# DAY 3 – CIT Training

| | |
|---|---|
| **8:00-8:30am** | **The Living Room** – Tatiana Shearer, Program Supervisor BHN |
| **8:30-9:30am** | **BATTLEMIND:** Special Mental Health Considerations for Returning Veterans – Nicole Darden, Regional Team Leader Western/Central Mass, SAVE Team, Massachusetts Department of Veterans' Services |
| **9:30-11:00am** | **Hearing Voices** – Bridget Kelly, MSW, Crisis Clinician CCRT, Behavioral Health Network |

# Presentation #2

**8:00- 8:300am The Living Room (Crisis)**

Tatiana Shearer, Program Supervisor, Behavioral Health Network

# BHN The Living Room

21 Warwick St, Springfield Ma 01104. Phone #: 413-310-3312

# The Living Room

- 24/7 Peer Supported Recovery-Oriented Environment
  - Open to the public

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- Supports adults 18+ seeking support throughout an ongoing crisis
  - Emergency Department Diversion Program
- Intervention between a guest and a provider
  - Recovery based environment, non-clinical language

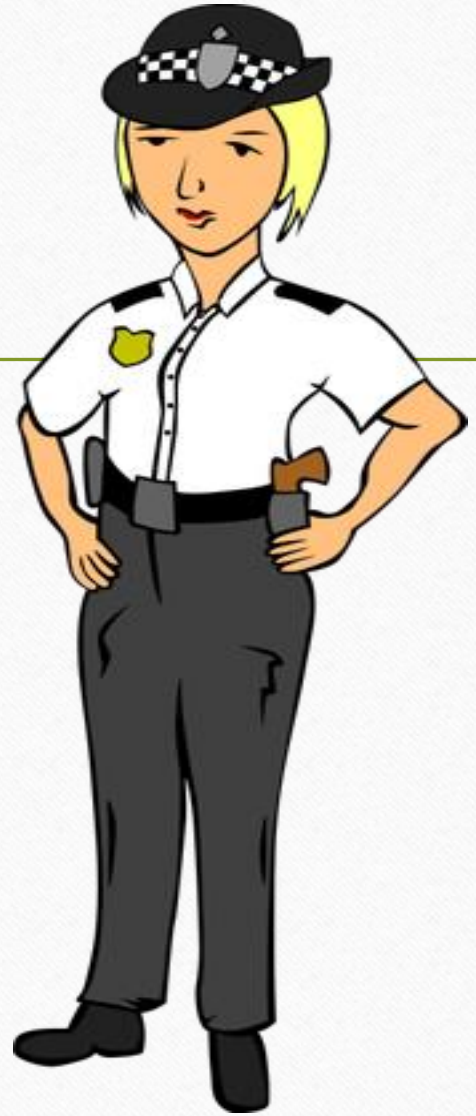
- Trauma Informed Care
  - Certified Peer Specialists provide person centered care

# Emergency Services Collaboration

- Appealing alternative to Emergency Department utilization
- Emergency Department and Crisis Diversion
- Direct connection to all local hospitals

# Law Enforcement

- Police Departments often facilitate transport of individuals to our program and we aim to assist anyway we can.
- Officers and staff members may call us directly to ensure there is space.
- TLR prioritizes emergency calls to ensure safety of the individuals served.



# Who We Serve

**Adults 18+**

**Navigating Challenges with:**

- Substance Use Disorders
- Mental Health & Wellness
- Domestic Violence & Intimate Partner Violence
- Shelter & Housing Support
- Anyone experiencing, has experienced, or potentially experiencing a mental health crisis 24/7.

# TLR Community

- We connect with various healthcare providers in the Western Ma
- We frequently update resources utilizing current information:
  - **www.413Cares.org**
- Our Certified Peer Specialists often provide referrals to community programs
  - Treatment facilities
  - Emergency Shelters
  - Residential Sober living programs

# Peer Support Services

- When individuals have experienced emotional distress or a traumatic event we provide hope, understanding, and resources.
- IN but not OF the system
  - Non-clinical language
- Change agent
  - We advocate for self determined goals and walk beside those who want recovery.

# Code of Ethics

## Certified Peer Specialists

- Our role is to support their personal goals
- CPS openly share recovery stories
- CPS advocate for self determined goals
- CPS respect the **privacy** and **confidentiality**
- CPS are knowledgeable about current resources

# Peer Support Connections

- **RICH** relationship
- **R**: Respect
- **I**: Information
- **C**: Connection
- **H**: Hope

# What We Provide

- Resources
- Emergency beds for overnights
- An accessible kitchen
- Books, movies, arts and craft supplies
- Peer support with trauma informed Peers
- Connections with the community
- Public Use Phone

# The Living Room:

# Success Stories

# End of Presentation

- Recap
- Evaluation
- Thank You

# Presentation # 3

**8:30am -9:30am**

**BATTLEMIND:** Special Mental Health Considerations for Returning Veterans

Nicole Darden, Reg. Team Leader Western/Central Mass,

SAVE Team, Massachusetts Department of Veterans' Services


COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF VETERANS' SERVICES

S·A·V·E

# STATEWIDE ADVOCACY FOR VETERANS' EMPOWERMENT

WHEN YOUR SERVICE ENDS, OUR MISSION BEGINS.

# Special Mental Health

# Considerations for

# Returning Veterans

# Battlemind

Walter Reed Army Institute of Research

## Continuing the Transition Home

- **Joined the Army in 2004**
- **Served with the 1 – 10 Cav, 2ndBCT, 4ID**
- **Deployed to Iraq in November 2005**
- **Participated in over 250 Combat missions and operations throughout the Southern Baghdad region.**
- **Was medically discharged in March of 2008**
- **Transition!**
- **Have been working with Veterans since 2011 and joined the Department of Veterans' Services in early 2012**

**Battlemind** is the Soldier's inner strength to face fear and adversity in combat with courage. Key components **INCLUDE**:

- Self-confidence
  - Taking calculated risks
  - Handling challenges
- Mental toughness
  - Overcome obstacles or setbacks
  - Maintain positive thoughts during times of adversity and challenge

**Battlemind** skills helped soldiers survive in combat, but may cause problems if not adapted when they get home.

**Battlemind Checks** allow Soldiers and clinical staff to identify if and when help is needed.

**B**uddies (cohesion) **vs.** Withdrawal
**A**ccountability **vs.** Controlling
**T**argeted Aggression **vs.** Inappropriate Aggression
**T**actical Awareness **vs.** Hypervigilance
**L**ethally Armed **vs.** "Locked and Loaded" at Home
**E**motional Control **vs.** Anger/Detachment
**M**ission Operational Security (OPSEC) **vs.** Secretiveness
**I**ndividual Responsibility **vs.** Guilt
**N**on-Defensive (combat) Driving **vs.** Aggressive Driving
**D**iscipline and Ordering **vs.** Conflict

# Buddies (Cohesion) vs. Withdrawal

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**In Combat**: The soldier may believe that no one understands their experience except their buddies who were there.

**At Home**: The soldier may prefer to be with battle buddies rather than with spouse, family, or other friends. May avoid speaking about themselves to friends and family.

## Transitioning the Combat Skill

**Cohesion**: Combat results in bonds with fellow Soldiers that will last a lifetime; back home, their friends and family have changed, re-establishing these bonds takes time and work.

# Accountability vs. Controlling

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**In Combat:** Maintaining control of every single minor detail is essential for survival.

**At Home:** Soldier may not let others share in making minor decisions, try to control things that don't really matter or overreact to minor events.

## Transitioning the Combat Skill

**Accountability:**

*Back home, the small details are no longer important; family decisions and personal space are best shared.*

# Targeted vs. Inappropriate Aggression

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**In Combat:** Targeted aggression involves making split second decisions that are lethal in a highly ambiguous environment, which keeps the soldier and their buddies alive.

**At Home:** Soldier may be easily irritated. Get into fights or heated arguments, assault, spouse abuse, snapping at the kids or buddies or your NCO.

## Transitioning the Combat Skill

**Targeted Aggressiveness:**

In combat, the enemy is the target; back home, there are no enemies.

# Tactical Awareness vs. Hypervigilance

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**In Combat:** Survival depends on the soldier being aware at all times of their surroundings and reacting immediately to sudden changes.

**At Home:** The soldier may feel easily startled, anxious, have nightmares, consume alcohol to calm down.

## Transitioning the Combat Skill

**Tactical Awareness:** *Combat requires alertness and sustained attention; back home it takes time to learn to relax.*

# Lethally Armed vs. "Locked and Loaded" at Home

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**In Combat:** Soldiers carrying their weapons at all times was mandatory and necessary.

**At Home:** Soldiers may feel a need to have weapons on them, in their home and/or car at all times. They may believe that they and their loved ones are not safe without them.

## Transitioning the Combat Skill

**Armed:** In combat, it's dangerous to be unarmed; at home, it's dangerous to be armed.

# Emotional Control vs. Anger/Detachment

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**In Combat:** Controlling emotions during combat is critical for mission success.

**At Home:** Failing to display emotions or only showing anger around family and friends will damages the soldier's relationships. Soldier may be seen as detached or uncaring.

**Transitioning the Combat Skill**

**Emotional Control:** In combat, controlling emotions is necessary; at home, limiting emotions leads to relationship failures.

# Mission OPSEC vs. Secretiveness

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**In Combat:** Talk about mission only with those who need to know. Can only talk about combat experiences with unit members.

**At Home:** Soldiers may avoid sharing their deployment experiences with spouse or significant other. Soldiers may feel angry when asked about their experiences.

**Transitioning the Combat Skill**

**OPSEC:** *The "need to know" now includes friends and family.*

# Individual Responsibility vs. Guilt

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**In Combat:** Your responsibility in combat is to survive and do your best to keep your buddies alive.

**At Home:** You may feel you have failed your buddies if they were killed or seriously injured. You may be bothered by memories of those wounded or killed.

## Transitioning the Combat Skill

**Responsibility:** In the *"heat of battle"* Soldiers must act—they must make life and death decisions. Later, it's learning from these decisions…without second guessing.

# Non-Defensive (Combat) vs. Aggressive Driving

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**In Combat:** Unpredictable, fast, rapid lane changes, straddling the middle line, keeping other vehicles at a distance, designed to avoid IEDs and VBIEDs.

**At Home:** Aggressive driving leads to speeding tickets, accidents, fatalities. Soldier may be chasing an "adrenaline high" or often get angry while driving.

**Transitioning the Combat Skill**

**Combat Driving:** In combat, driving fast is necessary to avoid danger; back home, driving fast 'feels right,' but is dangerous.

# Discipline & Ordering vs. Conflict

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**In Combat:** Survival depends on discipline and obeying orders.

**At Home:** Inflexible interactions (ordering and demanding behaviors) with your spouse, children, and friends often lead to conflict.

**<u>Transitioning the Combat Skill</u>**

**Discipline & Ordering:** Giving and following orders involves a clear chain of command, which does not exist within families.


# STATEWIDE ADVOCACY FOR VETERANS' EMPOWERMENT

888-844-2838

WWW.MASS.GOV/VETERANS

# Presentation # 4

## 9:30am -11:00am

## Hearing Voices

Bridget Kelly, MSW, Crisis Clinician,
CCRT, Behavioral Health Network

# Hearing Voices – Dr. P. Deegan

# Hearing Voices – Dr. P. Deegan

# Hearing Voices

SIMULATION EXERCISE

# Presentation # 5

## 11:00am-4:00pm

## De-Escalation Presentation, Skills & Documentation

Carl Girouard – Police Consultant, BHN

Nicola Howe, MSW CIT-TTAC Coordinator

Bridget Kelly, MSW Crisis Clinician

Brian Person, Resident Agent/ ATF

Sharman Douglas, Crisis Counselor - CCRT

Sean Farrell Co-Response Counselor & Trauma Response Team Member

Melissa Suarez, Administrative Director

William Witherspoon, MA – Law Enforcement Coordinator

Richard Winning, MSW, LICSW

Natalie McDonald, MA

Kristin Ciancolo, MA

# Crisis Intervention & De-escalation Techniques

Presented by

Western MA CIT De-escalation Training Team

# Objectives

- At the end of this training, participants will be able to:
  - Give details on what happens in the brain when someone is in crises.
  - Explain what is Crisis Intervention.
  - Have knowledge of the guidelines for a Crisis Intervention.
  - Summarize the logics of de-escalation
  - Expound on the benefits of the C.A.F. Model.
  - Explicate what is Crisis Negotiation.
  - Understand effective communication in Crisis Intervention and De-escalation.

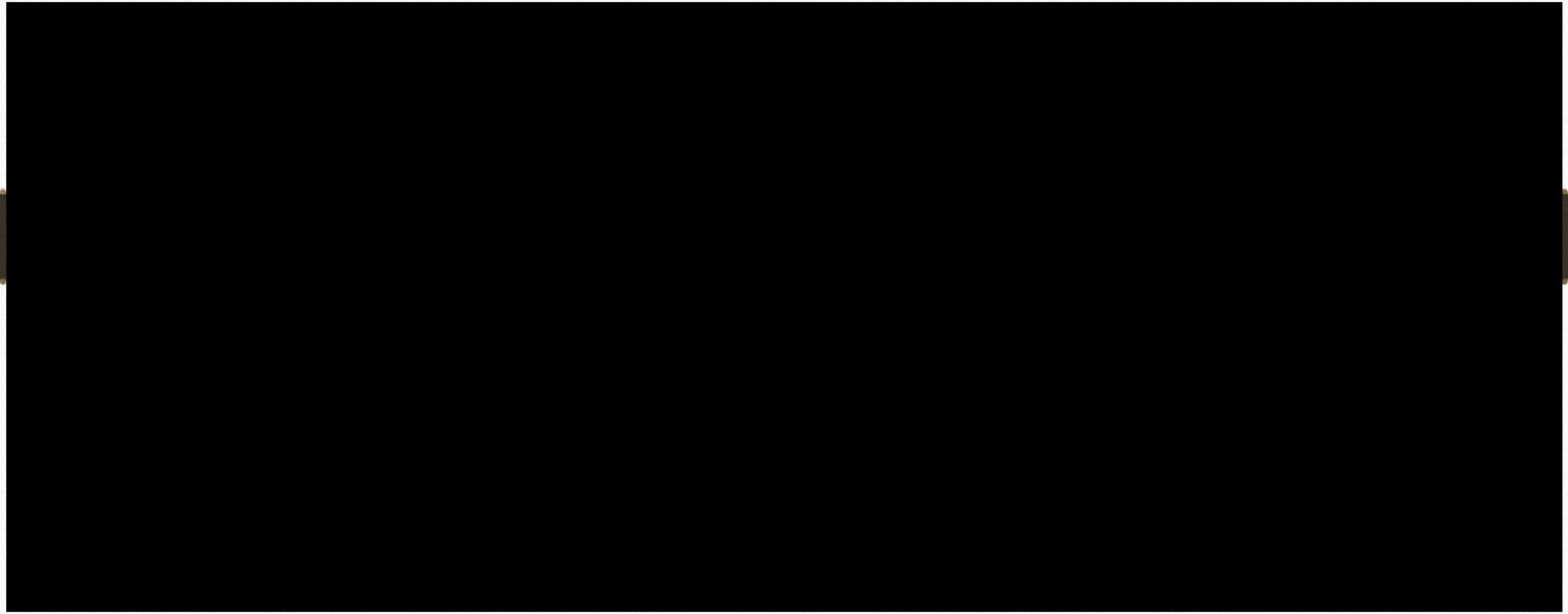
# Training Segments

- Brain System – Moving from Limbic to PFC – Bridgett Kelly
- Crisis Intervention – Sean Farrell/Sharman Douglas
- Logics of De-escalation – Nicola Howe & Carl Girouard
- Crisis Negotiation – Brian Persons
- Communications in De-escalations – Nicola Howe
- Documentation – Nicola Howe
- Role Play/Debriefing – Groups
  - Group 1: Brian Persons
  - Group 2: Nicola Howe
  - Group 3: Carl Girouard/Sharman Douglas
  - Actors: Sean Farrell, Melissa Suarez, Bridgett Kelly

# The Brain System

- An important part of the fight-or-flight response in our brain is the limbic system, where our emotional reaction to something takes place
- When confronted with a crisis: Brain shuts down, can be temporary, but what happens when this is prolonged?
- The first thing that happens in this system is the processing of an event, what should I do? Fight, fright, freeze, fawn?
- Amygdala- Hypothalamus- Adrenal glands - PFC

# Fight, Flight, Freeze Response



# What happens in a crisis?

- Fight, Flight, Freeze
- Loss of Coping Mechanisms
- Declining Problem Solving
- Helpless, Hopeless, Overwhelmed

# The fight or flight response

Dilation of pupil

Dry mouth

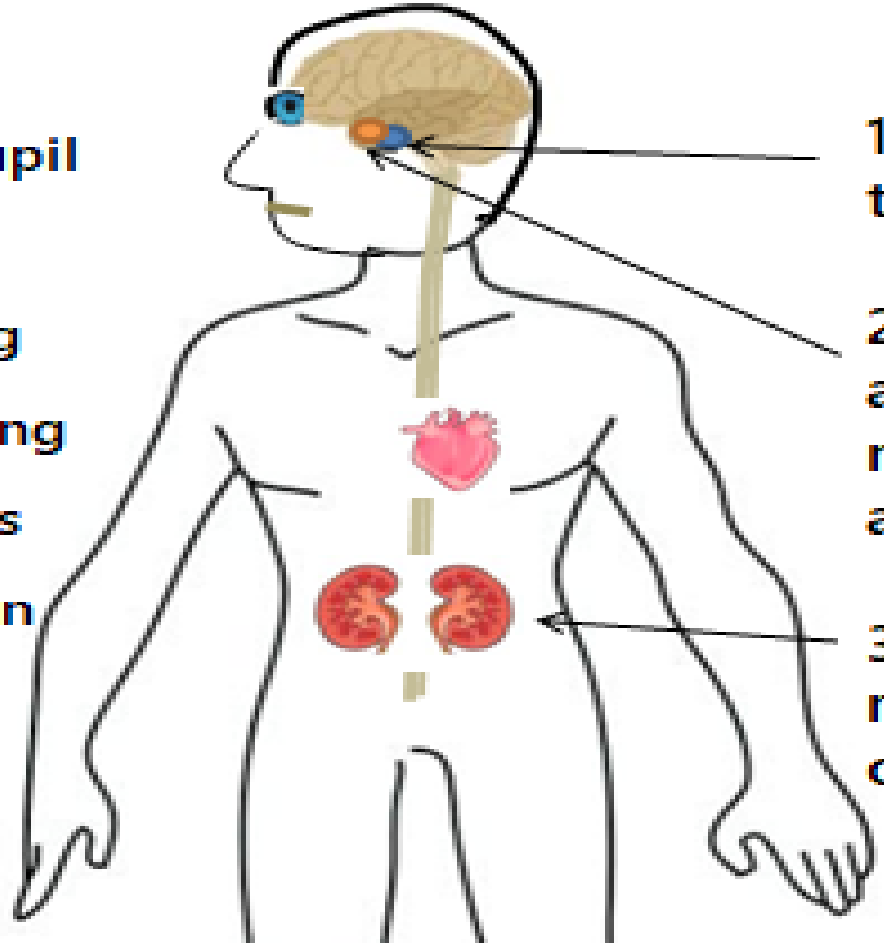
Fast breathing

Heart pounding

Tense muscles

Slow digestion

Sweating of palms



1. The amygdala reacts to threat

2. The hypothalamus activates the sympathetic nervous system, release of adrenaline

3. The adrenal cortex releases cortisol for continued alertness

# Introduction to Crisis Intervention

# Crisis Intervention

## Definition of a Crisis

- Crisis by definition is short-term and overwhelming and involves a disruption of an individual's normal and stable state where the usual methods of coping and problem solving do not work

# Crisis Intervention

- Crisis intervention is generally characterized by:
  - a here and now orientation
  - time limited interactions
  - a view of the individual's behavior as understandable (rather than a pathological) reaction to stress
  - the CIT officer may be expected to analyze the situation quickly and be very active and directive

# Crisis Intervention

- Crisis Intervention Guidelines for Crisis Intervention:
  - Immediate intervention will interrupt a prolonged crisis
  - Action. Be active in helping, exploring and resolving
  - Limited goals. Focus only on goals related to addressing the crisis
  - Build hope and expectations. Resolution is possible

# Crisis Intervention

- Foster support because lack of it can lead to increased negative outcomes
- Focus on resolution of solving the problem(s) underlying the crisis
- Build self-image and self-confidence

# Crisis Intervention

- Crisis for People with Mental Illnesses:
  - Most people with serious mental illness have symptoms that change over time – they get better or worse as a result of normal life stressors
  - The nature of symptoms can lead to a crisis
  - Many people with serious mental illness have difficulty coping with stressful situations
  - When person stops taking medication and symptoms increase

# First Interaction

# SCENARIO

ROLE PLAY – CRISIS INTERVENTION

# The Logic of De-escalation

- If you take a LESS authoritative, LESS controlling, LESS confrontational approach, you actually will have MORE control.
- You are trying to give the consumer a sense that he or she is in control.
- Why? Because he or she is in a crisis, which by definition means the consumer is feeling out of control. The consumer's normal coping measures are not working at this time.

# Crisis Intervention and De-escalation

**C.A.F MODEL – Calm, Assess, Facilitate**

**Calm:** to decrease the emotional, behavioral, and mental intensity of a situation

**Assess:** to determine the most appropriate response as presented by the facts

**Facilitate:** to promote the most appropriate resolution based on an assessment of the facts presented

# Benefits of the C.A.F. Model

- C.A.F is a “fluid process”
- C.A.F. helps to define the intervention
- C.A.F. provides a blueprint
- **C.A.F enhances officer safety**

# CALM: Response, Communication and De-escalation

- Goal: to decrease the emotional, physical and mental stress levels of a situation using verbal and non-verbal de-escalation techniques
- The officer's initial response can often facilitate the direction of the encounter toward a more practical and appropriate resolution

# De-escalation Suicide Prevention

# Guidelines for De-escalation

- Maintain safe distance (5-6 ft or 21 ft rule)
- Use clear voice tone
- Use volume lower than that of the aggressive individual
- Use relaxed, well-balanced, non-threatening posture (yet maintaining tactical awareness
- Set limits

# Guidelines for De-escalation (con't)

- Be active in helping
- Build hope – resolution is possible
- Focus on strengths
- Present self as a calming influence
- CIT officer demonstrates confidence and compassion
- Do not personalize

# Guidelines for De-escalation (con't)

- Remove distractions, disruptive or upsetting influences
- Be aware of body language/congruency
- Be aware that uniform, tools can be intimidating

# Guidelines for De-escalation (con't)

- Be consistent
- Use "I" statements
- Here and now
- Validation/acceptance
- No promises you cannot keep

# Guidelines for De-escalation (con't)

- Recognize that mentally ill person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds, environment – provide careful explanations, instructions
- Determine need for food, water and basic needs
- Use active listening skills

# De-escalation – Delirium

# Brian Person- ATF Supervisory Special Agent

WSU – “The Harvard of Western MA”

WSPD

BOP

CT DOC

USMS

FAMS

ATF -CN T2- TL  - BHN CIT attendee

Foster Parent

# ???


NO
PARKING
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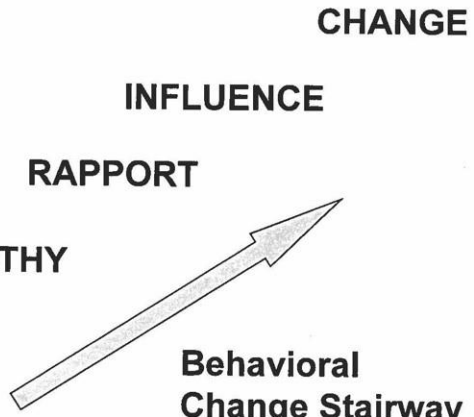
# Influencing Behavioral Change
# Active Listening is the Foundation

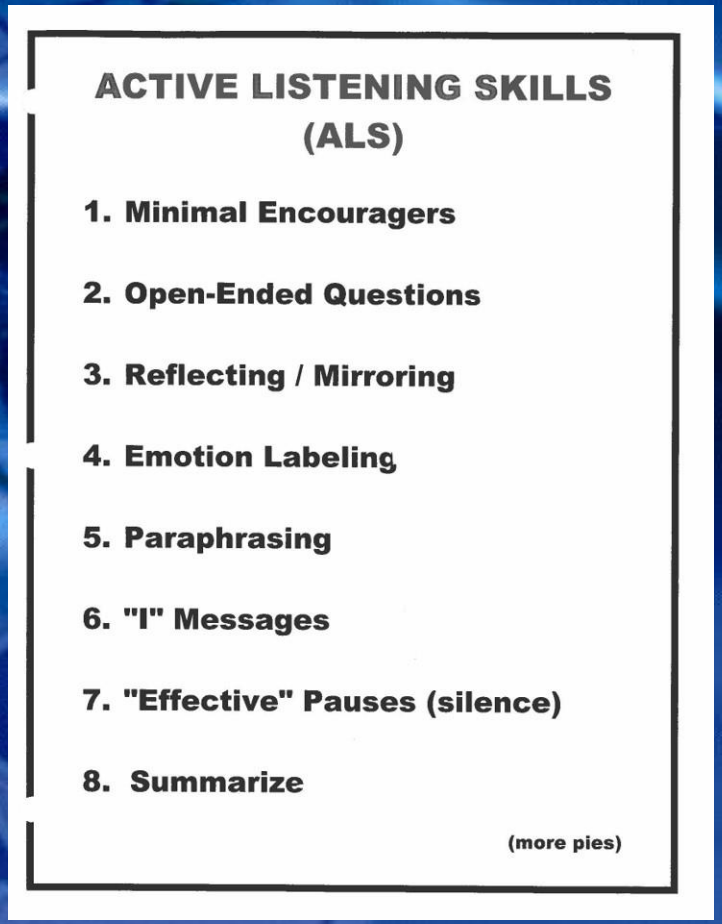
**The Negotiator's Role:**
**Influencing Behavioral Change**




Behavioral
Change Stairway

is the foundation that supports everything else

# Active Listening Skills



# ACTIVE LISTENING

# Its not about the Nail

# Scenario

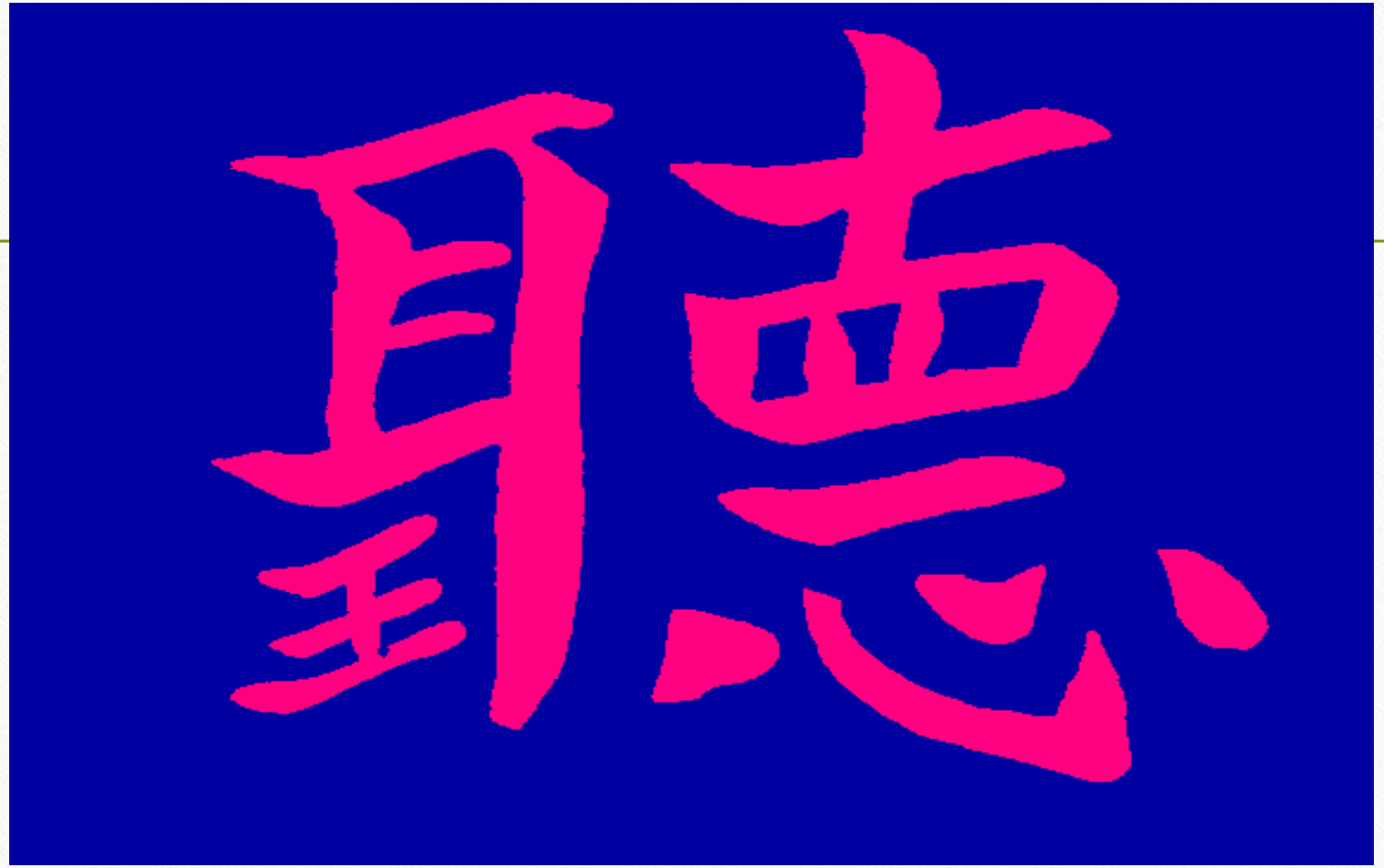
## ROLE PLAYING – ACTIVE LISTENING

# Quick Reference Card

# Reality

# Effective Communication

- 70% of communication misunderstood
- Effective communication is defined as passing information between one person and another that is mutually understood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# Effective Communication – Scenario based

- Introduction
- Active Listening Skills
- Re-instatement
- Accurate Reflection
- Show Empathy
- Build Rapport

# Introduce Yourself

- An introduction promotes communication
- Hi, my name is Doug (or Deputy Smith). I am a CIT officer with the Sheriff's Department.
- Can you tell me your name?
- State what you see/know ("I can see you're upset.")
- State or convey that you are there to help.
- Be prepared to explain the reason you are there

- (e.g., a neighbor called to say someone is upset)

# Effective Communication

- Paraphrasing/Restatement: summarizing what the person said
- Reflection
- Attending
- Open-ended questions: requires more detailed answers
- Minimal Encouragers
- Effective Pauses
- Silence: sends the message that your are willing to listen

# Restatement

- **Restatement Restating or *Feeding Back* the facts of the person's crisis situation**
- **Person in Crisis:**
- *"I stopped taking my medicine after I was fired and I'm sleeping in my carin my car."*
- **CIT Officer:**
- *"You recently stopped taking your medicine, you lost your job, and you don't have a place to stay."*

# Restatement

- **The Facts**
- **Consumer:** *"I started back using and me and my old lady went to fighting. She left me. I didn't go in today. It was my last chance. I'm fired. It's just not worth it anymore."*
- **CIT Officer:** *"Let me see if I understand. You've been using again and you and your wife have been fighting. You lost your job. And you want to give up."*

# Accurate Reflection

- **Reflecting or *Feeding Back* the person's feelings about the crisis**
- **Person in Crisis:**
- *"I'm afraid of sleeping in the car. How can I ever get a room without money?*
- **CIT Officer:**
- *"You're feeling scared and depressed because you don't have any money and no place to stay."*

# Reflection

- **The Feelings**
- **Consumer:** *"I'm a real fuck up. I had two years. I was going to meetings. My wife and I were doing okay. Work was good. I can't do anything right."*
- **CIT:** *"You sound embarrassed and pretty hopeless about getting your life back together."*

# Empathy: An Essential Concept

**"Identification / understanding of another's situation, feelings and motive."**

***Understanding*** is Not Agreement

# Empathy: An Essential Concept

- Empathy is not Sympathy

  Sympathy - "...an expression of pity or sorrow for the distress of another..." American Heritage Dictionary

  Pity and sorrow are not productive

- It's not necessary to actually *"feel what they feel"* to provide empathy

# Rapport

- Rapport
- Relationship of mutual trust

# Communicating Acceptance

**Person in Crisis**

- **Fearful**
- **Anxious**
- **Angry / hostile**
- **Insecure**
- **Paranoid**
- **Acting strangely**
- **Speaking bizarrely**
- **Poor personal hygiene**

**CIT Officer**

- Respectful Introduction
- "Please"
- "Thank you"
- Smiling when appropriate
- Considers: "What if this person in crisis were a member of my family?"

# Effective Verbal Intervention Must Be:

- Specific – precise, explicit, clear
- Concise – short, to the point, simple
- Directive – instructive, communicating clearly what you want the individual to do

*Broken Record Technique – purposeful use of repetition*

# ASSESSMENT: Evaluate the Situation

- Goal: To determine the most appropriate response as presented by the facts
- Assess for a mental illness and/or substance use
- Assess for Orientation (time, place, person)

# ASSESSMENT (con't)

- Focus on verbal, behavioral and environmental indicators
- Be aware of signs for suicide and/or violence
- Medical emergencies
- Medical/physical conditions that could mimic mental illness

# Assessing- B.E.F.A.S.T.

- B – Behaviors
- E - Emotional/Mood
- F – False Beliefs and Perceptions
- A – Appearance
- S – Speech
- T – Thinking Form

# Assessing – B.E.F.A.S.T.

- ***B - Behavior***: actions, gait, movement, mannerism
- ***E - Emotions/Mood***: steady or sustained emotional state assess, expressions and feeling tone
- ***F - False beliefs & Perceptions:*** delusions and Hallucinations
- ***A - Appearance***: dress, grooming, posture, gestures, facial expressions
- ***S - Speech***: rate, volume, and pace, abnormalities
- ***T - Thinking form*** (flow) of thought

# Strategies for Frequently Encountered Situations

# Strategies for Frequently Encountered Situations

**Psychotic (Disorganized Thinking) and verbally aggressive**

Allow person to vent energy, maintain safe distance, talk in low voice, broken record, reassure

# Strategies for Frequently Encountered Situations

**Hallucinations**

Validate the experience for the person, can indicate you don't hear the voices, have person focus on you, offer help, safety

# Strategies for Frequently Encountered Situations

**Delusional statements (may include paranoia)**

Recognize their view, indicate it is not your view, but you are willing to help, do not argue or debate, focus person on what you need them to do

# Strategies for Frequently Encountered Situations

**Compulsive Talking (mania)**

Ask concise, specific, concrete questions; use broken record technique

# Strategies for Frequently Encountered Situations

**Intoxication**

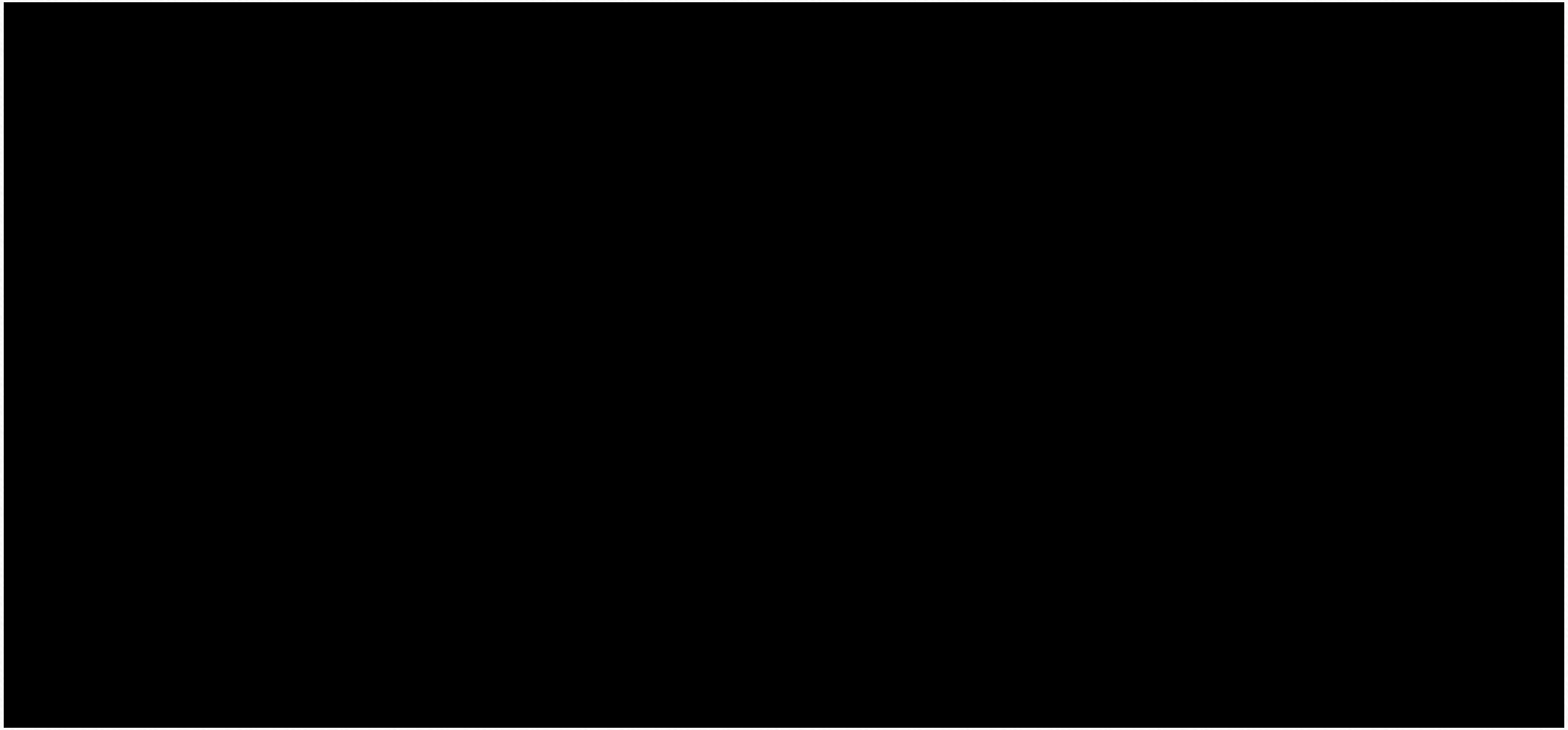
Let them vent, listen, use a calm, even tone, move person away from others if possible, be reassuring

# Strategies for Frequently Encountered Situations

**Depression**

Active listening, empathy, take time, reassure, offer hope, validate feelings

# De-Escalation – Suicide By Cop



# Strategies for Frequently Encountered Situations **Suicidal Person:**

- What position is person putting you in (consider suicide by cop)
- Present in calm, understanding, non judgmental manner
- Listen
- Emphasize temporary time-frame of crisis
- Suggest alternatives
- Emphasize effect on survivors
- Lethality assessment (plan, lethal, access, support)
- Be active in offering hope and help

# DONT'S

- Use Aluminum Foil
- Listen forever
- Argue with logic of delusions
- Agree with delusions/no deception
- **Let your guard down**
- Assume condition will remain constant

# DO's

- Get comfortable asking questions
- Try to understand cause of behavior
- Hand off as necessary
- Seek consultation
- Know your limits

# FACILITATE: Response Resolution

- The goal is to promote the most appropriate
- disposition/resolution to the crisis situation
- based on the assessment of the facts
- gathered, policy and legal obligations of the
- officer

# Tips for Effective Facilitation

- Appropriate assessment directs appropriate facilitation
- Know your community resources
- Be flexible with alternatives when appropriate

# Courage

**“Each time someone stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope.”**

***Robert F. Kennedy***

# OFFICER SAFETY Is The PRIORITY

**Role Play Instructions**

You will be in 3 groups.

You will use 10 minutes to try and de-escalate  an individual who is decompensating due to precipitating factors and without.
There will be a debrief after each role play.

At the end of role play. Each participant will write a report about what occurred and what they did to de-escalate if possible.

# DRAMATIZATION – NOTE TECHNIQUES USED


THANK YOU!
FOR
POLICE OFFICER
YOUR
SERVICE!