

CIT Training

Day 2

March 28, 2023

SUICIDE PREVENTION

STOP STIGMA

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
- Identify Risk and Protective Factors
- Identify Resources available
- Consider the importance of self care

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.

TRAINING EXPECTATIONS: SUICIDE IS A SENSITIVE TOPIC



Introduction

March 29, 2023

Suicide Prevention

Suicidal thoughts vs Suicidal Intensity

Committed, Completed vs died by suicide

Successful vs Failed

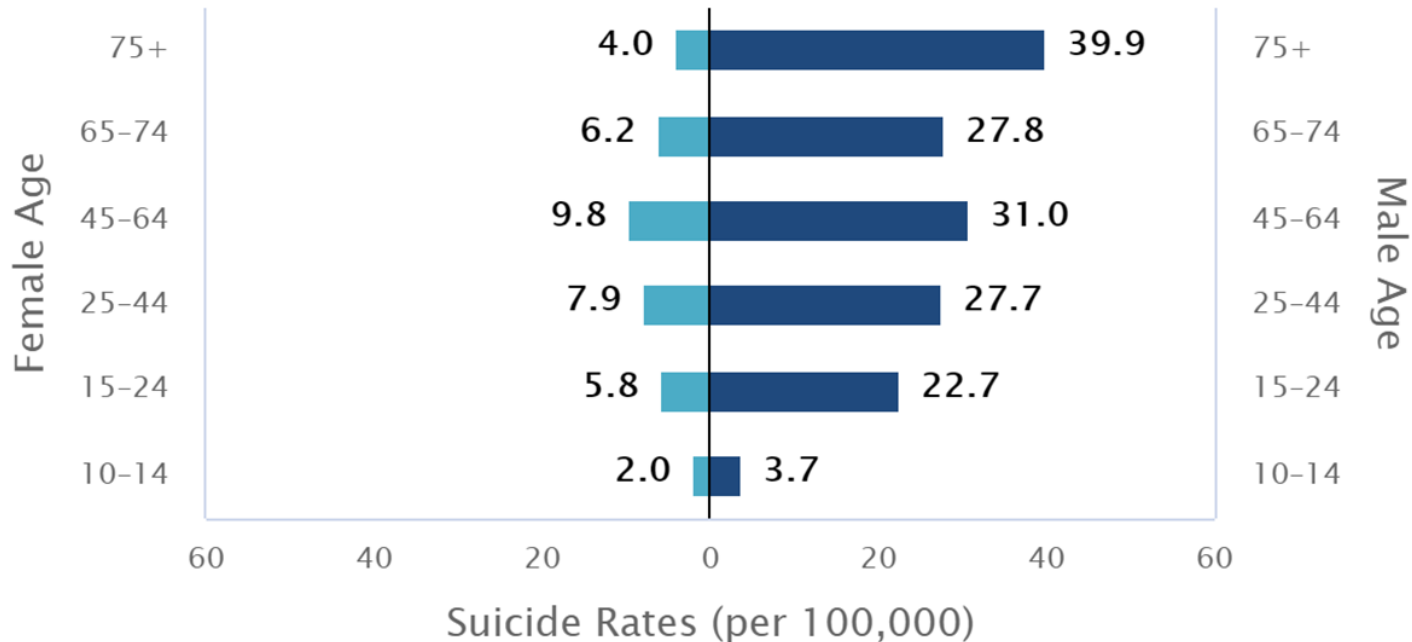
Serious vs level of lethality

Attention seeking vs Attention needing

PREFERRED LANGUAGE

Suicide Rates by Age (per 100,000; 2018)

Data Courtesy of CDC



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

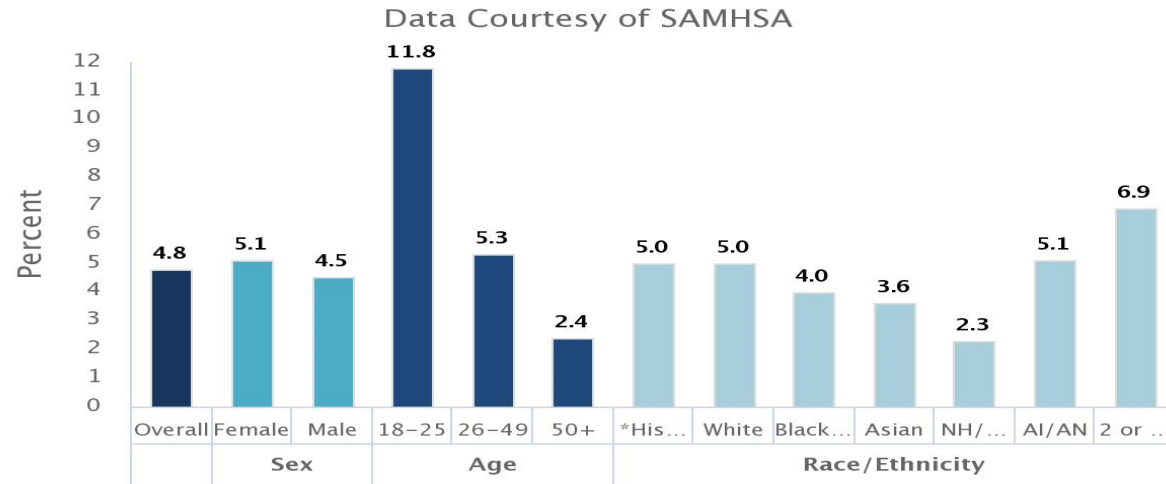
For children: Black male children are the highest risk

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

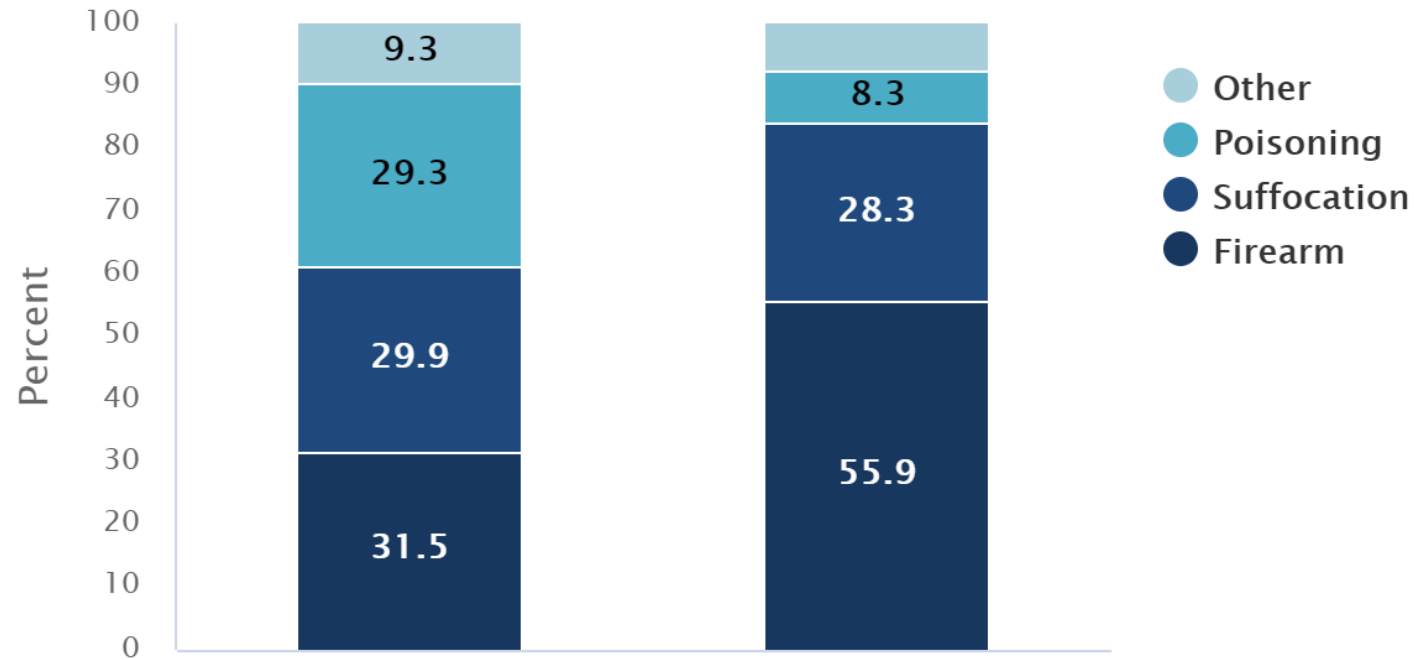
AND RESEARCH INDICATES THESE NUMBERS ARE ON THE RISE.....

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



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

Data Courtesy of CDC



Access to lethal means!

WHAT EXPLAINS THE DISCREPANCY?



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

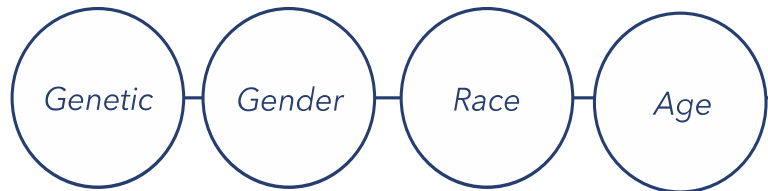
Suicide is a multi-factorial event. It is almost never caused by only one thing or event.

SUICIDE AS A MULTI-FACTORIAL EVENT

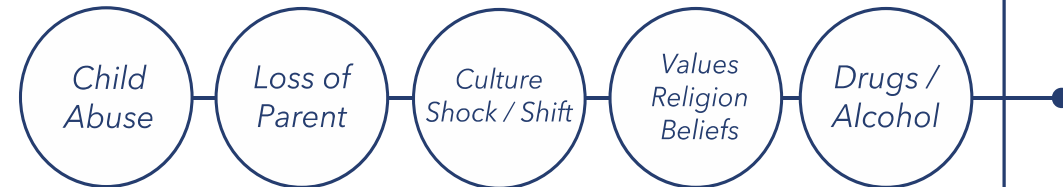
The Many Paths to Suicide

Fundamental Risk Factors

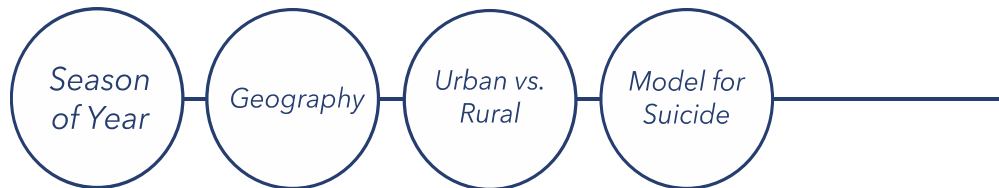
BIOLOGICAL



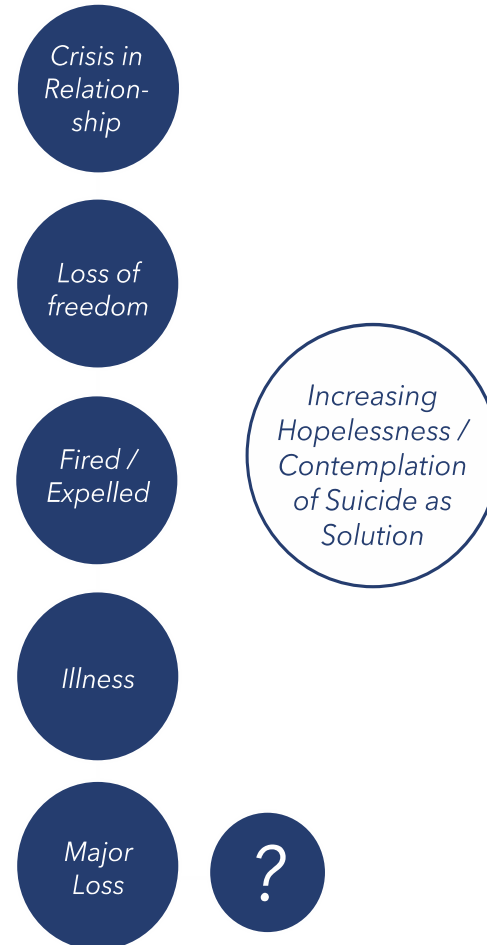
PERSONAL / PSYCHOLOGICAL



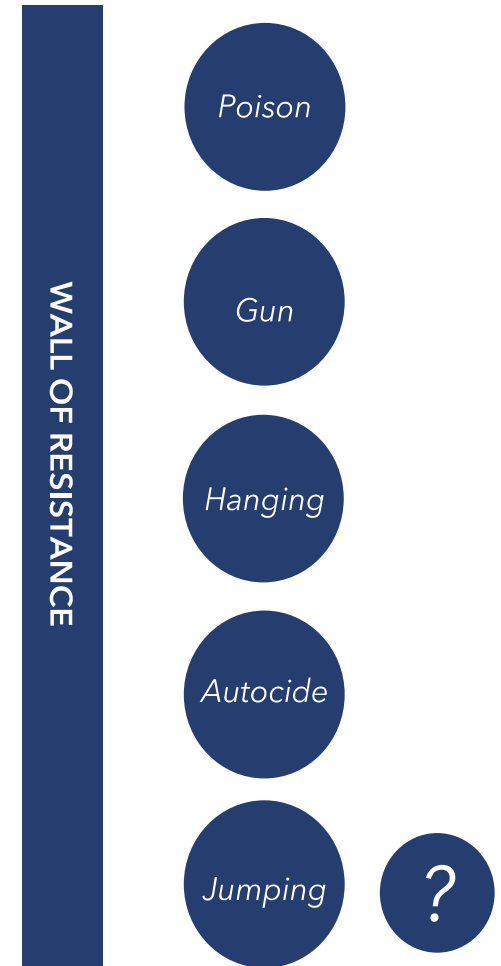
ENVIRONMENTAL



Proximal Risk Factors "Triggers or Final Straws"



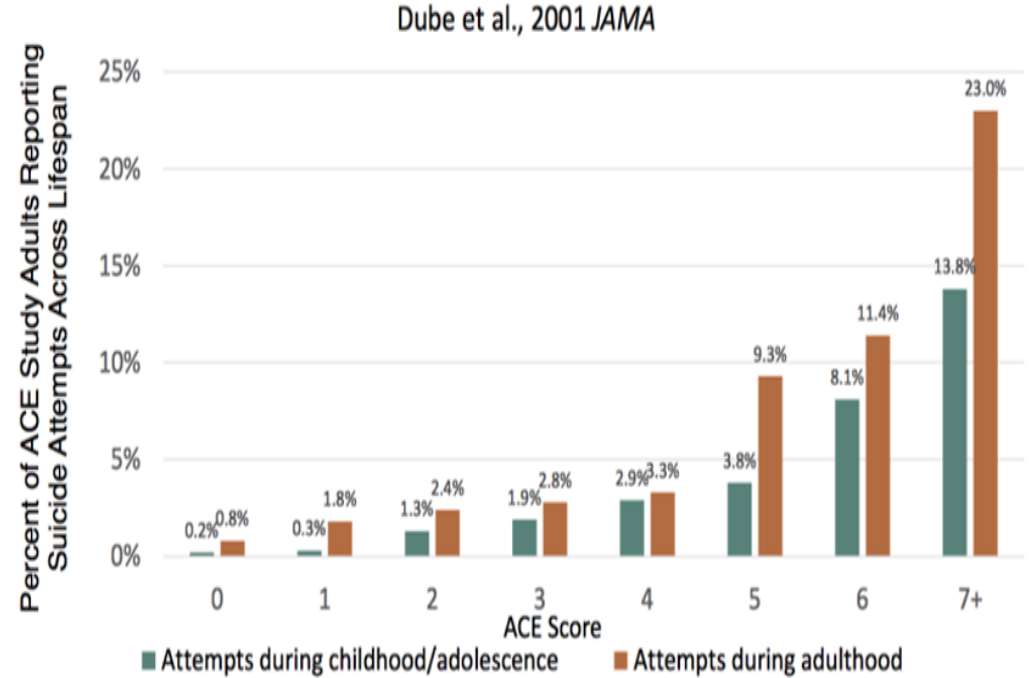
Cause of Death



INVISIBLE RISK: ADVERSE CHILDHOOD EXPERIENCES



ADVERSE CHILDHOOD EXPERIENCES



- **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.

SUICIDE: MYTHS AND FACTS

- **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.

MYTHS AND FACTS (CONT)



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

CAUSATION OF SUICIDE - RISK FACTORS ADULTS

- **A suicide risk factor is a measurable demographic, trait, behavior, or situation that has a positive correlation with suicide attempts and/or death by suicide.**
- *Previous suicide attempt*
- *Mental illness, such as depression*
- *Social isolation*
- *Criminal problems*
- *Financial problems*
- *Impulsive or aggressive tendencies*
- *Job problems or loss*
- *Legal problems*
- *Substance use disorder*

CAUSATION OF SUICIDE - RISK FACTORS CHILDREN

- Adverse childhood experiences such as child abuse and neglect
- Bullying
- Family history of suicide
- Relationship problems such as a breakup, violence, or loss
- Sexual violence
- Barriers to healthcare
- Cultural and religious beliefs such as a belief that suicide is a noble resolution of a personal problem
- Suicide cluster in the community
- Stigma associated with mental illness or help-seeking
- Easy access to lethal means such as firearms or medications
- Unsafe media portrayals of suicide
- Decision making capabilities

CHILDREN SUICIDE — AT RISK GROUPS

- Specific groups as well can be more vulnerable to suicide ideation such as:
 - Those who are being bullied at school or online through social media
 - LGBTQ+ youth
 - Minority group members
 - Black youth - a group that has seen a dramatic increase in suicide rates compared to other racial and ethnic groups
 - Those who may already have a mental health concern, even children with ADHD

SUICIDAL PROTECTIVE FACTORS

- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Connections to friends, family, and community support
- Supportive relationships with care providers
- Availability of physical and mental health care
- Limited access to lethal means



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?”

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

KEY POINT!

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.

P: PERSUADE

- 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.

R: REFER

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.

REMEMBER

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

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

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



Is it Legal or illegal

Which countries still consider
Suicide as illegal

Uni-bombers (in the name of a
religion)



Euthanasia vs Physician Assisted
Death (PAD)

Euthanasia - which is defined as
the act of assisting people with
their death in order to end their
suffering, but without the
backing of a controlling legal
authority

PAD - Suicide by a patient
facilitated by means (such as a
drug prescription) or by
information (such as an
indication of a lethal dosage)
provided by a physician aware of
the patient's intent

PAD legal in 10 US States and
the District of Columbia

COUNTRIES THAT HAS SUICICDE AS AN OFFENCE

Uganda

Bangladesh

Lebanon

Malaysia

United Arab Emirates

Kenya

Syria

Malawi

Brunei

Lebanon

Cyprus

Jordan

Sudan

Georgia

Myanmar

Papa New Guinea

Yemen

Oman

Bahamas

Pakistan

Guyana

Nigeria

South Sudan

Gambia

PAD in United States

- California- (End of Life Option Act; approved in 2015, in effect from 2016)
- Colorado - (End of Life Options Act; 2016)
- District of Columbia - (D.C. Death with Dignity Act; 2016/2017)
- Hawaii - (Our Care, Our Choice Act; 2018/2019)
- Maine - (Death with Dignity Act; 2019)
- New Jersey - (Aid in Dying for the Terminally Ill Act; 2019)
- New Mexico - (Elizabeth Whitefield End of Life Options Act; 2021)
- Oregon - (Death with Dignity Act; 1994/1997)
- Vermont - (Patient Choice and Control at the End of Life Act; 2013)
- Washington - (Death with Dignity Act; 2008)
- ---
- **In MA- General Laws Part II, Title II, Chapter 201D Section 12 – Suicide or Mercy Killing**
- *Section 12. Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one's own life other than to permit the natural process of dying.*

PAD in MA

- The Joint Committee on Public Health has extended their consideration of the End of Life Options Act ([H.2381/S.1384](#)). That means they are giving themselves more time to decide what they want to do, and if it will ultimately come up for a vote by the end of the 2022 legislative session.
- **End of Life Options Act will establish a proven death with dignity law and stop needless suffering.**
- The proposal is that adults with terminal illness should have the right to end their lives peacefully, in a dignified way, surrounded by family and loved ones.

TERMS associated w/Death

Double Effect

This is the doctrine established by St. Thomas Aquinas in the 13th century in which an action that has two effects—one that is intended and positive and one that is foreseen but negative—is ethically acceptable if the actor intends only the positive effect. The doctrine is often used to describe the impact of administering high doses of morphine or terminal sedation—treatments intended to relieve suffering but that often hasten death. Since the intention is comfort care, this is not considered euthanasia and is legal and generally practiced throughout the United States and around the world—generally in private and without publicity.

Assisted Death

This is also known as “physician-assisted suicide”, “physician-assisted dying” or “aid in dying” and is legal in the US states of Oregon and Washington. It permits mentally competent, terminally-ill adult patients to request a prescription for life-ending medication from their physician. The Oregon and Washington laws mandate that the medication must be self-administered.

Autonomy

This is the exercise of self-determination and choice among alternatives, based on the individual’s values and beliefs.

Advance Directive

This is a general term describing two kinds of legal documents [See Living Will and Durable Powers of Attorney]. Such documents allow a person to give instructions about future medical care in case they are unable to participate in medical decisions due to serious illness or incapacity. Each state has its own regulations concerning the use of advance directives. Find yours here.

TERMS associated w/Death

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

TERMS associated w/Death

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

TERMS associated w/Death

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

"What is a Suicide by Cop (SbC) incident?"

A Suicide by Cop incident is an encounter in which a suicidal person attempts to die by suicide by forcing a law enforcement officer to use lethal force.

For example, a suicidal person may point a firearm (or toy gun, replica gun or other object that resembles a firearm) at the officer or a bystander.

Or the suicidal person may run toward the officer with a knife or other dangerous object.

In some SbC incidents, the suicidal person repeatedly tells the officer, "Shoot me." However, in other cases, the person says nothing.

The defining characteristics of SbC incidents are that the subject:

- Threatens the life of the officer or another person, or
- Attempts to make the officer *believe* he poses such a threat,
- In order to give the officer no choice but to use lethal force to stop the threat.

How often do Suicide by Cop incidents occur?

- **Fatal incidents:** Each year from 2015 to 2018, there were approximately 900 to 1,000 fatal officer-involved shootings in the United States. And by various estimates, approximately 10 to 29 percent or more of officer-involved shootings involve Suicide by Cop incidents. Thus, it is reasonable to believe that there may be 100 or more fatal SbC incidents each year.
- **Nonfatal incidents:** A major research study in Los Angeles indicated that for every SbC incident that ended with the subject's death, there were approximately 60 *attempted* SbC incidents, in which the police de-escalated the incident without using lethal force.
- **Officer safety:** One of the 419 SbC cases in the Los Angeles study involved an injury to an officer.
-

How to recognize a SbC incident

- SbC incidents should be handled differently from other types of calls, in order to protect everyone's safety. Indicators of a possible SbC incident:
- The subject says "kill me" or "shoot me" or otherwise expresses a wish to die.
- The subject appears to be depressed or in a mental health crisis.
- The subject is not behaving like a criminal offender. For example, the subject does not attempt to leave the scene.
- The subject is behaving aggressively toward the police for no apparent reason.
- The subject is exhibiting strange behavior, such as committing random acts of vandalism or ramming a police car.
- Types of SbC
 - Planned
 - Spontaneous

Suicide by Proxy

- Any case involving a deliberate effort to cause a person's own death to be carried out by another individual is suicide by proxy. This subset covers suicides by trains, trucks, and public transit vehicles.
- High degree of lethality
- High level of intent
- Foolproof
- Convenient (most attempts occurred close to home)
- Planned, rather than impulsive

First Responders to a Suicide Call

- In order to respond well, officers need to be trained about suicidal behavior.
 - Mood destabilized
 - Comorbid substance abuse and dependence
 - Altered Mental Status
 - Means

First Responders to a Suicide Call

- Preparing officers mentally is important in responding effectively to suicidal suspects. Training should emphasize emotional regulation.
- Officers must maintain control of their emotions and not meet hostility with hostility or fear with fear.
- Every first responder should be given crisis intervention training. This training must emphasize officer safety by discussing the importance of maintaining a safe distance, the importance of having more than one officer on scene, and skill building in the area of crisis de-escalation.
- Training should teach facts and be scenario based and interactive, rather than simply a traditional lecture and slideshow didactic delivery method

Safe Approach

- During this therapeutic approach, officers must not get careless when exercising officer safety at calls for service involving suicidal subjects. Be mindful of use of force policy.
- It is imperative to remember the basics: watch the subject's eyes and hands, keep a safe distance, have another unit on the scene with you, command the scene by way of a nonthreatening supportive approach, maintain a calm demeanor, explain to the subject what is occurring, and repeat your desire to help.
- The aim of this is not only to de-escalate a crisis situation, but also to better serve persons with mental illness in our communities that also deserve a community policing approach.
- Steps to take in case an offense was committed.

Partnerships in Responding to Suicide

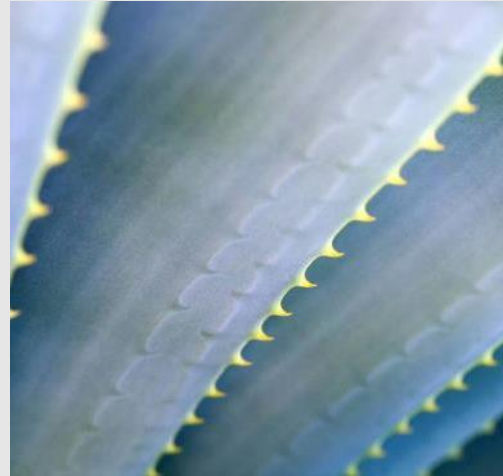
- Law enforcement alone cannot work with suicidal suspects.
- Partnerships in responding to persons with serious mental illness and specifically suicidal suspects are crucial.
- In the past, law enforcement entities throughout the United States operated in “silos,” not willing to trust or confide in a multitude of professional resources that were available to assist them.
- However, in recent years, law enforcement leaders have learned the benefits of partnering with other disciplines when responding to calls that require expertise and services beyond their competence or duties.

Thank you

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CIT-TTAC Coordinator

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Presentation #2

9:30am- 10:30am

Youth in Crisis

Zianna Dillon– YMCI Supervisor

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



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

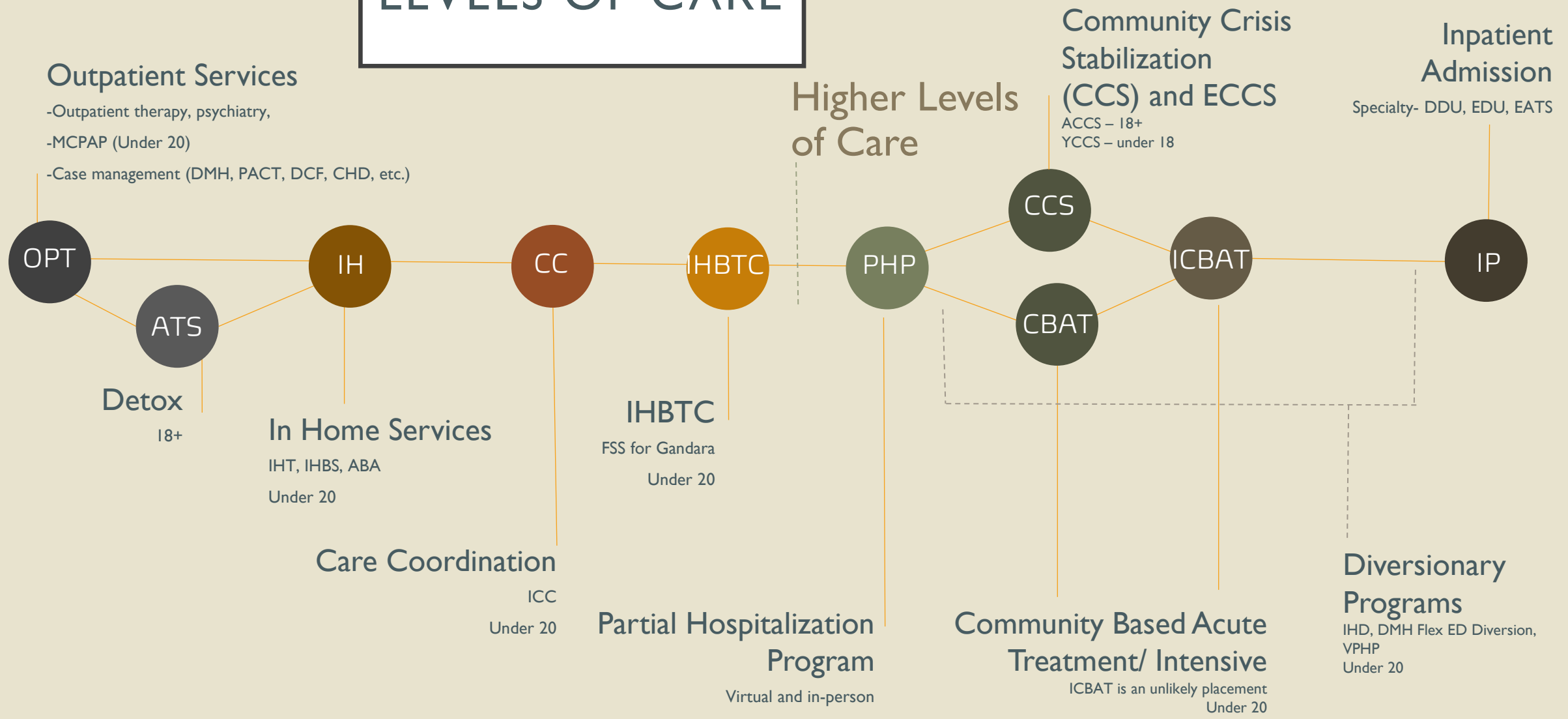
Push for an overall community approach and avoid Emergency Departments (ED)

- 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; 413-218-5845

Danielle McBain, YMCI Senior Family Partner – Danielle.McBain@bhninc.org; 413-657-0534

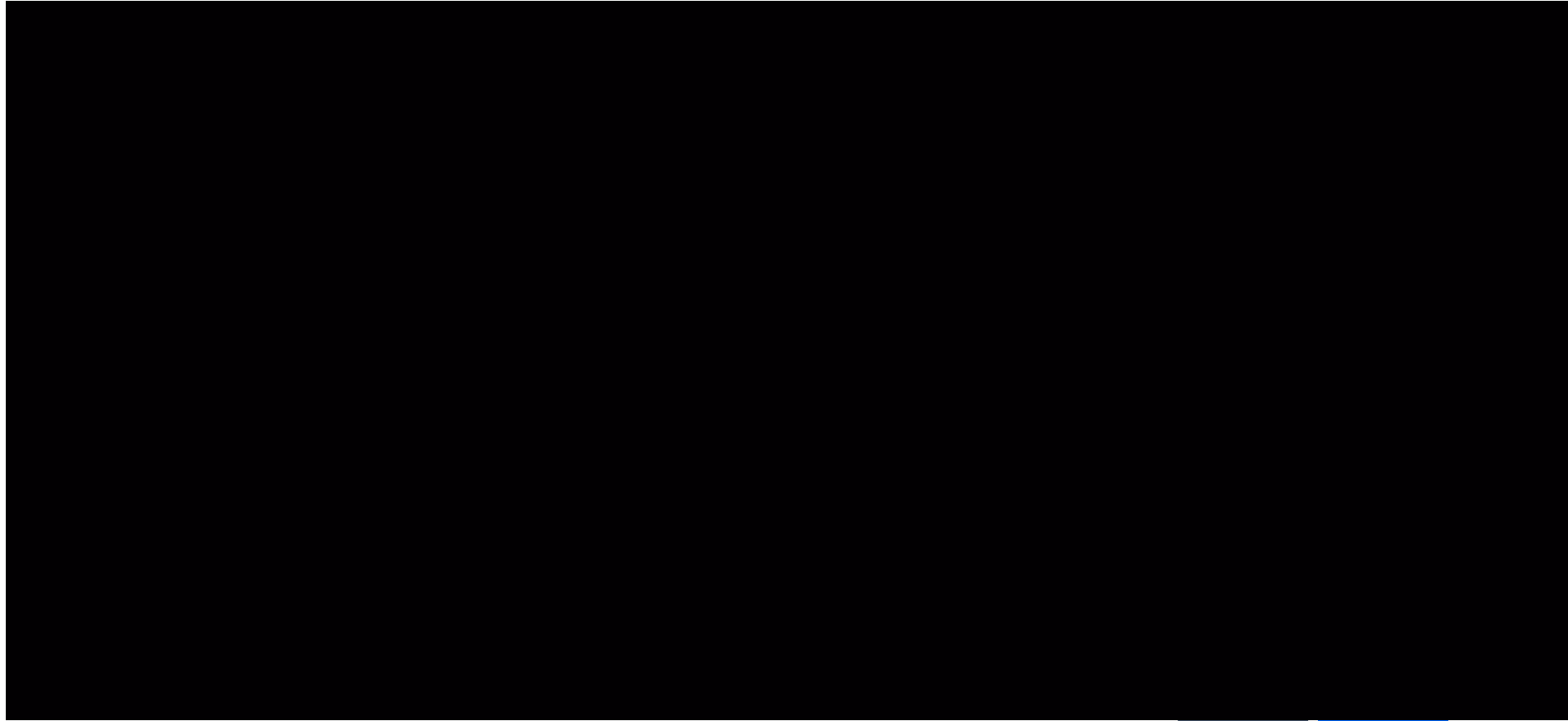
Presentation #3

10:30am – 12:00pm

Hearing Voices

Western MA CIT De-Escalation Training Team

Hearing Voices – Dr. P. Deegan



Hearing Voices – Dr. P. Deegan

A Tale of Mental Illness



Hearing Voices

SIMULATION EXERCISE

Presentation # 4

1:00pm-2:00pm

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:

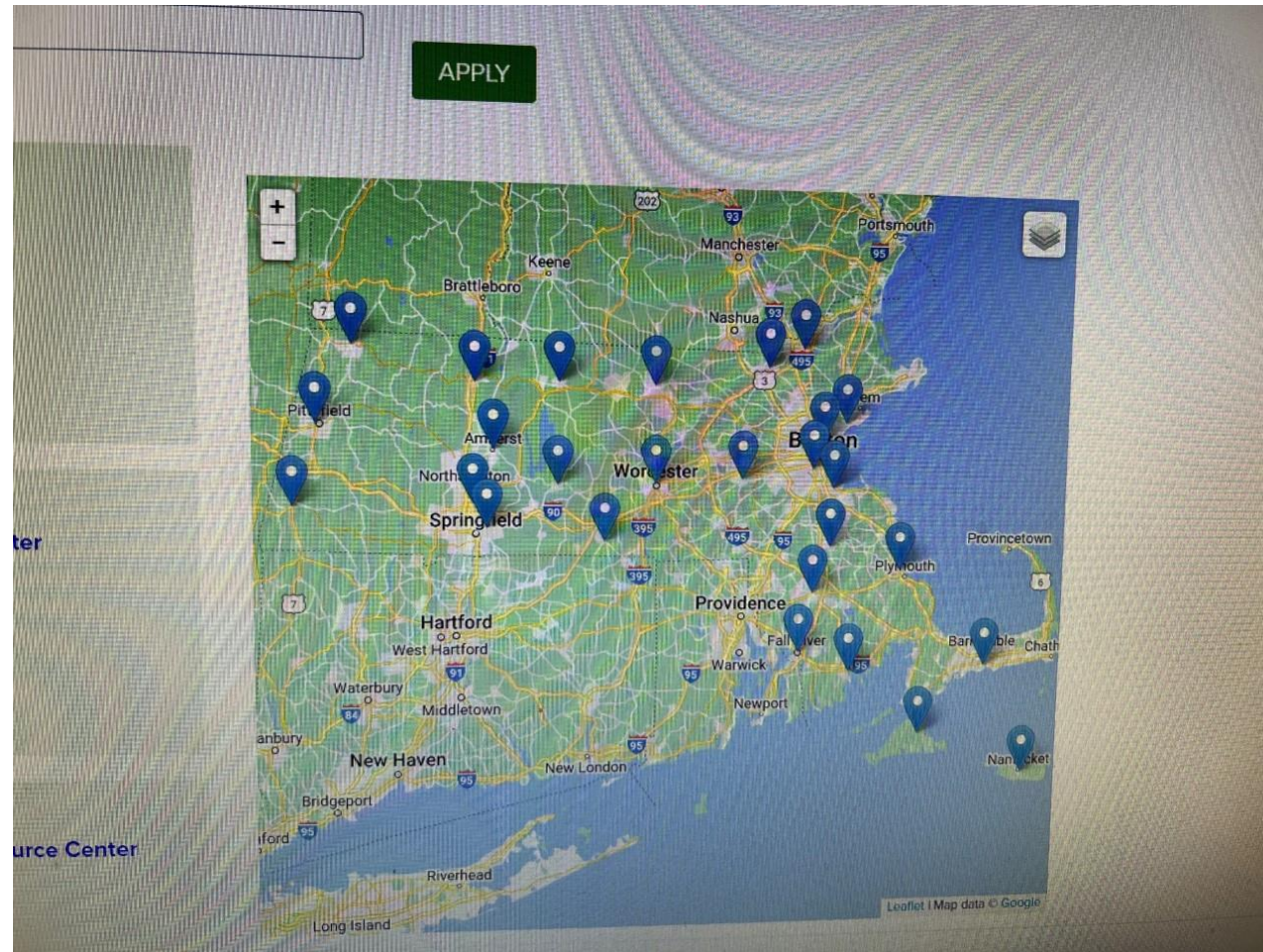
- If a parent is concerned about mental health, the crisis team (EMH) is more appropriate than police response. Mobile crisis will go to family, ER or site open 24/7.
- Anyone can call 211 at any time in 140 languages for referrals to counseling, detox, and other family issues.
- Parent/guardian can 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

2:00-3:00pm

DMH Community Services

Wayne Delusso, LICSW

Adult Case Manager, DMH



DMH Community Services

EOHHS

DEPARTMENT OF MENTAL HEALTH

MARCH 2022

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)

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Christine Fowle (413) 587-6448 (Westfield)

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Jennifer Dugan (413) 452-2310 (Springfield)

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Dan Sontag (413) 772-5600 (Greenfield)

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

Tracy.Harris@massmail.state.ma.us

Presentation # 6

3:00-4:00pm

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

End of Day 2
