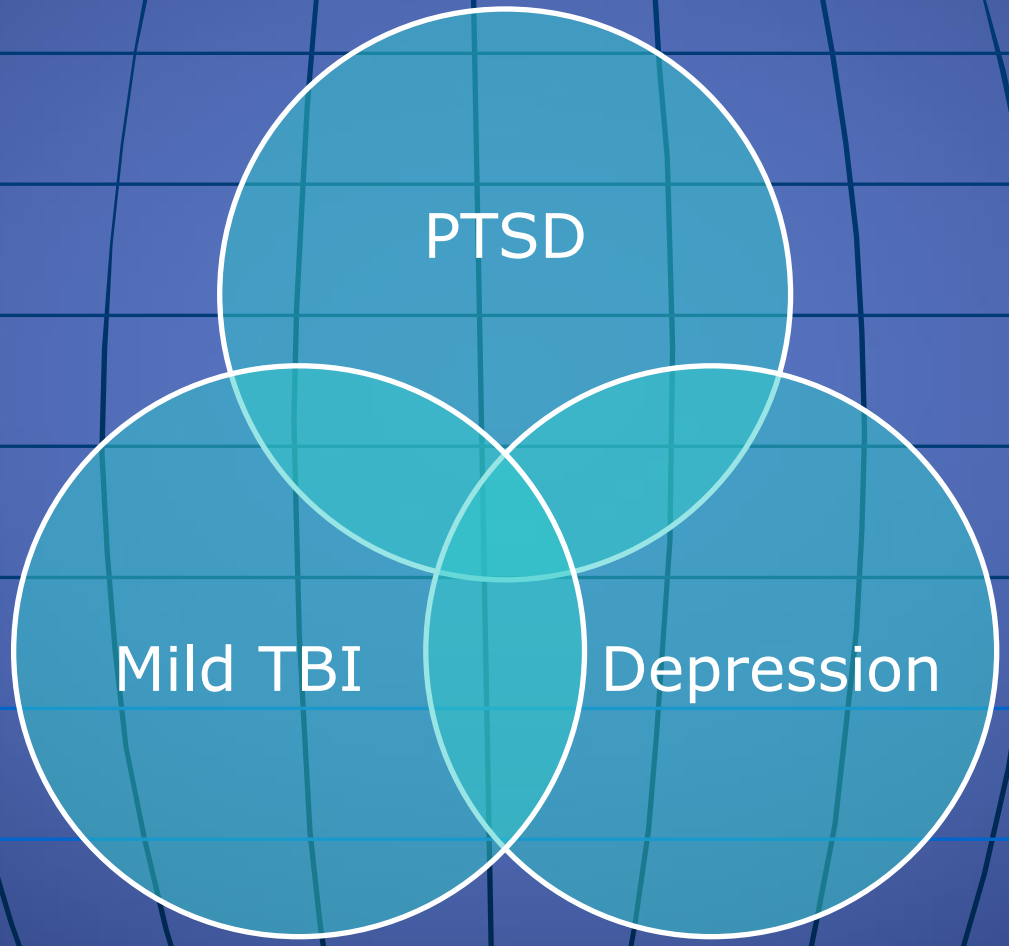
Behaviors We May See

- 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

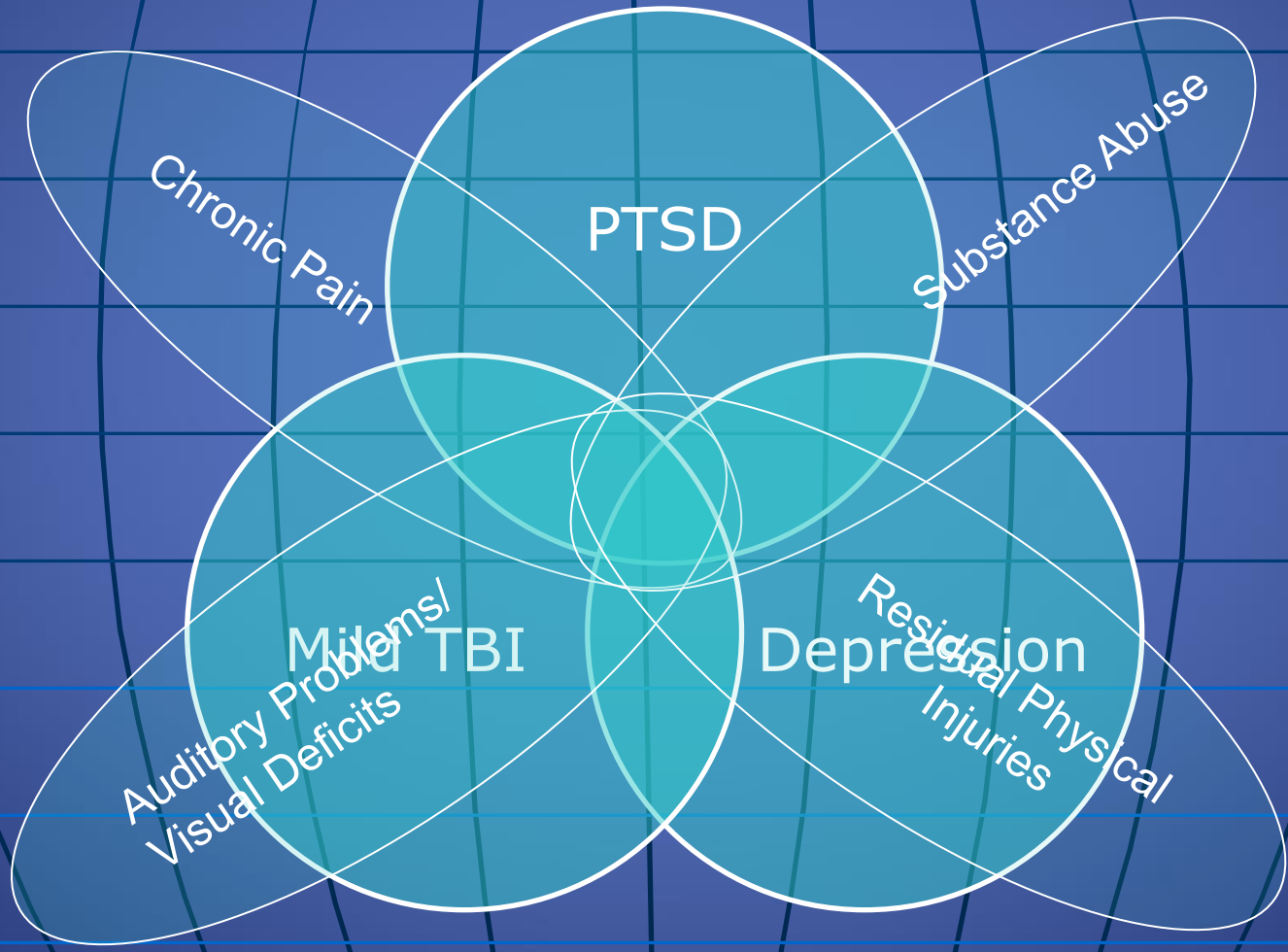
Domestic Violence

- 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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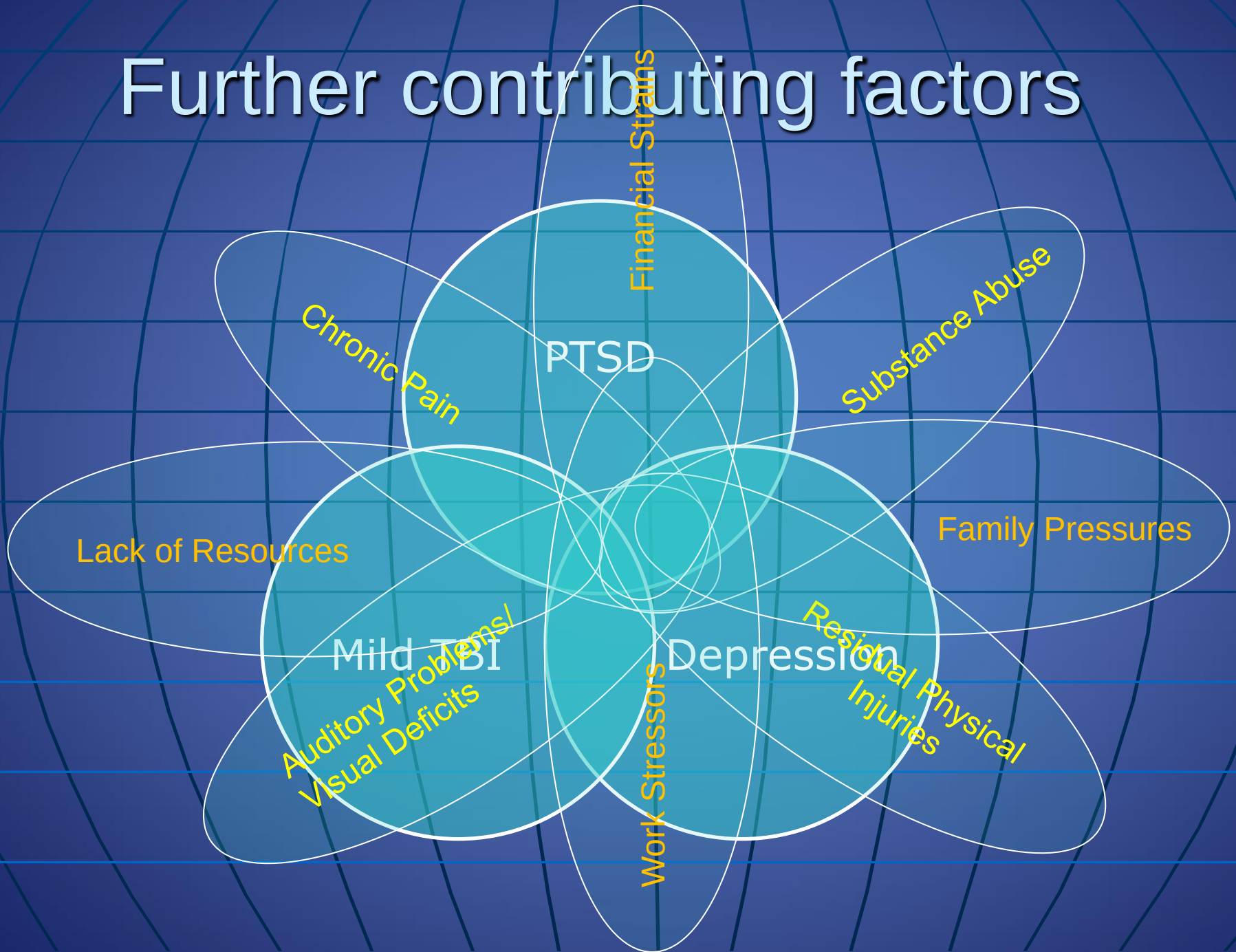


Veterans Crisis Line:
Call, Chat, or Text

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

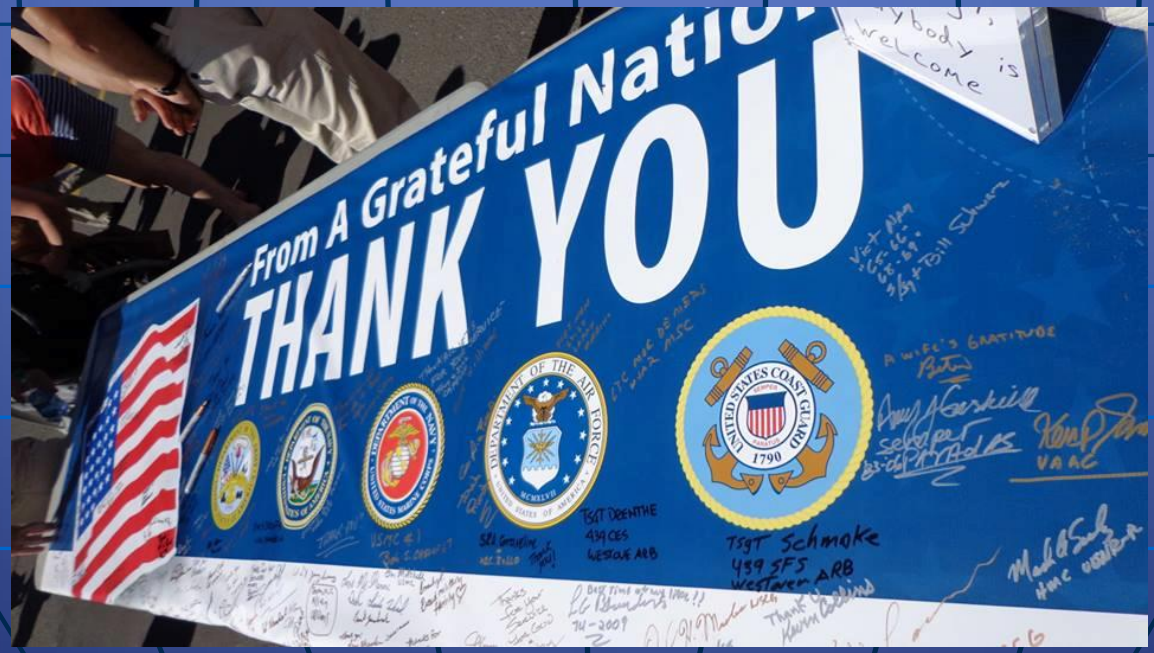
- *Eligibility determination is based on each individual's service. We encourage all Veterans to apply for VA services.*

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)

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

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

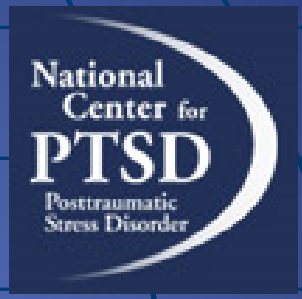
@VAVetCenters

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

Presentation # 6

3:00-4:00 pm

Department of Children & Families (DCF) Intersections with Law Enforcement

Michael Collins, MS, Criminal Justice, Area Director, DCF Springfield Area Office