DAY 5 CIT Training

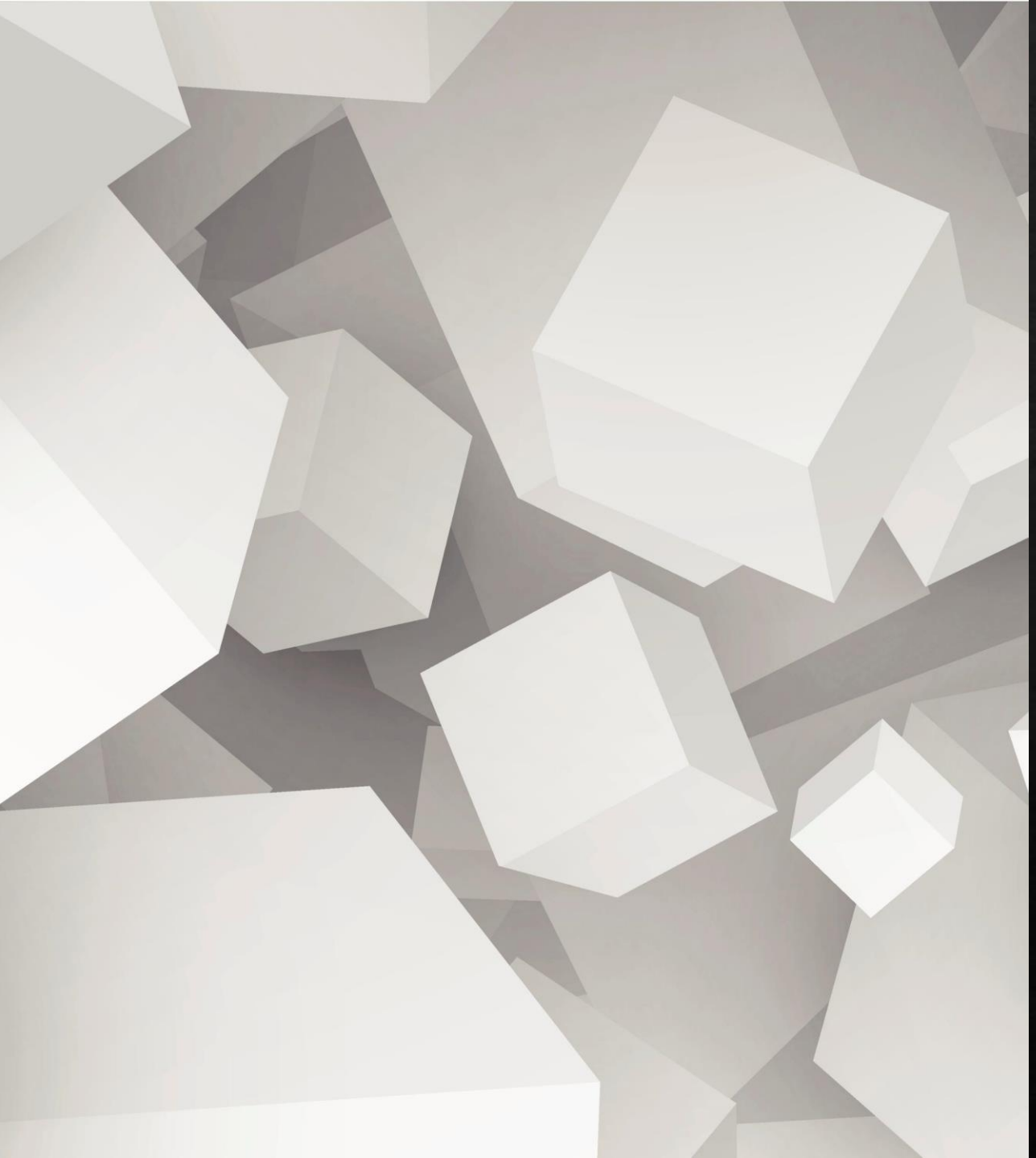
8:00-9:00am	**Cultural Awareness** – Brian Mitchell & Natasha Mitchell
9:00-10:00am	**Homelessness –** Bill Miller, Director CSO
10:00- 11:00am	**Sheriffs County Department Mental Health Programs** Amber Beauchemin, *Forensic Mental Health Clinician*
11:00am-12:00pm	**Opiate Crisis Response –** Alison TellierFox

Cultural Awareness

Brian Mitchell &

Natasha Mitchell

Potter's Wheel Community Services



Welcome and Overview

Group Norms :

Respect each individual's social location

Freedom to go deep

Reach out for help and someone reach back

Description

COURSE DESCRIPTION:
This workshop introduces oppressive language and actions of power and privilege in the workplace and the larger community. We explore various assumptions and aggressions displayed in various organizations and ways to combat them while attempting to shift attitudes toward equitable distribution of power. Breaking down oppressive power dynamics impacts all organizational practices. Addressing the need for a deeper understanding of bias, privilege, and the many aggressions influenced by such abuses of power is imperative Therefore, a defined understanding of how these elements of social structure show up internally and externally is necessary for individual and community-based change.

OUTCOMES: Participants will…

- Understand Diversity within the context of Cultural Awareness
- Understanding of Perception and how it plays a role in the impact of Power Dynamics
- Skills to shift power to minimize assumptions that lead to microaggressions.
- Attitude and understanding for equitable & inclusive power distribution and its impact in the served community.

Objectives
To examine and discuss the impacts that racial inequality has on our business/organization, our families, and our communities.

Opening Circle

“The Power of Your Voice”

Terminology

Microaggression

Anti-racism

Implicit/Explicit Bias

Intersectionality

Institutional Racism

White Privilege

Internalized Racism

Large Group Discussion

Identify the term(s) that stands out to you the most?

Small Group Discussion

Topics: Power, Bias, Privilege, Oppression

When working with your served community, what does this look like for those individuals?

5 Minutes – Self Care!

Large Group Discussion

Healthy Dialogue

Review

Closing : Questions and Comments

Presentation # 2

9:00-10:00am

Homelessness

Bill Miller, Director CSO

Friends of the homeless

Shelter, services and housing for individuals

a program of Clinical and Support Options

CSO

CLINICAL & SUPPORT OPTIONS

Homeless Services in Western MA

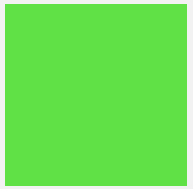
A Snapshot of the Issue and Strategies to Address Them

Bill Miller
VP, Housing and Shelter Services

Crisis Intervention Team Training

July 22, 2022

Overview of Homelessness and Homeless Services in Western MA



Trauma Informed Care

Homelessness and ACES

CLINICAL & SUPPORT OPTIONS

There are two categories of homelessness in MA:

Families and Individuals

In MA, families have a “right to shelter.” Family homelessness presents a complicated set of issues.

Individuals do not have a legal right to shelter.

The state does pay for some shelter beds but it does not dictate policy.

So, different shelters operate with different rules despite their common funding sources.

CLINICAL & SUPPORT OPTIONS

There are 5 "Emergency" Shelters for Individuals in Western MA

CLINICAL & SUPPORT OPTIONS

Friends of the Homeless, Worthington Street, Springfield (133 beds—flexible cap—behavior based—average 150 per night)

Grove Street Inn (ServiceNet), Northampton (20 beds-wait list-dry shelter)

Samaritan Inn, Westfield (30 beds--dry)

Greenfield Shelter (ServiceNet) (20 beds-dry)

Barton's Crossing, Pittsfield, (ServiceNet) (20 beds)

Winter only:

- Amherst Shelter, Craig's Doors, (behavior based)
- Cot Shelter, Northampton (ServiceNet)
- Taylor Street, Springfield (Rescue Mission)

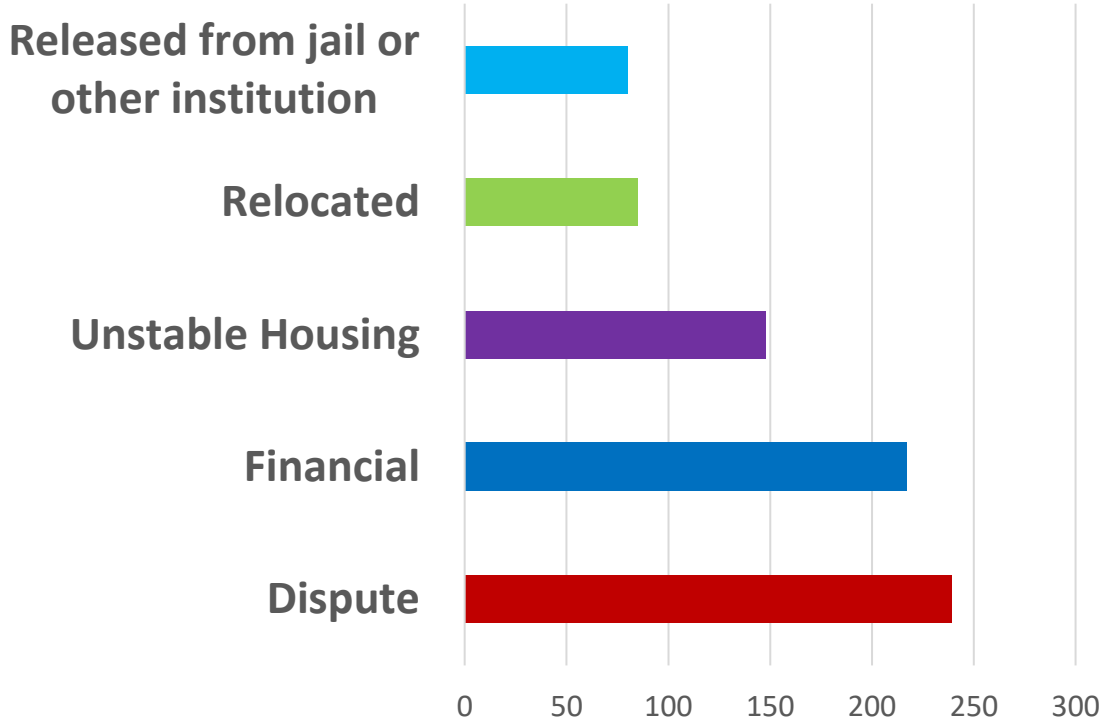
Friends of the Homeless Campus on Worthington Street

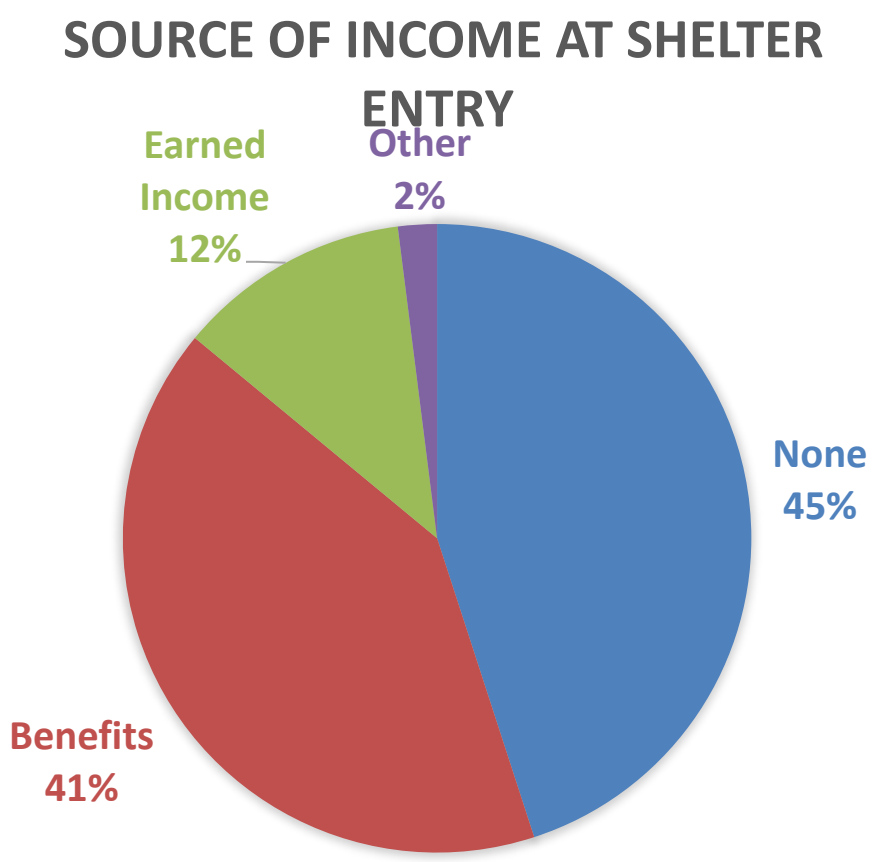
Friends of the Homeless, Worthington Street Shelter:

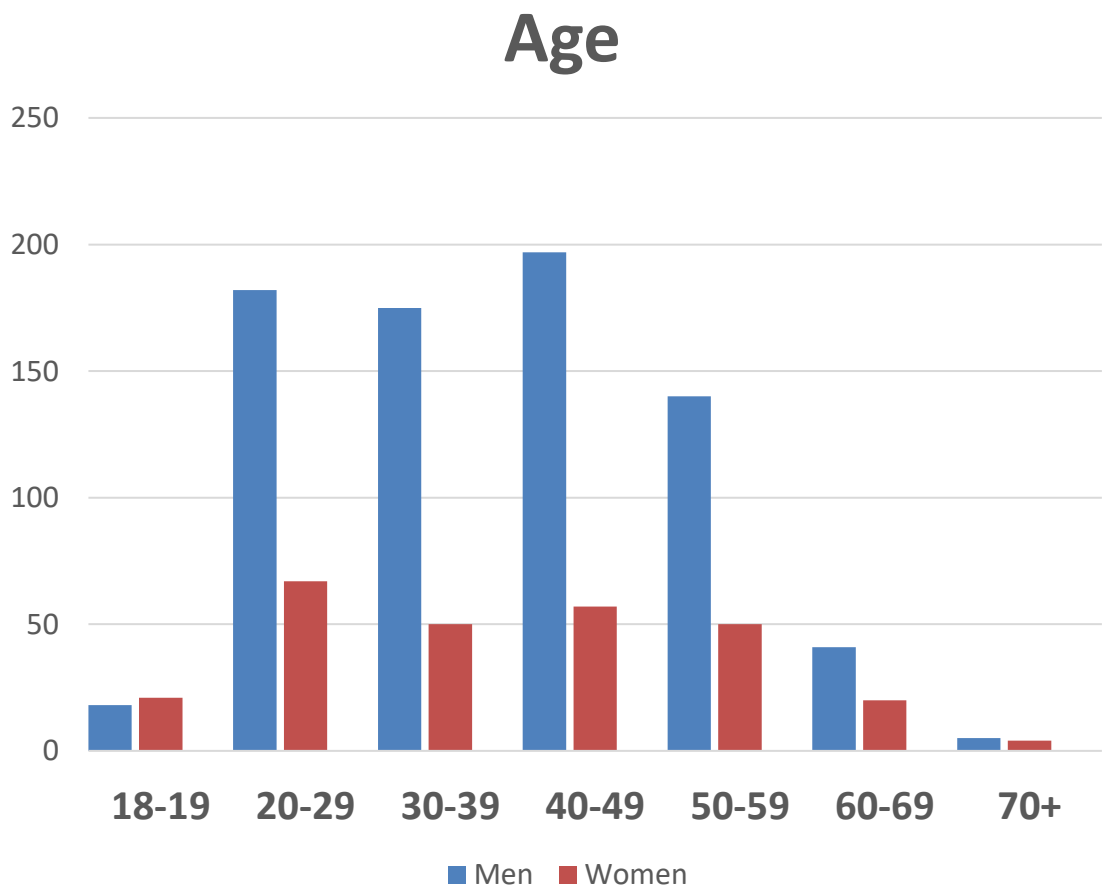
- The largest facility of its type outside the city of Boston
- Shelter: Over 1,000 people per year
- Housing: We operate 110 units of single room housing
- Meal program: We served more than 155,000 meals this past year
- Resource Center: We have case workers, clinic, open 24/7/365
- Just under 50 total staff for around the clock services

CSO
CLINICAL & SUPPORT OPTIONS

Top 5 Reported Reasons for Homelessness




SOURCE OF INCOME AT SHELTER ENTRY
Earned Income 12%
Other 2%
None 45%
Benefits 41%


Age
250
200
150
100
50
0
18-19
20-29
30-39
40-49
50-59
60-69
70+
Men
Women

Crisis Intervention Team

- What have you seen as key variables in contributing to homelessness in your community?
- What potential partnerships do you see within your community in addressing homelessness?

CLINICAL & SUPPORT OPTIONS

- Young woman speaks about homelessness in NYC

This is a picture of our dining room. There can be more than a hundred people waiting in line for a meal.

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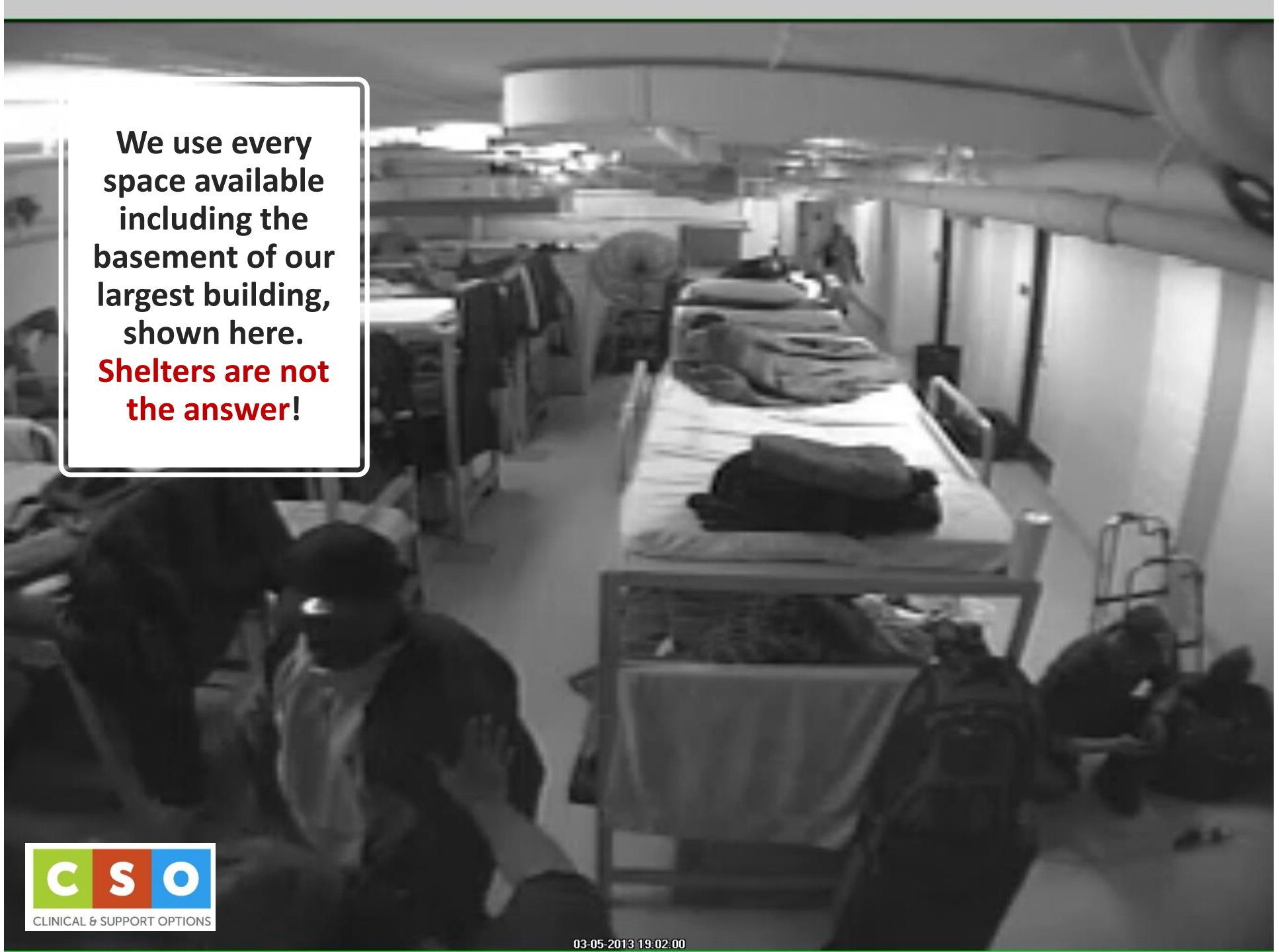
CLINICAL & SUPPORT OPTIONS


We are averaging about 150 people in shelter per night right now. All beds are full, and people are sleeping on the floor as well.
CSO
CLINICAL & SUPPORT OPTIONS
03-05-2013 21:56:00

On any given evening, FOH can have between 230-280 very diverse persons “on campus” with 4-7 staff persons monitoring.


We use every space available including the basement of our largest building, shown here.
Shelters are not the answer!
CSO
CLINICAL & SUPPORT OPTIONS
03-05-2013 19:02:00

What can we do?

- Focus on high end utilizers
- We reduce costs and recidivism by targeting these individuals for supportive housing
- Studies have shown expenses to the community are reduced by housing chronically homeless individuals as opposed to waiting for them to become more compliant with treatment before housing

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CLINICAL & SUPPORT OPTIONS

We are "outcome" focused and adhere to "best practices" in the field

CLINICAL & SUPPORT OPTIONS

Housing First

is a strategy designed for people who are “chronically homeless”

is essentially a harm reduction model of housing

is the idea that people should be housed first and that services should be voluntary and used to sustain housing

We have substantially reduced the numbers of homeless individuals living on the streets in Springfield since the Tent City years in 2005.

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CLINICAL & SUPPORT OPTIONS

Does addiction or alcoholism cause homelessness?

NO. THERE ARE LITERALLY HUNDREDS OF THOUSANDS OF PEOPLE WHO ARE HOMELESS EACH NIGHT IN AMERICA. MOST YOU WOULDN'T NOTICE.

NO. BUT, THERE ARE OBVIOUS CASES OF PEOPLE WITH LATE STAGE ADDICTIONS/ALCOHOLISM WHO CAN BE SEEN LIVING ON THE STREETS.

NO. BUT THE TRAUMA OF HOMELESSNESS CAN CONTRIBUTE TO ADDICTION THAT DID NOT EXIST PRIOR.

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CLINICAL & SUPPORT OPTIONS

Addiction and Recovery

Substance Abuse is a complex problem

There are no guarantees of recovery regardless of the treatment methodology

CLINICAL & SUPPORT OPTIONS

What are the broad categories of "recovery methods" and the breakthroughs in treatment over the last few decades?

Social model: 12 step breakthrough beginning in the 1950's and blossoming in 70's and 80's as significant social figures such as Betty Ford made their addiction and recovery public

Harm reduction/public health breakthrough: creation of methadone

The latest, is a trauma informed care approach. (and this is where the intersection occurs)---ACE study and subsequent effects on understanding and treatment

CLINICAL & SUPPORT OPTIONS

Trauma Informed Care

All homelessness and housing programs should implement trauma informed care practices to provide an environment that supports stability and healing.

Trauma informed care is an overarching structure and treatment attitude that emphasizes understanding, compassion, and responding to the effects of all types of trauma.

Becoming “trauma-informed” means recognizing that people have many different traumatic experiences which often intersect in their lives.

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CLINICAL & SUPPORT OPTIONS

How the ACES Work

Adverse Childhood Experiences

- Abuse and Neglect (e.g., psychological, physical, sexual)
- Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)

Impact on Child Development

- Neurobiologic Effects (e.g., brain abnormalities, stress hormone dysregulation)
- Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)

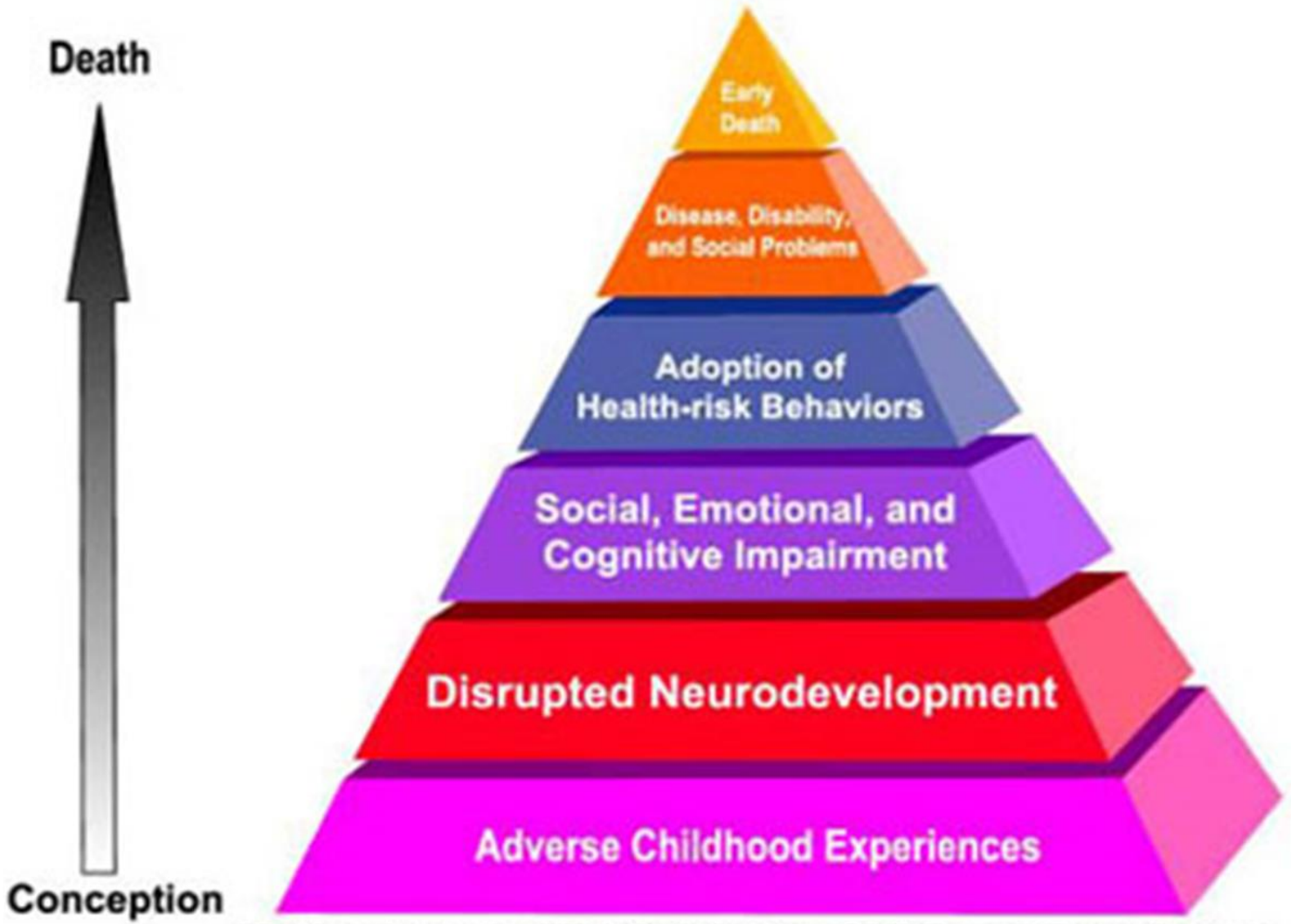
Long-Term Consequences

Disease and Disability

- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational transmission of abuse

Social Problems

- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services
- Shortened Lifespan



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

CLINICAL & SUPPORT OPTIONS

ACES and Homelessness

"Homelessness is not recognized as one of the ACEs, but children experiencing homelessness have everyday exposure to these risks." – Dr. Regina Olasin, Chief Medical Officer, Care for the Homeless

CLINICAL & SUPPORT OPTIONS

ACES and Homelessness

The experience of housing-insecurity, defined as high housing costs, poor housing quality, unstable neighborhoods, overcrowding, and especially homelessness, places children at risk of ACE exposure.

Housing-insecure youth and families report instances of physical and emotional abuse, financial exploitation, and sex-trafficking while staying in shelters, on the streets, and “doubled-up”

Children experiencing homelessness often have caregivers with untreated mental illness and substance use disorders - two additional ACEs.

What are the resources?

- Shelter, with varied service capacity and philosophies
- Medical interventions—HealthCare for the Homeless, including limited outreach
- Street outreach, now BHN/police collaborative; Eliot in some communities
- **Newly added clinical services on site at FOH**
- **Trauma informed care approach**

CLINICAL & SUPPORT OPTIONS

Friends of the Homeless Resource Center

Lighting the way for men and women in our community

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CLINICAL & SUPPORT OPTIONS

Friends of the homeless

Shelter, services and housing for individuals

a program of Clinical and Support Options

CSO

CLINICAL & SUPPORT OPTIONS

Thank You!

Bill Miller
VP, Housing and Shelter Services

Presentation # 3

10:00- 11:00am

Sheriffs County Department Mental Health Programs

Amber Beauchemin, *Forensic 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…

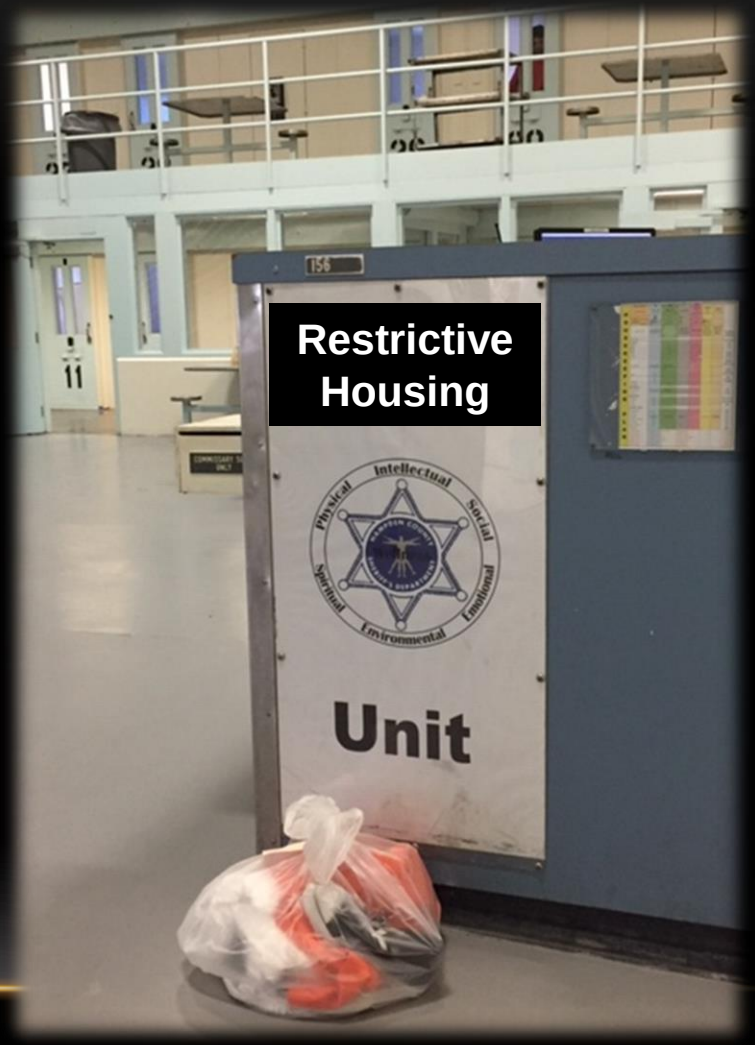
- Restrictive Housing – Serious Mental Illness
- Transgender Rights
- Youthful Offenders

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)

AISS
ALL INCLUSIVE SUPPORT SERVICES
Rooted in community, Supporting growth

OUTPATIENT MENTAL HEALTH SERVICES

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

OPIOID TREATMENT PROGRAM & MEDICALLY ASSISTED TREATMENT

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

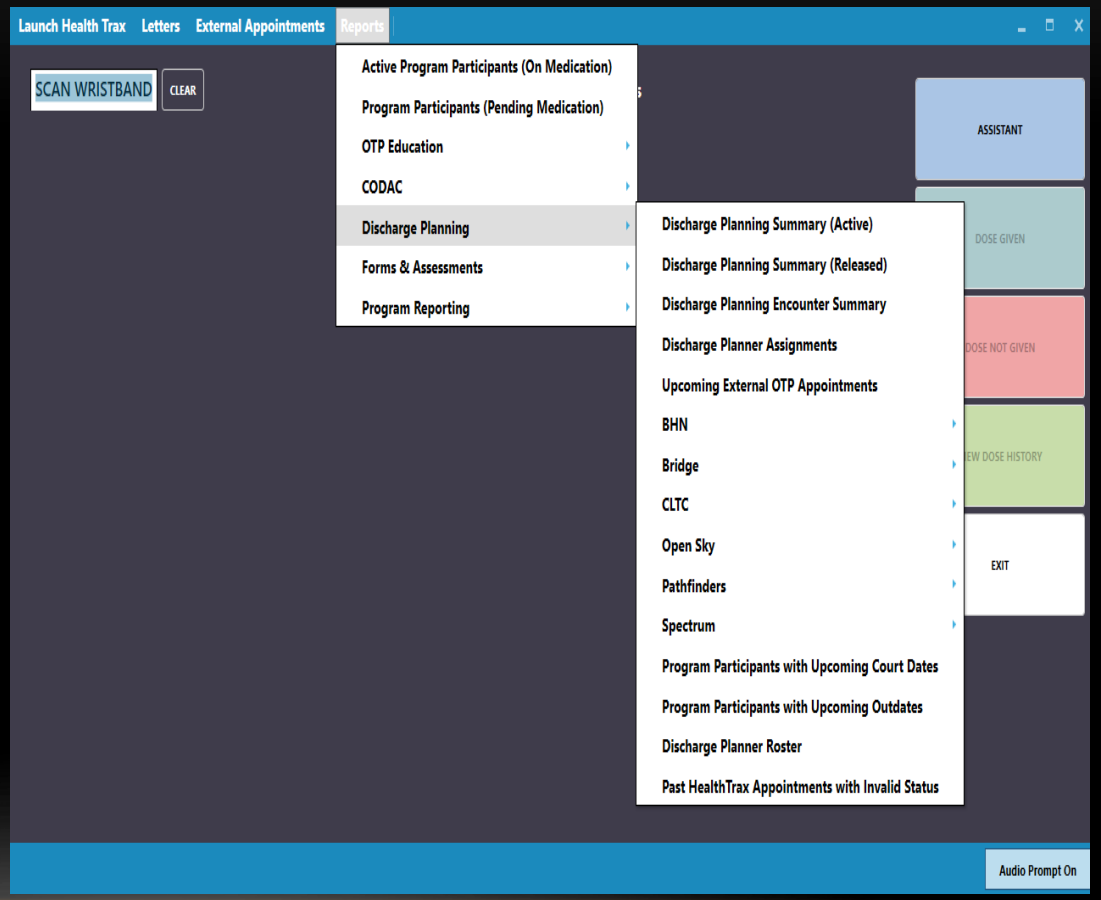
HCSD AND COMMUNITY PARTNERS

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

KEEPING TRACK WITH OTP ASSISTANT

Home grown internal database created to keep track of:

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



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

SUICIDE PREVENTION & INTERVENTION

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

SUICIDE PREVENTION AT HCSD

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

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

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

SAFETY PRECAUTIONS

SUICIDE PREVENTION/INTERVENTION

Restraint Bed/Suicide Resistant Cell

Safety Smock/Blanket

Restrictive Housing –

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

STONYBROOK STABILIZATION TREATMENT CENTER

SECTION 35

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

STONYBROOK STABILIZATION TREATMENT CENTER

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

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

STONYBROOK STABILIZATION TREATMENT CENTER

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

EMOTIONAL SUPPORT DIVISION

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

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

Any Questions???

Contact Information

Amber Beauchemin, M.A.

Forensic Mental Health Clinician

Restrictive Housing

Regional CIT Instructor for MSA

Hampden County Sheriff's Department

413-858-0732

amber.beauchemin@SDH.state.ma.us

Presentation # 4

11:00am-12:00pm

Opiate Crisis Response – Alison TellierFox

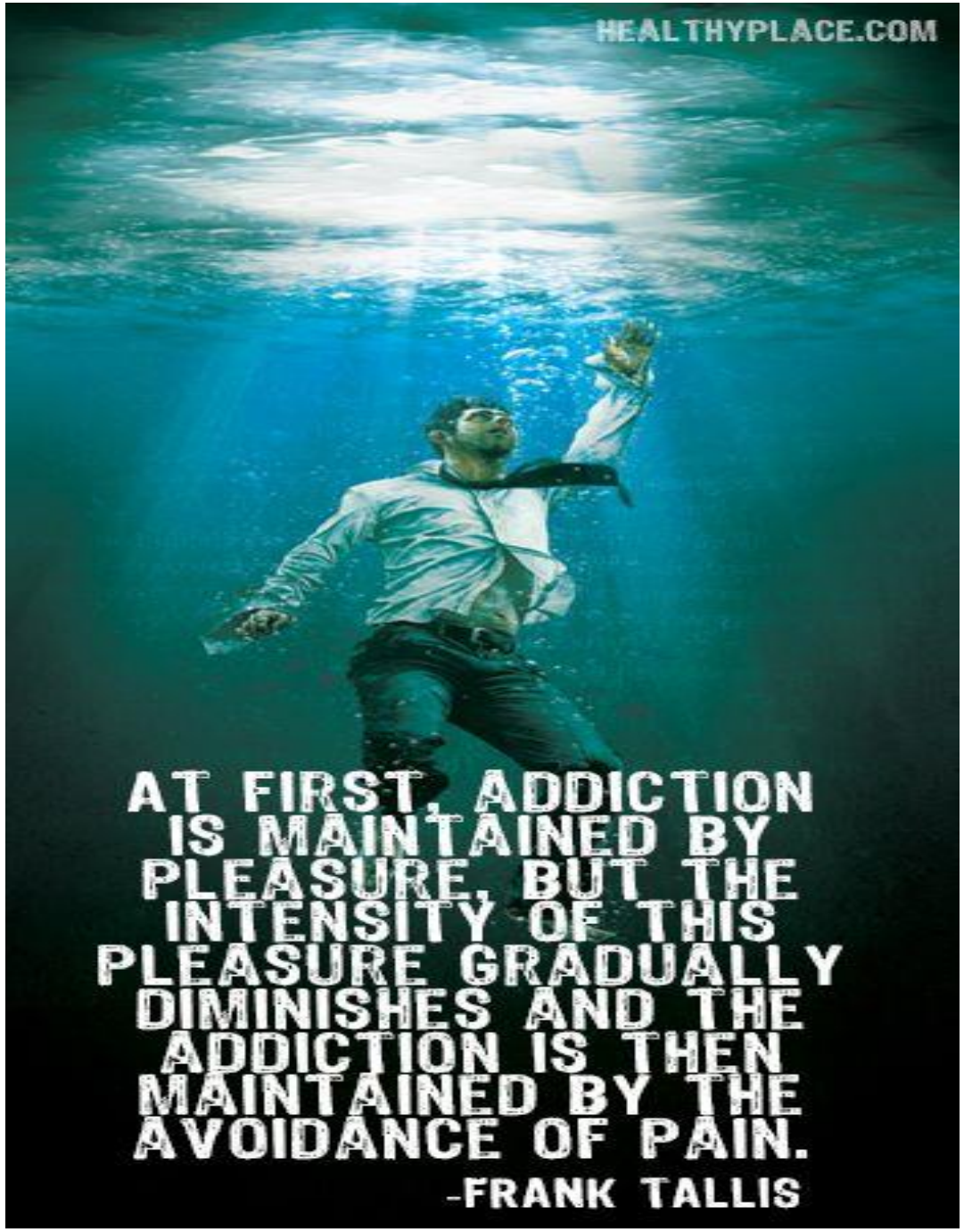
Medicated Assisted Treatment

Addiction and the medication used to treat addiction

Alison TellierFox, RN, BSN, MBA, CARN

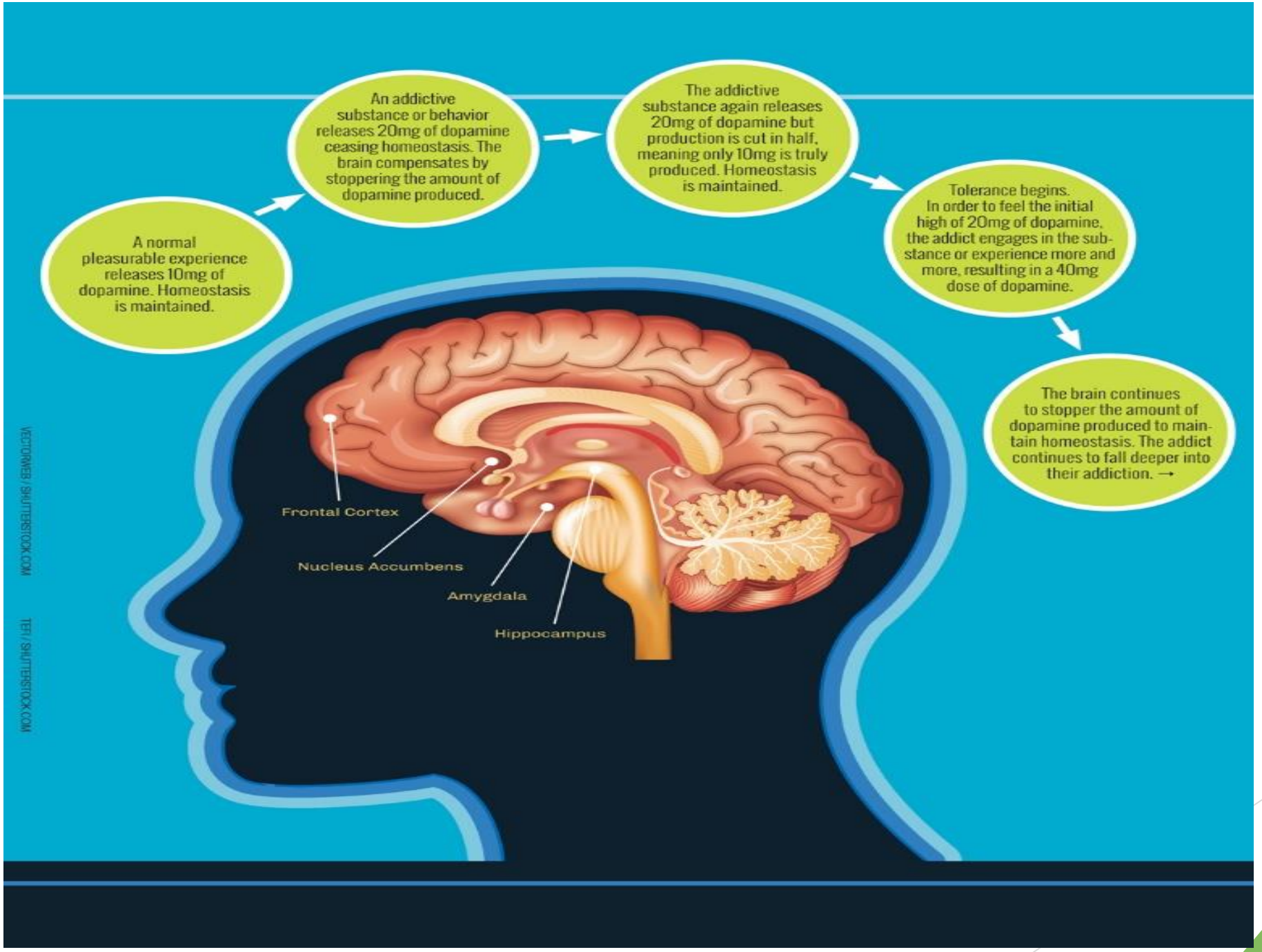
Addiction

- Addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences.
- The initial decision to take drugs is voluntary for most people, but repeated drug use can lead to brain changes that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs.
- These brain changes can be persistent, which is why drug addiction is considered a "relapsing" disease—people in recovery from drug use disorders are at increased risk for returning to drug use even after years of not taking the drug.
- It's common for a person to relapse, but relapse doesn't mean that treatment doesn't work.
- As with other chronic health conditions, treatment should be ongoing and should be adjusted based on how the patient responds.
- Treatment plans need to be reviewed often and modified to fit the patient's changing needs.


HEALTHYPLACE.COM
AT FIRST, ADDICTION IS MAINTAINED BY PLEASURE, BUT THE INTENSITY OF THIS PLEASURE GRADUALLY DIMINISHES AND THE ADDICTION IS THEN MAINTAINED BY THE AVOIDANCE OF PAIN.
-FRANK TALLIS

The Brain

- Most drugs affect the brain's "reward circuit," causing euphoria as well as flooding it with the chemical messenger dopamine.
- A properly functioning reward system motivates a person to repeat behaviors needed to thrive, such as eating and spending time with loved ones.
- Surges of dopamine in the reward circuit cause the reinforcement of pleasurable but unhealthy behaviors like taking drugs, leading people to repeat the behavior again and again.
- As a person continues to use drugs, the brain adapts by reducing the ability of cells in the reward circuit to respond to it.
- This reduces the high that the person feels compared to the high they felt when first taking the drug—an effect known as tolerance.
- They might take more of the drug to try and achieve the same high.
- These brain adaptations often lead to the person becoming less and less able to derive pleasure from other things they once enjoyed, like food, or social activities.
- Despite being aware of these harmful outcomes, many people who use drugs continue to take them, which is the nature of addiction.


A normal pleasurable experience releases 10mg of dopamine. Homeostasis is maintained.
An addictive substance or behavior releases 20mg of dopamine ceasing homeostasis. The brain compensates by stoppering the amount of dopamine produced.
The addictive substance again releases 20mg of dopamine but production is cut in half, meaning only 10mg is truly produced. Homeostasis is maintained.
Tolerance begins. In order to feel the initial high of 20mg of dopamine, the addict engages in the substance or experience more and more, resulting in a 40mg dose of dopamine.
The brain continues to stopper the amount of dopamine produced to maintain homeostasis. The addict continues to fall deeper into their addiction. →
Frontal Cortex
Nucleus Accumbens
Amygdala
Hippocampus
VECTORWEB/SHUTTERSTOCK.COM
TEFI/SHUTTERSTOCK.COM

Common Medications Use To Treat Addiction

- Methadone
- Buprenorphine
  - Sublocade
  - Subutex
  - Suboxone
- Vivitrol

Methadone

- Is a full mu opioid agonist, continues to produce effects on the receptors until either all receptors are fully activated, or the maximum effect is reached.
- Daily dosing
- Can be used in pregnancy
- Half-life is anywhere from 8 to 59 hours for methadone.

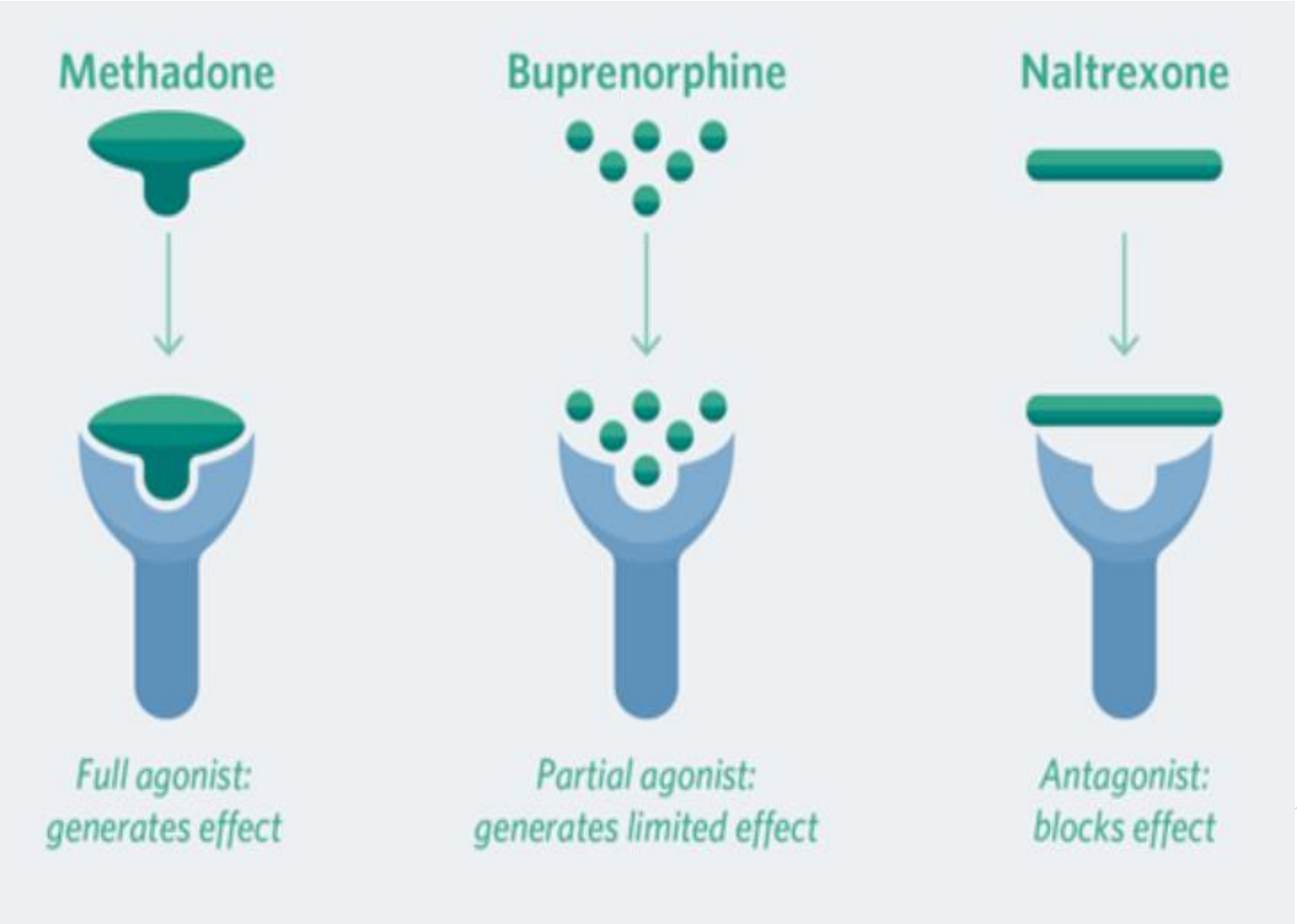
Buprenorphine

- Is a partial agonist, does not activate mu receptors to the same extent as methadone. Its effects increase until they reach a plateau.
- Buprenorphine reaches its ceiling effect at a moderate dose, which means that its effects do not increase after that point, even with increases in dosage.
- Requires a prescription
- Half-life can vary from 24 to 60 hours for buprenorphine
- Not safe in pregnancy
- Pushes other opioids off the receptor due to strong bond

Buprenorphine Products

- Suboxone
  - Film or tablet
  - Dissolves under the tongue or in cheek
  - Taken daily
  - Contains Naloxone
- Subutex
  - Only comes in tablet form
  - Dissolves under the tongue or in cheek
  - Taken daily
  - Does not contain Naloxone
- Sublocade
  - Injection in the abdomen
  - Taken every 28 days

Buprenorphine	Methadone	Heroin
Partial agonist	Full agonist	Full agonist
Long half-life (24 to 60 hours)	Long half-life (8 to 59 hours)	Short half-life
Ceiling effect; good safety profile	No ceiling effect (useful in patients dependent on high doses of opioids)	No ceiling effect


Methadone
Buprenorphine
Naltrexone
Full agonist:
generates effect
Partial agonist:
generates limited effect
Antagonist:
blocks effect

Vivitrol

- Is a large dose of naltrexone
- Is an opioid antagonist
- Must be opioid free for 7-10 days prior to taking it
  - If taken sooner the person can go into acute withdrawal immediately
- Injection every 28 days
- Blocks the effects of opioids
  - Effects dissipate over time
  - However if taken enough opioid one can override the naltrexone on the receptor

Questions???

DAY 5 CIT Training

1:00-2:00pm	**What is an ESP?** Hallie-Beth Hollister, M.Ed., Program Director, BHN Crisis Services; Jennifer LaRoche, LICSW VP Clinical Operations, Clinical & Support Options Acute & Day Programs
2:00-2:30pm	**Questions and Answers Session**
2:30pm	**Graduation**

Presentation # 5

1:00-2:00pm

What is an ESP?

Hallie-Beth Hollister, M.Ed., Program Director, BHN Crisis Services;

Jennifer LaRoche, LICSW, VP Clinical Operations, Clinical & Support Options, Acute & Day Programs

Crisis Services Overview

Hallie-Beth Hollister
Program Manager
BHN Emergency Services

Jennifer LaRoche, LICSW
VP Clinical Operations
Clinical & Support Options
Acute & Day Programs

Emergency Services Provider (BHN)

- Southern Pioneer Valley Catchment Area
  - Agawam
  - Belchertown
  - Blandford
  - Bondsville
  - Chester
  - Chicopee
  - E. Longmeadow
  - Granby
  - Granville
  - Hampden
  - Holyoke
  - Huntington
  - Longmeadow
  - Ludlow
  - Monson
  - Montgomery
  - Palmer/Thorndike/Three Rivers
  - Russell
  - Southampton
  - South Hadley
  - Southwick
  - Springfield
  - Tolland
  - Ware
  - West Springfield
  - Westfield
  - Wilbraham

Community Based Locations

- Southern Pioneer Valley – BHN Crisis
  - 417 Liberty Street, 413-733-6661
    - Available 24 hours a day, 7 days a week
    - RAP Drop off
    - Police Drop Off with CCRT Office (Dedicated Police Line)
    - On site assessments/walk ins accepted (call ahead preferred)
    - Phone consultation, phone support
    - Telephonic Triage including de-escalation, brief risk assessment
    - Mobile Response
    - CIRT/ Project HOPE
    - Shift supervisors in house and on call
    - On campus access to The Living Room and Psych Urgent Care

Emergency Service Provider (CSO)

- Clinical & Support Options (CSO) Crisis is the ESP for much of Hampshire County, Franklin County & Athol/North Quabbin areas

- CSO Crisis is available 24 hours a day, 7 days a week, 365 days a year.

Emergency Services Provider (CSO)

- Ashfield
- Athol
- Bernardston
- Buckland
- Charlemont
- Colrain
- Conway
- Deerfield
- Erving
- Gill
- Greenfield
- Hawley
- Heath
- Leverett
- Leyden
- Millers Falls
- Montague
- New Salem
- Northfield
- Orange
- Petersham
- Phillipston
- Rowe
- Royalston
- Shelburne
- Shutesbury
- Sunderland
- Turners Falls
- Warwick
- Wendell
- Whately
- Amherst
- Chesterfield
- Cummington
- Easthampton
- Florence
- Goshen
- Hadley
- Hatfield
- Middlefield
- Northampton
- Pelham
- Plainfield
- Westhampton
- Williamsburg
- Worthington

Community Based Locations

- Hampshire County -

29 North Main Street in Florence or
Cooley Dickinson Hospital in Northampton
413-586-5555

- Franklin County

296 Federal St in Greenfield or
104 High St. in Greenfield
413-774-5411

- Orange/Athol

491 Main Street in Athol
978-249-3141

Mobile Response

- Provides Emergency Services as a mobile response
  - Homes, providers offices, schools, residential programs, other treatment programs, doctors offices, police stations, places of employment, etc.
    - Higher comfort level in familiar environment, person more likely to open up, more opportunity for family interaction and safety planning, less stigmatizing
  - Safety of our staff
  - Diversion from ED when possible
  - Mobile Response times

Emergency Department (ED)

- Crisis staffing in ED's
- Process of referral to crisis in ED
- Diversion
  - Helps lower hospitalization rates
  - ED often has crisis patients waiting hours before even being referred and sometimes hours after being referred
- Best Practices
  - Call Crisis if making decision to send to ED
    - May help avoid discharge by doctor without referring to crisis
    - Will help with gathering of information around reason for visit to ED, reason for crisis assessment, clarification of information or help answer questions related to scene
    - Information sharing ensures more informed disposition

Crisis and Police intersection/collaboration

- Crisis might request police presence to help determine if a section 12 is warranted for transport to the ED for assessment to take place in contained environment
- Crisis might request police guidance if being asked to respond in a mobile capacity to a neighborhood where there has been recent violent activity
- Crisis might request police presence to the community based locations for a person who cannot be de-escalated by crisis staff or a person who has a history of violence , destroying property, engaging in criminal activity
- Enforcement of Rogers Order
- Crisis may request police assistance in the execution of a section 12 for containment while awaiting psychiatric placement of a person who is not voluntary but found to meet criteria for an involuntary committal
- Duty to Warn/Tarasoff

Crisis and Police intersection/collaboration

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

Section 12

- Section 12

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

_____
_____
_____

B). <u>Likelihood of Serious Harm (check all categories that apply):</u>

_____ (1) Substantial risk of physical harm to the person himself/herself as manifested by evidence of threats of, or attempts at suicide or serious bodily harm; and/or

_____ (2) Substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; and/or

_____ (3) Very substantial risk of physical impairment or injury to the person himself/herself as manifested by evidence that such person's judgment is so affected that he/she is unable to protect himself/herself in the community and the reasonable provision of his/her protection is not available in the community.

Specify evidence including behavior and symptoms:

_____
_____

Section 12 cont.

- Section 12 cont'd

3). <u>Applicant Certification (check all applicable boxes)</u>

a. I am a: Licensed Physician or Nurse Practitioner (GL. Ch 112 §80i) Qualified (i.e. Licensed) Psychologist Qualified (i.e. Licensed and Certified) Psychiatric Nurse Mental Health Clinical Specialist Police Officer Licensed Independent Clinical Social Worker (LICSW)

b. I have OR I have not personally examined this person. If not, why?

_____

c. I have consulted with either the receiving facility or emergency screening program.

d. I have not so consulted because_____

_____

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

Address:_____City/Town_____State____

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

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

Helpful Information

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

Helpful Information

- Call Crisis if you are unsure what someone needs
- Call Crisis for resources and information
- Call if you feel as though an assessment is needed
- Call the crisis workroom number if you have sent someone to the ED (also can connect in person with Crisis staff stationed in the ED if available)
- Bring someone into the Community Based Crisis office, Crisis can interact with them in the community based location right away

Critical Incident Stress Management

Presented by Officer Robert “Chip” Thrasher, Deerfield Police Department

Introduction

- Officer Robert Thrasher, Deerfield Police
- Graduate of Northeastern University with 39 years in Massachusetts law enforcement
- Attended the Barnstable County Police Academy working at the Yarmouth Police Department, followed by 34 years at University of Massachusetts @ Amherst retiring in 2017 as a Lieutenant and Commanding Officer of the crowd management team
- Post retirement work as a part time officer with DPD and the MPTC's Instructor Development Team

Introduction

- We will review the following
- What is Critical Incident Stress
- The Western Massachusetts CISM Team and the who, what, where, how and why you should utilize the WMCISM Team
- Available resources to the First Responder in addressing Critical Incident Stress

Critical Incident Stress

- Critical Incident Stress is a normal reaction to an abnormal incident.
- Most Police Officers handle serious incidents daily without issue.
- A Critical Incident can include;
  - Death of a peer
  - Death of a child
  - Mass casualities
  - Prolonged situations
  - Events the bring intense media attention/perceived administration betrayal

The Western MA. CISM Team

- The WMCISM is based out of WMEMS in Northampton.
- The team is available 24 hours a day, 7 days a week made up of Police, Fire and EMS peers, mental health professionals and area clergy.
- Since the founding of the team it has grown providing service to the four western Massachusetts counties police, fire, EMS and dispatchers. We utilize the Mitchell Model

- The team responds to any police, fire or EMS department as well as area SAR Teams, Ski Patrol and similar emergency responders

What does the WMCISM Team provide

- Education on stress in emergency services
- Support Teams at the scene or immediately following the incident
- Defusing, Debriefings and One on One services
- Resource and Referral Networks including area clinicians with a background in helping 1st Responders, in and out patient programs like On Site Academy.

What does the team bring to a response?

- The team are all volunteer, ICISF trained and qualified
- The interactions are all confidential under Massachusetts General Law
- The team is made of up of veteran responders with experience.

How does the WMCISM provide service?

- If an agency has an incident and feels they need a team response the first step is to call 1 413 586 6065. After hours this will page Lisa at WMEMS.
- The second step is to determine what resources are needed. This can include;
  - Defusing
  - Debriefing
  - One on One

Defusing

- This is done in an more informal method following an incident with a couple of keys points
- Ground Rules
- Confidentiality
- Not an operational review
- Share information

Debriefing

- The is a larger, more formal program with a substantial education block focusing what is a “normal” response to a critical incident
- Same ground rules and confidentiality
- 6 stage process

Why does this work?

- Hearing what the other responders heard, saw and did
- Learning that feeling like s#$ after some calls is normal and in fact healthy.
- How to get help within the police or fire “world” before you can’t deal with it.

How does CISM and CIT come together

- Some calls requiring a CIT response may require a CISM response later.
- You may respond to another 1st Responder in crisis and need someone with information on a referral .

Questions

- Officer Robert Thrasher
- Deerfield Police, Conway St. Deerfield, MA. 01373
- Email rathrasher35@gmail.com
- 413 800 4223

END OF CIT TRAINING

DISCUSSIONS

COLLECTION OF EVALUATIONS

GRADUATION NEXT !!!!!!!!!!!!!!!!!!!