

Two Case Studies

Read before or during the session. Both are composites built for training — no real persons or agencies are depicted.

CASE 1 — THREE HOURS ON THE OVERPASS — THE CALL THAT RAPPORT CLOSED

A co-responder unit — an officer and a crisis clinician — took a 2 a.m. call for a man standing on the wrong side of an overpass railing. Traffic units wanted the bridge closed and a negotiator staged; the clinician asked for ten minutes first.

The pair slowed everything down. The officer positioned the vehicles to kill the light bar glare and stayed back. The clinician approached to conversation distance, introduced herself in one sentence, and then said almost nothing for four minutes. When the man finally spoke — 'you people always come in pairs now?' — she reflected instead of redirecting: 'You've done this before.' He had. Twice. Both ended in handcuffs-to-gurney transports he described as 'the punishment for saying it out loud.'

Over the next ninety minutes the clinician worked the reflection ladder while the officer quietly ran the options ledger by radio: the man's old case manager was gone, but the county's new stabilization center took walk-ins — and, critically, would let the clinician walk in with him. The offer that landed was not 'we can take you somewhere' but 'I can go with you, and I'll tell them what you told me so you don't have to start over.'

What happened next

He climbed back over the railing on his own. The clinician rode with him, completed the warm handoff face-to-face with the stabilization staff, and the unit's report documented the two phrases that had worked and the transport framing that had failed twice before. The reconnect call happened 48 hours later; he kept the follow-up appointment. Six months on, his two prior addresses on the call log had zero repeats.

Discussion questions

- Map the first ten minutes onto S and T: which specific choices lowered the temperature before any words were exchanged?
- The winning offer was less restrictive than a transport but more connected than a referral. What made it credible to him?
- What in the documentation made the 48-hour reconnect actually happen — and what does your unit's paperwork do instead?
- Traffic command wanted the standard callout. When is slowing the machine down the right call, and who carries that decision in your jurisdiction?

CASE 2 — THE TUESDAY REGULAR — WHEN THE SYSTEM IS THE CRISIS

Every agency knows a 'Tuesday regular'. This one was a woman in her 40s with schizoaffective disorder whom one suburban department had contacted 31 times in a year — parking lots, bus shelters, a grocery store. Twenty-two contacts ended in ER transports. Average ER stay: seven hours. Follow-through on discharge referrals: zero. Officers were frustrated, the ER was frustrated, and she had learned that talking to anyone in a uniform ended in a waiting room.

A newly trained crisis responder pulled the call history and treated the pattern, not the incident, as the case. The 31 reports held the map: contacts spiked in the last week of the month (when her money ran out), she always engaged around her dog, and one note buried in report #14 mentioned a sister in the next county she trusted.

On contact 32 the responder led with the dog, never mentioned the hospital, and asked one navigation question: 'Who's the last person who helped in a way that actually helped?' The sister. With consent, the responder called her on scene and stayed through the conversation. The sister hadn't known the ER cycle was happening. Together they reached the county's assertive community treatment (ACT) team, which had capacity but had never received a referral for her — twenty-two transports and not one had generated a community follow-up.

What happened next

Contact 33 was the ACT intake, with the sister present. Police contacts dropped from roughly weekly to twice in the following six months — both resolved on scene by the same responder, both documented against the care plan. The department now flags any individual with three crisis contacts in ninety days for a pattern review instead of waiting for contact thirty-one.

Discussion questions

- Twenty-two transports, zero connections: at which STAND move did the system — not the officers — keep failing?
- What information in the old reports was assessment gold, and why did it take a pattern review to surface it? What would D-quality documentation have changed at contact 5?
- The winning navigation option (the sister) wasn't in any resource directory. Where do options like that live, and how do you ask for them?
- What would a 'three contacts in ninety days' review look like in your agency — and who owns it?