Making the Most of Your

CIT De-escalation Training

September 5, 2012

Interacting with Someone who has Hallucinations and/or Delusions

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Hallucinations

A hallucination is a misperception, or a mistake made by one of our five senses. It involves sensing things while awake that one experiences as real, but it happens without an outside stimulus (like a real person's voice) being present. Hallucinations can occur in neurological conditions like brain tumors or epilepsy, in degenerative disorders such Alzheimer's dementia, or in conditions associated with sensory deficits like visual impairment or deafness. Hallucinations can also be symptoms of a psychiatric disorder such as schizophrenia or severe depression. *Auditory hallucinations* (hearing voices) are the most common types of hallucinations in serious psychiatric disorders like schizophrenia. Listed below are tips for Crisis Intervention Team (CIT) officers when interacting with someone who is experiencing hallucinations.

Tips for Interacting with Someone who is Experiencing Hallucinations

- If you suspect the person is hearing voices, it's okay to ask if he or she is hearing voices. If he or she says yes, it's okay to ask what the voices are saying.
- Give the individual time to process what you are saying since he or she may be hearing voices at the same time while trying to listen to you. Also, limit the number of questions you ask at a time.
- Reduce unnecessary stimuli (for example, sirens and flashing lights).
- Allow the individual time to vent some of his or her frustrations.
- Remember to not reassure the individual that the voices "are not real," because people with hallucinations really do experience them.

Delusions

A delusion is a *fixed, false belief*. Delusions can be seen in delirium, dementia, depression, and mania, but are most common in schizophrenia and related psychotic disorders. Some common types of delusions are *delusions of grandeur* and *paranoid delusions*. Delusions of grandeur are false beliefs that one has special powers or is extremely important; these are common in people with mania. Paranoid delusions are beliefs that one is being followed, watched, or maliciously pursued and are common in schizophrenia. Persons experiencing paranoid delusions can be extremely suspicious and tense. Listed below are tips when interacting with someone who has delusions or paranoia.

Tips for Interacting with Someone who is Delusional

- Avoid attempts to refute or disconfirm delusions.

- Affirm that the belief is important to the person and express a desire to understand, without "going along with" delusional ideas.
- Rather than commenting on the actual content of the delusion, try to connect in terms of the feelings that the person appears to be experiencing.
- Allow him/her to vent frustrations.

Tips for Interacting with Someone who is Paranoid

- Let the person know that you are here to help, not harm him/her.
- Avoid rapid, unexpected, or unexplained/unannounced movements that may be misinterpreted due to paranoia.
- Provide enough personal space.
- Keep your hands visible (for example, not in your pockets).
- Try to offer choices (for example, where to sit down to talk, who should be present when you talk, which side of the car to get into).

From: "Michael Compton" <mcompton@mfa.gwu.edu>
Date: Wed, January 11, 2012 3:24 pm
To: admin@thebarbaraschneiderfoundation.org
Cc: "Beth Broussard" <bbroussard@mfa.gwu.edu>
Priority: Normal
Options: View Full Header | View Printable Version | Download this as a file | View Message details | View as plain text

Dear Mark,

Please find attached a CIT International Newsletter article for your consideration. Our intent with this brief article is to give CIT officers some pointers on working with people who have hallucinations or delusions.

Sincerely,

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De-escalation

This course of study is specific to the Law Enforcement Officer and those in related fields that encounter a person with mental illness in a crisis situation.

Course Objectives:

- The Officer will increase their awareness of verbal and non-verbal cues of a person with mental illness during a crisis situation.
- The Officer will improve existing skills, as well as learn new skills and techniques, to help in the de-escalation of a person with mental illness in a crisis situation.
- The Officer will gain therapeutic communication skills to increase potential for successful interactions during a crisis situation with a person with mental illness.
- The Officer will exhibit their newly attained skills and techniques in handling a crisis situation with a person with mental illness in an interactive practicum at the conclusion of course study.

Law Enforcement Specific: Communication Factors

1. Effective communication skills are the key to any successful interaction; but it is especially important when dealing with a mentally ill person in crisis.
2. The law enforcement officer is working under a set of parameters that is unlike that of any other professional, such as:
    A. Safety and protection of the general public.
    B. The public's perception of Law Enforcement Officers – public microscope.
    C. Political ramifications.
    D. Potential restrictions of duration of interaction.
3. The parameters stated above, as well as many others, make it imperative for the CIT Officer to be highly skilled in the therapeutic communications that are necessary to de-escalate a mentally ill person in a crisis situation.

Principles of Therapeutic Communication

For use in de-escalating a person with mental illness in a crisis.

Adapted from *Listening and Responding in Crisis Intervention* by Dr. B. Gilliand and Dr. R. James, University of Memphis

1. Empathy (Empathic Understanding)

Empathy means to accurately and sensitively understand the other person's experience, feelings, and concerns. The empathic CIT Officer will accurately sense the person's feelings as if they were his or her own, without becoming lost in the other person's concerns. If the CIT Officer can effectively show empathic understanding, the he or she will be setting up the conditions whereby the crisis situation may be defused, calmed, and contained. The person in crisis is more likely to feel understood, to feel a sense of safety and self-control, and to begin to trust the CIT Officer. The major components of communicating empathic understandings are:

A. **ATTENDING** – To the person's words, voice, and body language.

B. **ACCURATE RESTATEMENT** – Of the person's essential message content.

C. **ACCURATE REFLECTION** – Of the person's moment-to-moment feelings.

Empathy is different from sympathy. When we're sympathetic, we may become sad, angry, etc. over the other person's dilemma. In crisis intervention, sympathy is not helpful because we lose objectivity and the ability to act in a logical and linear manner.

Conversely, by responding in an empathic manner, we are attempting to approximate and anticipate, as closely as possible, the thinking, feeling, and behaving of the recipient of our services.

When we are able to perceive the world as the other person does, we are able to establish trust, convey understanding, and open the door to less traumatic or violent intervention.

CIT Officers who practice and use, practice and use (over and over again) the technique of empathic understanding will become more proficient and more successful as time goes on. Empathic responding is a skill that will make the CIT Officer more successful, not only in police work, but also in one's daily living.

2. Genuineness (Congruency, Realness, Transparency)

Genuineness means to interact with the other person without any pretensions. The CIT Officer who is genuine will be perceived by the other person as:

BEING ROLE-FREE: The interventionist (CIT Officer) assumes no facades. "I do not pretend to be something I'm not, that is, Superman, Rambo, Wonder Woman, or Sigmund Freud. What you see is what you get!" Being role-free conveys to the other person that, "I'm real, I'm vulnerable, too, I can be afraid, glad, happy, aggravated, caring, supportive, and can experience all the other emotional states anyone else can."

BEING SPONTANEOUS: By communicating the interventionist (CIT Officer) thoughts and feelings in an open and honest manner, the CIT Officer is able to adapt to changing conditions without operating out of a "rule book" that may exacerbate the crisis.

BEING CONSISTENT: Saying one thing and doing another is not helpful in gaining confidence and credibility. "When I am consistent, my mouth is not saying one thing, 'I want to be helpful,' while my body language is saying another, such as vigorously tapping my flashlight in my hand."

SELF-DISCLOSURE: Self-disclosure does not mean "sharing my innermost secrets, or telling my war stories." It means owning my own feelings about what is going on at the present time.

USING "I" STATEMENTS: "I" statements mean taking responsibility for what is happening. "We," "They," "The Captain," "God," are all ways of distancing oneself from the client and not taking responsibility for one's own feeling, thinking, and acting.

STAYING IN THE "HERE-AND-NOW": Staying in the here-and-now means just that. We sometimes call it "immediacy." It is extremely easy, and of little help, to talk about other people, other places, and past or future time. Staying in the present is critical in keeping clients in touch with reality and moving toward problem resolution.

GENUINENESS: This has to do with who you are, the person you are. The "real person" (the self) the CIT Officer brings to the crisis situation is who the person in crisis will see and who the person in crisis will respond to. The admonition: BE YOURSELF, in the immediacy of the crisis situation is critical.

3. Acceptance (Caring, Prizing, Unconditional Positive Regard)

Acceptance means recognizing that the other person has a right to his or her own thoughts, feelings, or behaviors, and deserves to be respected as a human being of intrinsic worth, regardless of that person's station in life, race, religion, ethnic origin, sex, sexual orientation, economic condition, or personal looks. The CIT Officer who shows acceptance or unconditional positive regard toward the person in crisis will have an immediate advantage in gaining trust and beginning to stabilize or calm the crisis situation.

At times, acceptance may be extremely difficult when clients act in bizarre, angry, or hostile ways. Most clients' actions are motivated by fear, anxiety, and insecurity. No person that we know of decided as a child to use schizophrenia, drug addiction, acute depression, or any other mental illness or affliction as an emotional or vocational choice when they grew up. If we are able to accept a heart patient, and take this disability into consideration, then surely we can do the same for a mental patient.

The CIT Officer who can truly accept all persons encountered in crisis as people of intrinsic worth, without judging, blaming, or other negative responses, will be immediately modeling this quality to the clients in distress. The clients may then begin to sense and take on the quality of acceptance, too. That is of enormous value in the crisis intervention process.

4. "I" Owning Statements (Assertion)

The CIT Officer may use "I" owning statements to indicate to the other person, "These are my wants, thoughts, and/or feelings, and I take responsibility for them."

The purpose of "I" owning statement is NOT to resolve the problem of crisis, but rather to communicate to the person that the CIT Officer is aware of his/her wants, thoughts, desires, and/or feelings. The client is also aware that the CIT Officer is being honest about his/her own motivations at the present moment. Appropriate use of "I" owning statements does not put the client on the defensive and should not embarrass, diminish, or discount the other person.

OBJECTIVES OF ASSERTION: The purpose is to simply and concretely communicate what the CIT Officer wants, needs, desires. A clue – K.I.S.S. (Keep It Short and Simple).

EXAMPLE OF ASSERTION: "What I'm trying to do is to make sure that nobody gets hurt and that you are safe. What I want you to do right now is to sit down here so we can talk calmly about what is going on with you today, and how I can help." Or, "What I want you to do now is to come with me so we can get you safe and back on your medication."

For many clients, because of their agitated state, they will not hear an initial request. Thus, the CIT Officer will need to use the "broken record" technique. In a calm, clear voice, the request for compliance needs to be repeated without the Officer showing the least bit of disturbance over the client's not hearing the first time.

5. Facilitating Listening

FOCUSING TOTAL MENTAL POWER INTO THE OTHER PERSON'S WORLD: The CIT Officer must focus to the exclusion of background noise or any other distractions. Much like the excellent athlete, the interventionist (CIT Officer) excludes all other distractions and concentrates on the goal of stabilizing the crisis situation.

FULLY ATTENDING TO ALL THE VERBAL AND NON-VERBAL MESSAGES: Attending to what the client is doing is as important as what the client is saying.

When the two are put together, they tell us a great deal about how congruent the client is. Congruency means that what the person is doing, saying, and feeling fits together and makes sense in the given moment in the given situation.

SENSING THE OTHER'S READINESS TO ENTER INTO EMOTIONAL AND POSITIVE PHYSICAL CONTACT WITH OTHERS, ESPECIALLY THE CIT OFFICER:

By asking open-ended questions, such as "How?" and "What?," we allow the client to tell his or her tale, which gives us information, allows us to make an assessment as to client lethality (danger to self, the police officers, and to others), makes the client contact with reality, and facilitates communications.

You will be better off if you stay away from "Why?" questions. "Why?" questions are likely to put individuals on the defensive. Frankly, most of the time they won't know, or have a legitimate reason for, why they did what they did.

Hold "Do," "Are," and "Have" questions to a minimum early on. You close the deal with these, i.e., "Do you want me to call your doctor so we can go there?" Early on, you'll do better with "How?" and "What?" which allows the person to ventilate and elaborate.

MODELING ATTENDING BEHAVIOR BY BOTH VERBAL AND NON-VERBAL CUES:

Modeling this behavior strengthens the relationship bond and pre-disposes the person to begin to trust the CIT Officer. By restating

and encapsulating the client's statements, we affirm that we are listening and also confirm what we have heard is correct. By reflecting emotional content, we affirm feelings as real and legitimate. By our own body language, we show our openness to communication and to helping the person regain control and calmness and to begin to stabilize the crisis situation.

6. Assumptions

SET LIMITS: Provide routine and negative sanctions against behavior that is pre-disposing toward violence or non-compliance.

ASSUME THAT THE CLIENT IS FRUSTRATED: In the client's mind's eye, the client perceives there is a reason to be frustrated.

ASSUME NEGATIVE EMOTIONS: Respond positively and confidently by reinforcing and modeling pro-social behavior.

ASSUME A THREAT TO THE CLIENT'S SELF-ESTEEM AND SELF-CONTROL: Provide choices; provide a way for the client to save face.

ASSUME TENSION AND AROUSAL: Provide a calm, relaxed atmosphere – and, at the same time, be aware that clients can be both powerful and explosive when arousal and adrenaline is high.

ASSUME CONFUSION: Provide a careful explanation of all procedures; be prepared to repeat explanations using the "broken record" technique.

ASSUME RESPONSIBILITY BY ONE PERSON AND ACT AS THE CLIENT'S ADVOCATE: Be perceived by the client as the one person in charge at the moment.

ASSUME THAT THE CLIENT IS UNIQUE: Don't assume that the person or the story he or she is telling is like some other story you have heard. Deal with each new crisis client as a new, emergent situation and say to yourself, "Let me try to understand what this particular person is feeling, thinking, and wanting." Thus, turning over a new leaf with each new crisis client, the CIT Officer will avoid the

trap of stereotyping and assuming that he or she already knows what the client is feeling, thinking, and wanting, even before the client's unique story unfolds. Take the time to let the story unfold or emerge without prejudging the situation.

7. Communication Precautions

DON'T deny the possibility of violence when early signs of agitation are first noticed.

DON'T underestimate information given by others regarding behavioral clues.

DON'T engage in behaviors that can be interpreted as aggressive.

DON'T allow others to interact simultaneously while you are attempting to talk.

DON'T make promises you cannot keep.

DON'T allow feelings of fear, anger, or hostility to interfere with self-control and professional demeanor.

DON'T argue, give orders, or disagree unless absolutely necessary.

DON'T be placating by giving in and agreeing to all the real and imagined ills of the person.

DON'T become condescending by using cynical, sarcastic, or satirical remarks.

DON'T let your own importance be acted out in a know-it-all manner.

DON'T raise your voice, use a sharp edge, or use threats to gain compliance.

DON'T mumble, speak hesitantly, or use a tone so low that you can't be understood.

DON'T argue over small points.

DON'T attempt to reason with anyone under the influence of a mind altering substance.

DON'T attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.

DON'T allow a crowd to congregate.

DON'T corner, or be cornered – give the person expanded space.

DON'T ask "Why?"

DON'T deny the opportunity to save face.

DON'T rush, be rushed, or lose your own cool!

Quick Assessment Techniques

A. When approaching an individual in crisis, go through this quick check-list to give you insight into the situation at hand.

1. Is the individual alone or operating with others?
2. Is the individual pacing?
3. Is the individual talking to themselves?
4. Does the individual back away and/or look around?
5. Is the individual loud and/or animated?

B. When beginning initial verbal intervention with the mentally ill individual in crisis, continue your quick assessment techniques, and take the first few minutes to gather further assessment information.

1. Does the individual make eye contact?
2. Are the individual's emotions rapidly changing?
3. Is the individual alert, confused, or lethargic (possible OD)?
4. Is the individual in touch with reality?
5. Assess their mood – are they angry, crying, overly quiet, or confrontational?
6. Is the individual disheveled or inappropriately dressed?
7. Does the individual exhibit rapid speech, slurred speech, or sexual preoccupation?

Principles of Crisis Interaction

10 Phases

1. Approach individual in a non-threatening manner.
2. Give individual time to vent, explain, or complain, and you time to assess.
3. Using calm tones, give supportive, confident, and emphatic statements.
4. Establish trust and rapport, don't push initial interaction.
5. Be aware of the individual's and your posture (non-verbals) at all times.
6. Refocus client to problem at hand.
7. Ask about medication and doctor's name.
8. Take a few minutes to re-establish rapport.
9. Ask about last appointment and medication compliance.
10. Begin to give options and bring interaction to a conclusion.❖

❖ If Phase 10 is unsuccessful the first time, realize that is okay. This is a process. Move back to Phase 8 and then begin a more assertive Phase 9 and 10.

Setting Limits

A Five-Step Approach to Setting Effective Limits

1. Explain to the individual exactly which behavior is inappropriate.
2. Explain why the behavior is inappropriate.
3. Give reasonable choices or consequences.
4. Allow time.
5. Enforce consequences.

Guidelines for Dealing with a Person with a Mental Illness

- Be respectful: Talk to adults as adults.
- Be calm, clear, and direct in communication.
- Be as consistent and predictable as you can.
- Set clear limits, rules, and expectations.
- Keep a professional distance.
- Accept the person as ill.
- Attribute the symptoms to the illness.
- Don’t take symptoms of the illness personally.
- Maintain a positive attitude, even during failures.
- Allow the client to be unable to do things yet retain dignity.
- Notice and praise any positive steps or behavior.
- Offer frequent praise and, separately, specific criticism.
- Translate long-term goals into a series of short-term goals.
- Help your client attain realistic short-term goals.
- Take an *“I don’t know”* attitude in response to long-term questions.

Helpful Hints to be an Effective CIT Officer

- **Carry a notebook with important contact numbers:** Such as psychiatrists, psychologists, area mental health agencies, case managers, mental health housing apartments, etc.
- **Keep a running list:** Of client's names, dates of each intervention, reason for intervention, and results of intervention. This will help you build a rapport with clients as you remind them of past helpful interventions.
- **Always remember:** You are called or have contact when client is at their worst and usually off of their meds. When they are medication compliant, they will be more lucid (clear thinking) and will remember what you said, and how you treated them. This will impact greatly on future interventions.
- **In departments across the country, only the best law enforcement officers are CIT officers:** An officer cannot be mandated into CIT and be a truly effective CIT officer. It takes a will to be a notch above the rest.
- **Take pride in being part of an elite team.**

Ten Commandments of

De-escalating

1. Your safety comes first.
2. Keep therapeutic spacing.
3. Speak in tones that fit the situation.
4. When appropriate, use non-threatening posture.
5. Personalize the conversation (i.e., use first names).
6. Ask how you can help the client.
7. Don’t be afraid to set firm, but calm, limits.
8. Never validate hallucinations.
9. Don’t internalize the client’s negative comments.
10. Never forget that schizophrenia, bipolar disorder, and major depression are organic and genetic disorders. The client did nothing to inherit them.

Engagement

GOAL: Build trust by validating the person and their situation

Awareness- Be aware that a uniform, gun, and handcuffs may frighten the person with mental illness so reassure the person that no harm is intended.

Calmness- Provide a calm and relaxed atmosphere. If it helps, try and reduce background noise and distractions. Don't allow others to interact simultaneously while you are talking. Keep a safe distance. Don't corner the person or allow a crowd to congregate. Remain calm.

Genuineness- Be yourself, be consistent. Keep verbal and non-verbal cues in sync and non-threatening. Own your feelings about the situation/person. You will likely have contact with the person again and how you treat them now will go a long way in establishing trust.

Empathy- Ask how you can help them. Use their first name early and often. Find things in common. Attend to their words, restate their message, and acknowledge their feelings/situation.

Acceptance- Don't stereotype, remember, the person is sick and deserves to be respected regardless of their illness, gender, religion, looks, etc. Don't take the symptoms of their illness personally.

Assessment

GOAL: Gather necessary information to make a safe resolution

DON'T maintain continuous eye contact, crowd the person or touch the person unless you ask first or it is essential for safety.

Patience- Speak in a calm and clear voice, and give the situation time. You may need to repeat requests. *Don't assume that a person who does not respond cannot hear you.*

Tone- Don't be placating, condescending, or sarcastic. If they are hallucinating, don't lie, deceive or trick them to get compliance. Rather, validate the person by stating you know what they are experiencing is very real TO THEM.

Question- Ask open ended questions, allow the person to vent. Stay away from WHY questions as they can put the person on the defensive. Don't argue or debate unless necessary. Don't use threats to get information. Remain friendly but firm.

Focus- Keep the person focused in the here-and-now. Get information about the person's illness, medications, treatment compliance, and treatment professionals.

Other sources of information- Are there family members or others involved who can give you reliable information on the person's illness and past behavior?

DON'T force discussion, express anger, or impatience. Don't use inflammatory language such as crazy, psycho, or mental subject. Don't mislead the person to believe that officers on the scene think or feel the same way the person does.

Resolution

Goal: Gain control of the situation and return to pre-crisis state

Set Clear Limits- Use "I" statements, respond positively and confidently. Explain what behaviors are appropriate and inappropriate. Explain why it is inappropriate. Refocus the person to the problem at hand.

Communicate Directly- Be honest about your wants, needs, and motivations and state them to the person (I need to make sure no one gets hurt, I want to make sure everyone stays safe). Restate your expectations and link these to safety issues. Set short-term goals.

Create Options- Provide options for the person regarding the desired outcome. Don't make promises you can not keep. Try and retain their dignity. Praise positive steps or behaviors. Take an "I don't know approach to long-term questions.

Take Action- Assume confusion. Once you decide on a course of action, tell the person what you are doing and what is expected. Be prepared to repeat these. Follow procedures indicated on medical alert bracelets or necklaces.

Sometimes it's better not to arrest someone, even if you have probable cause!

Front-line staff Training Objectives

After participating in this training, attendees will be able to:

1. Learn from the experience of the other students what works and what does not work with respect to de-escalation

This objective will be met by reviewing the pre-training survey results, specifically the answers to the de-escalation questions on what to do and say to de-escalate the various encounters and what to NOT do and NOT say to escalate an encounter.

Students will also be oriented to the Communication Web and De-escalation Building Blocks.

2. Identify the three phases of every encounter

This objective will be met through a PowerPoint presentation on the EAR model with a description of the three phases and the goals specific to each phase.

The original list of interventions identified on the survey results will be classified as either Engagement Skills, Assessment Skills, or Resolution Skills.

3. Identify the 4 types of encounters

This objective will be met through a PowerPoint presentation on the LOSS model with a description of each of the four types of encounters.

4. Review the skills needed to safely de-escalate a situation

Specific intervention strategies will be reviewed for handling out of control encounters and loss of reality encounters. A description of escalating behaviors will be reviewed.

Two application exercises will be used to tie the EAR and LOSS models together with a focus on the skill set. Recorded 911 calls will be used and the students will identify effective and ineffective techniques of de-escalation. Students will match intervention strategies with the various types of encounters.

5. Identify three actions they can take when they do not feel safe in their work environment.

Students will review the safety decision tree and a facilitated discussion will identify options staff can take to ensure their safety.

6. Demonstrate and observe the use of de-escalation skills

Students will role play a variety of situations and the process will be facilitated to identify the kills used in each phase and type of an encounter they may face.

Case 01

Clients: Sally Clark, female; Jim Clark, male; Ages 30s-50s

Diagnosis: Paranoid schizophrenic

Location: Jim & Sally's apartment: messy

Dress: disheveled dress and appearance

Dispatch call:

Dispatcher receives a call from client regarding her husband. "My husband is starting to talk to the TV again. He's getting really upset and I am starting to feel scared. When he starts getting this way, he always ends up in the hospital."

Situation:

Both Sally and Jim are disheveled and upset. Sally meets officers at the door. She urges them to come I and help her husband who has been yelling at a turned-off TV. He believes that the TV station has been putting scary thoughts in his head and is pacing and yelling at unseen voices.

When the officers begin talking to Jim, he is initially angry and defensive, but as he settles down, he begins to express concern for Sally. He says that she has been off her meds for several months and has not been taking care of herself or him. He says that her thinking has been more confused and that she called the police because of this confusion, not because there is anything wrong with him.

While Jim is talking with the officer, Sally goes to the sink and takes a pill. Sally, who made sense at first, becomes increasingly disorganized and bizarre. Each believes the other is sick, but initially denies that they need any help themselves.

Props: Pill Bottles – Zyprexa for Jim; Clozaril for Sally. Both are nearly full and were last filled 5 or 6 months ago.

Case 02

Clients: Judi Hart; provocative, histrionic young woman

Diagnosis: Borderline personality disorder

Location: Judi's apartment – late evening; midnight; music may be playing softly – remember that you, not the music, are the center of attention;

Dress: Provocative (lingerie showing through robe) and somewhat disheveled.

Dispatch Call:

Next-Door neighbor calls 911 to report concern about next-door neighbor, Judi.

Situation:

Judi is disheveled but alert when she answers the door. She is dressed in a bra and panties with a house coat/robe over. She is calm and somewhat seductive, but denies that there are any problems.

She is surprised when the police officers arrive. When carefully questioned, she reveals that she had a fight with her boyfriend, who she found out had been cheating on her. She kicked him out and now feels alone and abandoned. If asked about her boyfriend, she gets upset and says, "he better not come around if he knows what is good for him."

She will acknowledge calling her neighbor, but says she was only blowing off steam. "I bet she told you something about my taking pills. I only took a handful [of Prozac] when I was upset. I was not trying to hurt myself." She admits to having a couple drinks earlier in the evening. She is really upset that her neighbor called the police.

Judi, you fear abandonment and cannot tolerate being left alone. You need to have people with you. Your frantic efforts to avoid being alone/abandoned are acted out in yor behavior toward the policeman, specifically, your sexual advances/impulses.

Judi, when your sexual advances are turned down by one of the officers, you react with sarcasm, bitterness, and a verbal outburst toward this officer. You then turn your advances toward the second officer. You do not discriminate sexually between male and female officers. You may make sexual advances toward the female officer as well.

Props: A couple of empty beer cans or ½ empty bottle of wine; half empty Rx bottle of Prozac 20 mg capsules.

Case 03

Clients: George Hunter & Charlie; males 60-70s

Diagnosis: Dementia vs. delirium

Location: Senior citizen apartment complex; messy apartment

Dress: Disheveled; both gentleman are dressed in pajamas/robes

Dispatch Call:

Housing manager has called police to express concern about a resident that has not been down to dinner in the past few days. Manager has tried to enter the apartment to check on resident, but resident will not let him in. He has been heard shouting but as far as he knows; no one else lives there except George; his wife died 3 years ago. His children live out of town.

Situation:

George is confused and paranoid. When officers come to the door and he lets them in, he states that he is waiting for his wife, Gracie, to return. He is afraid that someone may have hurt her. Also, he believes that there are many unsavory characters about who are after his money. George believes it is sometime in the 1970s, that he is in his 30s, and that Gracie is still alive. If he sees himself in the mirror, he gets scared and thinks a stranger is in the apartment.

Charlie is also in the apartment. He is claiming that this is his apartment and that George just wandered in and is "crazy". Charlie tells the officers to get George out of his apartment. Charlie at first appears to be more coherent than George.

Props: An empty bottle of Digoxin 0.25mg dated 1999 with George's name.

Case 04

Client: Joseph Nunn; male mid 40s

Diagnosis: Chronic paranoid schizophrenic

Location: Outside a local convenience store.

Dress: Disheveled & dirty clothing - coat with pockets; smelly.

Dispatch Call:

Police dispatcher receives call from storeowner regarding an individual that is bothering and menacing shoppers. Storeowner asked him to leave and he put hand in coat pocket. Storeowner feels he may have a gun.

Situation:

Joseph , you are talking to self and muttering that police officers are demons working for Satan. Joseph will not make eye contact with police officers initially.

Initially, hands are in pockets. As soon as officers ask to see your hands, remove them slowly from your pockets. You will be holding a cross in one of your hands. It is very important that you remove your hands promptly and slowly when asked. This allows police officers to move from police mode to CIT mode.

Joseph is religiously pre-occupied. He is quoting bible verses, complaining of bright lights that hurt his head and that he cannot breathe. He repeats things over and over and points the cross at visual hallucinations which are evil and trying to hurt him.

Joseph eventually admits that he usually gets injections at the local psychiatric clinic (PES – Portage Path Emergency Services). He has not been there to get injections of Haldol for about 3 months.

At first, Joseph does not want to go to PES because, "They strap me down there. I do not like the doctor there." Eventually, Joseph does agree to go there because he wants to feel better.

Props: None

Case 05

Clients: Female; Davida Adams; 30-50's

Diagnosis: Bipolar disorder – manic phase

Location: Client's apartment; music playing loudly

Dress: Dressed in bright colors, lots of jewelry, and heavy make-up

Dispatch Call: Neighbor called complaining of loud music

Situation:

Davita you greet the officers and are somewhat condescending. Your speech is rapid and you are euphoric. You are an artist and feel that they should know who you are. If the officers ask to turn down the music, you refuse – the music is driving your artistic creativity and you need to continue painting/sculpting because you have a show coming up in New York City.

If asked about your sleeping and eating, you admit that you have not slept in 2 or 3 days and you art is your food right now! You will sleep and eat when you finish this masterpiece.

If asked if you have ever been to PES (Portage Path Emergency Services) or to see a doctor, you initially deny having been there. You will eventually admit that you do go "sometimes" if needed. However, you are feeling great and really do not need to go. Actually, you are feeling so great that you have not been taking your medication lately – it just slows you down anyway – and you have so much work to do for the upcoming art show!

Eventually, you will agree to go to PES with the officers.

Props: Bottle of Lithium (300mg) in purse

Case 06

Client: Jessica Murphy; female 30's

Diagnosis: Paranoid schizophrenic

Location: Laundromat

Dress: Somewhat disheveled

Dispatch Call: Someone from the laundromat calls to say that a women has been sitting/standing in front of an empty dryer all night.

Situation:

Jessica, you are sitting/standing in front of an empty dryer. Occasionally, you will talk to the dryer. When the police approach, you initially will not respond to them. When you begin to respond to them, you will not necessarily make sense. You may respond to their questions with responses to the conversation you are having with your deceased parents.

You are having visual hallucinations and seeing and speaking with your deceased mother and father, who you see in the dryer.

You will have a Rx bottle (1/4 full) with you in your pocket. You will eventually admit that you have not been taking your medication for over 3 weeks. And you have missed work the past week. You were feeling pretty good so you stopped taking your meds.

You will also admit that you go to PES to see a doctor and get your Rxs refilled. However, you do not like your doctor. You will eventually agree to go with the officers to PES.

Props: ¾ empty prescription bottle; Risperdal (6mg)

Case 07

Clients: Female; 30-50s

Diagnosis: Delusional disorder

Location: Client's apartment ; apartment is messy

Dispatch Call: You have called the police department and have requested help in your apartment

Dress: A bit disheveled;

Situation:

You greet officers warmly. You are glad that they have stopped by. You ask them if they would like something to eat or drink. You would just like them to stay for awhile.

You admit that you are having difficulty sleeping. You are being "kept up at night." Eventually you will admit that there are Martians in your lamp that are keeping you up. You think that they are friendly but you are not sure and they have been in the apartment so much more often lately and are constantly talking!

You are cooperative with the police officers and eventually agree to go with them to PES (Portage Path Emergency Services) to talk with someone who can help you.

Props:

Case 08

Client: male; age 40-60s

Diagnosis: schizophrenic

Location: Darkened alley on steps outside an apartment complex

Dress: dressed casually wearing an “FBI” cap

Situation:

The police officers have stopped to check on you as you are sitting out on steps and it is the middle of the night. You greet the officers with a whisper “I am one of you guys”

You tell the officers that you are on a stakeout and that you do not want them blowing your cover. You tell the officers “I think they know I am here. Go ahead let them know I am checking on them – they are not going to get away with anything!”

You also tell them that you know Lt Woody and you are working with him and you pull out one his cards.

You will eventually agree to leave with the officers and go talk with someone.

Props:

Case 09

Client: Male 30-40s

Diagnosis: Major depression, recurrent

Location: Area bookstore

Dress: drab clothing; a bit disheveled

Dispatch Call: Manager of upscale bookstore calls dispatcher and complains of a male that has been sitting on reading couch for hours with head down. Individual will not respond to anyone and periodically cries loudly. He is disturbing other patrons.

Situation:

When the officers approach, you do not look at them right away. You are looking down and crying. When you do respond, your speech is slow and you are slow. You do not smile or laugh.

You will eventually begin talking to the officers and if asked, admit to planning to kill yourself. You feel you have nothing to live for. Your wife and children were killed in an auto accident several months ago. You were driving and are the only survivor. You feel guilty that you are alive and that you were not able to save them.

You have not been able to go to work and you think that you will lose your job or be fired soon.

You will admit that you have been like this before (depressed/suicidal) and that you were seeing someone but feel hopeless and that it is useless to try to go on. You will eventually agree to be escorted to PES (Portage Path Emergency Services) to get help.

Props:

Case 10

Client: Male 30-40s

Diagnosis: Cocaine addiction

Location: Bridge

Dress: A bit disheveled

Dispatch Call: Person calls dispatcher to notify someone that there is a male on the bridge and that he is threatening to jump.

Situation:

When the officers approach, you do not look at them right away. You are looking down and may be crying. You do not smile or laugh. You initially do not want the officers to approach you. You tell them that if they approach you will jump.

You will eventually begin talking to the officers about your situation and why you want to kill yourself. You feel you have nothing to live for. You are unemployed – having recently lost your job and your wife has left you. You eventually admit that your addiction to cocaine has caused you to lose everything you care about – a good paying job in the technology field and your family.

For quite a few years, things were booming in the technology field and you and a partner had a great web-based start-up company. The work was stressful but business was great. You were using cocaine frequently – you had a lot of money coming in, a lot of work to do and with the cocaine you did not need to eat or sleep and the high it gave you was incredible. Then business went bust when the bottom fell out of the tech field. But you could not kick the cocaine. Your wife left you 3 months ago when you had emptied out all the bank accounts to keep your habit up. Your family & friends have refused to lend you any more money. You have no health insurance, no job, and no money and you are ready to end the misery.

Props: None

Case 01 (Sisters)

Clients: Sally Clark & sister , females; Ages 30s-50s

Diagnosis: Paranoid schizophrenic

Location: Their apartment: messy

Dress: disheveled dress and appearance

Dispatch call:

Dispatcher receives a call from client regarding her sister. "My sister is starting to talk to the TV again. She's getting really upset and I am starting to feel scared. When she starts getting this way, she always ends up in the hospital."

Situation:

Both sisters are disheveled and upset. Sally meets officers at the door. She urges them to come I and help her sister who has been yelling at a turned-off TV. The sister believes that the TV station has been putting scary thoughts in her head and is pacing and yelling at unseen voices.

When the officers begin talking to the sister, she is initially angry and defensive, but as she settles down, she begins to express concern for Sally. She says that Sally is actually the one off her meds and has been off her meds and has not been taking care of either of them. The sister says that Sally's thinking has been more confused and that she called the police because of this confusion, not because there is anything wrong with her.

While the sister is talking with the officer, Sally goes to the sink and takes a pill. Sally, who made sense at first, becomes increasingly disorganized and bizarre. Each believes the other is sick, but initially denies that they need any help themselves.

Props: Pill Bottles – Zyprexa for one sister ; Clozaril for Sally. Both are nearly full and were last filled 5 or 6 months ago.

Scene 11:

MEDICAL ALERT

DX. Diabetes

Insulin Dependent