DAY 4 – CIT TRAINING

8:00-9:00am	**Psychological Trauma** – Amber Robinson-Green, PsyD, DFP (Designated Forensic Psychologist), Adult Court Clinic
9:00-10:30am	**Forensics Service Overview** – John Barber, LICSW, Western MA Area Forensic Director, Statewide Coordinator of CIT-TTACs
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 helpless 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

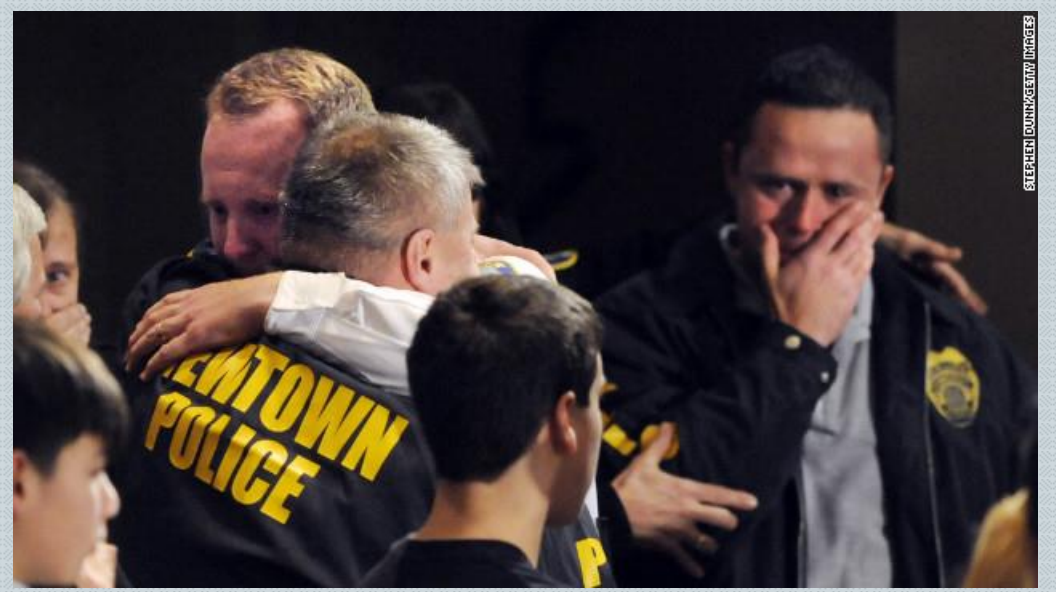
The more categories of trauma experienced in childhood, the more likely one experiences the following…..

- **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

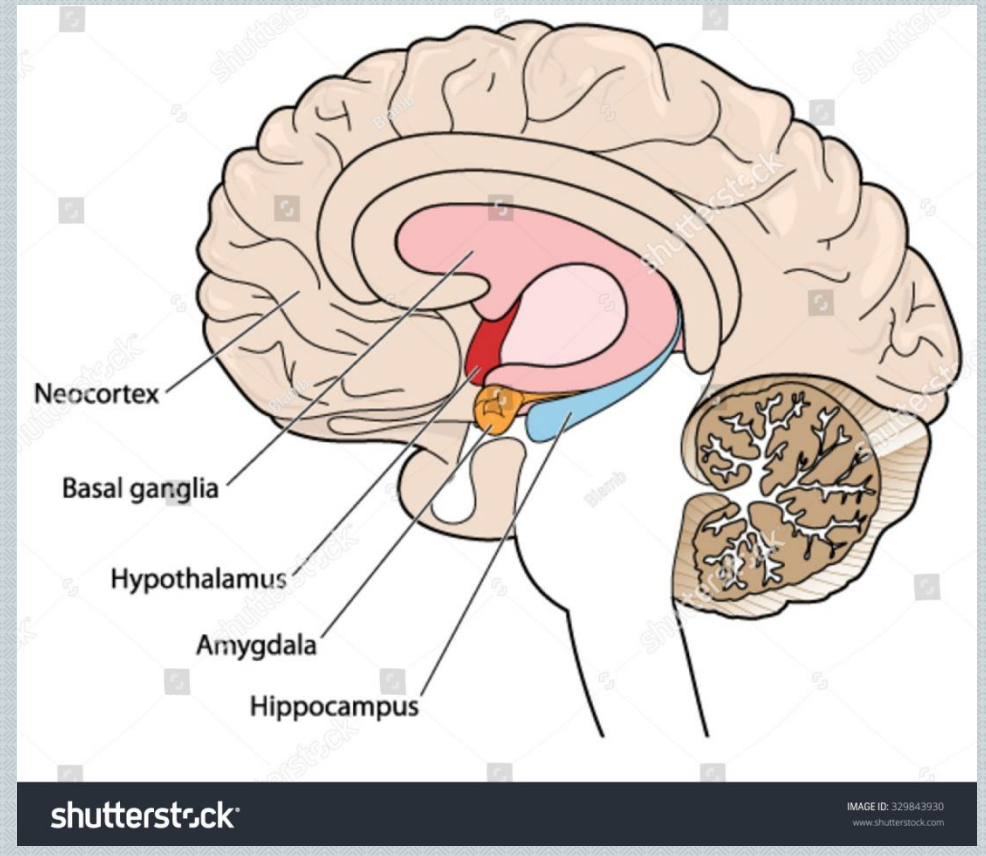
- Work-related trauma exposure following:
  - listening to individual clients recount their victimization
  - looking at videos or images of exploitation and abuse
  - reviewing case files
  - hearing about or responding to the aftermath of violence and other traumatic events day after day
  - responding 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

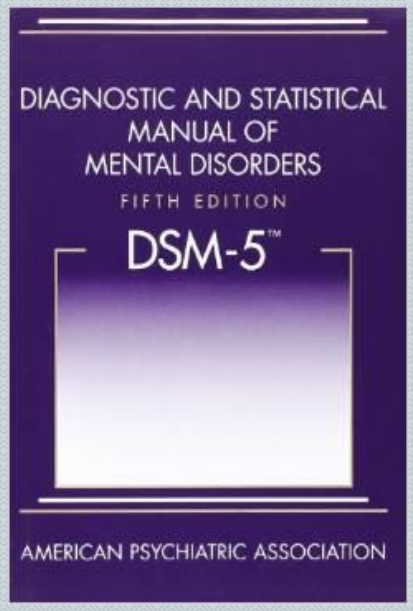
In PTSD multiple neurobiological systems are dysregualted and maladaptive

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

Neutrotransmitter/ Neurohormomonal System (Noradrenergic, Serotonergic, Hipothalamic-Pituitary-Adrenal axis (HPA axis)

A diagnosis but .....

It is natural to feel afraid. Fear triggers a "fight-or-flight" response – a typical reaction meant to protect a person from harm. Most people recover from initial trauma symptoms naturally. Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened even when they are not in danger.



...so while the criteria may not be fully met, trauma lies at the root of much of what we see in the criminal justice system

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

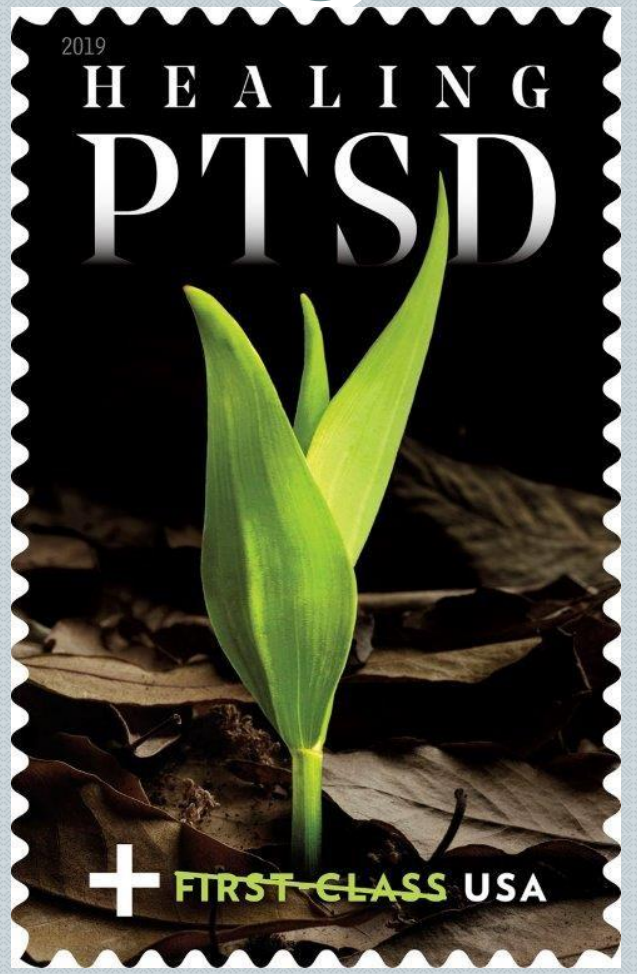
  (Trouble sleeping, Irritability, Reckless or self-destructive behavior Exaggerated startle response, Poor concentration)

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

Department of Mental Health (DMH)
Forensic Services Overview

John Barber, LICSW,
Western MA Area Director of DMH Forensic Services

DMH FORENSIC SERVICES OVERVIEW

PRESENTED BY:

JOHN C. BARBER, LICSW,

WESTERN MA AREA FORENSIC DIRECTOR, STATEWIDE COORDINATOR OF CIT-TTACS

EOHHS

DEPARTMENT OF MENTAL HEALTH

MARCH 30, 2022

DMH FORENSIC SERVICES

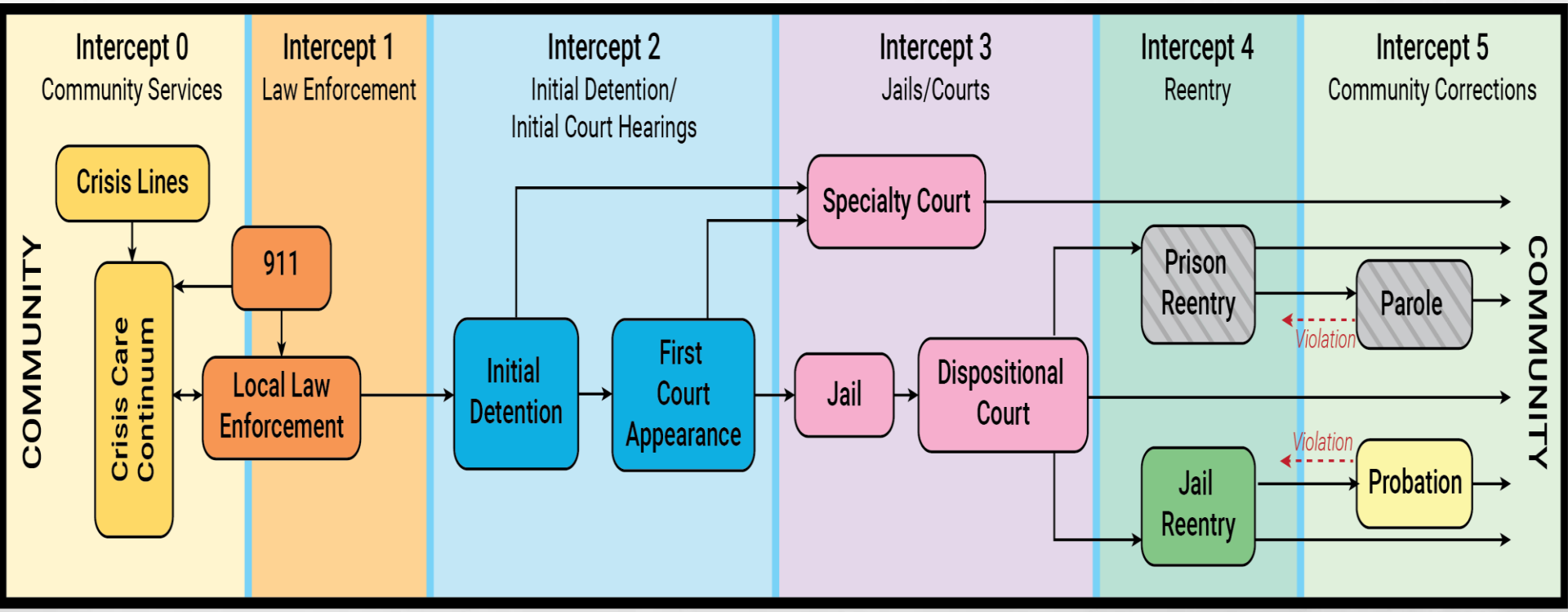
DMH FORENSIC MENTAL HEALTH SERVICES (FORENSIC SERVICES)

IS INVOLVED AT THE INTERSECTION BETWEEN BEHAVIORAL HEALTH AND ACROSS MULTIPLE POINTS IN THE JUSTICE SYSTEM

DMH FORENSIC SERVICES OVERVIEW

- JAIL/ARREST DIVERSION PROGRAMS (CIT/CO-RESPONDER)
- COURT CLINICS - BHN CONTRACTED ACC AND JCC IN WM
- INPATIENT FORENSIC EVALUATIONS*
- MI/PSB EVALUATIONS (MENTALLY ILL/PROBLEMATIC SEXUAL BEHAVIOR)*
- SPECIALTY COURT SERVICES
- FORENSIC TRANSITION TEAM (FTT)
- DFP CERTIFICATION AND TRAINING*
- INSPECTION OF CORRECTIONAL HEALTH SERVICES IN SEGREGATION UNITS*

MENTAL HEALTH AND SUBSTANCE ABUSE INTERCEPTS IN THE CRIMINAL JUSTICE PROCESS: A BROAD OVERVIEW



POLICE-BASED JAIL DIVERSION

- EARLY INTERCEPT FOCUS
- DMH FUNDING FOR POLICE-BASED DIVERSION BEGAN IN 2007
- DMH CURRENTLY FUNDS AROUND 100 JDP'S (JAIL DIVERSION PROGRAMS) IN MA, IMPACTING OVER 170 CITIES AND TOWNS
- EMERGENCY SERVICE PROGRAMS ARE KEY PARTNERS – §12 MERRY-GO-ROUND VS. WARM HANDOFF?
- EXAMPLES

JAIL DIVERSION PROGRAM TYPES

- POLICE DROP OFF CENTERS
- CRISIS INTERVENTION TEAM: COMMUNITY INITIATIVES THAT ARE LAW ENFORCEMENT LED
- POLICE-BASED CLINICIAN
  - CO-RESPONSES
  - FOLLOW UP RESPONSES
- TTACS: TRAINING AND TECHNICAL ASSISTANCE CENTERS
  - CRISIS INTERVENTION TEAM
  - CO-RESPONSE

WHY JAIL DIVERSION MATTERS

- DISPROPORTIONATE PERCENTAGE OF PEOPLE WITH SMI (SERIOUS MENTAL ILLNESS) IN JAIL: ABOUT 14.5% OF MALES, 31% OF FEMALES
- 1 IN 16 PEOPLE HAVE A SMI, BUT PEOPLE WITH SMI ARE 3-4X AS LIKELY TO BE IN JAIL
- OPPORTUNITY TO ENGAGE WITH TREATMENT THROUGH PROBATION AND SPECIALTY COURT SERVICES
- CASE EXAMPLE

CO-RESPONSE IMPACTS

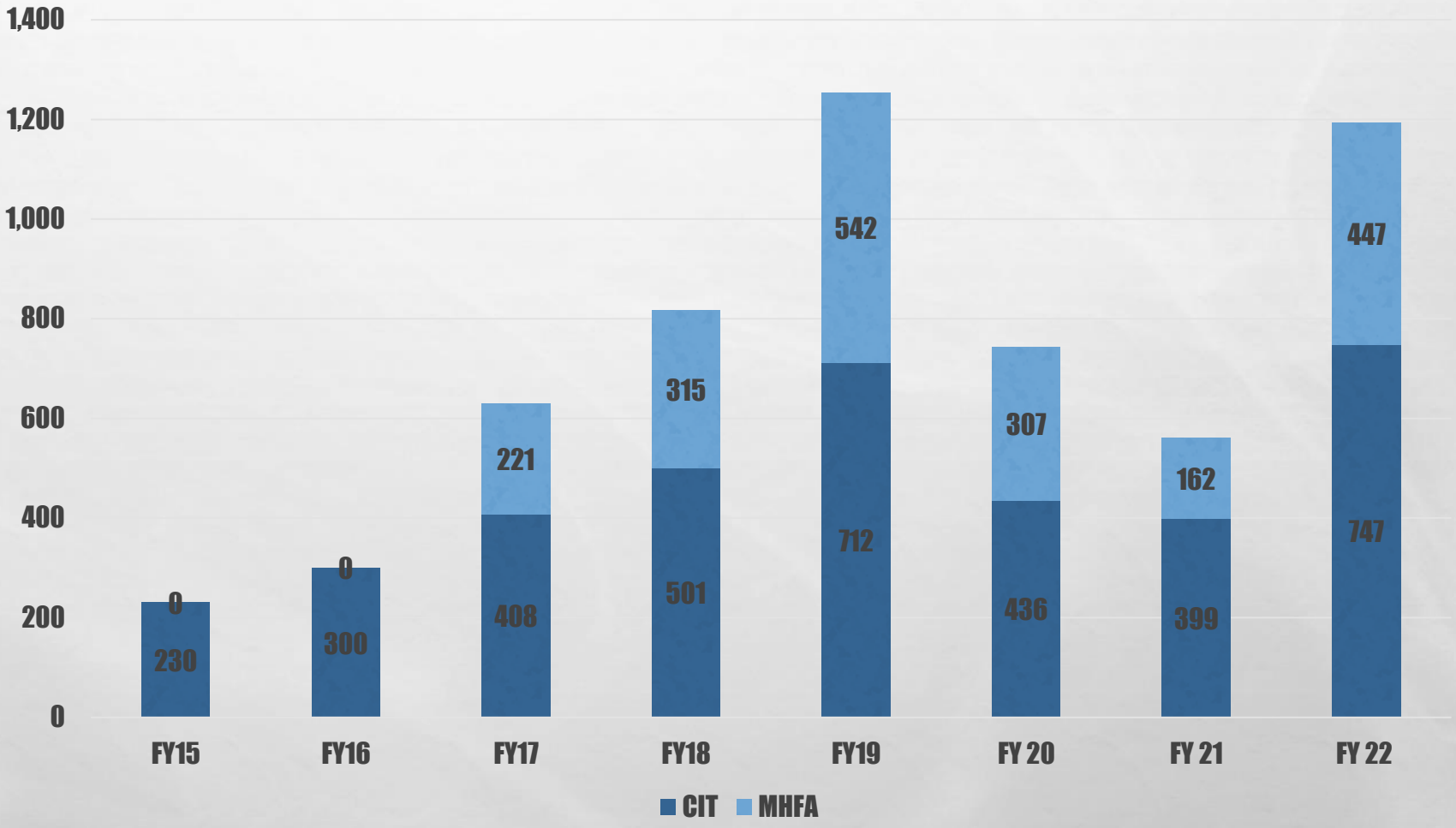
USE OF POLICE-BASED CO-RESPONSE CLINICIANS RESULT IN:

- 1) LESS USE OF ER'S
- 2) PSYCHIATRIC SITUATIONS BEING RESOLVED AT THE SCENE
- 3) LESS ARRESTS, MORE DIVERSIONS INTO TREATMENT APPROPRIATE SERVICES
- 4) LESS TIME THAT OFFICERS NEED TO WAIT FOR CLINICIANS/MENTAL HEALTH RESPONSE.

PUBLIC SAFETY

- PEOPLE WITH MI MUCH MORE LIKELY TO BE VICTIMS THAN PERPETRATORS OF VIOLENCE
- SKILLFUL INTERVENTION AND FINDING APPROPRIATE OPTIONS FOR TREATMENT MAY BE MORE EFFECTIVE AND REQUIRE LESS TIME
- LESS USE OF FORCE AND MORE FOCUS ON EFFECTIVE DE-ESCALATION TECHNIQUES AND APPROACHES THAT MANAGE, NOT INFLAME THE CRISIS
- PEOPLE WITH UNTREATED MENTAL ILLNESS ARE 16X MORE LIKELY TO BE FATALLY SHOT BY LAW ENFORCEMENT DURING AN ENCOUNTER

DMH GRANT SUPPORTED POLICE OFFICER TRAINING FY 16-22



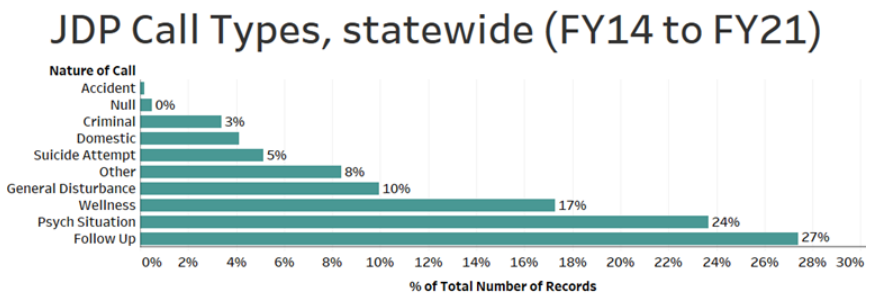
CIT TRAINING RESULTS

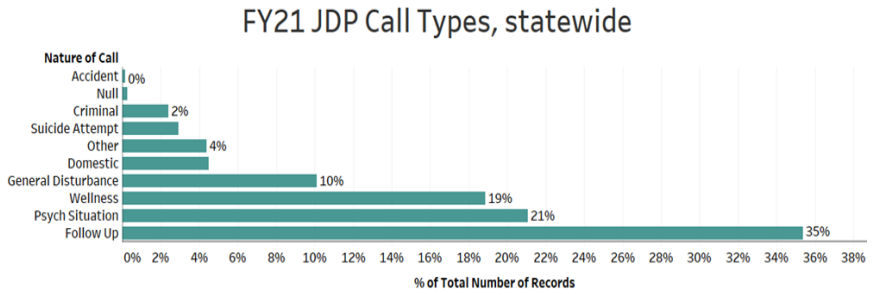
- STUDIES INDICATE THAT CIT TRAINING DEVELOPS INCREASED CONFIDENCE AMONG POLICE OFFICERS[1,2]
- CIT OFFICERS HAVE VERY EFFICIENT CRISIS RESPONSE TIMES
- INCREASED DIVERSIONS FROM ARREST AMONG THOSE WITH MENTAL ILLNESS
- IMPROVES TREATMENT CONTINUITY
- SIGNIFICANTLY DECREASES POLICE OFFICER INJURY RATES

1. COMPTON ET AL. "A COMPREHENSIVE REVIEW OF EXTANT RESEARCH ON CRISIS INTERVENTION TEAM (CIT) PROGRAMS" J AM ACADEMY PSYCHIATRY LAW 36:1:47-55 (MARCH 2008)

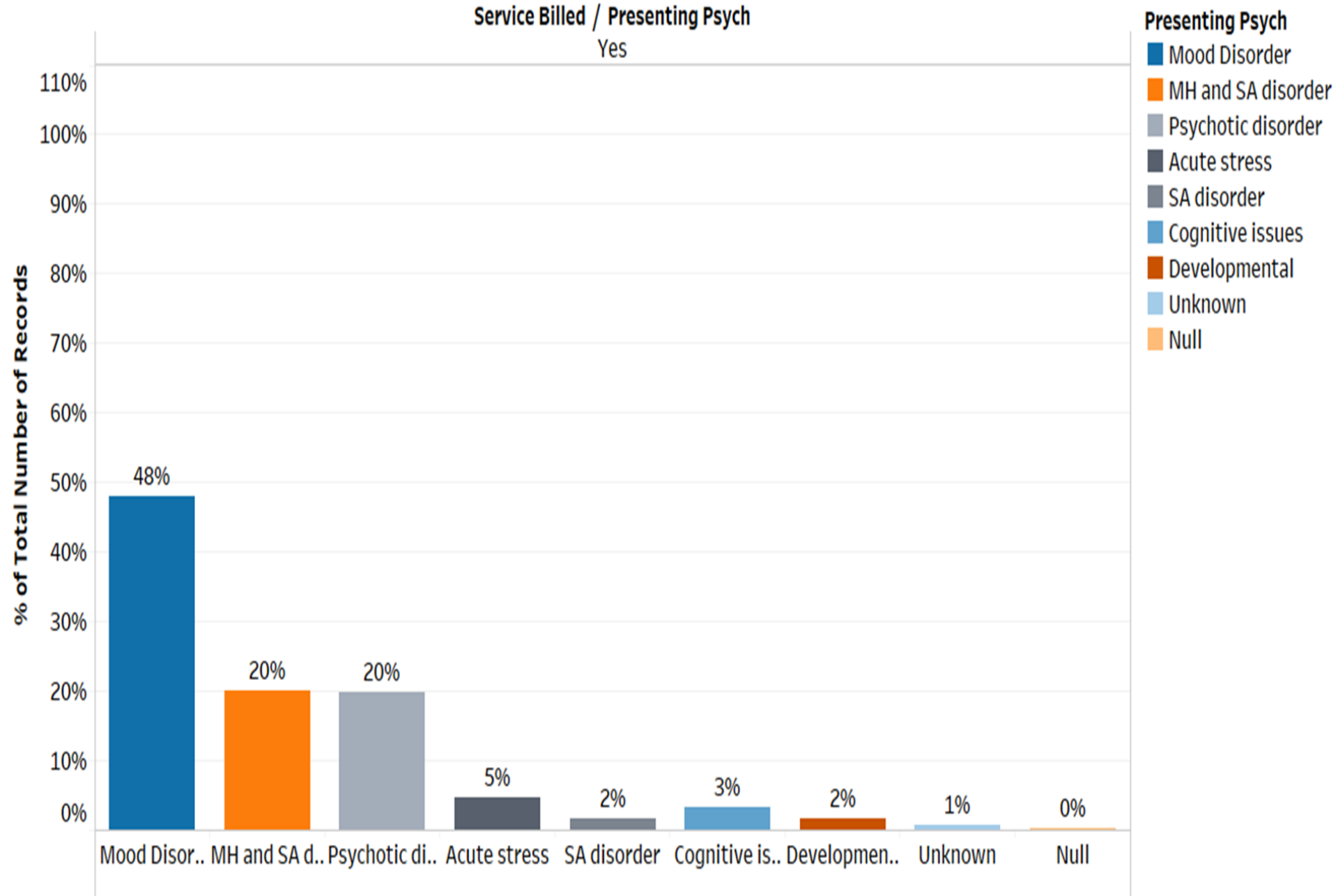
2. HTTP://WWW.CITINTERNATIONAL.ORG/TRAINING-OVERVIEW/163-MEMPHIS-MODEL.HTML

JDP Call Types

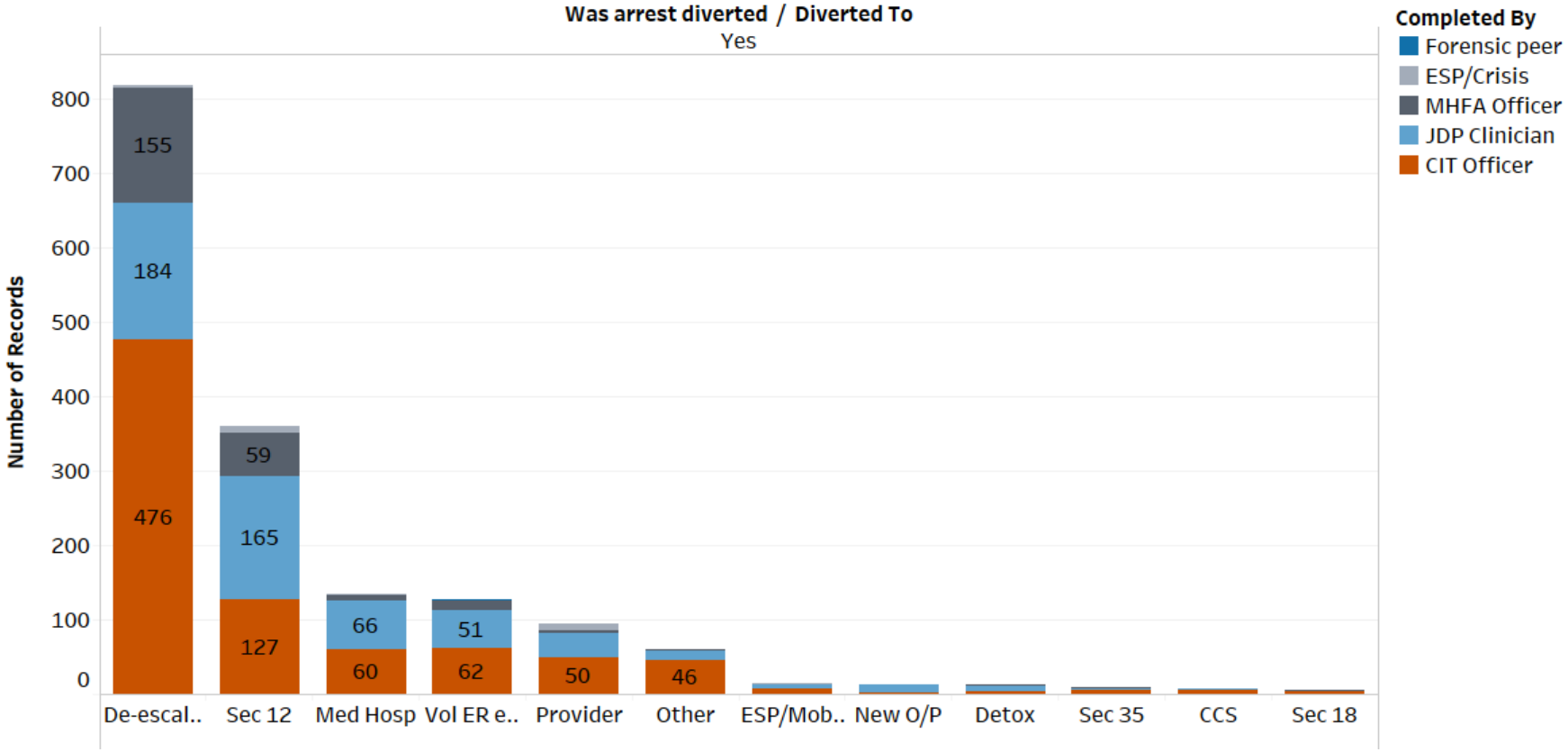




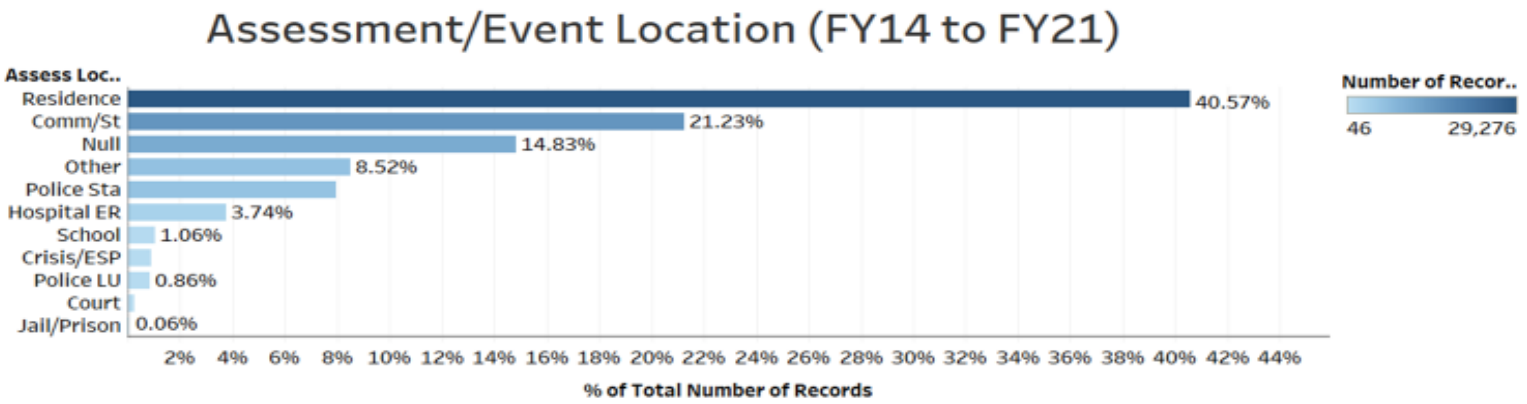
Primary Behavioral Health Issue



Diverted to by Model (FY21)



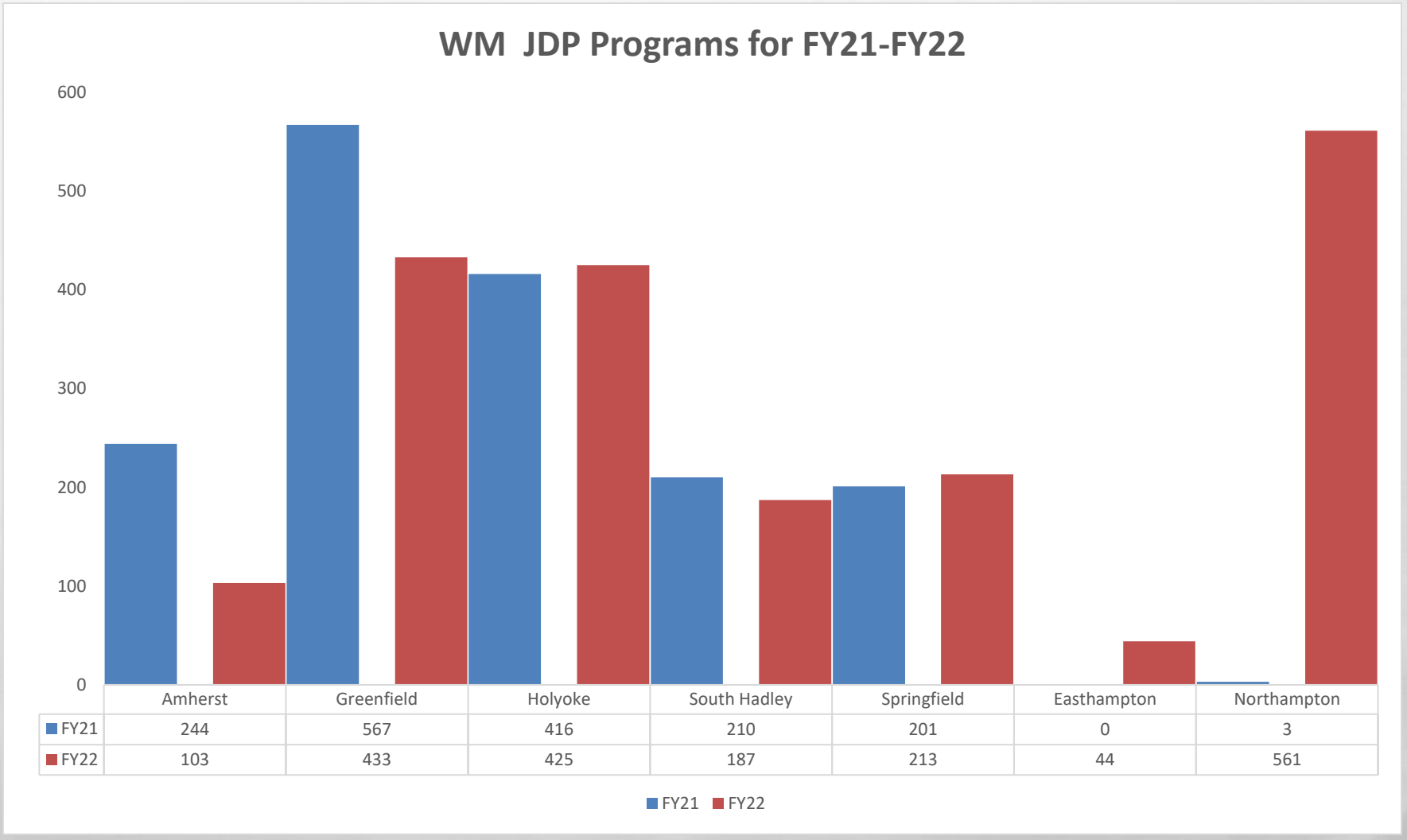
JDP Assessment/Event Locations



WM DMH JDP GRANTEES

- BHN CIT-TTAC (CIT TRAINING &TECHNICAL ASSISTANCE CENTER)
- BHN: POLICE DROP OFF CENTER (SPRINGFIELD), CSO: FRANKLIN AND HAMPSHIRE COUNTIES
- CURRENT POLICE DEPARTMENT AWARDEES: AMHERST, BELCHERTOWN, CHICOPEE, DEERFIELD, EASTHAMPTON/HADLEY, GRANBY, GREENFIELD, GREENFIELD REGIONAL, HOLYOKE, LONGMEADOW, MONTAGUE, NORTHAMPTON, SOUTH HADLEY, SOUTH HADLEY REG, SPRINGFIELD, WARE, WILBRAHAM
- OTHER WM COMMUNITIES INVOLVED WITH CIT TRAINING: E. LONGMEADOW, GREAT BARRINGTON, HAMPSHIRE COUNTY SHERIFF DEPT, HATFIELD, UMASS, WESTFIELD, W. SPRINGFIELD, AND…
- PAST WM GRANTEES INCLUDE: EGREMONT, AND WESTFIELD

WM JDP DATABASE INPUTS



	Amherst	Greenfield	Holyoke	South Hadley	Springfield	Easthampton	Northampton
FY21	244	567	416	210	201	0	3
FY22	103	433	425	187	213	44	561

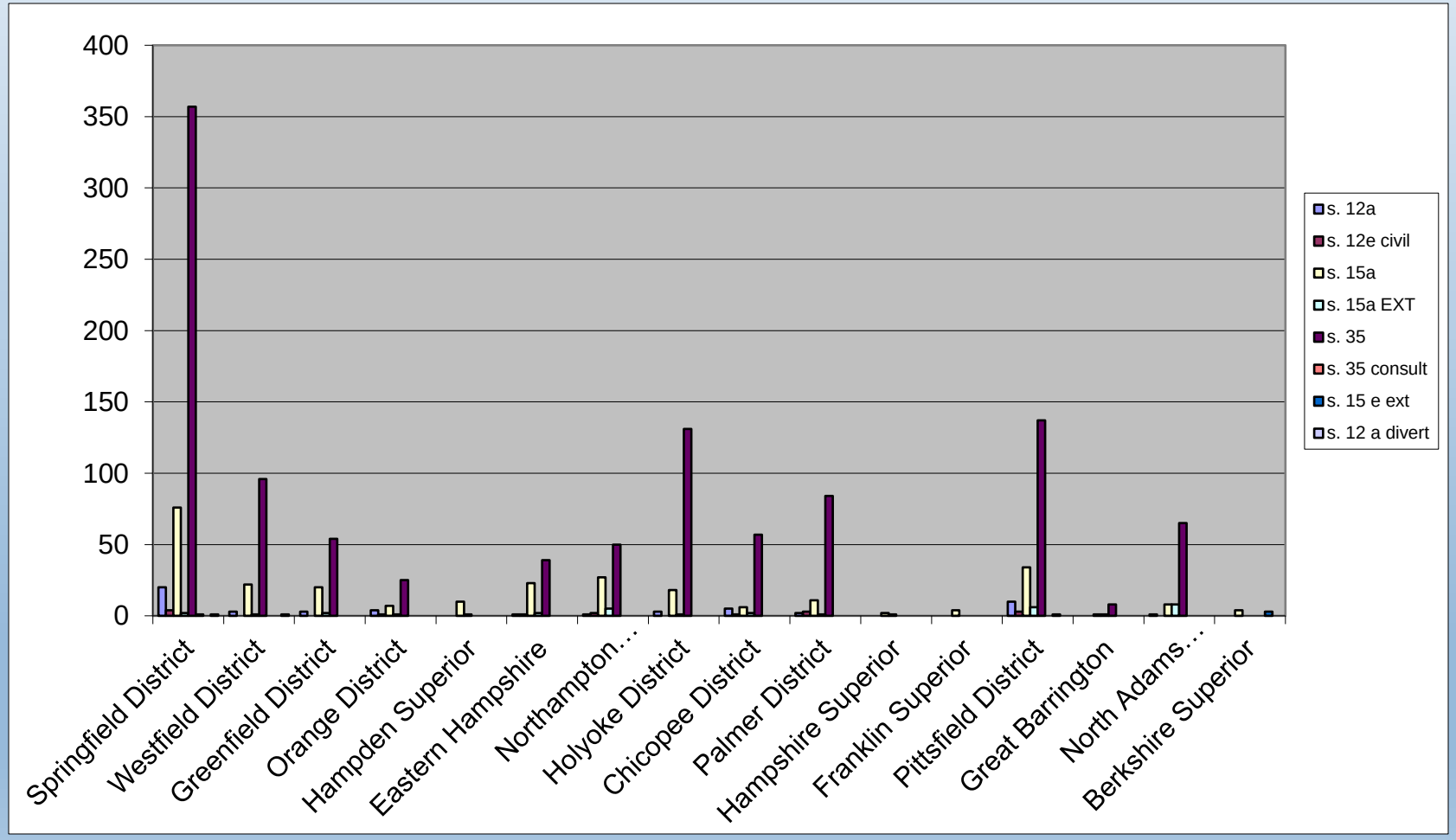
OTHER DMH POLICE TRAINING EFFORTS

- ANNUAL MENTAL HEALTH AND LAW ENFORCEMENT CONFERENCE (JUNE)
- OTHER SPECIALIZED TRAININGS (EX: MHFA FOR PUBLIC SAFETY, ADVANCED CIT, BLUE COURAGE, DISPATCH, CIT-Y, ETC.)
- LOCAL MH-LE COLLABORATIVE MEETINGS (5 LOCAL ONES)
- WORKING WITH THE MPTC ON MENTAL HEALTH TRAINING

COURT CLINIC EVALUATIONS

- BEHAVIORAL HEALTH NETWORK (BHN, INC.) IS DMH PROVIDER FOR COURT CLINIC EVALUATIONS (ADULT AND JUVENILE) IN WESTERN MA*
- REFERRALS AND CONSULTATION SERVICES CAN PROVIDE INFORMAL DIVERSION INTO TREATMENT
- §12E'S ROUTINELY TURN INTO §12A'S

TYPES OF WM COURT ORDERED EVALUATIONS COMPLETED, FY 22



MGL CHAPTER 123, §15A AND §15B

- §15A SCREENING– OUTPATIENT COMPETENCY TO STAND TRIAL (CST) OR CRIMINAL RESPONSIBILITY (CR) EVALUATIONS

- §15B – INPATIENT COMMITMENT FOR EVALUATION PURPOSES (CST AND/OR CR) – 20 TO 40 DAYS

LEGAL BASIS FOR COMPETENCY TO STAND TRIAL

- IN MASSACHUSETTS A DEFENDANT IS FOUND COMPETENT TO STAND TRIAL IF HE HAS "SUFFICIENT PRESENT ABILITY TO CONSULT WITH HIS LAWYER WITH A REASONABLE DEGREE OF RATIONAL UNDERSTANDING, AND IF HE HAS A RATIONAL AS WELL AS FACTUAL UNDERSTANDING OF THE PROCEEDINGS AGAINST HIM"

(*COMMONWEALTH V. VAILES, 1971*)

WHY DOES COMPETENCY MATTER?

- CASE EXAMPLES
- WHAT HAPPENS IF SOMEONE IS FOUND INCOMPETENT?
- WHAT IF THE DEFENDANT REMAINS INCOMPETENT?

CST AND CR TIMELINES

- COMPETENCY REPORTS LOOK AT WHETHER THE ACCUSED INDIVIDUAL IS COMPETENT ***NOW*** : CAN BE FOUND INCOMPETENT TO STAND TRIAL AND THEN LATER FOUND CST
- CRIMINAL RESPONSIBILITY LOOKS AT THE MENTAL STATUS AT THE TIME OF THE CRIME
- EXAMPLE OF CR CASE

NGI: NOT GUILTY BY REASON OF INSANITY

- WHAT PERCENTAGE OF CASES USE NGI DEFENSE?
- *LESS THAN 0.1% AND ONLY 25% SUCCEED*
- WHAT HAPPENS WHEN SOMEONE IS FOUND NGI? WHERE DO THEY GO?
- WHY ARE THERE SO FEW NGI'S?
- PUBLIC PERCEPTION VS. REALITY

NGI CRITERIA

MASSACHUSETTS LEGAL CRITERIA FOR BEING FOUND NOT CRIMINALLY RESPONSIBLE:

- INABILITY TO APPRECIATE WRONGFULNESS DUE TO MENTAL ILLNESS OR MENTAL DEFECT AT THE TIME OF THE CRIME
- INABILITY TO CONFORM CONDUCT DUE TO MENTAL ILLNESS OR MENTAL DEFECT AT THE TIME OF THE CRIME

FORENSIC HOSPITALIZATION

- WHERE DO PEOPLE GO WHEN THEY ARE FORENSICALLY HOSPITALIZED?
- HOW LONG ARE THEY HOSPITALIZED FOR?
- WHERE DO THEY GO WHEN THEY COMPLETE A FORENSIC HOSPITALIZATION?
- WHY ARE SOME MI PEOPLE HOSPITALIZED AFTER A CRIME, AND SOME ARE NOT? DOES THAT OCCUR BEFORE OR AFTER SENTENCING?

DMH INPATIENT UNITS

- SOLOMON CARTER FULLER (SCF), BOSTON
- WORCESTER RECOVERY CENTER AND HOSPITAL (WRCH)
- HAWTHORNE MENTAL HEALTH UNITS, TEWKSBURY STATE HOSPITAL
- METRO BOSTON MENTAL HEALTH UNITS AT LEMUEL SHATTUCK HOSPITAL (LSH)
- VIBRA WM UNIT (SPRINGFIELD)*
- TAUNTON STATE HOSPITAL**

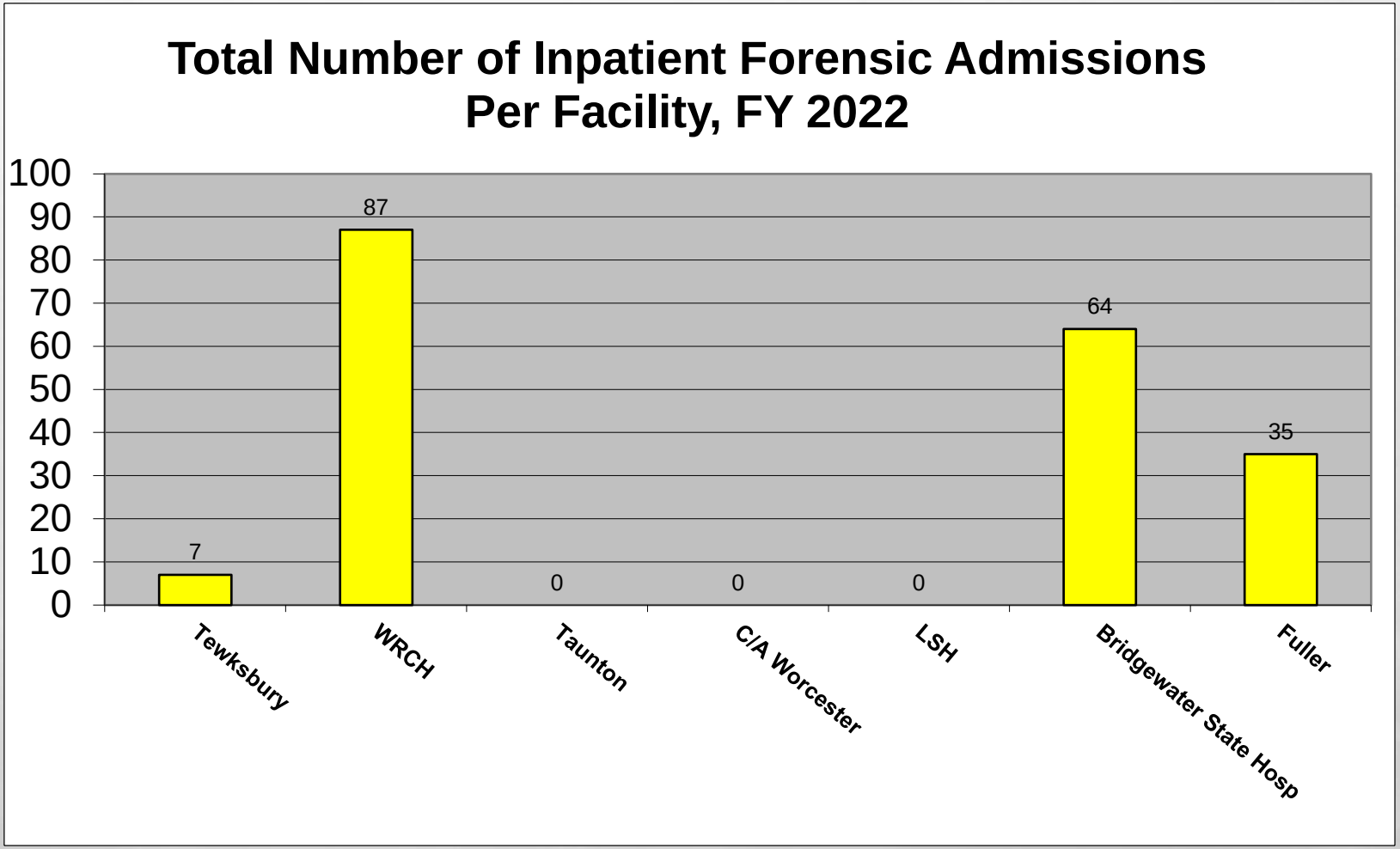
DMH ADULT INPATIENT

- AGE 19 AND OVER
- EVALUATION AND COMMITMENT FOR TREATMENT
- FORENSIC CASES COMPRISE OVER 50% OF ALL ADMISSIONS
- CIVIL AND VOLUNTARY PATIENTS
- PRE-ARRAIGNED PRISONERS IN POLICE CUSTODY VIA SEC.18(A)

DMH ADOLESCENT INPATIENT

- UNDER AGE 19, OCCURS AT WRCH'S ADOLESCENT UNIT
- EVALUATION AND COMMITMENT FOR TREATMENT
- FORENSIC CASES COMPRISE ONLY A SMALL FRACTION OF ADMISSIONS, BUT LENGTH OF STAY MAY BE LONGER
- CASES COME FROM ADULT AND JUVENILE COURT SETTINGS

WM FORENSIC HOSPITALIZATIONS AND PLACEMENTS, FY 22



§15E: "AID IN SENTENCING"

- EVALUATION CONDUCTED AFTER FINDING OF GUILT
- EXAMINES NEED FOR HOSPITALIZATION AND OTHER TREATMENT NEEDS
- EXAMINES MENTAL HEALTH FACTORS RELATED TO CRIMINAL CONDUCT
- WHY ARE 15E'S ORDERED?

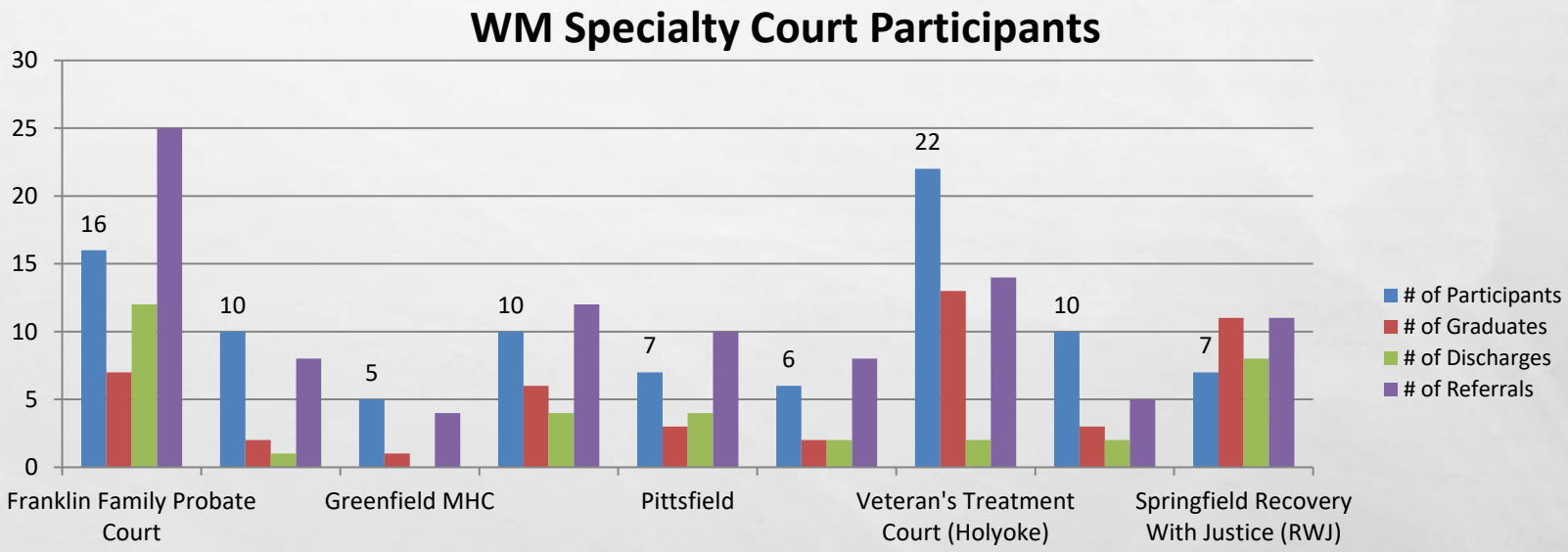
SECTION 16'S

- §16 (A): COURT ORDERED INPATIENT EVALUATION OF A CRIMINAL DEFENDANT AFTER A FINDING OF INCOMPETENCE TO STAND TRIAL (IST) OR NOT GUILTY BY REASON OF INSANITY
- §16(B) AND §16(C): COURT ORDERED COMMITMENT FOR CONTINUED TREATMENT OF A PERSON WHO HAS PREVIOUSLY BEEN FOUND EITHER IST OR NGI. NEED TO BE DEEMED A RISK TO SELF OR OTHERS
- §16(B) COMMITMENT – UP TO 6 MONTHS; §16(C) COMMITMENT– UP TO 1 YEAR
- PERIODIC COMPETENCY RE-EVALUATIONS (§17A)

WESTERN MA SPECIALTY COURTS

- SPRINGFIELD MENTAL HEALTH COURT – RECOVERY WITH JUSTICE; GREENFIELD ALSO HAS A MENTAL HEALTH COURT
- GREENFIELD, FRANKLIN FAMILY PROBATE, ORANGE, NORTHAMPTON, HAMPSHIRE PROBATE AND FAMILY, PITTSFIELD, AND SPRINGFIELD DRUG COURTS (BHN VENDOR)
- VETERANS SPECIALTY COURT (SERVING HAMPDEN, HAMPSHIRE, AND FRANKLIN COUNTIES) AT HOLYOKE DISTRICT COURT
- VETERANS TREATMENT COURT: SOLDIER ON IS DMH-CONTRACTED PROVIDER
- HOW DO SPECIALTY COURTS WORK?

WM SPECIALTY COURT DATA – FY 22



§18A TRANSFER

§18: TRANSFER OF PRISONERS IN NEED OF HOSPITALIZATION BY REASON OF MENTAL ILLNESS:

- **COURT-ORDERED INPATIENT EVALUATION OR COMMITMENT OF A PRISONER IN NEED OF TREATMENT**
- **MOST GO TO BSH AND REQUIRE STRICT SECURITY AS THEY ARE INCARCERATED**
- ***WOMEN PRISONERS COME TO DMH FACILITIES***

CIVIL COMMITMENT §35'S

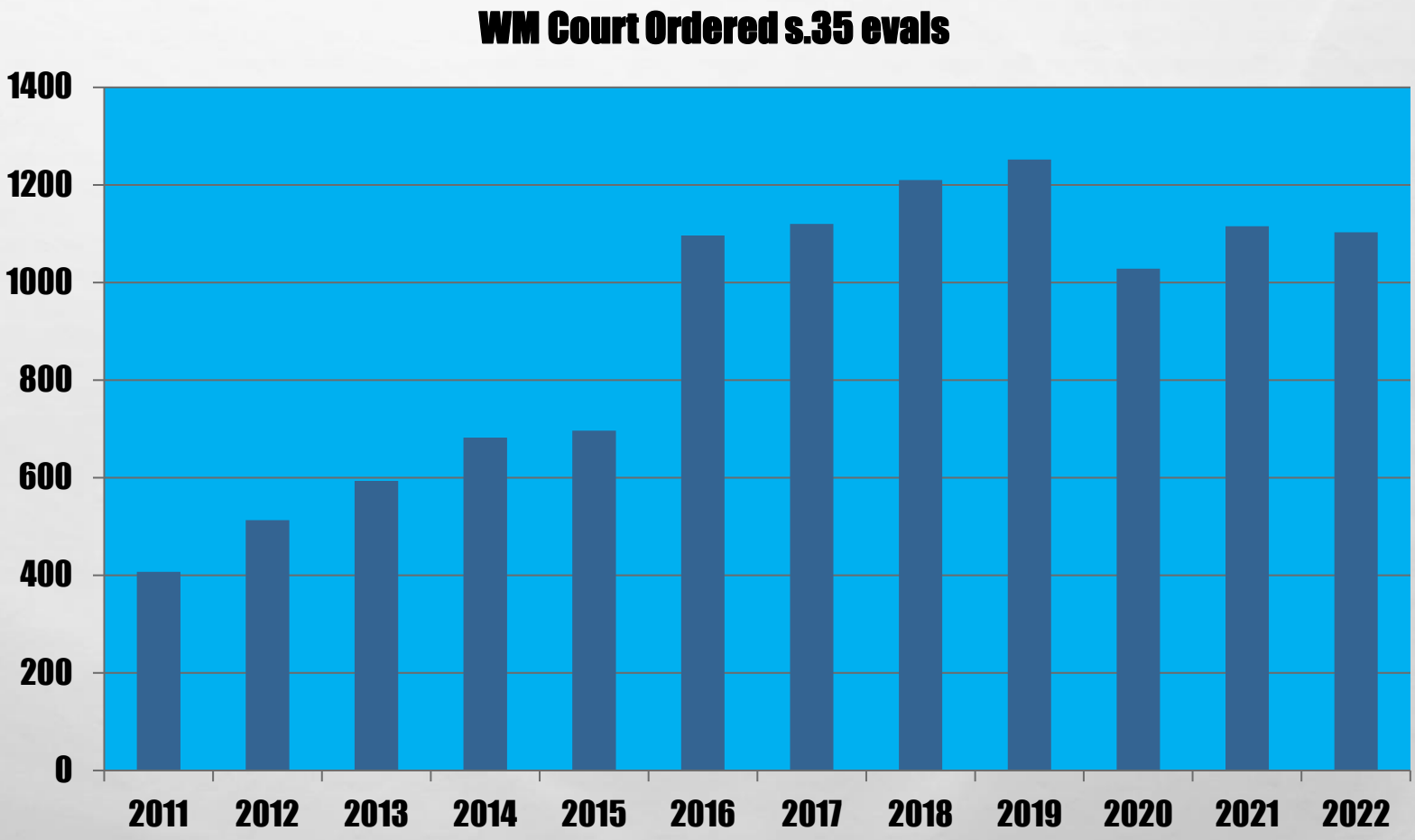
- CIVIL COMMITMENT OF SUBSTANCE ABUSER FOR UP TO 90 DAYS, BECAUSE OF IMMINENT SERIOUS RISK TO SELF OR TO OTHERS BECAUSE OF ALCOHOL OR DRUG USE.
- WHO CAN PETITION? SPOUSE, BLOOD RELATIVE, GUARDIAN, POLICE OFFICER, PHYSICIAN OR COURT OFFICIAL
- CAN BE EITHER AN ADVERSARIAL PROCESS OR "UNCONTESTED"
- AVERAGE LOS VARIES
- CASE EXAMPLE

§ 35 TREATMENT FACILITIES

- WOMEN ON CIVIL §35'S GO TO:
- WATC (WOMEN'S ADDICTION TREATMENT CENTER) IN NEW BEDFORD
- DMH'S RAP (RECOVERY FROM ADDICTION PROGRAM) IN TAUNTON
- RCA – RCA DANVERS FACILITY
- BHN – NEW VIEW
- WOMEN ON "DUAL STATUS" MAY BE SENT TO MCI-FRAMINGHAM

- MEN ON CIVIL §35'S CAN GO TO:
- MATC (MEN'S ADDICTION TREATMENT CENTER) IN BROCKTON OR DMH RAP PROGRAM
- MEN COMMITTED UNDER S.35 CAN ALSO BE SENT TO STONYBROOK STABILIZATION AND TREATMENT CENTER AT HAMPDEN COUNTY SHERIFF OR TO MASAC/PLYMOUTH

WM §35 TRENDS


WM Court Ordered s.35 evals
1400
1200
1000
800
600
400
200
0
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

SPOTLIGHT ON S. 35'S AND OPIATE EPIDEMIC

- OPIOID EPIDEMIC IS PERSISTENT
- NEW §35 FACILITIES HAVE OPENED
- LOCAL OPIOID TASK FORCES ASSIST WITH IDENTIFYING SUPPORT FOR RECOVERY, TREATMENT OPTIONS, AND COMMUNITY COALITIONS
- POLICE WORKING MORE AND MORE WITH TREATMENT PROVIDERS AND RECOVERY COACHES TO RESPOND AND OFFER LINKAGE TO TREATMENT TO PREVENT FUTURE OVERDOSE
- FOCUS IS ON EDUCATION, DE-STIGMATIZATION, TREATMENT, MAT AND NARCAN AVAILABILITY

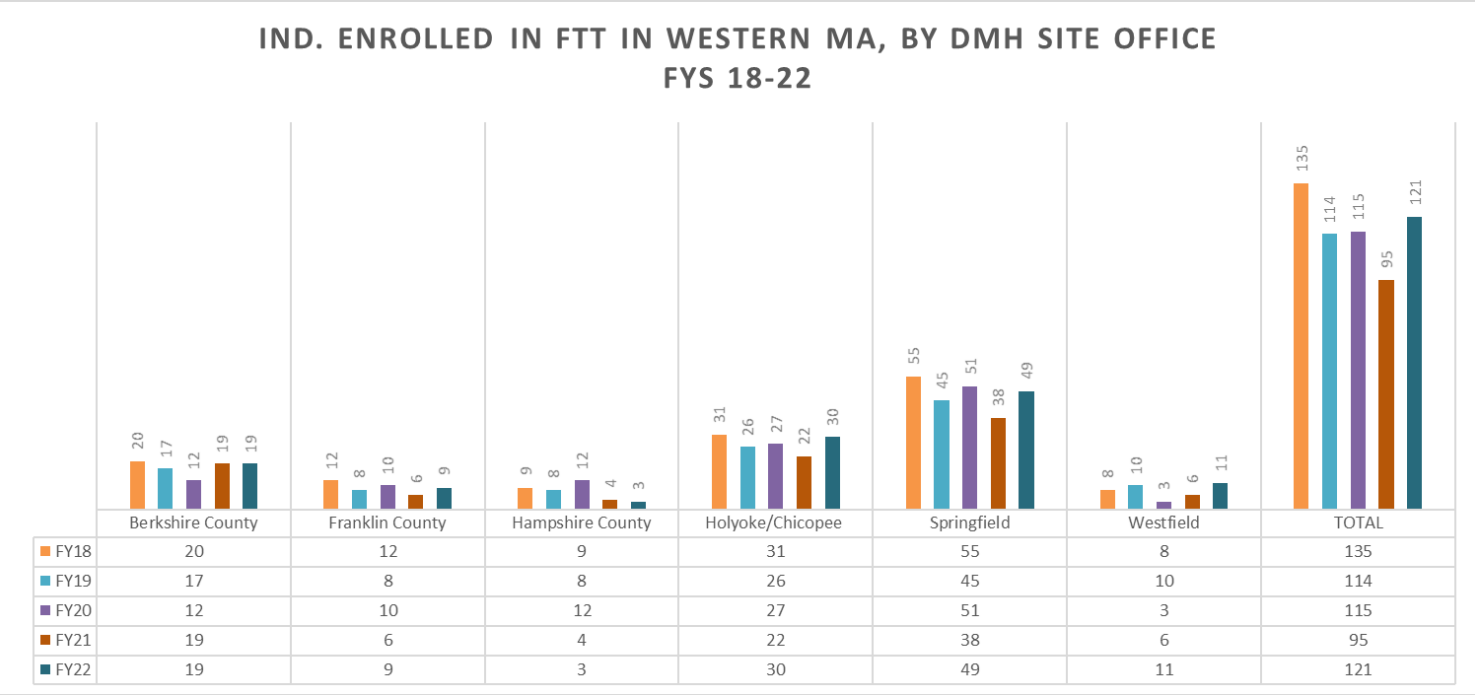
BRIDGEWATER STATE HOSPITAL

- SOME STATUTORY OBLIGATIONS ARE SHARED WITH BRIDGEWATER (§15B'S, §16'S, AND §18'S THAT REQUIRE STRICT SECURITY).
- CONCEPT OF "STRICT SECURITY" – LEGAL TERMINOLOGY, NOT DEFINED –HOW DO OUR ACC STAFF VIEW IT?
- BSH, A DOC STATE HOSPITAL: MINIMUM, MAXIMUM, ITU, MED WEST/INFIRMARY
- BSH CHANGES UNDER NEW VENDOR: WELLPATH 60 – 80 ADMISSIONS A MONTH AT BSH, MOSTLY 18A'S (60%)

FORENSIC TRANSITION TEAM (FTT)

- DMH ESTABLISHED THE FTT IN 1998
- FTT IS A BOUNDARY SPANNING, STATEWIDE SERVICE OF DMH FORENSIC SERVICES THAT ENSURES AN EFFECTIVE REENTRY PLAN FOR DMH-SERVICE AUTHORIZED INDIVIDUALS FROM STATE PRISONS AND COUNTY HOUSES OF CORRECTION
- ALL HOC'S/DOC FACILITIES HAVE AN ASSIGNED FTT STAFF

FTT IMPACT IN WESTERN MASS



	Berkshire County	Franklin County	Hampshire County	Holyoke/Chicopee	Springfield	Westfield	TOTAL
FY18	20	12	9	31	55	8	135
FY19	17	8	8	26	45	10	114
FY20	12	10	12	27	51	3	115
FY21	19	6	4	22	38	6	95
FY22	19	9	3	30	49	11	121

QUESTIONS AND EVALUATIONS

CONTACT INFORMATION:

JOHN BARBER

(413) 587-6244

JOHN.BARBER@MASS.GOV

PRESENTATION # 3

10:30am- 12:00pm

ALEC – Autism and law Enforcement Education Coalition

Captain Victor Caputo,

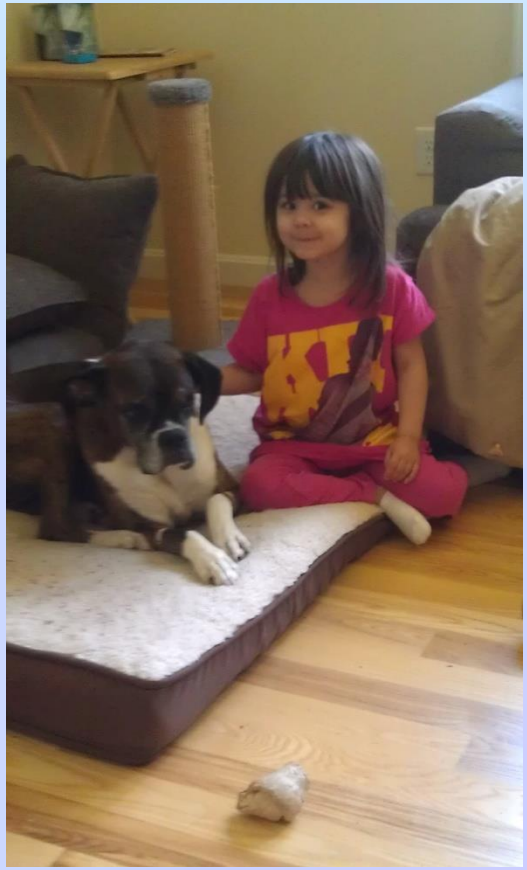
Northampton Police Department

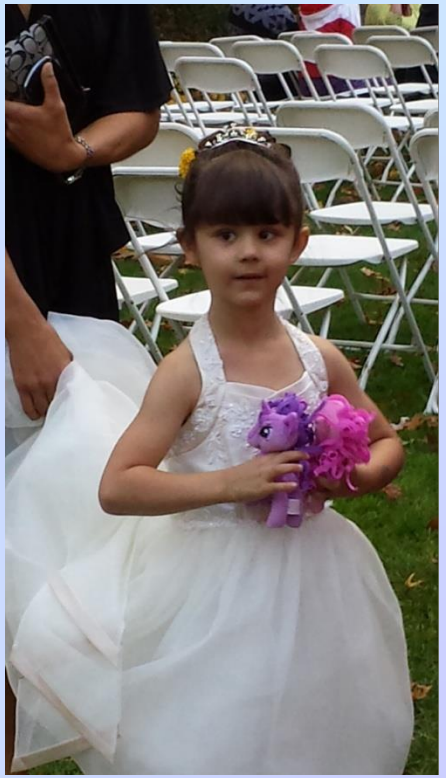
Law Enforcement Autism Training

What Is Autism?


THAMPTON POLICE


B





What is Autism?

- Autism Spectrum Disorder (ASD) is a developmental disability that usually appears during the first three years of life

- Asperger's can be diagnosed as late as early adult-hood

What is Autism

Autism is a neurological disorder that impacts:

- Social interactions
- Communication and language skills
- Behavior

Autism is a spectrum disorder with varying levels of functioning

- Low functioning
- Middle functioning
- High functioning

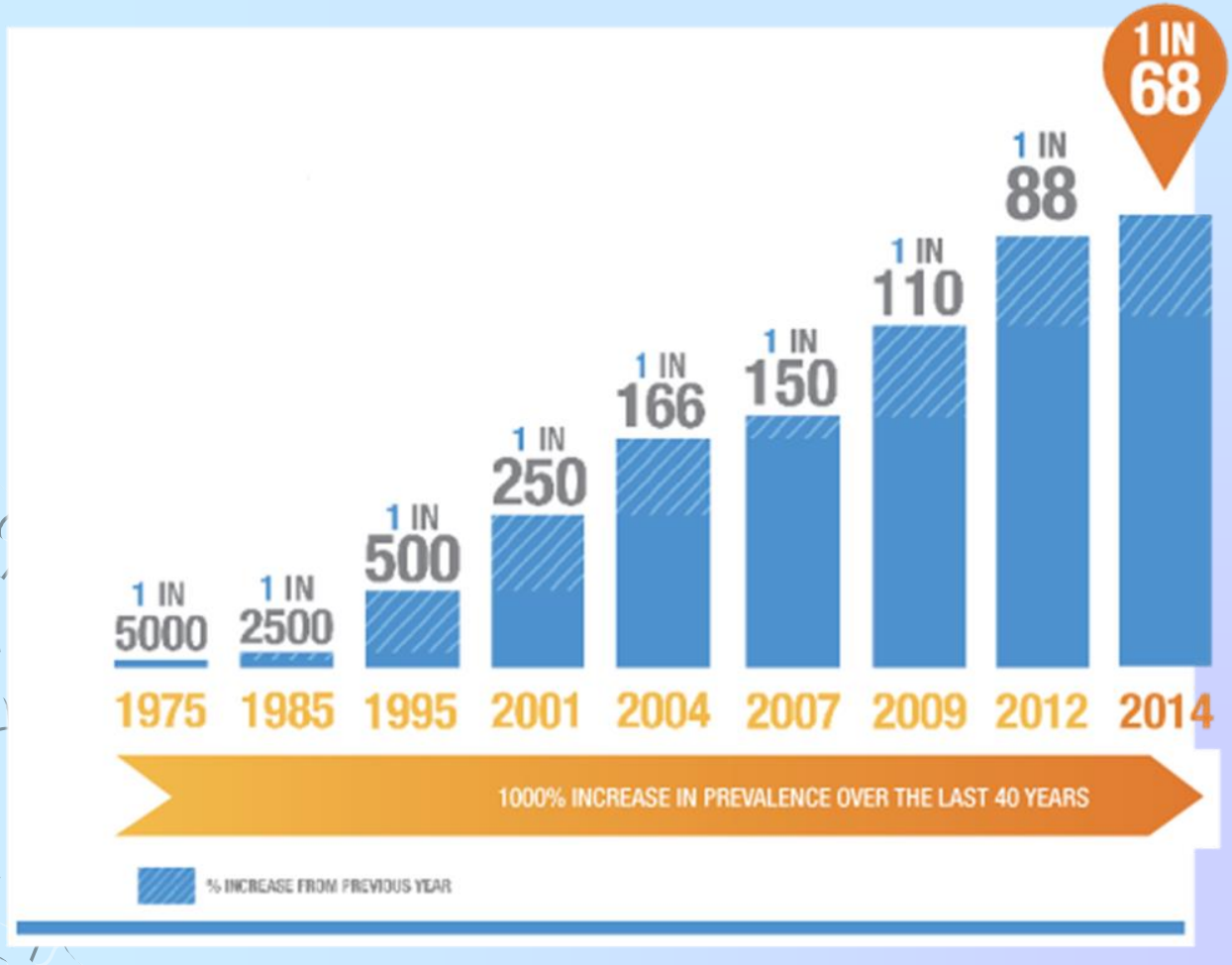
The 5 Categories of Autism

1) Autism
   Language and communication deficits with challenging behavioral traits
2) Childhood Disintegrative Disorder
   Complete loss of language at age 2 with little subsequent improvement
3) Retts Syndrome
   90% affected are female who are multiply and severely disabled
4) Asperger Syndrome
   Typically high intellect and verbal abilities, but still lack common social skills
5) PDD-Pervasive Developmental Disorder or PDD-NOS (Not otherwise specified)

Autism Facts

- More than 3 million people live with ASD in the United States
- 1 in 50 people are born today have ASD
- ASD is growing at a rate of about 10-17% per year
- A new case of autism is diagnosed every 20 minutes.

PREVALENCE STATISTICS



- Autism knows no racial, ethnic, or socio-economic boundaries.
- It is four times as prevalent in males as in females.

There are no known causes of autism; however, it is generally thought to be triggered by abnormalities of brain structure or function.

- “When you have met an individual with autism, you have met one individual with autism.”

  -Dr. Stephen Shore, a professor with Asperger Syndrome

Most Common Theories for Cause of Autism

- Genetic Vulnerability
- Environmental triggers (chemicals, toxins)
- Vaccine Injury (immunizations, thimerosal)

Simple answer

We Don’t Know The Cause

How Autism is Diagnosed

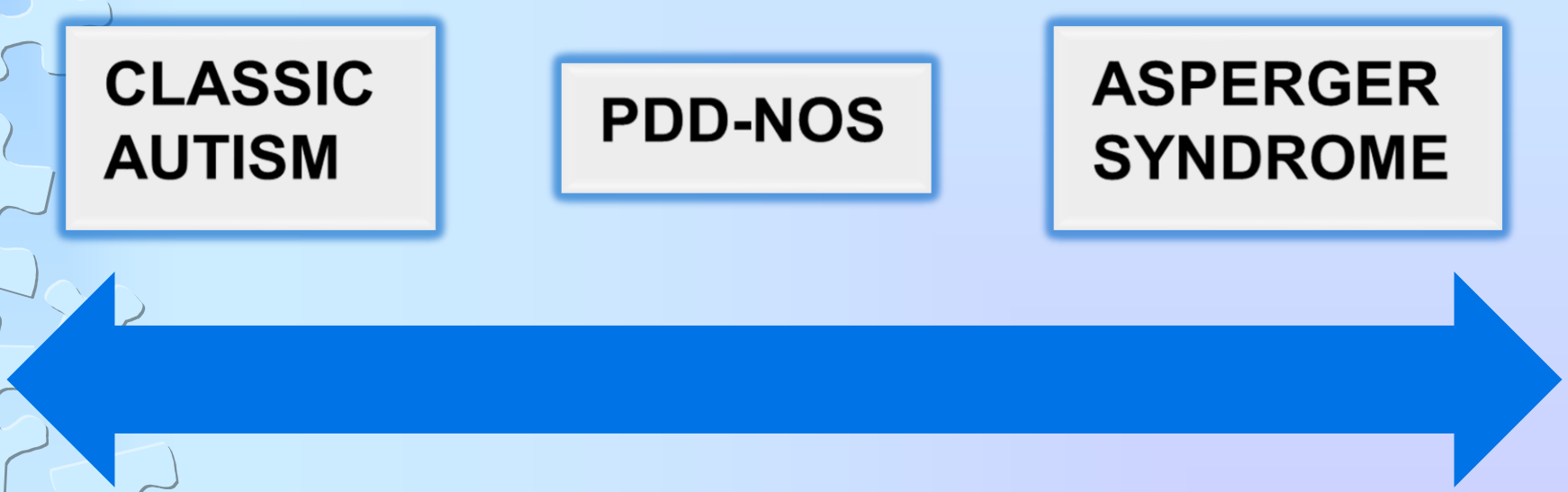
- No medical or blood test available to detect ASD
- Diagnosis based on observation of communication, behavior, and developmental levels

Who Makes an ASD Diagnosis

Generally, a multidisciplinary diagnostic team, which may include:

- Neurologist
- Psychologist
- Developmental pediatrician
- Speech Therapist
- Occupational Therapist

AUTISM SPECTRUM DISORDER



A Few Common Characteristics

Temple Grandin PHD

- Love of Animals
- Designed Curved Loading Chutes and the Center-Track Restrainer System.
- Design within ½ Inch

Stephen Wiltshire

- London Born
- Photographic Memory
- 20 Minute Helicopter Ride around NYC
- Recreated NYC Skyline from memory, to scale.

It is essential to remember that every person on the spectrum is affected by autism in a different way though certain similarities do exist.

Loud noises and other sensory stimuli may overwhelm the person and cause sensory overload

It is common for people with ASD to have seemingly inappropriate reactions to situations, commands and body language.

How to Recognize Someone with ASD

Common Speech Patterns

- Many people with ASD will simply repeat words that have been spoken to them (known as echolalia)
- Many people with ASD will repeat phrases that they have learned in the past (known as scripting)
- The above should not be confused as comprehension of your words or commands

Speech

- Many people with ASD are non-verbal
- People with ASD who are verbal may have limited speech and struggle to express themselves, especially in stressful situations
- People with Asperger's Syndrome may appear to be more verbally sophisticated but still lack comprehension capabilities

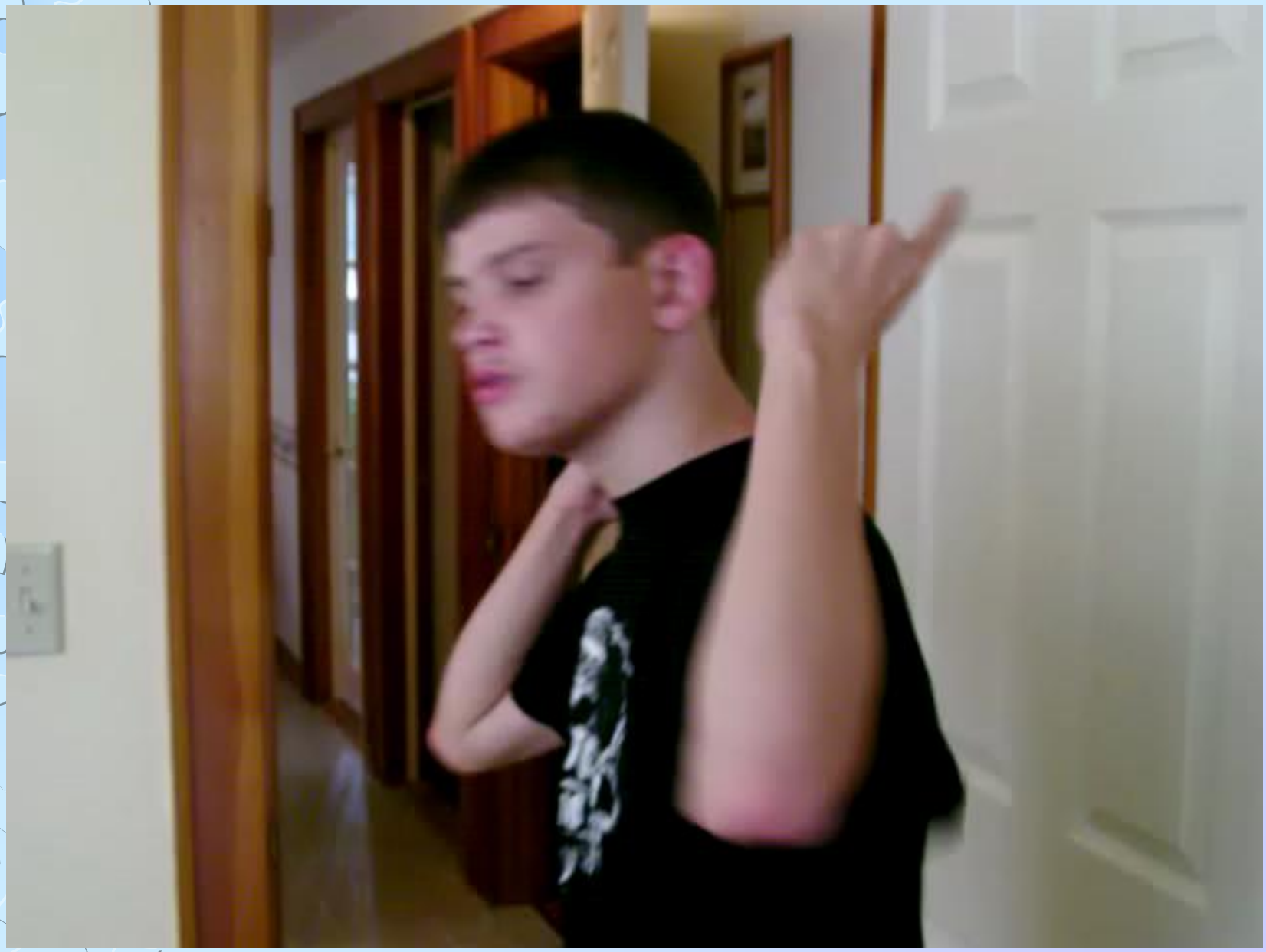
Body Language

- Appear to be poor listeners
- Little or no eye contact
- Flat facial affect
- May have an inappropriate reaction to the situation (laughing when afraid)

Body Movements

May have the following:

- Unusual walking pattern or balance
- Prone to repetitive actions, including spinning of objects, rocking self back and forth, flapping of hands, and pacing or constant movement
- Tend to wander without reacting to surroundings



Sensory Impairment
Hypersensitive/Hyposensitive

- Sights
- Hearing
- Smell
- Touch
- Taste

Little Sense Of:

- Pain
- Fear
- Danger
- Safety

How to Best Approach a Person with ASD

Try to utilize communication cards to communicate, though not all people with ASD are familiar with them

- Use calm, simple language
- Be literal and specific
- Avoid slang words

“Go Fly A Kite”

Speak in short clear phrases

- Sit down
- Get in
- Wait here
- Stop

Some non-verbal people with ASD communicate with sign language instead of or in addition to using the PECS picture cards

Repetitive Behavior

- Stimming (Stereotypy)
- Compulsive behavior
- Sameness-resistance to change
- Ritualistic behavior-activities the same way each time.
- Restrictive behavior-limited in focus, interest, or activity
- Self Injury-30% of children with ASD

Never try to stop a repetitive behavior unless it is self-injurious or dangerous to others.

Allow the person to finish the behavior because this self-stimulating behavior (“stimming”) can be self-soothing.

- Avoid touching or standing behind the person.
- Always be aware of the possibility of bolting: people with ASD are very prone to running away.

May invade personal space of others

Close Talker

It is important to remember that stressful or upsetting situations overwhelm people with ASD and can adversely affect them. They may struggle with tasks they could normally perform (regression)

Avoiding Unfortunate Situations

Every year, numerous people with ASD suffer psychological trauma, physical injury, or even death as a result of a lack of understanding.

- Be Patient and Calm.
- Get correct information

  (speak with a parent or caregiver, check 911, biographical information forms, etc).

Roll Call DVD

Dennis Debbaudt

autismriskmanagement.com

Police Response

- No one expects a responding officer to be able to diagnose a child or adult's autism in the field.
- Disclosure or discover will more likely come via a 911 call, from a parent, care provider, or neighbor on scene.

Behaviors generating 911 calls

Escalated behaviors may be in the form of:

- Violent rocking often in a car seat
- Pacing
- Loud grunting
- Noisemaking
- Utterances
- Running into walls
- Head banging
- Hiding under mattresses or other large objects

These behaviors may be a form of self-stimulation or a sensory reaction to objects and influences in the environment or a change in their normal routine.

Behaviors generating 911 calls

- Citizens or officers may interpret what they see as someone high on illegal drugs, as violent, suspicious or as a possible crime taking place.
- If verbal, the individual may talk to themselves or no one in particular.
- Parent or caregiver actions such as hugging or wrapping arms around a child or adult may be misinterpreted or appear as assault.

Response

- Be as patient as the situation will safely allow. Autism field responses will require more time to resolve.

Response

- Make sure person is unarmed
- Approach in a quiet, non-threatening manner

Response

- Police dogs or mounted patrol may be present. Be aware that these animals may cause the person to quickly move towards or away from the animals.
- If possible, move the person away from crowds of strangers to a quiet place or make the scene as quiet as possible.

Stimming Behavior

- If the individual is holding and appears to be fascinated with an inanimate object, consider allowing him or her to hold the item for the calming effect (if officer safety is not jeopardized by doing so).

- Be aware that these behaviors can be severe, for example a person slapping, pinching or even biting themselves.

Self Injurious Behavior

De-escalation of Behavior

Anyone can become upset and display anger, frustration and aggressive behavior.

Remember that calm creates calm.

After the discovery of the person's autism at the scene, consider the use of geography, space, positioning and available time.

De-escalation of Behavior

Personal Space

If safe to do so, take a step or two back from the person's space. You are not retreating and are still a buffer to escape.

Explain in a calm voice that you are there to help, not hurt. Let the person know that they can take all the time they need to calm down. Explain this in simple terms.

De-escalation of Behavior

Positioning & Time

Use your discretion. If the person's behavior escalates, use geographic containment and maintain a safe distance until any inappropriate behaviors lessens. Use time to allow the person to deescalate themselves without your intervention.

De-escalation on the Scene

Explain the rules beforehand even when the person doesn't appear to be listening to your commands. Verbalize everything before you do it.

If the person has to wear handcuffs in order to leave, tell them what will happen before it happens. Give them time to process the information.

Remain alert to the possibility of sudden invasion of your personal space, outbursts or impulsive acts such as bolting into traffic.

Hypotonia

- Be aware of hypotonia-people with ASD may have under developed trunk muscles and may be unable to support their airway when lying flat on their chest

- If individual has to be restrained, if situation allows sit the individual upright or roll the individual to his/her side, monitor breathing to avoid positional asphyxiation .

Custody

Alert supervisors of your discovery of the person's autism.

Consider a medical evaluation for seizure disorder.

The person may have medication requirements or special dietary needs.

Seek information from care providers that will assist jail, lock-up or mental health facility authorities.

Interview

Why ASD is tricky

- Concrete answers
- Inability to grasp abstract concepts
- Inability to make or maintain eye contact
- Sensory overload
- Apparent inattentiveness
- Little to no understanding of non-verbal communication
- Insistence on changing the subject or controlling the conversation

Why you need to know

- Standard interrogation techniques can
  - Confuse the concrete thinker
  - Lead to unexplainable anxiety responses like giggling or uncontrollable laughing
  - Inaccurate answers or misleading statements
    - Based on leading questions by interviewer or
    - The individuals desire to please the interviewer or
    - Overwhelming need to escape a stressful and confusing situation

Conducting an Interview

- Use his name at the start of each sentence so they know you are addressing them
- Explain how long the interview is going to last, and what will happen at the end
- Allow for frequent breaks
- Maintain a calm environment; minimize distractions e.g., sensory
- Use clear concise and simple language
- 1 question at a time
- Increase allowed processing time

Typical Police and Autism Offender Interactions

- Stalking or making threats in person, via the internet, postal service or telephone
- Intentional or unintentional shoplifting or peeping tom
- Inappropriate sexual advances
- Downloading child pornography

Typical Police and Autism Offender Interactions

- Accomplice crime with false friends
- Physical outbursts at school or in the community
- Other violent crimes such as assault and homicide

Wandering-Elopement

- Many Individuals with ASD wander; it may even be the call first responders get most often

THE CHALLENGE OF WANDERING

- ***49%*** of children with ASD wander/elope
- More than ***1/3*** of children with ASD cannot communicate their name, address or phone #
- Drowning accounts for ***91%*** of autism wandering deaths - *AWAARE*
- Wandering occurs across all settings, by people with ASD of ***all ages***, under every type of adult supervision
- Risks increase with autism severity
  - Drowning, Exposure, Dehydration, Hypothermia, Traffic Injuries, Falls, Physical Restraint, Encounters with Strangers, Encounters with Law Enforcement

Remember that the first responder should check attractive hazards:

- Water (pools, lakes, rivers, etc.)
- Construction sites
- Drainage areas
- Train and Traffic

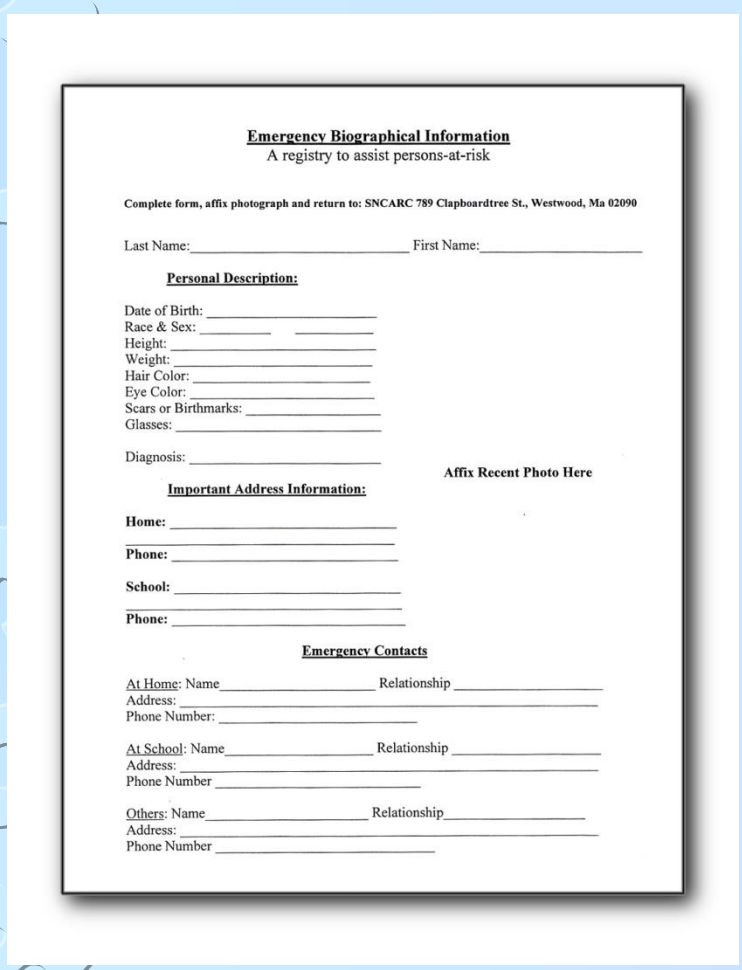
Missing Children Strategies

- **Team Adam will deploy on cases of missing children with special needs**
  - **Specialized Team Adam search personnel may also deplo**

Parents or caregiver to develop and carry a handout.

SafetyNet™ by LOJACK®

Emergency Biographical Information Form



Emergency Biographical Information
A registry to assist persons-at-risk

Complete form, affix photograph and return to: SNCARC 789 Clapboardtree St., Westwood, Ma 02090

Last Name:_____ First Name:_____

Personal Description:

Date of Birth: _____
Race & Sex: _____ _____
Height: _____
Weight: _____
Hair Color: _____
Eye Color: _____
Scars or Birthmarks: _____
Glasses: _____

Diagnosis: _____

Affix Recent Photo Here

Important Address Information:

Home: _____
_____
Phone: _____

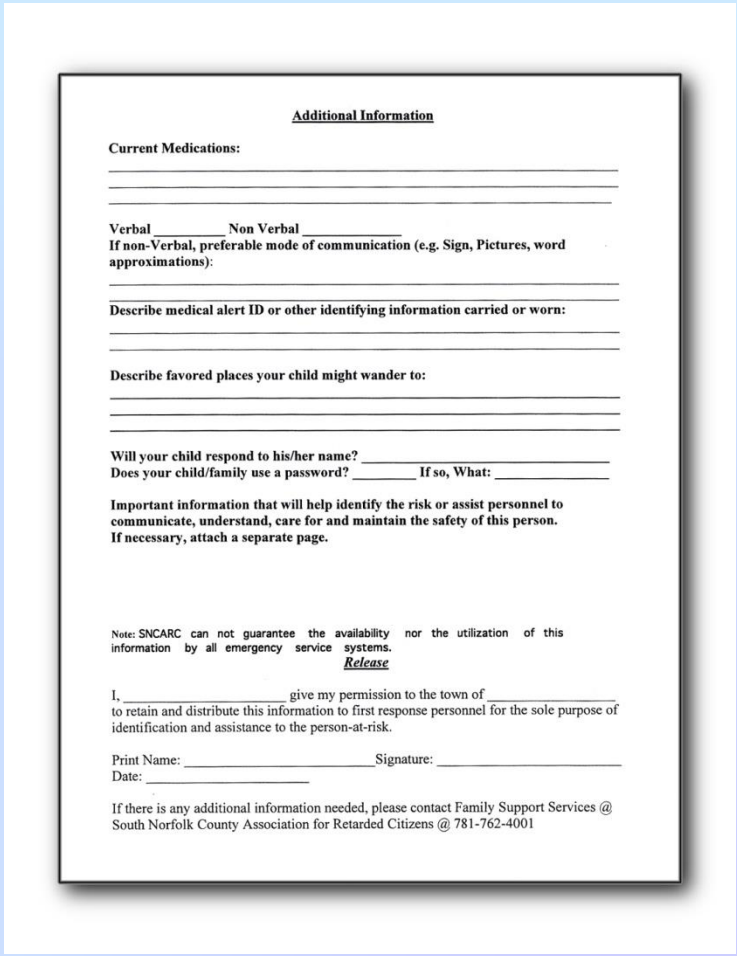
School: _____
_____
Phone: _____

Emergency Contacts

At Home: Name_____ Relationship _____
Address: _____
Phone Number: _____

At School: Name_____ Relationship _____
Address: _____
Phone Number _____

Others: Name_____ Relationship_____
Address: _____
Phone Number _____



Additional Information

Current Medications:
_____
_____
_____

Verbal _____ Non Verbal _____
If non-Verbal, preferable mode of communication (e.g. Sign, Pictures, word approximations):
_____
_____

Describe medical alert ID or other identifying information carried or worn:
_____
_____

Describe favored places your child might wander to:
_____
_____
_____

Will your child respond to his/her name? _____
Does your child/family use a password? _____ If so, What: _____

Important information that will help identify the risk or assist personnel to communicate, understand, care for and maintain the safety of this person. If necessary, attach a separate page.

Note: SNCARC can not guarantee the availability nor the utilization of this information by all emergency service systems.

Release

I, _____ give my permission to the town of _____ to retain and distribute this information to first response personnel for the sole purpose of identification and assistance to the person-at-risk.

Print Name: _____Signature: _____
Date: _____

If there is any additional information needed, please contact Family Support Services @ South Norfolk County Association for Retarded Citizens @ 781-762-4001

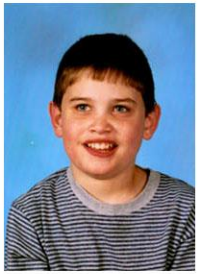
Emergency Biographical Information

A registry to assist persons-at-risk

Complete form, affix photograph and return to: Att: Veronica Kane
SNCARC 789 Clapboardtree St., Westwood, Ma 02090

Last Name: _____ First Name: EDWARD "TED"

Personal Description:



Date of Birth: _____
Race & Sex: W M
Height: 5'2½"
Weight: 100
Hair Color: BROWN
Eye Color: BLUE
Scars or Birthmarks: _____
Glasses: NO

Diagnosis: AUTISM + RECEPTIVE/EXPRESSIVE LANGUAGE DISORDER

Important Address Information:

Home: _____
_____
Phone: _____

Day Program: _____
_____
Phone: _____

Emergency Contacts

At Home: Name _____ Relationship PARENTS
Address: _____
Phone Number: _____

At Day Program: Name _____ Relationship TEACHER
Address: _____
Phone Number _____

Others: Name _____ Relationship GRANDPARENTS
Address: _____
Phone Number _____

Please complete back side of form

HANDOUT INFORMATION

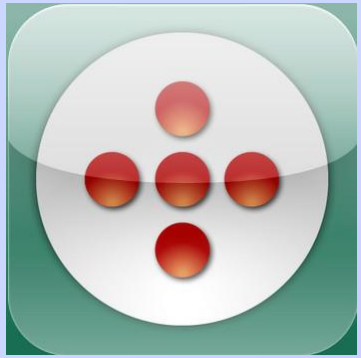
- Emergency contact numbers
- Name, address, phone & photo, physical description
- ID jewelry and clothing tags
- Medical/medication requirements, dietary needs, any sensory issues
- Favorite places to go
- Best way to communicate: verbal, PECS, ASL, computer

Emergency Contact Temporary Tattoos

ICE


at&t
Contact List
19
abc
Home
508-660-9515
Howie
+15082655322
Ice
617-943-1102
Options
Back
SAMSUNG

Phone Apps




MEDIC ALERT
MedicAlert®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MEDIC
ALERT®


MEDIC
ALERT®

Rescue from Heights

- Extreme caution should be used with any rescue from heights. A fire department aerial tower or platform would be the easiest way to remove an individual with ASD. This person may aggress towards a rescuer during this operation. Always make sure you are secured before you attempt to rescue the individual

Bolt Risk

- People with ASD are a bolt risk after rescue. A first responder must stay with the person

Routines

- People with ASD often prefer a routine, and adjusting the routine even slightly may result in disruptive behavior.
- Remember, a 911 call is not in this person's routine!

- Speak simply using a calm voice
- Give plenty of time for the person to respond to questions. A 3-10 second delay is not uncommon
- Be prepared to repeat your question. Also, try inverting your questions to validate the patient's response

- Provide paper and a pen or a laptop for the best chance of getting the information required from the person
- Use established communication systems if available

- People with ASD may not respond to directives because they do not understand what's being asked of them or because they are scared. The fact that they're scared is the only thing they will be aware of-they may not be able to process language or understand the directive when fearful


IN CASE OF
EMERGENCY
OCCUPANT WITH
AUTISM MAY:
• RUN AWAY
• NOT RESPOND
• RESIST HELP
ASA

MVA's

- The parent/caregiver will be your best asset
- Beware of answering yes to all questions
- C-Spines will be difficult
- Befriend the patient
- BOLT RISK even into traffic

Sensory Issues

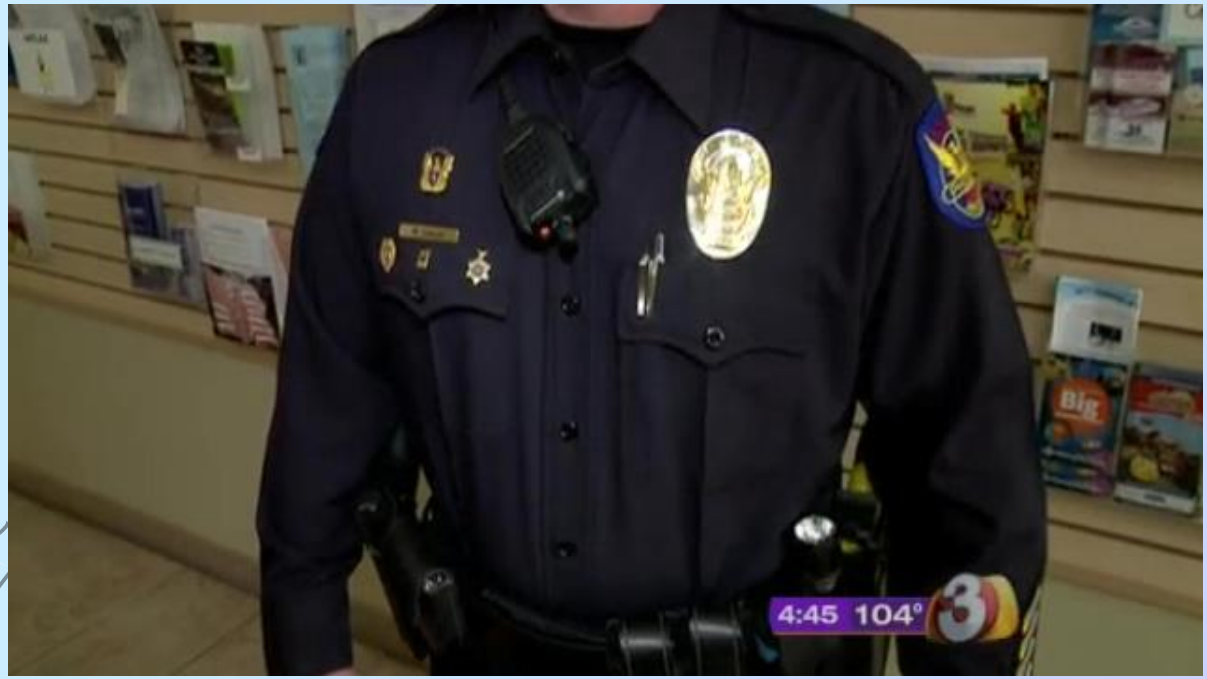
- Because of sensory issues, scene noise such as breaking glass, equipment, and vibrations during an extrication may cause a negative reaction from a person with ASD

Reactions

- Aggression
- Regression
- Sensory Overload

Super Strong

- They may fixate on an object in a room or on your body such as a badge, earrings.



- They may also fixate on your personal gear such as a hat, radio, cuffs and flashlight.

Community Day

Community Day

Community Day

- The goal of these trainings is to provide additional tools to use in assessing the risk of a situation in order to complement but not replace your previous training

Credits

- Autism and Law Enforcement Education Coalition (ALEC)www.sncarc.org/alec.htm
- Autism Society-www.autism-society.org
- Bill Cannata, www.firerescueautism.com
- Dennis Debbaudt-Autism Risk Safety www.autismriskmanagement.com

CIT Training – Afternoon Session

12:30 – 1:30 PM – Mental Health in Elders

1:30: - 3:00 PM – DMH Overview – Forensic Services

3:00 – 4:00PM – DDS Services/ Support

PRESENTATION #4

1:00-2:00 pm

Mental Health in Elders

Jenny Cox, Director – Behavioral Health, Baystate Medical Center

Presentation # 5

2:00pm - 3:00pm

Sheriffs County Department Mental Health Programs

Nusean Mayfield, *Mental Health Clinician*

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

Amber Beauchemin, *Forensic Mental Health Clinician*

OVERVIEW

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

FOUR SECURE SITES OF HCSD

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

OPEN MENTAL HEALTH CASES

JAILS REALLY ARE THE NEW HOSPITALS…

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

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

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

EVALUATION & STABILIZATION UNIT

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

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

ESU LEVEL SYSTEM & ADMISSONS

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

Reasons for Admission:

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

EVALUATION & STABILIZATION PROGRAM

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

MENTAL HEALTH UNIT

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

MENTAL HEALTH UNIT (MI)

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

SECURE TREATMENT UNIT (WCC)

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

CRIMINAL JUSTICE REFORM

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

CRIMINAL JUSTICE REFORM

HOW IT AFFECTED CORRECTIONS FROM MENTAL HEALTH STANDPOINT…

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

CJ Reform – RH – Serious Mental Illness

- All inmates are screened by a qualified Health Professional for **Serious Mental Illness (SMI).**

- If RH is found to be **clinically contraindicated,** then, based on the qualified Mental Health Professional's clinical judgment, alternate housing would be recommended.

- Mental Health Service staff are utilizing the JMS alert **MHCI** to indicate if there is a contraindication related to moving an inmate to C1/C2 due to Mental Health related issues.

CJ Reform – RH – Serious Mental Illness

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

(1) schizophrenia and other psychotic disorders;

(2) major depressive disorders and all types of bipolar disorders;

(3) a neurodevelopmental disorder, dementia or other cognitive disorder;

(4) any disorder characterized by breaks with reality or perceptions of reality;

(5) all types of anxiety, trauma and stressor related disorders;

(6) severe personality disorders; or,

(7) a finding by a Qualified Mental Health Professional that the inmate is at **serious risk of substantially deteriorating mentally or emotionally** while confined in Restrictive Housing, or **already has so deteriorated while confined in Restrictive Housing**, such that diversion or removal is deemed to be clinically appropriate by a Qualified Mental Health Professional.

Restrictive Housing

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

(1) to the safety of others;

(2) of damage or destruction of property; or

(3) to the operation of the Correctional Facility.

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

The Sheriff or a designee certifies in writing:

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

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

Restrictive Housing

- A Qualified Mental Health Professional **must announce and make daily rounds** in every Restrictive Housing Unit.

- Can conduct out-of-cell meeting with an inmate if, in the clinicians professional judgment, confidentiality is warranted.

YOUTHFUL OFFENDERS

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

(a) Has previously been committed to the Department of Youth Services; or

(b) Has committed an offense which involves the infliction or threat of serious bodily harm in violation of law.

YOUTHFUL OFFENDERS

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

Goal:

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

YOUTHFUL OFFENDER UNIT

MAGIC PROGRAM

Mission

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

- **M**eaningful
- **A**ccomplishments
- **G**ain
- **I**ncreased
- **C**haracter

"Your thoughts determine your actions."

CRIMINAL JUSTICE REFORM (CJR) LAWS

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

ALL-INCLUSIVE SUPPORT SERVICES

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

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

Some of the ways AISS can help the client includes:

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

OUTPATIENT MENTAL HEALTH SERVICES

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

OPIOID TREATMENT PROGRAM & MEDICALLY ASSISTED TREATMENT

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

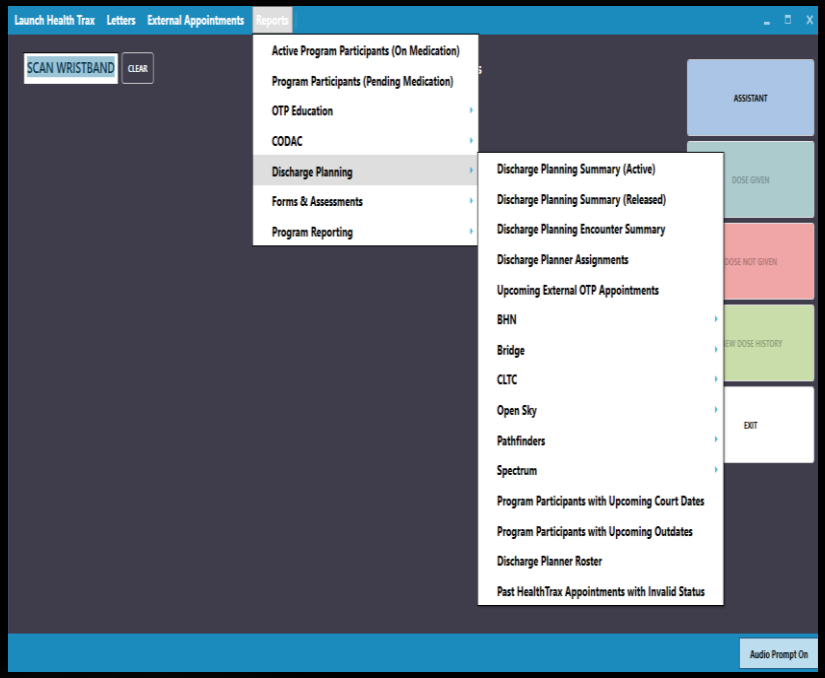
HCSD AND COMMUNITY PARTNERS

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

KEEPING TRACK WITH OTP ASSISTANT

Home grown internal database created to keep track of:

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



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

SUICIDE PREVENTION & INTERVENTION

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

SUICIDE PREVENTION AT HCSD

- It is the policy of the Hampden County Sheriff's Department to effectively monitor all inmates for the potential for self-harm and suicidal behavior.

- All staff are trained in warning signs, major risk factors and mental health referrals; coupled with their experience and knowledge of inmate behavior.

- This combination can have a positive impact on reducing these incidents.

SAFETY PRECAUTIONS

SUICIDE PREVENTION/INTERVENTION

Restraint Bed/Suicide Resistant Cell

Safety Smock/Blanket

Restrictive Housing –

Remain RISK or Admit to ESU
Partially Clear w/ re-evaluation every 24 hours until disposition is reached
Clear Precautions

STONYBROOK STABILIZATION TREATMENT CENTER
SECTION 35

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

STONYBROOK STABILIZATION TREATMENT CENTER

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

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

STONYBROOK STABILIZATION TREATMENT CENTER

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

EMOTIONAL SUPPORT DIVISION

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

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

Any Questions???

Contact Information

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Forensic Mental Health Clinician
Restrictive Housing
Regional CIT Instructor for MSA

Hampden County Sheriff's Department

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Presentation # 6

3:00pm - 4:00pm

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/department-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/department-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/