Minnesota Department of Human Services

CRISIS CURRICULUM

A Mental Health Manual

May 2002

TABLE of CONTENTS

INDEX OF QUESTIONS

Chapter

INTRODUCTION

Mental Health Rehabilitation Option Services
Adult Mental Health Crisis Response Services
Background

In 2001, legislation (Minnesota Statute § 256B.0624) was passed that created a new set of mental health services: **Adult Mental Health Crisis Response Services**.

This legislation continues:

- improvements in the array and the accessibility of community-based crisis response services,
- improvements in responsiveness of services to people in mental health crises and emergency situations, and
- obtains matching federal funding for these services through the Medicaid (Medical Assistance program).

The Minnesota State Medicaid Plan has been amended to include these new crisis response services for recipients of Medicaid services. This plan amendment has been approved by the federal Center for Medicare and Medicaid Services.

The crisis response services include **crisis assessment**, **crisis intervention**, and **crisis stabilization services.**

Crisis assessment is an existing Medical Assistance (MA) service; crisis response services expands the sites of these services, expands qualified providers of the service, expands hours of services to seven days a week, 24 hours a day,365 days a year, uses a "team" model, and adds a "mobile" capacity to services.

Crisis intervention services also expands the sites of these services, expands qualified providers of the service, expands hours of services to seven days a week, 24 hours a day,365 days a year, uses a "team" model, and adds a "mobile" capacity to services.

Crisis stabilization services are short-term additional supports for those recipients who need more than brief crisis intervention because the individual's stability is fragile, his/her support system is weak or inconsistent, and relapse is likely without these additional supports.

In defining qualifications of providers of these services, the legislation requires Medicaid-qualified mental health practitioners to have additional crisis services-specific training to provide these crisis assessment, crisis intervention, and crisis stabilization services.

Medicaid qualified mental health rehabilitation workers can provide crisis stabilization services if they have additional crisis services-specific training.

Successful completion of the following crisis services training curriculum is one way the mental health practitioners and rehabilitation workers can obtain the required crisis services-specific training.

This model of a 30-hour crisis training curriculum reflects the planning of the state-county Rehabilitation Option workgroup that met for over two years to assess the service needs, develop the services models, and craft the draft legislation for the new Adult Rehabilitative Mental Health Services and these Adult Mental Crisis Response services.

This curriculum is an attempt to assist provider entities, counties, and trainers in providing that training. A Crisis Curriculum Advisory Committee was established to develop and review this curriculum. The Advisory Committee included Nancy Carlson, Maureen Malloy, Mike Pattison, and Marilyn Kiloran. DHS extends a special thanks to these individuals and the organizations in which they work for the time and expertise that they provided in reviewing and improving this curriculum.

Please call the Department of Human Services Adult Mental Health Division at 651-296-4497 to request additional copies of this curriculum, to ask questions, or to offer suggestions for improvement.

Minnesota Department of Human Services
Adult Mental Health Division
444 Lafayette Road N.
Saint Paul, MN 55155-3828
Phone 651-296-4497

This information is available in other forms to people with disabilities by contacting 651-296-4497 or 800-627-3529, TTY, or 877-627-3848, speech-to-speech, through the Minnesota Relay Service.

1
MENTAL HEALTH CRISIS and MENTAL HEALTH EMERGENCY: HISTORY and DEFINITION

What crisis services have been available in the past?

Minnesota is the land of 10,000 lakes and 87 counties. According to the Minnesota Mental Health Act of 1987 (Minn. Stat. § 245.461 to 245.486) each of these eighty-seven counties is the local mental health authority within the county boundaries. As the local mental health authority, counties are required to provide a number of mental health services to citizens who reside there. Among these is Emergency Mental Health Services.

The 1987 Mental Health Act (Minn. Stat. § 245.462 subd.11) defines emergency services as "an immediate response service available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency." The goals of the required emergency services are to

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further deterioration of adults with mental illness or emotional crises;

(3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs.

These services "must include assessment, crisis intervention, and appropriate case disposition." At the present time most counties are providing these services through crisis intervention telephone lines which are paid for by county funds.

With the implementation of the 2001 legislation and federal approval of Minnesota's Medicaid plan amendment to include these new services, the state, in cooperation with counties and providers, will develop additional crisis services that will be reimbursable via Medicaid. The hope is that these services will improve the ability of citizens to handle mental health crises and emergencies and to be able to continue to live productively in the community.

What is a mental health crisis?

The mental health rehabilitation act defines a **mental health crisis** as "an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

In the Chinese language, there are two symbols in the ideograph, or graphic symbol, for crisis. One represents danger and the other represents opportunity.[1] The two symbols combine to identify a crisis as a dangerous opportunity. A crisis is a turning point that can have a positive or negative outcome.

"A crisis can be thought of as a system out of balance. Normally all of us maintain our state of equilibrium on a day-to-day basis without too much trouble. Obstacles are overcome because we've learned good coping skills to reestablish equilibrium after some event has temporarily knocked us off balance. Crises occur when the balance cannot be regained, even though we are trying very hard to correct the problem.

"Two different types of crisis occur. One is a developmental crisis, like a job change, retirement, having a baby, or your baby turns 14. The other is a situational crisis like rape, robbery, sudden death, or being diagnosed with a chronic or terminal disease.

"Most crises occur because a person is just overloaded. A reprimand from a supervisor may be accepted without issue one day. However, if it happens when you already have several stressors eating up your reserve of coping ability, it may be the event or precipitator* that pushes you off balance." [2]

What is a mental health emergency?

A mental health emergency is defined as "an adult behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services." In other words, the person is pushed enough off balance that, without assistance, he or she will be unable to rebalance his/her system and as a result will not be able to function at an independent level.

This definition focuses on the assistance needs of a person who is being stressed rather than the cause that evokes this response. Individuals vary in the amount and intensity of stressor that it takes to overwhelm their ability to function without assistance. One person

[1] Albert R. Roberts, *Crisis Intervention and Time Limited Cognitive Treatment* (Thousand Oaks, CA: Sage Publications, 1995), 7-8.
[2] Charles G. Cook. Unpublished manuscript; "Crisis Management, Assessment and Intervention Training Manual," (1995), 5.

* Precipitator: An event, action, or concern that causes a crisis.

may have been overwhelmed by a situation that would not faze another. Or a person may find a situation overwhelming on one day but not another. Because of this variability, people's internal assessments of when they are experiencing an emergency or crisis must be respected.

2
MENTAL HEALTH CRISIS RESPONSE SERVICES: WHAT THEY ARE and WHO PERFORMS THEM

What kinds of crisis response services will be available?

The 2001 Mental Health Rehabilitation Act will provide a funding stream for crisis assessment, crisis intervention services, and crisis stabilization services. The addition of mobile crisis intervention services and crisis stabilization services will create a broader array of services for adults who experience a mental health crisis or emergency. These services will be added to the crisis/emergency mental health telephone screening and intervention that are now available in every county.

What is a screening and who performs it?

Prior to initiating any crisis assessment services, it is assumed that some sort of **screening** of the potential crisis situation will be conducted. The screening may occur through a phone call to an already existing crisis line, an interview with a case manager or provider of mental health services, or information from a family member or friend. This screening information (which may be incomplete or from an untrained person) helps determine if a formal crisis assessment service is warranted.

What is included in a formal crisis intervention screening?

The screener must gather information, determine whether a crisis situation may exist, identify parties involved, and determine an appropriate response. The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances. For some individuals, information about services or a referral to a service provider would be an appropriate and sufficient intervention. Others may need counseling over the phone or a face-to-face intervention. Based on the information gathered to this point, the screener determines whether a crisis exists and requires further assessment. It should be noted that disruptions in life that may not create a crisis situation for one person at any given time might create a crisis situation for another person. Alternately, disruptions that might not have posed a challenge during one time may cause significant turmoil at other times in the person's life. If the person believes that he or she is experiencing a crisis, it is best to honor that belief.

What is included in a crisis assessment? What is covered and who does it?

If a crisis situation probably exists, a **crisis assessment** must be completed. A crisis assessment evaluates any immediate need for emergency services and, as time permits, the recipient's

- current life situation,
- sources of stress,
- mental health problems and symptoms,
- strengths,
- cultural considerations,
- support network,
- vulnerabilities, and
- current functioning.

Who may conduct a crisis assessment?

A physician, mental health professional, or a mental health practitioner with special training who is under the supervision of a mental health professional must conduct the crisis assessment. The assessment helps to determine the need for **mental health mobile crisis intervention services** or referral to other appropriate services or supports.

What are mental health mobile crisis intervention services?

"Mental health mobile crisis intervention services" means **face-to-face**, **short-term**, **intensive mental health services** initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.* This service is provided on-site by a mobile crisis intervention team outside of an inpatient hospital setting. Service settings may include the recipient's home, the home of a friend or family member, a clinic, emergency room, provider office, or a community setting such as a restaurant or a community center. Mental health mobile crisis intervention services must be available to meet promptly with a person in mental health crisis or emergency 24 hours a day, seven days a week.

* Baseline level of functioning: The usual abilities of the person to perform daily activities effectively.

Possible determinants indicating the need for a face-to-face intervention include

- extreme dysphoria,*
- extreme depression,
- suicidal intent,
- homicidal intent, and
- acute psychosis[3]

If the crisis assessment determines that mobile crisis intervention services are needed, the intervention services must be provided promptly.

How soon must a crisis treatment plan be developed and what does it include?

As part of the mobile crisis intervention services, the team must develop an initial, brief **crisis treatment plan** as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

What are mental health crisis stabilization services?

If the mobile crisis team determines that the person requires **mental health crisis stabilization services**, the team provides or arranges for the provision of these services either directly or through other resources. Mental health crisis stabilization services are individualized mental health services that are provided to a recipient following crisis intervention services. Crisis stabilization services are designed to restore the recipient to the recipient's prior functional level.

Where can mental health crisis stabilization services be provided?

Mental health crisis stabilization services may be provided in a number of settings. These settings include the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Partial hospitalization or day treatment is not considered mental health crisis stabilization services.

Who is eligible for mental health mobile crisis services and crisis stabilization services?

In order to be eligible for crisis response or stabilization services, the recipient

- must be age 18 or older;
- must be screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed,

[3] Joseph J. Zealberg and Alberto Santos, *Comprehensive Emergency Mental Health Care*, (New York: W. W. Norton and Company, 1996), 69.

* Dysphoria: Deep sadness, anxiety, and restlessness.

- must be assessed as experiencing a mental health crisis or emergency, and
- mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

In other words, these services must be available to any adult who needs the services.

What qualifications must a crisis stabilization responder have to provide adult mental health crisis response services?

Telephone responders: According to the Minnesota Mental Health Act, "The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional, or a mental health practitioner."

Who qualifies as a mental health professional?

For the provision of Medicaid Services "mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) **In psychiatric nursing:** a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) **In clinical social work:** a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) **In psychology:** a psychologist licensed under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(4) **In psychiatry:** a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) **In marriage and family therapy:** the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Please note that for purposes of medicaid reimbursement, "allied professionals" as defined in the mental health act are not considered to be mental health professionals. Individuals in this category MAY be considered to be mental health practitioners for purposes of Medicaid billing depending on their supervised experience and educational level.

Who qualifies as a mental health practitioner?

Mental health practitioner means a person providing services to persons with mental illness who is qualified in at least **one** of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and

(i) has at least 2,000 hours of supervised experience in the delivery of services to persons with mental illness; **or**

(ii) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to persons with mental illness, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;

(2) has at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness;

(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; **or**

(4) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness.

What qualification must a mobile crisis team member meet?

For provision of adult mental health mobile crisis intervention services, the mobile crisis team must have at least two people with at least **one member providing on-site crisis intervention services when needed**. The team must be comprised of

either

- at least two mental health professionals

or

- a combination of at least one mental health professional and one mental health practitioner.
  - The mental health practitioner must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years and
  - be under the clinical supervision of a mental health professional on the team.
- Either team member may provide mobile crisis response services individually as long as a mental health professional is available for consultation.

Team members must be experienced in

- mental health assessment,
- crisis intervention techniques,
- clinical decision-making under emergency conditions,

and must have knowledge of local services and resources.

The team must be able recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

What qualifications must a crisis stabilization responder meet?

Qualified individual staff of a qualified provider entity must provide adult mental health crisis stabilization services. Individual provider staff must have the following qualifications:

(1) be a mental health professional; **or**

(2) be a mental health practitioner working under the clinical supervision of a mental health professional; **or**

(3) be a mental health rehabilitation worker who meets the qualifications below.

Mental health practitioners and mental health rehabilitation workers who provide crisis stabilization services must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Who qualifies to be a mental health rehabilitation worker?

A mental health rehabilitation worker is a staff person working under the direction of a mental health practitioner or mental health professional, and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan.

Mental health rehabilitation workers must

- be at least 21 years of age;
- have a high school diploma or equivalent; and
- have successfully completed 30 hours of training during the past two years.

The thirty hours of training must address the following areas:

- recipient rights,
- recipient-centered individual treatment planning,
- behavioral terminology,
- mental illness,
- co-occurring mental illness and substance abuse,

- psychotropic* medications and side effects,
- functional assessment,
- local community resources,
- adult vulnerability, and
- recipient confidentiality.

A mental health rehabilitation worker must also

either

(1) have an associate of arts degree in one of the behavioral sciences or human services,
or
(2) be a registered nurse without a bachelor's degree,

or

(3) have the following within the previous ten years:

- three years of personal life experience with serious and persistent mental illness;
- three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; **or**
- 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; **or**

(4) Meet all of the following qualifications:

- be fluent in the non-English language or competent in the culture of the ethnic group to which at least 50 percent of the mental health rehabilitation worker's clients belong;
- receive during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;
- have 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;
- have a mental health professional or practitioner review and cosign all charting of recipient contacts during field supervision; and
- have 40 hours of additional continuing education on mental health topics during the first year of employment.

Who can provide crisis stabilization services in a supervised, licensed, residential setting?

If the supervised licensed residential setting serves **no more than four adult residents** and **no more than two are recipients of crisis stabilization services**, the residential staff must include, for at least eight hours per day, at least one individual who is a mental health professional, a mental health practitioner *or* a mental health rehabilitation worker.

* Psychotropic: Acting on the brain or mind.

What about a four-bed dedicated crisis home? What staffing requirements exist?

If a crisis stabilization service is provided in a supervised, licensed residential setting that serves **more than four adult residents and one or more are recipients of crisis stabilization services,** the residential staff must include, 24 hours a day, at least one individual who is a mental health rehabilitation worker who has had 30 hours of training in crisis services in the last two years. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours per day. Staffing levels may be adjusted after the first 48 hours according to the needs of the recipient as specified in the individual's crisis stabilization plan.

Additionally, if crisis stabilization services are provided in any supervised licensed residential setting, the recipient must be **contacted daily by a qualified mental health practitioner or mental health professional.** In addition, the residential setting must have 24 hour a day staffing. The residential staff must have 24 hour a day immediate direct or telephone access to a mental health professional or practitioner

3
INTERVENTION PROCESS

What is involved in the crisis intervention process?

Alan A. Roberts, in his book *Crisis Intervention and Time Limited Cognitive Treatment,* identifies seven stages of working through a crisis. These stages include

1. assessing lethality and safety needs,
2. establishing rapport and communication,
3. identifying the major problems,
4. dealing with feelings and providing support,
5. exploring possible alternatives,
6. formulating an action plan, and
7. follow up measures[4]

A brief assessment of lethality* and safety needs should be done in any telephone screening and should hold an important place in any intervention. (Is the person safe? Is the person alone? Does the person intend harm to self or others?) These screenings must be done with sensitivity. Some callers are offended if asked questions about suicidal or homicidal intent before they are allowed identify the issues that they are calling about. Assessment of danger to self or others should continue **throughout** any crisis assessment, crisis intervention, and crisis stabilization process. A full chapter on assessing dangerousness to self or others follows.

What is the first step in intervening in a mental health crisis or emergency?

"In the midst of a crisis, or most other times for that matter, people want to be heard, understood, validated and valued as a human being. Instead, we are likely to get advice, "I told you so," or "you think you have it bad." A person in crisis needs to be empowered, given choices, options, resources, encouragement, and hope. A responder needs to establish rapport and communication with the recipient. One of the best tools in building rapport and communicating clearly is active listening. Active listening is a major part of communicating well. By actively listening to a person's story, the responder will

- help them make sense of what happened;
- validate their concerns, emotions, and reactions;
- offer perspective from your objective viewpoint;

[4] Albert R Roberts, *Contemporary perspectives on crisis intervention and prevention* (Englewood Cliffs, NJ: Prentice Hall, 1991), 22

* Lethality: Potential for harm to self or others.

- provide hope and a sense of direction;
- point out resources they may have forgotten; and
- give them power to make choices, and take action."[5]

What are active listening skills?

Active listening sounds easy, but it requires skill and practice. There are a number of parts to active listening. **Minimal encouragement,[6] paraphrasing, reflecting and emotional labeling, validating, reassurance, and waiting** are all parts of active listening. Active listening skills are essential to being a helper. In fact, most of us would benefit from consistently using these skills in everyday life. Good communication is a solid foundation for any relationship.

Communicating well sounds easy but is really quite complex in practice. Each skill is used concurrently with the others while attempting to remain objective, empathic, and human.[7]

What are minimal encouragements?

Minimal encouragements include a broad range of activities from saying "yes" or "go on" or asking "what happened next?" to non-verbal encouragement such as making eye contact, nodding, orienting your body toward the person and leaning slightly forward.

MINIMAL ENCOURAGEMENTS

Verbal encouragements
"Yes" or "Go on"

Non-verbal encouragements
Nodding
Eye Contact
Body Orientation

[5] Cook, "Crisis Management, Assessment and Intervention Training Manual," 1.
[6] Gary W. Noesner and Mike Webster, *Crisis Intervention: Using Active Listening Skills in Negotiations*, FBI Publications – Law Enforcement Bulletin, August 1997 issue, Retrieved 12/11/2002, www.fbi.gov/publications/leb/1999/aut974.htm>.
[7] Cook, "Crisis Management, Assessment and Intervention Training Manual," 2.

What is paraphrasing?

Paraphrasing expresses interest and focus on the individual and his/her problem. By actively seeking clarity, you achieve a shared meaning, avoid misunderstanding, and gain the trust of the person you are speaking with.[8]

PARAPHRASING means

Repeating in your own words

Clarifying

Making sure you have a shared understanding

As noted above, paraphrasing includes several parts. Repeating the intent or content of what the recipient has stated is very helpful in making sure that the responder understands the meaning of the words the recipient is using. Most people do this when communicating on a regular basis. Take this brief example:

> A woman walks into her house after being at work all day. "Boy, what a rough one!" she says.
>
> Her daughter asks, "You had a bad day?"
>
> The woman responds by saying "No, not the whole day, just the drive home. The traffic was horrible."

In this example, the daughter stated what she thought her mother meant, and the mother clarified. The daughter, however, does not use the same words to "paraphrase" her mothers' statement. Responders must be very careful about parroting phrases that the recipient uses. Unless done thoughtfully, this can come across as not hearing or mimicking the person.

Clarifying can be done in a number of ways. The responder can simply say, " I am not clear about what you mean when you say …" or "Tell me more about that." Simple paraphrasing also opens the door for the recipient to restate his or her intent in a different way.

In order to ensure a shared understanding of the situation, the responder may want to summarize the information to be sure that he or she has understood correctly and has the whole picture.

[8] Ibid.

What is reflecting?

Reflecting gives the person an idea of what you are interpreting from their presentation. It can help him/her identify what he or she is feeling and projecting. Your tone of voice and the fact that you are pointing out what you are hearing or sensing helps make sense of the confusion and adds to your rapport.[9]

REFLECTING means

Telling the person what you see
"You look really worried (scared, etc.)"

or hear
"You sound very anxious, (angry, etc.)"

REFLECTING is giving FEEDBACK –
YOUR SENSE OF THE SITUATION

"You seem so tense right now, what would help you relax while we talk?"

As an objective, or so-called disinterested party, you are in an ideal spot to provide this sort of feedback. Feedback is a way you can communicate your thoughts and reactions to another. Generally, you can use a specific form to present your feedback.

- Identify what you are thinking, feeling, etc.
- Identify the **behavior** that you think provoked your response.
- Indicate how this might impact the caller.

(For example), "It concerns me when you talk about committing suicide, even though you've said that you are not serious; it may scare others enough that they don't want to talk to you."

The recipient has a lot to gain by hearing honest, direct feedback. People who are too closely related to the problem may hesitate for fear of hurting someone, or a reprisal. Unfortunately, if the person is not aware of how his or her behavior effects others, he or she can't change.[10]

[9] Ibid., 3.
[10] Ibid., 2.

What is emotional labeling?

In crisis, feelings are often confusing and hard to define. Helping the recipient label the emotions that he or she is feeling helps him or her to make sense and gain some control of these emotions. Labeling the emotions also gives the recipient a chance to clarify and correct the perceptions of the responder.

Crises happen as a result of some loss, real or perceived, in a person's life. The pain felt in a crisis is grief over that loss. The loss may be something you can put your hands on like an automobile, money, or a home. It may also be less tangible, like loss of self-esteem, power, freedom, or prestige. The resulting grief is the same. There may be a number of losses present in a single event. For instance, it is not unusual for a widow to lose financial well-being because of her husband's death; thereby she loses security, power, prestige, and quite possibly friends and social contact. Two key elements to any crisis are **grief/loss** and **anxiety**.

No one can predict exactly what a grieving person will feel like. However, there are stages identified by Elizabeth Kubler-Ross, that we can identify in most people experiencing grief. The five stages of grief: **denial, anger, sadness/depression, bargaining, and acceptance** provide a road map of sorts that point out where someone may be in the process of his or her grief. Grief doesn't progress through the stages and end there. Rather, it seems like a series of loops, traversing the same ground over and over. We may be at different stages with each aspect of our grief at any given time.

The following responses may or may not occur as a grief reaction. This is not meant to be a complete list; other reactions may occur that are quite normal. Emotional reactions and their somatic, or physical, counterparts often occur in "waves" lasting a varied period of time.

Emotional responses

Sadness	Abandonment	Despair
Anger	Rage	Resentment
Relief	Fear	Panic
Anxiety	Guilt	Feeling Lost
Numbness	Worry	Hopelessness
Helplessness	Irritability	Vengefulness

Somatic (physical) responses

Tightness in the throat
Shortness of breath
Empty feeling in the stomach
Headaches
Dry mouth
Weakness, overall lack of physical strength

Behavioral responses
Crying at unexpected times
Hostile reactions to those offering help or solace
Restlessness
Lack of initiative or desire to engage in activities
Difficulty sleeping
Constantly talking about the loved one and his/her death
Isolation or withdrawal
Increased smoking/alcohol use

Cognitive responses

Delusions	Hallucinations	Nightmares
Poor attention span	Indecision	Slowed thinking
Disorientation	Memory problems	Blanking out

Anxiety is also a given in any crisis. Because there are no answers, and seemingly no resolution, people become afraid of what hasn't happened yet or what they fear might happen. This projecting into an unsure future is a normal, natural response to crisis. The anxiety also acts as a motivator, to find options, solace, and resolution. Sometime anxiety can be experienced as free-floating fear or panic.

What is validation?

Perhaps the most important thing you can give a person in crisis is validation. Validation is when you want to convey that it is OK to feel whatever it is the client is feeling. Further, that they are not alone, that given the same circumstances, others might feel the same way. Affirm their worth and their efforts to cope with the situation. Crises spawn feelings of inadequacy, reassure them that they can get through this, and that they deserve help when things seem intolerable.

Examples of VALIDATION

"You don't sound crazy to me."

"I'd be angry too if that happened to me."

"With so many things going on, of course you feel overwhelmed."

Somehow convey the idea that the feelings the person is having are NORMAL**!!**[11]

[11] Ibid., 4.

What are affirmations?

Affirmations are simple, direct statements that go a long way toward instilling confidence, hope, and reassurance. For example:

"I'm glad you decided to talk to me."

"You sound like a very (strong, caring, sensitive) person."

" I'm glad you've decided to get help, you deserve it."

"You have a good sense of humor, that's a great way to cope sometimes."[12]

DO NOT MAKE A STATEMENT THAT IS NOT TRUE.
If you say that the person sounds like a sensitive person but do not believe that, the recipient may sense that you are being less than truthful.

FALSE STATEMENTS RUIN RAPPORT AND TRUST

How does a responder identify the major problem?

A number of questions need to be answered to identify the nature of the crisis situation:

What happened to prompt the call?

What led up to the precipitating event?

Who is involved in the situation?

What does the person feel?

What do they fear?

Many of these questions will be answered as the person tells his/her story and rapport is built. However, if he/she has not covered all, the responder may wish to ask.[13]

[12] Ibid., 3 – 4.
[13] Ibid., 7.

How can a crisis responder assist a person who is experiencing specific symptoms or behaviors?

Symptom/ Behavior	**What might help**
Anxiety or agitation	Decrease stimuli that might increase agitation. Identify the agitating stimulus and remove it if possible. Remain calm. Ask the person to slow down. Reassure the person that there is plenty of time to sort the situation out. Give the person enough personal space. (You may wish to ask about what is "enough" as personal space varies. People who experience paranoia generally need more personal space.) Don't demand answers. Help the person find a safe, quiet space as needed.
Low self-esteem	Point out strengths. Do not discuss past failure or weaknesses unless brought up by the recipient. Then, discuss any weaknesses or past failure tactfully. Help the recipient problem-solve ways to deal with these perceived weaknesses.
Depression, frustration, loneliness, feelings of guilt	Allow the person to vent his/her feelings. Listen and accept his/her feelings as stated. Allow the person to cry. Beware of trying to cheer someone up. Help in problem solving and making changes in behavior that will have an impact on the feelings.
Hallucinations, delusions	Do NOT argue with delusions or hallucinations. Accept that this is what the person truly believes or perceives.
Disorganized or illogical thinking	Do not encourage the person to express accelerated or illogical thoughts. Encourage the use of a quiet place. Stay calm. Word sentences in simple terms. Ask one question at a time. Be clear, practical, and concrete. Allow time for the person to decode your communication and form an answer/response. Act as a buffer between the person and outside stimuli or other people if needed

Slow response time	Be patient. Allow the person time to formulate a response.
Loss of contact with reality/personal boundaries	Support reality-based statements. Do not encourage out of touch with reality statements Be careful with the use of touch
Difficulty with establishing self-initiated goal directed activity	Make expectations clear and realistic. Help the person identify meaningful tasks and break these down into "doable" pieces.
Difficulty making decisions	Decrease stimuli Limit number of decisions to be made if possible. Take a directive stance about issues that relate to the person's safety.
Bizarre behavior	Set firm limits. Identify bizarre or inappropriate behavior specifically. (It is better to say "Wrapping your fingers with aluminum foil to block thought transmissions might seem strange to many people," rather than "You have some habits that other people would find strange.")
Withdrawn behavior	People with schizophrenia need a quiet place to withdraw and may wish to be alone more often than other people. Allow the person some quiet time as a way to cope with chaos. Do not take withdrawal as rejection. Be available at the person's request.
Exaggerated response to stimuli	Reduce exciting stimuli. Assist the person to find a quiet space. Use clear, concise questions or statements.
Aggressive behavior	Set limits on behavior. Be aware of threatening statements and take them seriously.
Lethargy, loss of interest	Help the person set realistic, doable goals.
Sleep disturbances	Encourage adequate physical activities during the day. Encourage reduction of caffeine and other stimulants. Encourage a regular bedtime and wake-up time. Help the person identify a calming pre-sleep routine.

How does a responder help the recipient go about exploring possible alternative solutions?

Several questions are pertinent to exploring alternatives:

What does the person believe is the most important issue that he/she is dealing with?

What is the person hoping for?

What does the person think he/she needs?

What has he/she already tried?

What has worked in the past?

What personal and community resources does this person have to draw on?

Many people in crisis tend to see their world in black and white. They feel that they have limited options. Offer alternatives that the person may not have thought of. [14]

What is involved in formulating a crisis treatment plan?

Following the assessment, the mobile responder must assist the client in the development of a brief, **crisis treatment plan** as soon as appropriate, but not later than 24 hours after the initial face-to-face intervention. The plan that is developed should be short-term, clear, do-able and developed as much as possible by the person experiencing the crisis situation. Specific activities that will give the person the feeling of control over his/her life should be included. Alternatives to harmful or unproductive behavior should be included. For instance, instead of going for a drive when feeling upset, the person might decide to call a friend or play with the dog. Including resources identified by the individual is useful also. The person may be able to think of these resources when he/she is working with the crisis responder but may not be able to identify them when alone or in the midst of an escalating situation. Writing the plan down and making a copy for both the recipient and the crisis responder is important.

The **crisis treatment plan** must address

1. the needs and problems noted in the crisis assessment and
2. include measurable short-term goals,
3. cultural considerations, and
4. frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis.
5. The treatment plan must be updated as needed to reflect current goals and services.
6. This plan must include referrals to other professionals if needed after the crisis is stabilized. Coordination with the person's case manager or other service provider, if he/she has one, is very important.

[14] Ibid. 7.

The crisis team may also find it appropriate to make referrals to other services in the community. They may serve an "introductory role" to ensure that a person who has experienced a crisis makes connections with services that he/she needs to prevent further crises.

What are follow-up measures?

Many crisis intervention services provide follow-up services of some sort. These services can range from a phone call in the following week to a face-to-face contact the next day depending on the need of the recipient. Follow-up measures should be written into the intervention plan and agreed to by both the recipient and the crisis responder.

Some crisis intervention providers leave a satisfaction survey with the recipient at the end of the intervention services as a way to get feedback about the service and identify any areas of service that need improvement.

DO's and DON'Ts in De-Escalating Crisis Situations[15]

DO approach clients in a calm non-threatening manner.

DO be assertive, not aggressive.

DO allow clients to resolve a situation themselves, if possible.

DO remove any bystanders from the area.

DO remove any dangerous articles from the area.

DO encourage clients to use more appropriate behavior to get what they want.

DO work with other staff available in defusing a crisis.

DO give an agitated client time and space to calm down.

DO make use of PRN medication when appropriate.

DO negotiate temporary solutions to buy time.

DO be respectful toward the client.

DO leave a physical escape route for both yourself and the client.

DON'T get into an argument or power struggle with the client.

DON'T be authoritarian or demanding.

DON'T tell clients you are frightened even if you are.

DON'T argue with clients over the reality of hallucinations or delusions.

DON'T "humor" clients regarding hallucinations or delusions.

DON'T overreact to the situation.

DON'T insist that a client discuss a situation if he or she doesn't want to.

DON'T confront an intoxicated client.

[15] Maureen Malloy, R.N., Hennepin County Behavioral Emergency Outreach Program, Hennepin County Medical Center, Minneapolis, MN. DHS Crisis Advisory Group Meeting, Jan. 30, 2002.

4

HARM ASSESSMENT (SUICIDE, HOMICIDE, INJURY to SELF or OTHERS)

What should a responder know about suicide?

People become suicidal because of a crisis or series of crises in their lives. Sometimes people see suicide as a resolution to the pain they are experiencing in the midst of a crisis. What they may not see is that there are always other options. Suicide is rare, but devastating when it does occur. The information below shows a few relevant statistics.

- Suicide was the eighth leading cause of death for all Americans in 1998 (up from ninth in 1996) and the third leading cause of death for young people aged 15-24.
- Suicide took the lives of 30,903 Americans in 1996 (10.8 per 100,000 population). Suicides in that year accounted for only 1% of all deaths, compared with 32% from heart disease, 23% from cancer, and 7% from stroke—the top three causes of death in the U.S.
- More people die of suicide than from homicide. In 1996, there were three suicides in the U.S. for every two homicides committed.
- Suicide is a complex behavior usually caused by a combination of factors. Research shows that almost all people who kill themselves have a diagnosable mental or substance abuse disorder or both, and that the majority has depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses.
- The highest suicide rates were for white men over 85, who had a rate of 65.3/100,000. However, suicide was not the leading cause of death for this age group.
- Males are four times more likely to die of suicide than are females. However, females are more likely to attempt suicide than are males.
- In 1996, white males accounted for 73% of all suicides. Together, white males and white females accounted for more than 90% of all suicides in the United States. However, during the period from 1979-1992, suicide rates for Native Americans (a category that includes American Indians and Alaska Natives) were about 1.5 times the rates for the general population. There were a disproportionate number of suicides among young male Native Americans during this period, as males 15-24 accounted for 64% of all suicides by Native Americans.
- Suicide rates are generally higher than the national average in the western mountain states and lower in the eastern and Midwestern states.

- Nearly 3 of every 5 suicides in 1996 (59%) were committed with a firearm, while 79% of all firearm suicides are committed by white men.
- There are an estimated 16 attempted suicides for each completed suicide. The ratio is lower in women and youth and higher in men and the elderly. Suicide attempts are expressions of extreme distress that need to be addressed, and not just a harmless bid for attention. A suicidal person should not be left alone and needs immediate mental health treatment.[16]

In Minnesota:

- Suicide is the second leading cause of death for 10- to 34-year-olds.
- Suicide is the eighth leading cause of death for all ages combined.
- Approximately three times the number of Minnesotans die from suicide than from homicide (approximately 500 deaths per year).
- Males comprise approximately 80 percent of all suicide deaths.
- The suicide rate for American Indians is consistently higher than for any other racial or ethnic group.
- Minnesotans 65 and older have the highest suicide rate of all age groups.[17]

How should a responder deal with someone who may be considering suicide?

The statistics are nice as guidelines, but offer little help when dealing with an individual. Each individual has his/her own history and reasons for thinking of suicide. Should you suspect that someone might be thinking of suicide, the best thing you can do is ask directly, "Are you thinking of killing yourself?" By asking directly you are actually giving the person permission to talk about it. Talking it through is the best way to prevent a suicide. You will not be *putting the idea into someone's head.* Ask open-ended questions. Let the person talk about what happened, who else is involved, how long has he/she been thinking of suicide, what would happen if he/she went on living, how others would react, etc.[18]

[16]United States Public Health Service, Department of Health and Human Services*, The Surgeon General's Call to Action on Suicide*. 1999. Nov. 14, 2000. <www.surgeongeneral.gove/library/calltoaction/calltoaction.htm>.
[17]Minnesota Department of Health *Suicide Prevention Fact Sheet*, Jan. 22, 2001, Nov. 14, 2001 <www.health.state.mn.us/facts/suicide.pdf>.
[18] Cook, "Crisis Management, Assessment and Intervention Training Manual," 16.

What other things might a responder need to keep in mind?

Keep in mind the following predisposing factors. A person's history may actually make him or her more susceptible to completing a suicide.

PREDISPOSING FACTORS

- Chaotic or disjointed life style
- Mental illness, especially depression
- Adoption
- Isolation
- Physical health/weight concerns
- Family history of suicide
- Work/school performance
- Overly controlled, rigid personality
- Overachiever[19]

There are also certain perpetuating factors to take into account. If a person is in the midst of a crisis, these things may prevent him or her from getting assistance.

PERPETUATING FACTORS

- Negative coping patterns, i.e. hostile, no sense of humor
- Poor communication skills
- Low self-esteem
- Rugged individualism
- Anti-social behavior
- Drug/alcohol abuse or addiction or gambling addiction
- Depression:
  - Low mood that persists
  - Change in eating or sleeping habits
  - An inability to enjoy anything
  - Irritability
  - A hopeless, helpless outlook
  - Feeling guilty for no apparent reason
  - Crying or weeping with little or no provocation[20]

[19] Ibid., 17.
[20] Ibid., 18.

Additionally the Surgeon General's *Call to Action on Suicide* identifies the following risk factors:

RISK FACTORS

- Previous suicide attempt
- Mental disorders — particularly mood disorders such as depression and bipolar disorder
- Co-occurring mental and alcohol and substance abuse disorders
- Family history of suicide
- Hopelessness
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment
- Relational, social, work, or financial loss
- Physical illness
- Easy access to lethal methods, especially guns
- Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
- Influence of significant people — family members, celebrities, peers who have died by suicide — both through direct personal contact or inappropriate media representations
- Cultural and religious beliefs — for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide that have a contagious influence
- Isolation, a feeling of being cut off from other people [21]

Just as there are factors that create a higher risk for suicide, there are factors that lessen the probability of suicide.

PROTECTIVE FACTORS

- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships

[21] United States Public Health Service, Department of Health and Human Services, *The Surgeon Generals Call to Action on Suicide*.

- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts [22]

All of the perpetuating, risk, and protective factors listed are important considerations in assessing a person's ability to cope and gain assistance during periods of crisis. There are two, however, that deserve special consideration, **depression and alcohol/drug use.**

What makes depression and alcohol/drug abuse important?

Studies have shown that roughly 90% of those who complete a suicide have a diagnosable mental disorder, commonly a depressive disorder or a substance abuse disorder.[23] Most of us can relate to depression because we have felt a bit of the low mood, listlessness, restlessness, helplessness, and hopelessness that accompanies depression. However, true depression is far more intense than a blue mood. *The Diagnostic and Statistical Manual of Mental Disorder, 4th Edition* identifies criteria for a Major Depressive Episode. A condensed version of these criteria follows.
Five or more of the following symptoms have been present nearly every day during the same 2-week period and represent a change from previous functioning:

- Depressed mood most of the day
- Markedly diminished interest in all or almost all activities most of the day
- Significant weight loss or significant weight gain without attempting to either lose or gain weight, or a decrease or increase in appetite
- Insomnia (inability to sleep or stay asleep) or hypersomnia (need for more sleep than usual)
- Psychomotor agitation or retardation (as noted by observation by others)
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate or indecisiveness
- Recurrent thoughts of death, suicidal ideation or a suicide attempt

These symptoms must cause significant distress or impairment in functioning. (One depression sufferer described the effects of depression as having so little energy that lifting a pencil became an overwhelming task.)

Alcoholism is a primary diagnosis in 25% of people who complete suicide. For many people, alcohol and other drug abuse is both a risk factor and a symptom. Self-medication to relieve symptoms of depression or other mental illnesses is not uncommon. It is

[22] Ibid.
[23] National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, Jan. 1, 2001, Jan., 11, 2002,<www.nimh.nih.gov/publicat/numbers.cfm>.

estimated that approximately 50% of people who have a serious and persistent mental illness also abuse substances. When providing crisis intervention services it important to remember that the use of alcohol and drugs may increase impulsiveness and reduce judgement.[24] Additionally, drug intoxication or withdrawal from drugs (both licit* and illicit drugs) may cause symptoms that are similar to symptoms of a mental illness.

At the time someone completes suicide, there is often some identifiable event that precedes the act, a conflict or loss that pushes a person to believe that the pain is no longer tolerable and even death is preferable to living through this misery. The event is what most people think of as the *why* of suicide. Suicide is almost always much more complicated than simply being the result of one event in a person's life. History, concurrent stressors, and coping ability are all part of the equation. There are many facts of the circumstances that add up to the whole story.

When in the depths of despair, people are most likely to focus only on the negative, leaving out any positive aspects of their situation. The positives usually become obvious to anyone listening, and it is important to point them out. Pointing out positive aspects, "there are people who care, you do have value," will create ambivalence. The goal of course is to create enough ambivalence to tip the scale in favor of living rather than dying.[25]

Always start with the precipitator; what happened today or in the recent past that made the difference.

PRECIPITATING FACTORS

Usually an accumulation of life stressors, conflict, or loss

- A conflict with family member or love relationship
- Failure to get a job, get a promotion, achieve something
- Loss of money, income, material goods
- Legal problems, DUI, etc.
- Injury or illness
- Pregnancy

THERE ARE THREE WISHES IDENTIFIABLE PRIOR TO A PERSON ATTEMPTING SUICIDE:

- **The wish to die or be dead**
- **The wish to be killed**
- **The wish to commit murder**

[24] Steven E. Hyman and George E. Tesar. *Manual of Psychiatric Emergencies, 3rd Edition*. (Boston: Little, Brown, and Company, 1994), 23 – 24.
[25] Cook, "Crisis Management, Assessment and Intervention Training Manual," 18 – 19.

 * Licit: Legal.

Any one of these wishes may create ambivalence. The work of the intervener is to identify the ambivalence, point it out, and create more. The more time between the impulse to commit suicide and the act, the more likely it is the person will choose life.[26]

Certain steps should be followed when intervening with someone who feels suicidal.

Suggested guidelines for assessment and prevention

CAUTION! NO ONE CAN PREDICT A SUICIDE!

1. Assess lethality.[27] The following factors are important in determining if the person is likely to actually attempt suicide and how lethal the attempt may be:
   - The level of detail to which the person has planned the act
   - The dangerousness and availability of the method
   - The level of isolation
   - The number and seriousness of previous attempts
   - The level of stress and number of concurrent stressors
   - The intensity and duration of depression
   - The normal ability to cope with life's ups and downs
   - The person's physical health
   - Active symptoms of psychosis, especially command hallucinations* (Command hallucinations: Usually hallucinations that tell the hearer to act or behave in a particular way. In a true command hallucination, the hearer feels that he/she MUST behave in the way indicated by the hallucinatory voice.)
   - The level of external support available to the individual
   - Impulsivity/absence of protective factors
   - Alcohol and/or drug use[28]

TAKE EVERY THREAT OF SUICIDE SERIOUSLY. CONSULT OTHERS ON EVERY CASE.

Your own intuition or "gut sense" of the seriousness of this particular person's presentation is a very valuable tool in assessing suicide risk.

2. From the beginning of your interaction with the person, begin to ask for contracts or little agreements

   For example:

   "I know you feel lousy right now, but would you agree to sit and talk with me just for half an hour?"

NEVER PROMISE ANYTHING YOU CAN'T DO. DON'T SAY YOU CARE IF YOU DON'T.

[26] Ibid.
[27] See the various suicide/lethality assessment scales included for review, pp.39 - 47.
[28] Responders should ask about psychotropic medications as well as illicit drug use. Antidepressants may allow the recipient to regain physical energy before mood improves. Recipients may be at higher risk of suicide at this point.

"It is very hard to make decisions when you are feeling this bad. Can you let us help you with decisions until you are feeling better?"

3. Develop a strategy. Help the person make a decision on a **specific, short-term plan**. You won't resolve all the problems; stick to one issue that is doable.[29]

Develop a strategy

- What resources does he/she have?
- What resources can you offer?
- What has this person already tried?

OFFER OPTIONS — NOT SOLUTIONS
Choices empower a person to make decisions
and create a plan that is specific, doable, and short-term.[30]

What is the difference between parasuicide and suicide?

Parasuicide is a word used to describe behavior in which a person hurts himself or herself by cutting, burning, etc. but does not intend to carry out the suicide. These behaviors are also referred to as SIs (self-injuries), SIBs (self-injurious behavior) or self-mutilation. People who engage in parasuicidal behavior often indicate that their self-injury is a mechanism to cope with overwhelming emotion that they do not know how to regulate or express effectively. These individuals are often diagnosed as having borderline personality disorder.

What is borderline personality disorder?

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM IV)[31] borderline personality disorder is

"A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. **Note**: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note**: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

[29] Cook, "Crisis Management, Assessment and Intervention Training Manual," 17 – 18.
[30] Ibid., 18.
[31] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*: (Washington, DC: American Psychiatric Association), 650 – 654.

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms"

The DSM IV goes on to say:

"The essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

"Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect,* cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g. sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors, which are described separately in Criterion 5.

"Individuals with Borderline Personality Disorder have a pattern of unstable and intense relationships (Criterion 2). They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, is not "there" enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will "be there" in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternately be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

"There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). There are sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values, and types

* Affect: The expression of an emotion, usually through facial expression or physical behavior.

of friends. These individuals may suddenly change from the role of a "needy supplicant for help" to "a righteous avenger of past mistreatment." Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of meaningful relationship, nurturing and support. These individuals may show worse performance in unstructured work or school situations.

"Individuals with this disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly. Individuals with Borderline Personality Disorder display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (Criterion 5). Completed suicide occurs in 8%-10% of such individuals, and self-mutilative acts (e.g., cutting or burning) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that they assume increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil. Individuals with Borderline Personality Disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). The basic dysphoric mood of those with Borderline Personality Disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well being or satisfaction. These episodes may reflect the individual's extreme reactivity troubled by chronic feelings of emptiness (Criterion 7). Easily bored, they may constantly seek something to do. Individuals with Borderline Personality Disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver's nurturance may result in a remission of symptoms.

"Individuals with Borderline Personality Disorder may have a pattern of undermining themselves at the moment a goal is about to be realized (e.g., dropping out of school just before graduation; regressing severely after a discussion of how well therapy is going; destroying a good relationship just when it is clear that the relationship could last). Some individuals develop psychotic-like symptoms (e.g., hallucinations, body-image distortions, ideas of reference, and hypnotic phenomena) during times of stress. Individuals with this disorder may feel more secure with transitional objects (i.e., a pet or inanimate possession) than in interpersonal relationships. Premature death from suicide may occur in individuals with this disorder, especially in those with co-occurring Mood

Disorders or Substance-Related Disorders. Physical handicaps may result from self-inflicted abuse behaviors or failed suicide attempts. Recurrent job losses, interrupted education, and broken marriages are common. Physical and sexual abuse, neglect, hostile conflict, and early parental loss or separation are more common in the childhood histories of those with Borderline Personality Disorder."[32]

People who have borderline personality disorder and engage in self-injurious behaviors are typically frequent users of crisis services because they feel that they are in crisis frequently. While many of these people do not intend to kill themselves or seriously harm themselves, they can be at a significant risk of suicide. Their impulsivity and fear can lead them to accidentally lethal SIB's or they may genuinely reach the belief that their lives are hopelessly chaotic and not worth living.

How should a crisis responder handle a person with borderline personality disorder?

A crisis responder should take any suicidal ideation expressed by the person seriously. Additionally, the crisis responder should work closely with the individual's therapy team. If the individual does not have a therapist or therapy team, the crisis responder may wish to refer the individual to a therapist who is skilled in Dialectical Behavior Therapy (DBT).

What is dialectical behavior therapy?

"Dialectical Behavior Therapy (DBT) is a comprehensive cognitive-behavioral treatment for complex, difficult-to-treat mental disorders."[33] "DBT grew out of a series of failed attempts to apply the standard cognitive and behavior therapy protocols of the late 1970's to chronically suicidal patients. These difficulties included: 1) focusing on change procedures was frequently experienced as invalidating by the client and often precipitated withdrawal from therapy, attacks on the therapist, or vacillations between these two poles; 2) teaching and strengthening new skills was extraordinarily difficult to do within the context of an individual therapy session while concurrently targeting and treating the client's motivation to die and suicidal behaviors that had occurred during the previous week; 3) individuals with BPD often unwittingly reinforced the therapist for iatrogenic* treatment (e.g., a client stops attacking the therapist when the therapist changes the topic from one the client is afraid to discuss to a pleasant or neutral topic) and punished them for effective treatment strategies (e.g., a client attempts suicide when the therapist refuses to recommend hospitalization stays that reinforce suicide threats).

"DBT is designed to treat individuals with BPD at all levels of severity and complexity of disorders and is conceptualized as occurring in stages. In Stage 1, the primary focus is on stabilizing the client and achieving behavioral control. Behavioral targets in this initial stage of treatment include: decreasing life-threatening, suicidal behaviors (e.g., parasuicide acts, including suicide attempts, high risk suicidal ideation, plans and

[32] Ibid.
[33] The Behavioral Technology Transfer Group, *DBT in a Nutshell*, Jan. 11, 2002. < www.behavioraltech.com/basics>.

* Iatrogenic: Any state induced in a patient by a physician's words or actions.

threats); (e.g., parasuicide acts, including suicide attempts, high risk suicidal ideation, plans and threats), decreasing therapy-interfering behaviors (e.g., missing or coming late to session, phoning at unreasonable hours, not returning phone calls), decreasing quality-of-life interfering behaviors (e.g., reducing behavioral patterns serious enough to substantially interfere with any chance of a reasonable quality of life (e.g., depression, substance dependence, homelessness, chronically unemployed), and increasing behavioral skills (e.g., skills in emotion regulation, interpersonal effectiveness, distress tolerance, mindfulness, and self-management). In the subsequent stages, the treatment goals are to replace "quiet desperation" with non-traumatic emotional experiencing [Stage 2], to achieve "ordinary" happiness and unhappiness and reduce ongoing disorders and problems in living [Stage 3], and to resolve a sense of incompleteness and achieve joy [Stage 4]. In sum, the orientation of the treatment is to first get action under control, then to help the patient to feel better, to resolve problems in living and residual disorders, and to find joy and, for some, a sense of transcendence. All research to date has focused on the severely and multi-disordered patient who enters treatment at Stage 1."[34]

What if a suicide occurs despite your best efforts?

In the event that a suicide occurs, even after you have tried to help, get some support for yourself. Suicide is a very personal decision and no one else can ever take responsibility for another's suicide. In a like manner, each staff person will respond differently due to his or her individual history and relationship with the person who completes suicide. Take some time to support yourself and your colleagues.

"Debriefing, a review of activities that has the goal of gaining a better understanding of a team's capacity, should be offered after the team has emerged from the response cycle. Whereas debriefing is intended to focus on the team's activities executing the crisis plan, there is also an opportunity for the team members to express their personal reactions to the event and to identify steps that might relieve stress during future crisis responses. In some cases, a debriefing session may include staff members outside of the crisis team, such as for a teacher whose classroom was most directly impacted by the crisis. The debriefing session will also allow the team to develop plans to evaluate and address ongoing issues, such as the possibility of posttraumatic and anniversary reactions among staff."[35]

What are some of the legal implications of working with suicidal people?

If a person completes suicide after a responder intervenes it is possible that the family or friends of the individual may hold the responder responsible for the suicide. Three sorts of suicides are most prone to this sort of blaming and/or legal suits: (1) Outpatient suicides (should the clinician have hospitalized the individual?), (2) Inpatient suicides

[34] Ibid.
[35] Albert R. Roberts, *Crisis Intervention Handbook: Assessment, Treatment and Research, 2nd Edition* (Oxford University Press, 2000), 225.

(Did the institution provide a safe environment?), and (3) Suicide following discharge or escape.[36]
In determining malpractice/liability four elements must be present:

1. A therapist-patient relationship must exist which creates a duty of care to be present.
2. A deviation from the standard of care must have occurred.
3. Damage to the patient must have occurred.
4. The damage must have occurred directly as a result of deviation from that standard of care.[37]

Risk management guidelines:

- Documentation
- Information on previous treatment
- Involvement of family and significant others
- Consultation on present clinical circumstances
- Sensitivity to medical issues
- Knowledge of community resources
- Consideration of the effect on self and others
- Preventative preparation[38]

[36] Maureen Malloy, R.N. Behavioral Emergency Outreach Program.
[37] Ibid.
[38] Ibid.

DO'S AND DON'TS IN SUICIDE PREVENTION[39]

REMOVE opportunities

RECEIVE and accept suicidal communication

DO intrude

DON'T worry about saying the wrong thing

DON'T consider suicidal persons as special

DON'T assume ability to solve problem(s)

DON'T try to talk the person out of committing suicide

DON'T engage in abstract discussion about suicide, death, dying

USE self as instrument of prevention

GET precipitant*

DO know your own value system about suicide

DON'T be too accepting of suicide

DON'T delegitimatize

DON'T give cheap general reassurance

DON'T lose confidence (may need more limited goals)

PREVENT isolation and involve significant others

TRANSFER rather then refer

FOLLOW-UP

ALWAYS obtain consultation when unsure

[39] Maureen Malloy, R.N. Behavioral Emergency Outreach Program.

* Get precipitant: Identify those issues, concerns, and/or events that led up to the current crisis.

LETHALITY ASSESSMENT WORK SHEET

	{LOW LETHALITY				HIGH LETHALITY}
PLAN	Vague, indeterminate plan	Clear thoughts, philosophical	Some specifics	Note & or will thought out, written	Note written, time, place, method chosen
METHOD	Method undecided	Method: pills, cutting	Method: CO, oven gas, car	Method: Hanging, Jumping	Method: Gun
AVAILABILITY	Method unavailable	Can acquire easily	Some effort required to prepare	Method ready, in the home	Method in hand
TIME	No time specified	Specified vaguely, within weeks	Day and time chosen, within a week	Plan to complete today	Plan in progress
PREVIOUS ATTEMPTS	No Previous attempts	1 or 2 gestures	Hx of many threats, attempts	Hx of highly lethal attempt	Over 2 serious attempts
DEPRESSION	Feeling low or blue	Mild depression	Chronic depression	Major depression	Major depression, hopeless
RECENT LOSSES	No specific stress or loss	1 minor conflict or loss	Several concurrent stressors	Major loss or conflict	Several significant losses/changes
HEALTH	Physically healthy	Transitory illness	Disability or chronic health problems	Severe illness or injury, Recent Dx	Terminal illness, Recent Dx
ISOLATION	Others present and supportive	Roommate/SO there	Others close by	Alone, at home, no help nearby	Alone, rented room or car, isolated
COMORBIDITY	No presence of predictors listed below	1 predictor present	More than 1 factor present, comorbidity	Long term existence of several factors	Suicidal careers

Common single predictors of suicide listed in order*

1 Depressive illness, mental disorder
2 Alcoholism, drug abuse
3 Suicide ideation, talk, religion
4 Prior suicide attempts
5 Lethal means
6 Isolation, living alone, loss of support
7 Hopelessness, cognitive rigidity
8 Older white males
9 Modeling, suicide in family, genetics
10 Work problems, occupation, economics
11 Marital problems, family pathology
12 Stress, life events
13 Anger, aggression, irritability, 5-HIAA
14 Physical illness
15 Repetition and comorbidity of factors 1-14, suicidal careers

*(Excerpted from "Suicide and Life Threatening Behavior," volume 21, number 1, The Guilford Press, New York, New York, Introduction by Ronald W. Maris, Ph.D., University of South Carolina).

REGIONAL MENTAL HEALTH CRISIS SERVICES
SUICIDE ASSESSMENT[40]

Client: _____D.O.B._____Age_____

Y/N Presenting request is for suicide assessment?
Y/N Client acknowledges suicide ideation?

Current suicide ideations_____
-frequency of thoughts: _____
-intensity of thoughts: _____
-duration of thoughts: _____

Y/N **Suicide Plan?** Firearms/hanging/cutting/overdose/other _____
Y/N **Access to means?** _____
Y/N **Preparatory behavior?** _____
Y/N **Recent suicide threat?** _____
Y/N **Recent suicide related behavior?** _____

Y/N **Recent suicide attempts?** With injury? Without injury? _____

Y/N High-risk behaviors? _____

RISK FACTOR ASSESSMENT

Y/N **Family/friend suicide history?** _____
Y/N **Suicide attempts history?** _____
Y/N **Substance abuse?** _____
Y/N **Multiple Stressors?** _____
Y/N **Impulsiveness?** _____
Y/N **Health Problems?** _____
Y/N **Psychopathology?** Mood disorder/thought disorder/personality disorder_____

Date_____ Client_____Staff: _____

[40] Dr. David Jobes, Associate Director, Counseling Center, Catholic University, Adapted by Northern Pine Mental Health Center Crisis Program, Brainerd, MN.

REGIONAL MENTAL HEALTH CRISIS SERVICES
SUICIDE ASSESSMENT

Rating is according to how I believe my client feels right now.

1. **Rate PSYCHOLOGICAL pain{hurt, anguish, misery -not stress or physical pain}**
   Low Pain 1 2 3 4 5 High Pain

2. **Rate STRESS {general feelings of being pressured, overwhelmed}**
   Low Pain 1 2 3 4 5 High Pain

3. **Rate AGITATION {emotional urgency to take some action}**
   Low Pain 1 2 3 4 5 High Pain

4. **Rate HOPELESSNESS {expectation things will not get better no matter what they do}**
   Low pain 1 2 3 4 5 High Pain

5. **Rate SELF-HATE {general feeling of disliking self, poor self-esteem and self respect}**
   Low Pain 1 2 3 4 5 High Pain

6. **Rate Overall RISK OF SUICIDE Low Risk 1 2 3 4 5 High Risk**

Client agrees to maintain safety as per crisis plan Yes_____ No _____
Ability to maintain client safety in the community Yes_____ No_____
Clear and Imminent Danger of Suicide? Yes_____ No _____

CRISIS PLAN AND DISPOSITION:

Date:_____Client:_____Staff:_____

Suicide Status Form (Client)

This form is completed by all clients at the counseling center who are currently thinking about suicide. It is intended to help gather assessment information so that appropriate and helpful treatment decisions can be made. Please try to be as honest as possible in answering this form.

Please rate and fill our each item according to how you fell right now.

1) **RATE PSYCHOLOGICAL Pain (***hurt, anguish, or misery in your mind, not stress, not physical pain):*
   Low Pain: 1 2 3 4 5 :High Pain

   What I find most painful is _____

2) **RATE STRESS** *(your general feeling of being pressured or overwhelmed):*
   Low Pain: 1 2 3 4 5 :High Pain

3) **RATE AGITATION** *(emotional urgency; feeling that you need to take action:* ***not*** *irritation;* ***not*** *annoyance):*
   Low Pain: 1 2 3 4 5 :High Pain

4) **RATE HOPELESSNESS***(your expectation that things will not get better no matter what you do):*
   Low Pain: 1 2 3 4 5 :High Pain

5) **RATE SELF-HATE** *(your general feeling of disliking yourself; having no self-esteem; having no self-respect):*
   Low Pain: 1 2 3 4 5 :High Pain

6) **RATE OVERAL RISK OF SUICIDE:**
   Extremely Low Risk: 1 2 3 4 5 :Extremely High Risk
   (will not kill self) (will kill self)

This section is going to help give your counselor an understanding of your reasons for living and dying. For many suicidal people there is a struggle between wanting to live and wanting to die. This section will help your counselor to understand what some of those considerations might be for you.

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance. (1-5)

Rank	Reasons for Living	Rank	Reasons for Dying

Suicide Status Form (Client –page 2)

Some people who are suicidal are very focused on the suffering they feel inside themselves. Alternatively others who are suicidal are very focused on pain associated with their relationships with others. For yet other people there is a mixture of both. These ratings will help give your counselor a sense of what it is like for you. Please circle the number that most closely describes how you feel.

1) How much is being suicidal related to <u>you?</u>
   Not at all: 1 2 3 4 5 :Very Much

2) How much is being suicidal related to <u>other people?</u>
   Not at all: 1 2 3 4 5 :Very Much

The one thing that would make me no longer suicidal would be:_____

The items below inquire about how you see yourself. Each item consists of a pair of contradictory characteristics (i.e., you cannot be both at the same time). The letters form a scale between the two extremes. You are to circle the letter that describes where you fall on the scale.

Not at all independent	A	B	C	D	E	Very Independent
Not at all emotional	A	B	C	D	E	Very emotional
Very passive	A	B	C	D	E	Very active
Difficult to devote self completely to others	A	B	C	D	E	Easy to devote self to others
Very rough	A	B	C	D	E	Very gentle
Not at all helpful to others	A	B	C	D	E	Very helpful to others
Not at all competitive	A	B	C	D	E	Very competitive
Not at all aware of others' feelings	A	B	C	D	E	Very aware of others' feelings
Can make decisions easily	A	B	C	D	E	Has difficulty making decisions
Gives up easily	A	B	C	D	E	Never gives up
Not at all self-confident	A	B	C	D	E	Very self-confident
Feels very inferior	A	B	C	D	E	Feels very superior
Not at all understanding of others	A	B	C	D	E	Very understanding of others
Goes to pieces under pressure	A	B	C	D	E	Stands up to pressure well

I AGREE TO MAINTAIN MY SAFETY AS DISCUSSED WITH MY COUNSELOR: YES____ NO_____

Client signature:_____ Date:_____

CRITICAL ITEM SUICIDE POTENTIAL ASSESSMENT[41]

This tool should be used in assessing the risk of suicide for clients.

I. PRIMARY RISK FACTORS: If any **one** of the following is present, the client should be considered a high risk for potential suicide, which should be given serious consideration in placement decisions.

A. **Attempt:**

___ 1) Suicide attempt with lethal method (firearm, hanging/strangulation, jumping from heights, etc.).
___ 2) Suicide attempt resulting in moderate to severe lesions/toxicity.
___ 3) Suicide attempt with low rescuability (no communication prior to attempt, discovery unlikely
because of chosen location or time, no one nearby, active prevention of discovery, etc.).
___ 4) Suicide attempt with subsequent expressed regret that it was not successful and continued expression of intent or unwilling to accept treatment.

B. **Intent:** (as expressed directly by client or by another based on their observations)

___ 1) Intent to commit suicide **immediately**.
___ 2) Intent with lethal method selected and readily available.
___ 3) Intent with post-mortem preparations (disposal of personal property, writing a will, writing a suicide note, making business and insurance arrangements, etc.).
___ 4) Intent with planned time, place and opportunity.
___ 5) Intent without ambivalence or inability to see alternatives.
___ 6) Command hallucinations to kill self regardless of expressed suicidal intent.
___ 7) Intent with active psychotic symptoms, especially affective disorder or schizophrenia.
___ 8) Intent or behavior indicates intent, but client unwilling to cooperate in adequate assessment.

II. SECONDARY RISK FACTORS: An individual's risk increases with the presence of the following factors. If over half of the following factors are present, consider the person a high risk for potential suicide in making placement decisions.

___ 1) Expressed hopelessness.
___ 2) Recent death of significant other.
___ 3) Recent loss of job or severe financial setback.
___ 4) Significant loss/stress/change event (victimization, threat of prosecution, pregnancy, severe illness, etc.).
___ 5) Social isolation.
___ 6) Current or past major mental illness.
___ 7) Current or past chemical dependence/abuse.
___ 8) History of suicide attempt(s).
___ 9) History of family suicide (including recent suicide by close friend).
___ 10) Current or past difficulties with impulse control or antisocial behavior.
___ 11) Significant depression (clinical or not) especially with feelings of guilt, worthlessness or helplessness.
___ 12) Recent separation or divorce.
___ 13) Rigidity in adapting to change.

[41] Adapted from the CISPA form used at the Hennepin County Crisis Intervention Center, Minneapolis, MN.

Assessment/intervention with someone who may become violent

How does a responder deal with a recipient who may become violent?

Assessing for dangerousness to others is similar in many ways to assessing for suicidal intent. Many of the items considered and the process of developing a plan is similar. Risk assessment for dangerousness is a very in-exact science. Studies have shown that even trained professionals can accurately predict only one out of three episodes of violent behavior.[42]

What are some basic guidelines for interacting with a person who is potentially violent?

- Get as much information from records on file or other sources before going into any crisis situation.
- If you believe that a person may have a potential for violence do not intervene alone.
- Partner with another crisis responder or involve law enforcement personnel.
- Do not conduct an interview in a room with weapons present.
- If the person is armed, you may wish to ask the person why he or she feels a need to carry a weapon. The person's response to this question may help the responder to formulate a way to request the weapon be put aside that the person may be willing to cooperate with. If a potentially dangerous person refuses to give up the weapon, the responder should excuse him or herself and seek assistance from law enforcement officials.
- Do not interview potentially violent people in cramped rooms, especially if they are agitated and need to pace. Kitchen, bedrooms, and bathrooms are usually poor intervention sites due to the potential presence of items that may be used as weapons.
- Be aware of exit routes for yourself and for the person in crisis. A paranoid or agitated person must not feel that they are trapped, and a responder must have an avenue of escape if the recipient does become violent.
- Pay attention to the person's speech and behavior. Clues to impending violence include
  - speech that is loud, threatening or profane;
  - increased muscle tension, such as sitting on the edge of the chair or gripping the arms;
  - hyperactivity (pacing, etc.);
  - slamming doors, knocking over furniture or other property destruction.
- Use emergency contacts as necessary.[43]

Do not stay in a dangerous situation!

[42] Stephen Blumenthal and Tony Lavender, *Violence and Mental Disorder: A Critical Aid to the Assessment and Management* (United Kingdom: Zito Trust, 2000).
[43] Steven E. Hyman and George E. Tesar, *Manual of Psychiatric Emergencies 3rd Edition*.

What factors should be considered when assessing a recipient for potential of harm to others?

The following factors are important in determining if the person is likely to actually attempt to harm someone else.

- **Previous episodes of violent or assaultive behavior** (This is perhaps the best indicator of potential for violent behavior.)
  - *Under what circumstances was the person violent in the past?*
  - *What is the frequency of violence? How does the person behave in between episodes?*
  - *What is the most violent thing that the person has ever done? What was the intent?*
- Clarity of the plan for violence.
  - *Has the person identified a victim?*
  - *Do they have means or access to a means to harm the potential victim?*
  - *Does the person have or could he or she gain access to the potential victim?*
- The level of isolation, agitation, paranoia, or belief that another is planning to or is hurting or harming them in some way.
- Command hallucinations ordering violence.
- Intoxication from alcohol or other drug use, especially cocaine, amphetamines or other stimulants or withdrawal from alcohol, drugs or medications.
- Psychotic symptoms/lack of contact with reality
- The level of stress and number of concurrent stressors.
- The intensity and duration of homicidal or assaultive ideation.
- The normal ability to cope with life's ups and downs — coping skills and mechanisms.
- The person's physical health
- Any history of mental illness especially command hallucinations.
- The level of internal ability to control impulses.
  - *Does the person wish to control him or herself? And if so can she or he?*
  - *Is the person overly controlled?*
  - *Does the person have a brain injury or other cognitive impairment that makes control difficult?*
- The level of external support or external constraints available to the individual.

If a person's mental state is so agitated that a full evaluation or assessment cannot be completed, the crisis responder should consider the person as potentially violent. Collateral information from family, friends, and medical records is very important in intervening appropriately with potentially violent individuals.

Individuals in certain demographic groups are at a higher risk of violent behavior.

These include:

- Males
- Young people between 15 and 24 years,
- People living in poverty
- People with low educational level or lack of job skills[44]
- People with a cultural background that emphasizes a major importance of "loss of face" or of male dominance in relationships, or
- A peer group that endorses violence.[45]
- A person with a history of victimization has been identified by some practitioners as a demographic group at higher risk of violent behavior.[46]

Your own intuition or "gut sense" of the seriousness of this particular person's presentation is a very valuable tool in assessing risk.

TAKE EVERY THREAT SERIOUSLY.
CONSULT OTHERS ON EVERY CASE.
DO NOT STAY IN A DANGEROUS SITUATION.

How can a responder intervene with a potentially violent person?

1. Show concern for the person. Be respectful and offer some choices, even if they are small. (Where to sit, whether to have a snack or beverage).
2. Attempt to speak with the person at eye level.
3. Sit in a manner with feet solidly on the floor with heels and toes touching the floor; hands unfolded in your lap and your body leaning slightly forward toward the person. This position gives the person the feeling that you are attentive to what he or she is saying and it permits you to respond immediately if threatened *or*
4. Stand in a manner with feet placed shoulder width apart; one foot slightly behind the other; weight on the rear leg, knees slightly bent; hands folded, but not interlocked, on the upper abdomen or lower chest; arms unfolded. This stance allows instant response to physical threat. Do not place hands in pockets. This slows response and may be add to paranoia of the person. Folded arms also slow response and can be interpreted as threatening. Maintaining weight on rear leg with knees slightly bent also allows quick movement and response to any threat. **Practice this stance to become comfortable in it before using it in a crisis situation. If the stance is unfamiliar to you, your discomfort will only add to the stress of the situation**.

[44] Ibid.
[45] Stephen Blumenthal and Tony Lavender, *Violence and Mental Disorder*.
[46] Crisis Curriculum Advisory Group.

5. Develop some rapport with the person before asking questions about history or intent of violence.
6. Assure the person that you will do what you can to help them stay in control of violent impulses. Set firm limits but do not threaten or display anger.
7. If a person is experiencing paranoia, it is best to conduct the intervention as if the person and the intervener are facing the problem together. A crisis situation is *not* the time to tell the person that he or she is experiencing delusional thinking.
8. Give the person adequate physical space.
9. Develop a strategy. Help the person make a decision on a **specific, short-term plan**. You won't resolve all the problems; stick to one issue that is doable.

What do you do if you believe that a person is at risk of harming themselves or others?

If you believe that the person that you are working with is, indeed, planning to harm another person, it is your duty as a mental health crisis responder to warn the intended victim. It is important to maintain rapport with the person and offer him or her resources that would help to control violent impulses while he or she reconsiders plans. Crisis stabilization services may be offered in situations where the person can agree to put off harm to others. Hospitalization may be appropriate for others who can't make that agreement**.**

5
DATA PRIVACY, VULNERABLE ADULT REPORTING REQUIREMENTS, and DUTY to WARN[47]

DATA PRIVACY: RELEASE OF INFORMATION

Mental health data may be released as follows:

1. As necessary for the administration and management of programs specifically authorized by the Legislature or local governing body or mandated by the federal 13.05, subd. 3.)
2. With written consent of the person who is the subject of the data to be released. (Minn. Stat. § 13.05, subd. 4(d).)
3. With permission from the Commissioner of Administration to use data in a new way. (Minn. Stat. § 13.05, subd. 4(c).)
4. To the federal government, as determined by the responsible authority of the mental health center. (Minn. Stat. § 13.05, subd. 3.)
5. Under the authority of a new statute passed after the data was collected and when the Tennessen Warning is given. (Minn. Stat. § 13.05, subd. 4(b).)
6. If the data was collected and disseminated in a certain way before August 1, 1975, it may continue to be used in that way. (Minn. Stat. §13.05, subd. 4(a).)
7. If the data is summary data. (Minn. Stat. §13.05, subd. 7.)
8. Pursuant to court order. (Minn. Stat. § 13.46, subd. 7.)
9. Pursuant to a statute specifically authorizing access or disclosure. (Minn. Stat. § 13.46, subd. 7.)

[47] Entire chapter from the Minnesota Department of Human Services, Social Services Manual, Chapter XVI: "Adult Protective Service" Aug. 1, 1999, www.dhs.state.mn.us/childint/social_serv_manual/xvi3000.pdf.

Generally speaking, agencies of the welfare system may disseminate welfare data to mental health providers if the agencies have provided the person who is the subject of the data with a Tennessen Warning. **Mental health providers, on the other hand, must get informed consent of the individual to provide mental health data to other agencies in the welfare system; giving the individual a Tennessen Warning is not sufficient**. Even if another agency in the welfare system needs access to mental health data for the administration and management of programs, the mental health provider must first obtain the individuals' informed consent or find a specific statute allowing disclosure of the information.

County employees who are not employees of the mental health unit are not to have access to the mental health data unless the responsible authority determines that a statute authorizes access. The responsible authority of the mental health unit (which is usually also the director of the county human services agency) is required to determine who has the right to access mental health data pursuant to this statute.

Various laws specifically allow for or mandate the release of or access to mental health data. Two instances of this are the **Vulnerable Adult Abuse Reporting Act** and **the Duty to Warn Law.**

VULNERABLE ADULT REPORTING REQUIREMENTS:

All crisis responders will be considered mandated reporters of neglect or abuse of vulnerable adults due to their employment with a county social services agency or their contract to provide services for the county social services agency.

Who is a vulnerable adult?

A vulnerable adult is any person who is 18 years of age or older who is living in a facility licensed to provide services by the Minnesota Department of Human Services or any person who due to mental or physical impairment is unable or unlikely to report abuse or neglect.

What is considered to be abuse?

Abuse is any crime committed against a person including those relating to prostitution or criminal sexual conduct, any nontherapeutic conduct that causes or could cause pain or injury and is not accidental, any repeated conduct that produces or could produce mental or emotional distress, any sexual contact between facility staff and a resident or client, or any illegal use of a vulnerable adult's person or property for profit or advantage including situations where a person obtains money, property, or services from a vulnerable adult through the use of undue influence, harassment, duress, deception or fraud.

What is considered to be neglect?

Neglect is failure by a caretaker to supply or ensure the supply of necessary food, clothing, shelter, health care or supervision for a vulnerable adult. This may include self-neglect by the vulnerable adult.

What incidents should be reported?

Three sorts of incidents should be reported.

1. Knowledge of the abuse or neglect of a vulnerable adult
2. Reasonable cause to believe that a vulnerable adult is being or has been abused or neglected **or**
3. Knowledge that a vulnerable adult has sustained a physical injury which is not necessarily explained by the history of injuries provided by the caretaker or caretakers of the vulnerable adult

Who should abuse or neglect of a vulnerable adult be reported to?

Local police departments, county sheriff, local social services agency or appropriate licensing or certifying agencies all may receive reports of abuse or neglect of vulnerable adults. An initial report may be made orally but a written report is also required.

Can legal action be taken against a person who makes a vulnerable adult report?

A person who is making a mandated report of abuse or neglect of a vulnerable adult or participating in an adult protection investigation is immune from any civil or criminal liability that other wise might result from the person's actions, if the person is acting in good faith. (Minnesota Department of Human Services Social Services Manual, Adult Protective Service XVI-3000.)

DUTY TO WARN:

What is "Duty to Warn"?

"The "Duty to Warn" law is found in Minn. Stat. §§ 148.975-976. The law requires specified professionals to warn an intended victim if the professional knows that a patient has made a specific serious threat of physical violence against a specific person. If the target of the threat cannot be located, the professional may inform the local law enforcement agency.

Who is required to make a warning to an intended victim?

Psychologists, school psychologists, nurses, chemical dependency counselors, and social workers working in licensed facilities or community mental health centers are required to warn an intended victim. Social workers in county agencies who are not licensed are not

governed by this statute; however social workers in state hospitals, and mental health centers, and licensed social workers must comply with these provisions. Unlicensed county social workers **may** comply with the intent of the law and warn the intended victim through statutory provisions found in Minnesota Statutes § 13.46, subdivision 2(a)(10). That statute provides that in an emergency, welfare system employees may release information of they feel that knowledge of the information is necessary to protect the health or safety of the individual. Under this law, social workers are permitted also to warn persons other than the intended victim." (Minnesota Department of Human Services Data Practices Manual: Emergencies.)

Can legal action be taken against a person who discloses information by warning a potential victim?

The law provides immunity from liability for good faith disclosures pursuant to this statute. It also provides immunity when the professional warns the intended victim or contacts appropriate law enforcement regarding the patient's dangerous nature even if no specific threat was made."

6
Mobile Crisis Intervention

What issues should be considered before responding to a crisis call in the field?

Before a crisis response team steps out the door to respond to a crisis call, there are a number of things that the team should consider. These items include but are not limited to the following:

1. *Who is the caller? Is the caller the person in crisis? A family member? Friend?* Knowing who is requesting assistance is very important. If the person calling is not the person in crisis, the team may wish the caller to let the person know that the team is responding to their call. A surprise arrival of crisis response staff may be very upsetting to the person in crisis and may further exacerbate the situation.
2. *Is the caller or the person in crisis known to the team? If so, do the person have an advance directive or crisis plan on file with the crisis response team?* If the person is unknown to the team, caution is advised in making the initial contact. If the situation is uncomfortable, law enforcement notification or backup may be appropriate. If the person is known to the team and has an advance directive or a crisis prevention plan on file, the crisis responders should follow this plan to the best of their abilities.
3. *Is there a potential for violence or suicide from the person in crisis?* Again, if there is a potential that the person may be violent or suicidal, law enforcement backup may be appropriate.
4. *Has the person in crisis been using drugs or alcohol? Did the person sound as if he or she was intoxicated?* Crisis intervention with someone who is intoxicated is usually ineffective and can be unsafe. Allowing the person to "sleep it off" may be the best intervention if the person **is in his or her own home, is not threatening violence or self-injury, and in no other way seems to be in danger**. If the crisis responders are concerned about alcohol poisoning, overdose, medication reactions, or other physical complications as a result of the person's drug use, they should contact a health professional who can assess the situation more fully.
5. *Is there a likelihood of involving law enforcement in this call?* If the person is unknown to the responders or has indicated some potential for self-injury or violence, contacting law enforcement to request that an officer accompany the responders or to alert them to the potential that they may be requested to intervene is very appropriate.

6. *Is the proposed intervention site isolated or otherwise inappropriate as a place to conduct an intervention?*
   Crisis responders have the option of suggesting an alternative site for the intervention if the potential intervention site is not conducive to intervening. Finding a site where both the person in crisis and the responders are comfortable is important.
7. *How will the responders in the field consult with other staff?*
   Cell phones are highly recommended because of their mobility and immediate availability in an emergency.

What issues should be considered when responding to a crisis call in the field?

Zealburg and Santos include a list of procedures and questions that a mobile crisis team member might wish to keep in mind when approaching or when in an identified location in response to a crisis call.

"1. Survey the scene.
- What is taking place?
- Who is there?

"2. Survey the patients' behavior.
- Watch for clues that the patient may be violent (e.g., yelling, loud voice, presence of alcohol or drugs, opening and closing of fists, paranoid staring, agitation and pacing, hitting things, etc.)
- Does the patient have access to potential weapons (sticks, rocks, bottles, knives, guns, etc.)?
- Does the patient know that clinical staff are coming? Is he or she willing to meet and talk with a staff member? If the patient is unaware that the team is coming, then the risks of the visit are obviously greater. No one likes being surprised, especially by strangers. Whenever possible, a patient should be informed by a friend or family member of a mobile visit.

Note: Clinical staff cannot enter a patient's home or apartment unless invited by the patient or someone in co-ownership (e.g. family members) of the residence. Otherwise, clinicians may be sued or arrested and charged with trespassing.

"3. Check the physical setting.
- Are walkways and entrances lighted?
- Where are the exit doors?
- Are there people close by to assist if necessary?
- Can staff get to the car quickly?
- Are there barking dogs that may be dangerous or trained to attack?
- What is the hygienic condition of the place? Is urine or feces present? Foul odors? Soiled furniture? Unkempt pets? Unbathed client or family members? Insects? Spoiled food? Substandard housing? Does the patient have adequate heat?

Note: If the client could have an infectious disease such as TB or hepatitis, use

universal precautions and aseptic techniques. Most patients are understanding about professional job requirements and rules. If rubber gloves are worn, explain to the patient that this is a rule that you must follow.

"The mobile team may need to leave the location if they feel that the situation is unsafe. If the person continues to be agitated and his or her behavior escalates, if they are threatening or abusive to staff, etc. it may be time to leave the situation and request law enforcement assistance."[48]

How does a responder initiate contact with a recipient in a community setting?

Basic respect and cultural sensitivity are fundamental to intervention in any crisis intervention.

- If the person is unknown to the crisis team, some formality such as addressing the person as Mr. or Ms. is appropriate.
- Rules regarding interpersonal space, eye contact, and interaction may be unfamiliar if the person is from a culture different than that of the responder.
- Becoming aware of differences in cultures represented in the community served before interventions are attempted is the best policy but not always practical.
- Be aware of signs of discomfort about communicating with the interveners that may be based on cultural differences.
- If a person is unknown to the responder, it may be appropriate for the responder to introduce himself/herself and the responder's roles.
- If the person is unfamiliar or uncomfortable with the service, a brief explanation may be useful.
- Having identification that clearly indicates that the person is a crisis responder is sometimes helpful as well.
- Small talk regarding the environment, (what a lovely home, what about the weather, etc.) may be a way to reduce the clients feelings of anxiety about having a stranger present.
- Expression of concern about the person and a query as to what the person feels he/she need may also be helpful in building rapport. (Your brother called us because he is concerned about you. What do you think you need in order to feel better?) Never promise anything that cannot be done.[49]

It is the responsibility of the mobile crisis response team to carry out a crisis assessment. This assessment "evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental

[48] Joseph J. Zealberg, and Alberto Santos; *Comprehensive Emergency Mental Health Care (*New York, W. W. Norton and Company; 1996), 67 – 76.
[49] Ibid.

health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities and current functioning." Other areas of concern might include health, family, and social histories. "As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on-site providing crisis intervention services."

Following the assessment, the mobile responder must assist the client in the development of a brief, crisis treatment plan as soon as appropriate, but not later than 24 hours after the initial face-to-face intervention.

The Crisis Treatment Plan must address

1. the needs and problems noted in the crisis assessment,
2. measurable short-term goals,
3. cultural considerations, and
4. frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis.

The treatment plan must be updated as needed to reflect current goals and services." This plan must include referrals to other professionals if needed after the crisis is stabilized. Coordination with the person's case manager or other service provider, if the person has one, is very important.[50]

If, after the assessment and development of the plan, the team feels that the crisis situation has stabilized, they may deem it appropriate to arrange for appropriate follow-up and end the session. They must document which short-term goals have been met and why no further crisis intervention services are required.

If they feel that crisis stabilization services are needed, these services may be included in the plan. We will talk about these services further in the next chapter.

[50] Minnesota Session Laws 2001, 1st Special Session, *Chapter 9, Article 9*.

7
Crisis Stabilization Services

What is the goal of crisis stabilization services?

The goal of crisis stabilization services is to restore the individual to his or her prior functioning level following a crisis. Bolstering coping skills and assisting in revitalizing or developing a support system are essential portions of stabilization services. Stabilization services may be less active than intervention services. The recipient may not need "talk therapy." They instead may need a person who is capable of providing verbal support or their physical presence to make the recipient feel safe.

Where can crisis stabilization services be provided?

Crisis stabilization services can be provided in a variety of settings including the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised licensed residential program. Safety for the recipient and the staff are high priority in any setting, however. If the recipient has been experiencing suicidal or homicidal ideation, the responder must be aware of any potential weapons present in the environment.[51]

What is included in a crisis stabilization treatment plan?

If a person is receiving crisis stabilization services a crisis stabilization treatment plan must be developed. Specifically, the treatment plan must include:

1. A list of problems identified in the assessment
2. A list of the recipient's strengths and resources
3. Concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement
4. Specific objectives directed toward the achievement of each one of the goals
5. Documentation of the participants involved in the service planning. The recipient, if possible must be a participant. The recipient or the recipient's legal guardian must sign the service plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged including specific providers where applicable.
6. Planned frequency and type of services initiated
7. A crisis response action plan if a crisis should occur
8. Clear progress notes on outcome of goals

[51] *M.S. 256B.0624*

9. A written crisis treatment stabilization plan must be complete within 24 hours of beginning services with the recipient.
10. A mental health professional or mental health practitioner under the clinical supervision of a mental health professional must develop a treatment plan. The mental health professional must approve and sign all treatment plans.[52]

Services must be provided according to the treatment plan. Stabilization services must include face-to-face contact with the recipient by qualified staff. These staff must provide further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community as identified in the treatment plan.

[52] Ibid.

8

Cultural Identity and Impact on Crisis Intervention

What is cultural identity?

"Any individual's cultural identity is made up of language, country of origin, acculturation, gender, age, class, religious/spiritual beliefs, sexual orientation and physical disabilities."[53] Therefore, every person served by a crisis responder will have a slightly different cultural identity. This cultural identity will influence the way each individual responds to intervention. There are, however, significant differences in cultural identity related to a number of factors such as racial or ethnic identity that may be of particular interest in an intervention situation.

How does racial or ethnic culture impact on response to a crisis?

The federal government designates four major racial or ethnic minority groups in the United States: African American (Black), Asian/Pacific Islander, Hispanic American (Latino), and Native American/American Indian/Alaska Native/ Native Hawaiian. African Americans make up the largest group with 12.8% of the US population in 1999. Hispanics represent 11.4% of the US population and Asian/Pacific Islanders constitutes 4%. American Indians represent approximately .9% of the national population. While African Americans are currently the largest minority group, the Latino population is rapidly growing and is expected to become the largest minority group by 2050.[54]

The culture that members of minority groups identify with is often quite different from that of the majority population. They often have a different cultural heritage and set of beliefs, norms, and values. The Surgeon General's Report on Mental Health states that "research documents that many members of minority groups fear, or feel ill at ease with the mental health system." This is an important fact to remember when serving people in crisis. Respect for and understanding of, ethnic and racial groups as well as their histories, traditions, beliefs, and value systems are helpful in any intervention. The following information includes general and specific information about ethnic, racial, and other minority cultures.

---

[53] United States Public Health Service, Department of Health and Human Services, Mental Health: A report of the Surgeon General, Nov. 11, 2000 <www.surgeongeneral.gov/library/mentalhealth/home.htm>.
[54] Ibid.

Coping with day-to-day problems varies between cultures. Asian Americans emphasize restraint, and may discourage dwelling on morbid or upsetting thoughts, believing that avoidance of troubling internal events is preferred to outward expression. Outward expression may disrupt social harmony, a highly valued commodity.

African Americans also tend to emphasize willpower, increased striving, and minimization of stress as coping mechanisms. Many members of ethnic minorities seek support and reassurance through spiritual organizations or religious figures in their community rather than assistance through a mental health provider.

How does cultural or ethnic diversity impact on a recipient's response to a crisis responder and mental health services?

Generally, members of ethnic minorities seek services from mental health providers less often than members of the larger society. There are a number of reasons for this. First of all, many people of an ethnic minority have a significant **mistrust** of mental health services. This mistrust is based on many experiences that vary between cultures. Some groups such as Vietnamese, Laotian, Cambodian, Chechnyan, and other immigrants have experienced imprisonment, physical abuse, or assault at the hands of government agencies in their homelands. They have also experienced the stresses of arriving in a new country with a new culture that may be confusing and overwhelming.

Stigma also plays a role in discomfort with mental health service providers. Embarrassment or feelings of failure keep people from seeking assistance. This is true in the larger culture as well as in many minority groups. Additionally, many minorities encourage the use of family, traditional healers, and informal sources of care rather than mental health services.

While crisis response services are generally provided at no cost to people in crisis, concerns about **cost** of the service may be a factor in comfort and use of mental health services for minorities. Minorities are less likely to have private insurance and are more likely to live in poverty than whites. Funding for services should be considered when referrals to follow-up services are made.

Clinician bias may also play a role in minorities' hesitancy to avail themselves of mental health services. Because clinical judgement plays a very large role in the diagnosis of and services provided for mental illness, the knowledge of culturally specific behavior and manner of reporting symptoms is critical for the provision of appropriate services. Misinterpretation can lead to over-diagnosis or inappropriate services. [55]

[55] Ibid.

Does a person's sexual identity as gay, lesbian, bisexual, or transgender have an impact on response to a crisis or a crisis responder?

Mental health crisis intervention may involve lesbian, gay, bisexual or transgender clients. Studies suggest that up to 30% of adolescents who kill themselves are gay.[56] Because of this potentially higher suicide rate, crisis responders must include sexual orientation as a factor when identifying risks for an individual. They must also be sensitive to issues of shame and family conflict that may arise as a result of sexual orientation**.**

How might providing crisis intervention for farmers and others living in rural areas be culturally different from urban areas?

Rural America represents a range of cultures and lifestyles that are different from urban life. Rural culture presents some specific mental health issues. First of all, stigma may be intensified in rural communities because of lack of anonymity. (Everyone will know that if John Jones white pick-up is parked at the mental health center**,** he is likely receiving services.) Additionally, service supply and choice of provider is frequently limited unless an individual travels to a larger urban area. In some areas, mental health services are not available within a convenient distance.[57]

Farmers and others in agribusiness also tend to have a strongly independent mindset that discourages requesting help from others. Farmers tend to be more isolated in their work settings. Unlike factory workers or others who work in groups, farmers are not as likely to receive encouragement or support from their peers to seek assistance. Additionally, unlike most city dwellers, farmers' work life is intertwined with their personal life. The farm is both business and home. Therefore, any difficulty in one area has enormous impact on the rest of life as well. Farmers tend toward crisis when financial, health or family issues fare poorly.[58]

Are some cultural or ethnic groups at a higher risk of suicide?

- During the period from 1979-1992, suicide rates for Native Americans (a category that includes American Indians and Alaska Natives) were about 1.5 times the national rates. There were a disproportionate number of suicides among young male Native Americans during this period, as males 15-24 accounted for 64% of all suicides by Native Americans.
- Suicide rates are higher than the national average for some groups of Asian Americans. For example, the suicide rate among Asian Americans and Pacific Islanders in the state of California is similar to that of the total population. However,

[56] Albert R. Roberts, *Crisis Intervention and Time Limited Cognitive Treatment*, 295 – 296.
[57] *Mental Health: A Report of the Surgeon General*.
[58] Sowing the Seeds of Hope, Organizational Meeting, Sponsored by Wisconsin Primary Health Care Association and Federal Office of Rural Health Policy, Bloomington, MN, Dec. 8 – 10, 2001.

in Hawaii the rate for AAPI's jumps to 11.2 per 100,000 people, compared to 10.8 per 100,000 rate for all people residing there. Asian-American women have the highest suicide rate among women 65 or older.

- While the suicide rate among young people is greatest among young white males, from 1980 through 1996 the rate increased most rapidly among black males aged 15 to 19 — more than doubling from 3.6 per 100,000 to 8.1 per 100,000.
- It has been widely reported that gay and lesbian youth are two to three times more likely to commit suicide than other youth and that 30 percent of all attempted or completed youth suicides are related to issues of sexual identity. There are no empirical data on completed suicides to support such assertions, but there is growing concern about an association between suicide risk and bisexuality or homosexuality for youth, particularly males. Increased attention has been focused on the need for empirically based and culturally competent research on the topic of gay, lesbian and bisexual suicide.
- In a survey of students in 151 high schools around the country, the 1997 Youth Risk Behavior Surveillance System found that Hispanic students (10.7%) were significantly more likely than white students (6.3%) to have reported a suicide attempt. Among Hispanic students, females (14.9%) were more than twice as likely as males (7.2%) to have reported a suicide attempt. But Hispanic male students (7.2%) were significantly more likely than white male students (3.2%) were to report this behavior.[59]

Guidelines for Increasing the Crisis Intervener's Multicultural Awareness[60]

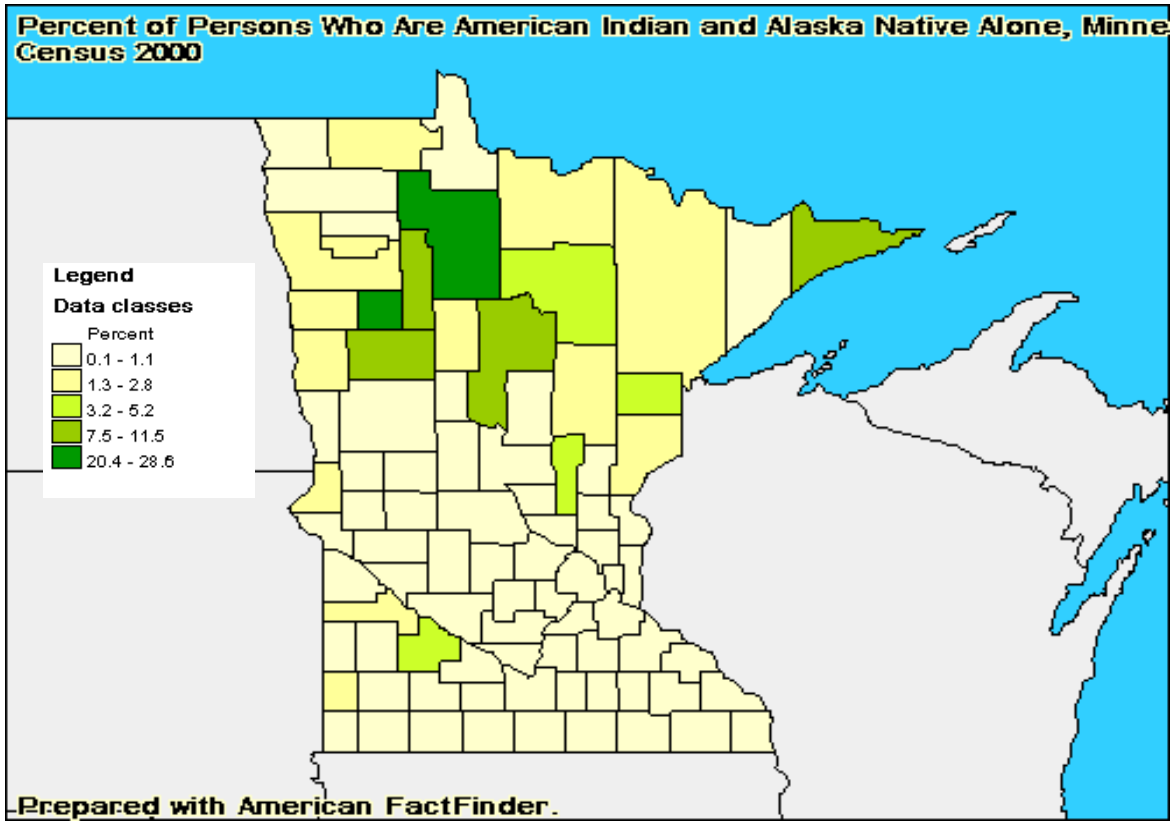
1. Attempt to become aware of your own cultural biases.
2. If possible, learn the language of those into whose crisis you might need to intervene. Find a qualified translator if necessary.
3. Ask for clarification if you are not clear what the victim said.
4. Do not assume that you understand any nonverbal communication unless you are familiar with the victim's culture.
5. Do not impose your personal values.
6. If the victim's nonverbal communication is insulting in your culture, do not take it personally.
7. Develop an awareness of anything in your own nonverbal communication that might be insulting in certain cultures.

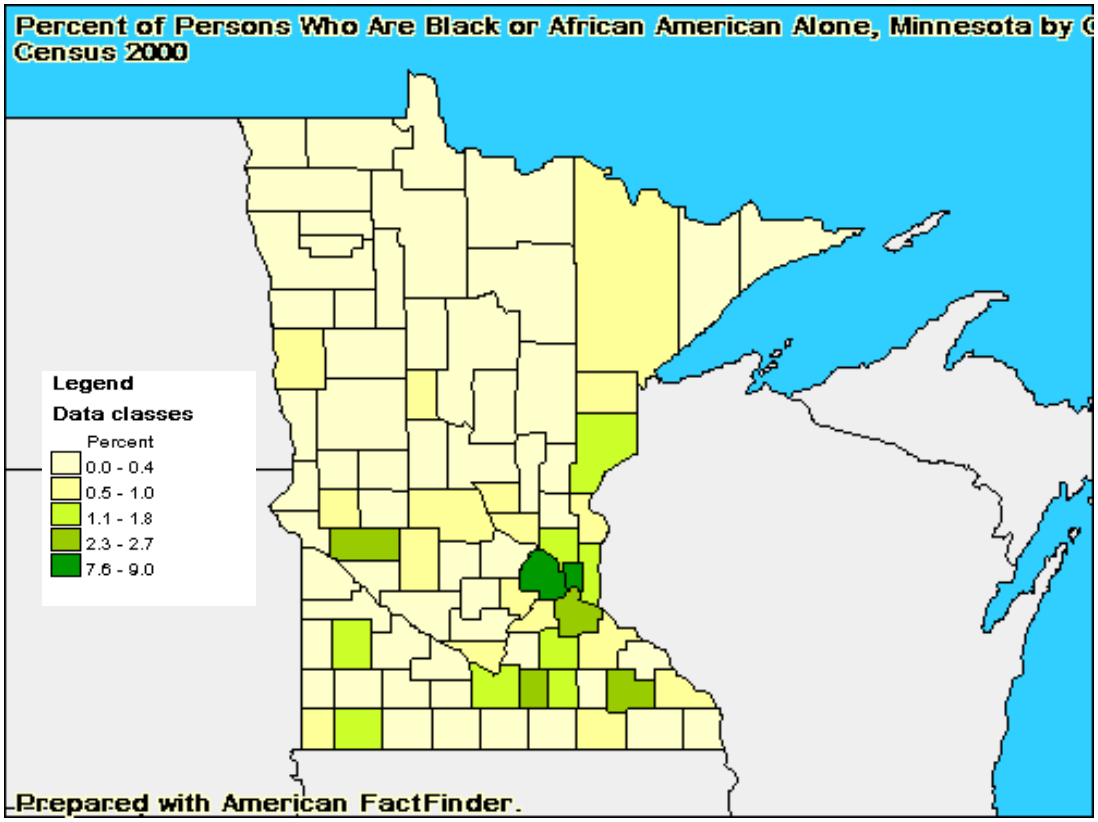
[59] United States Public Health Service, Department of Health and Human Services, *The Surgeon Generals Call to Action on Suicide*.

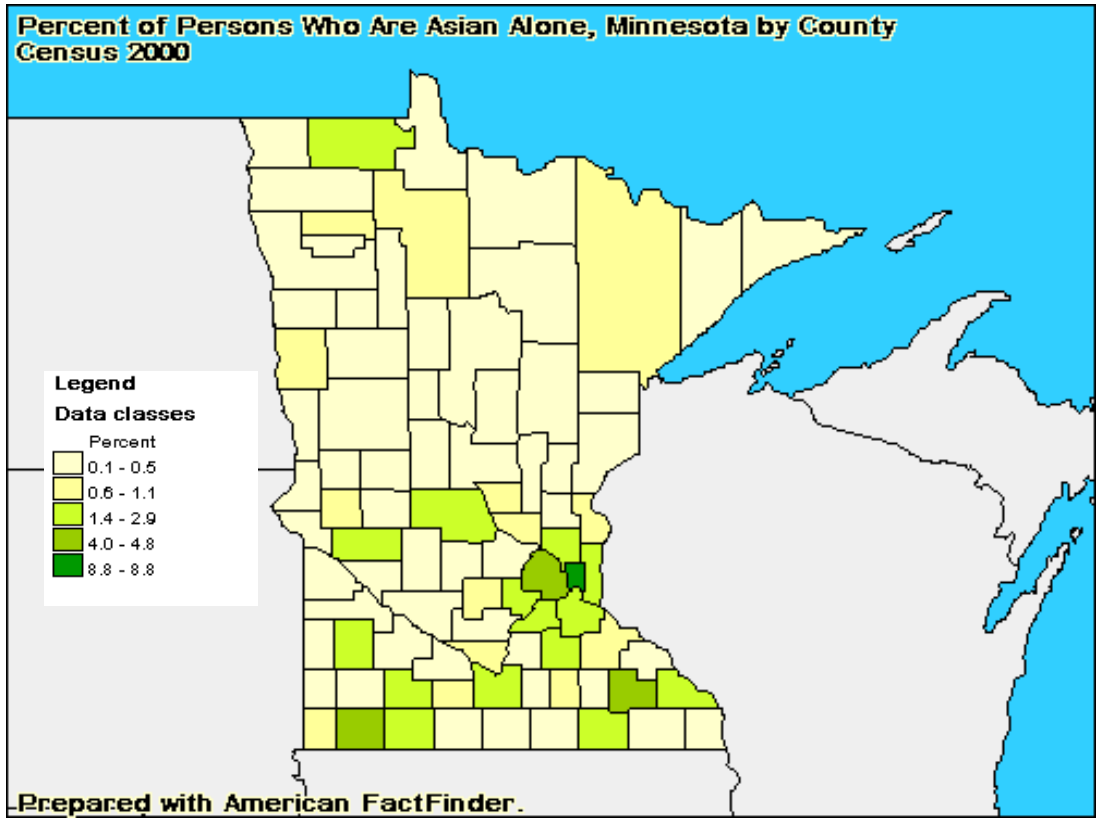
[60] James L. Greenstone and Sharon C. Leviton, *Elements of Crisis Intervention: Crises and How to Respond to Them, 2nd Edition* (Pacific Grove, CA: Brooks/Cole, Thomas Learning, 2002), 51 – 52.

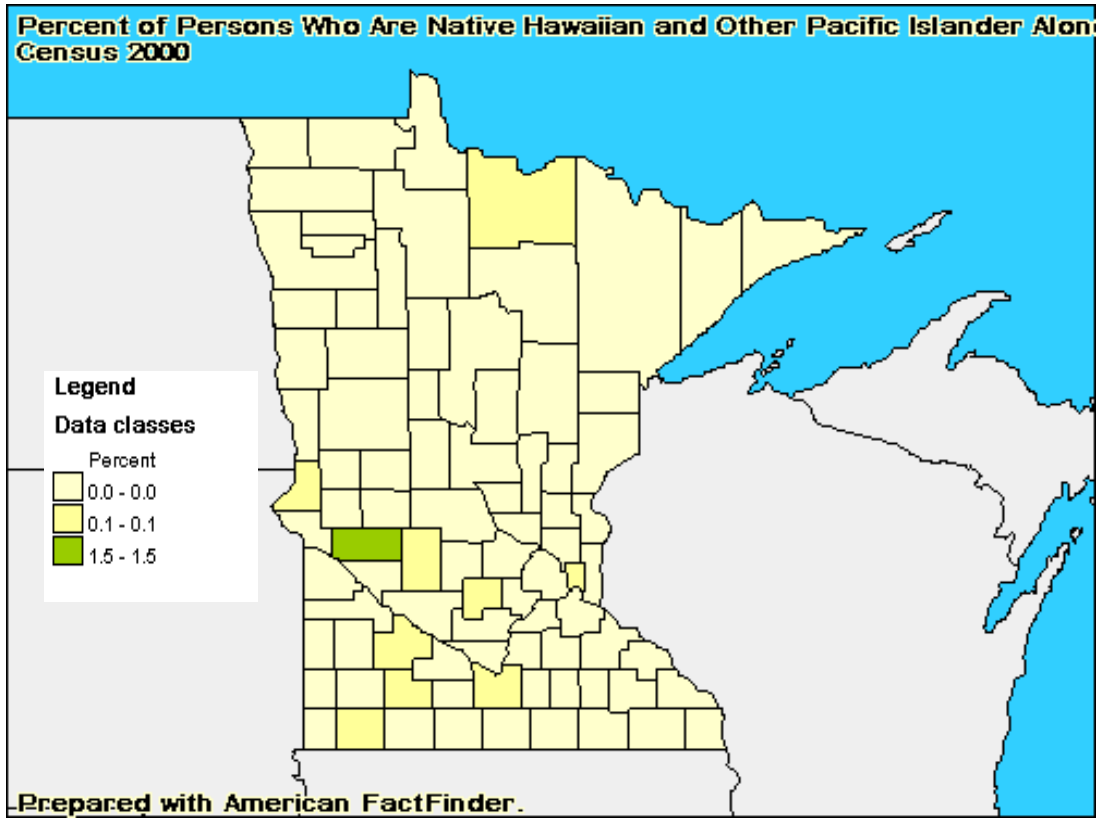
8. Make every effort to increase your awareness of your own preconceptions and stereotypes of the cultures you may encounter.
9. With your increased awareness, reinterpret the behavior of people of another culture from their cultural perspective.
10. Be willing to test, adapt, and change your perceptions to fit your new experience.
11. Maintain objectivity.
12. Recognize that you cannot change a person's cultural perspectives.
13. Do not judge people from another culture by your own cultural values until you have come to know the people and their cultural values.
14. Recognize that your lack of familiarity with a victim's culture might increase the stress within the intervention.
15. Clarify your role, knowledge, and experience with the parties so that you maintain the integrity demanded by your position as intervener.

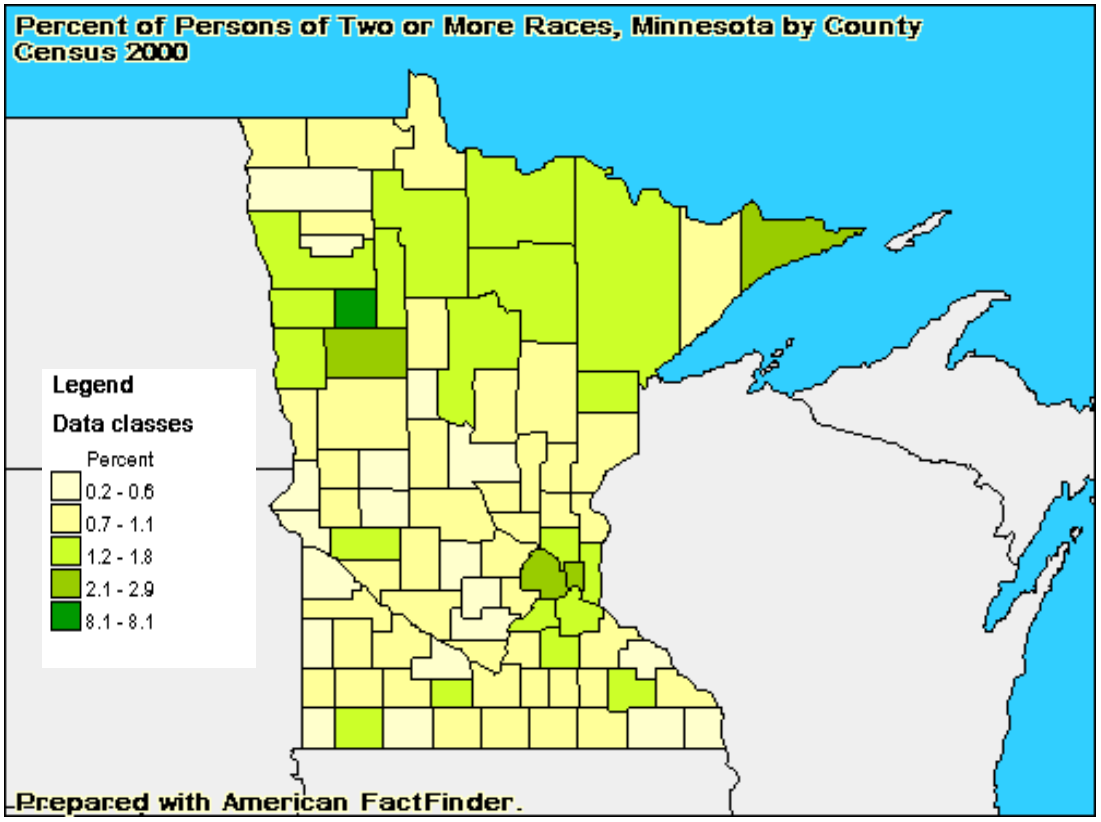
It will also be helpful to become aware of the various diverse groups in the area that the crisis responder will be covering. Please see attached maps that identify percentage of minority groups by county.


Percent of Persons Who Are American Indian and Alaska Native Alone, Minne
Census 2000
Legend
Data classes
Percent
0.1 - 1.1
1.3 - 2.8
3.2 - 5.2
7.5 - 11.5
20.4 - 28.6
Prepared with American FactFinder.


Percent of Persons Who Are Black or African American Alone, Minnesota by C
Census 2000
Legend
Data classes
Percent
0.0 - 0.4
0.5 - 1.0
1.1 - 1.8
2.3 - 2.7
7.6 - 9.0
Prepared with American FactFinder.


Percent of Persons Who Are Asian Alone, Minnesota by County
Census 2000
Legend
Data classes
Percent
0.1 - 0.5
0.6 - 1.1
1.4 - 2.9
4.0 - 4.8
8.8 - 8.8
Prepared with American FactFinder.


Percent of Persons Who Are Native Hawaiian and Other Pacific Islander Alon
Census 2000
Legend
Data classes
Percent
0.0 - 0.0
0.1 - 0.1
1.5 - 1.5
Prepared with American FactFinder.


Percent of Persons of Two or More Races, Minnesota by County
Census 2000
Legend
Data classes
Percent
0.2 - 0.6
0.7 - 1.1
1.2 - 1.8
2.1 - 2.9
8.1 - 8.1
Prepared with American FactFinder.

9
Crisis Intervention with Special Populations

Are there particular things to consider when working with people with SPMI?

Serious and persistent mental illness (SPMI) is a phrase developed and defined for the Minnesota Comprehensive Mental Health Act. A person must meet a number of criteria in order to be considered to be seriously and persistently mentally ill. However, these components boil down to the fact that a person must have a mental illness that interferes with his or her ability to function without some professional support in the community. Many people who have mental illnesses struggle with symptoms on a daily basis but function well when they receive the support that they need. Support may take the form of medications, assistance with living skills, supportive interaction with peers and professionals, etc.

People who regularly cope with symptoms of a mental illness may also experience mental health crises. Crises occur when something in the person's internal or external environment changes, and he or she cannot cope with that change. This change may be anything from the vacation of a significant person in their support system to a physical illness. The stress of environmental change can either decrease the person's ability to cope with the usual level of symptoms or increase the symptoms. Sometimes both occur. Thus people who have mental illness find that their response to developmental and external changes may be complicated by their mental illness.

In addition, many mental illnesses have a cyclical component. Symptoms may become more intense as a general course of the illness rather than as a result of external factors. This may also reach crisis proportion for a person with a mental illness.

As with any person experiencing a crisis, the responder must assist in identifying the problem areas, develop a plan, and assist with the completion of the plan. The plan for a person who suffers from a mental illness may include medication evaluation and changes if the person's symptoms are interfering significantly with his or her ability to think and function.

Ideally, a person who has some difficulty functioning on a day-to-day basis should develop an advance directive or a crisis assistance prevention plan before a crisis occurs. A plan might include items such as

- the symptoms the individual experiences at their baseline,
- triggers to increased stress and symptoms,

- early signs that the person is becoming more stressed or moving toward a symptom cycle,
- coping behaviors/thoughts, and
- supportive resources that the person can call on for assistance.

If a personal crisis intervention plan is filed with the crisis responders before a crisis occurs, it saves time and energy for both the recipient and the responders. The recipient does not need to relate his/her entire mental health history to the responder. The responder can better assist in identifying the stressor and can help the recipient in moving through his or her own crisis plan rather than developing a new one from scratch.

SAMPLE
Crisis Prevention Plan

Name	
Street Address	
City/County	
Phone #:	
Date prepared/updated	
Emergency Contact:	
Name	
Phone#	
Primary Physician	
Name	
Phone#	
Case Manager	
Name	
Phone	
County/Agency	
Psychiatrist	
Name	
Phone #	
Medications Prescribed	
Outpatient Therapist/CSP Worker/ Other support person	
Name	
Phone #	
Name	
Phone #	

What things (events, situations, people, etc.) cause me stress?
What symptoms let me know I am stressed?
What can I do to manage stress?
What can others do to help? What has worked in the past?
Friend or an escort that I will call **Name:**
Phone Number:
My strengths and reasons to succeed.

Are there special issues to consider for people who have a mental illness and chemical dependency issue?

As noted earlier, as many as 50 % of people who have a mental illness may have a co-occurring chemical dependency issue. Chemical abuse tends to increase impulsivity and this increases both the possibility of harm to self and harm to others. At times, drug intoxication may mimic symptoms of mental illness. The following table identifies various drugs by classes and their possible effects.

Drug class[61]	**Examples of Drugs included in the class**	**Possible Effects/Intoxication**
Narcotics	Morphine, Codeine, Heroin	Euphoria, drowsiness, respiratory depression, constricted pupils
Depressants	Barbituates, Tranquilizers, Chloral Hydrate	Sensory alteration, anxiety reduction, intoxication, calmness, relaxed muscles, slurred speech, impaired judgement, loss of motor coordination, difficulty concentrating
Stimulants	Cocaine, Amphetamines, Methamphe-tamines	Increased heart and respiratory rates, elevated blood pressure, dilated pupils and decreased appetite, loss of coordination, perspiration, blurred vision, dizziness, restlessness, anxiety, excessive activity, talkativeness, irritability, argumentativeness or nervousness
Hallucino-gens	PCP, LSD, Mescaline, Ecstasy	Rapidly changing feelings, anxiety, distorted perception of time, hallucinations, dizziness, confusion, suspicion, extreme changes in behavior and mood, chills, irregular breathing, sweating, shaking hands
Cannabis	Marijuana, Hashish	Euphoria, relaxation, impaired memory, poor concentration, loss of coordination, more vivid sense of taste, smell, sight and hearing, fluctuating emotions, disoriented behavior
Alcohol	Ethyl Alcohol, Ethanol	Sensory alteration, anxiety reduction, staggering, smell of alcohol on breath, loss of coordination, slurred speech, dilated pupils, confusion, disorientation
Steroids	Dianabol, Nandrolone	Quick weight and muscle gains, extremely aggressive behavior, skin rashes

[61] The National Clearinghouse for Alcohol and Drug Information, *Drugs of Abuse*, Retrieved Feb. 8, 2002. <www.health.org/govpubs/rpo926/>.

If a person is obviously intoxicated/high, the crisis responders may wish to call in paramedics or other medical staff who can assess the need for detoxification services

If a person has a mental illness and a chemical dependency issue, both of these issues should be addressed in their crisis assistance or prevention plan.

Are there special issues to consider when intervening with an older adult?

Older adults may experience a number of stressors in their lives that may lead to a mental health crisis. Many experience illness or the death of friends or spouses. Some are caretakers for their spouses or friends as they age. Others take on the responsibility of raising or assisting in the parenting of grandchildren. All of which add to the load that an older adult shoulders. Many older adults cope well with the stressors in their lives while others have more difficulty.

According to the Surgeon Generals Call to Action on Suicide:

- "Suicide rates increase with age and are highest among Americans aged 65 years and older. While this age group accounts for only 13 percent of the U.S. population, Americans 65 or older account for 20 percent of all suicide deaths.
- The ten-year period 1980-1990 was the first decade since the 1940s that the suicide rate for older Americans rose instead of declined, although that rate again declined during the 1990's.
- Risk factors for suicide among older persons differ from those among the young. In addition to a higher prevalence of depression, older persons are more socially isolated and more frequently use highly lethal methods. They also make fewer attempts per completed suicide, have a higher-male-to-female ratio than other groups, have often visited a health-care provider before their suicide, and have more physical illnesses.
- In 1996, men accounted for 84% of suicides among persons aged 65 years and older.
- The highest suicide rates in the country that year were among white men over 85, who had a rate of 65.3/100,000.
- From 1980-1996, the largest relative increases in suicide rates occurred among people 80-84 years of age. The rate for men in this age group increased 16% (from 43.5 per 100,000 to 50.6).
- Firearms were the most common method of suicide by both males and females, 65 years and older, 1996, accounting for 78% of male and 36% of female suicides in that age group.
- Suicide rates among the elderly are highest for those who are divorced or widowed. In 1992, the rate for divorced or widowed men in this age group was 2.7 times that for married men, 1.4 times that for never-married men, and more than 17 times that for married women. The rate for divorced or widowed women was 1.8 times that for married women and 1.4 times that for never-married women.

- Nearly 5 million of the 32 million Americans aged 65 and older suffer from some form of depression. Depression, however, is *not* a "normal" part of aging.
- Most elderly suicide victims — 70 percent — have visited their primary care physician in the month prior to their committing suicide. With that in mind, the National Institute of Mental Health has developed this cue card for recognizing the signs of depression in older adult:

(See Below)

Before you say, "I'm fine," ask yourself if you feel:

- nervous, or "empty"
- guilty or worthless
- very tired and slowed down
- you don't enjoy things the way you used to
- restless or irritable
- like no one loves you
- like life is not worth living

Or if you are:

- sleeping more or less than usual
- eating more or less than usual
- having persistent headaches, stomachaches, or chronic pain

These may be symptoms of depression, a treatable medical illness. But your doctor can only treat you if you say how you are really feeling."[62]

Older adults tend to report irritability or physiological symptoms of depression rather than feeling sad when experiencing an episode of depression. Some older adults believe that these feelings are part of the aging process and are irreversible. Because of this they are less likely to bring them up to a mental health crisis responder or to any health professional. The responder must make sure that symptoms such as irritability, fatigue, and pain that are not associated with any known physical causes are considered as potential indicators of depression.

Older adults experience an increased sensitivity to medications due to a decreased ability to clear drugs from their body. Many older adults take a number of medications and may experience drug interactions or toxicity that may mimic symptoms of mental illness. If a mental health crisis occurs shortly after a new dosage or a new medication is prescribed, the mental health crisis may be related to the new medications. Crisis responders should be aware of this possibility and get good information about any medications that a recipient is taking and consult with medical personnel if concerns about drug interactions or toxicity arise.

[62] *The Surgeon Generals Call to Action on Suicide*.

Medical disorders that may look like symptoms similar to mental illnesses

A number of **medical disorders** may cause symptoms similar to those experienced by someone with a mental illness. Cushing's syndrome, brain tumors, drug abuse, exposure to a toxin, or a medication reaction can prompt psychotic episodes. Cushing's syndrome, brain tumors, and multiple sclerosis may present with symptoms that seem similar to a manic episode. Delirium can look like mania or psychosis. Hypothyroidism, stroke and multiple sclerosis may mimic a depressive episode. Dementia may cause cognitive symptoms such as disorientation, apathy, difficulty concentrating, and memory loss that can look like symptoms of depression. Hyperthyroidism or cardiac conditions such as arrhythmia may cause symptoms that appear like an anxiety disorder.

Early stages of dementia or Alzheimer's disease can result in paranoia or persecutory delusions. Rapid onset psychotic symptoms that come on abruptly in hours or days may indicate delirium. Psychotic relapse can take days, weeks, or even months. Dementia comes on even more slowly over months or years.

If the person is presenting with symptoms of a mental illness for the first time, other physiological causes for these symptoms must be considered. A referral to a physician following the immediate intervention is appropriate in such situations.

A crisis responder must be aware of the possibility that exposure to a **toxin, drug abuse, and some medications** can cause manic, depressive, or psychotic symptoms. Taking certain drugs such as Inderol may cause symptoms of depression in some people. Cocaine or amphetamine abuse may mimic manic episodes. Cocaine, amphetamines, and caffeine can cause anxiety symptoms as well. Abrupt discontinuation of benzodiazepine drugs such as Librium, Xanax, or Valium can lead to withdrawal symptoms such as shaking, tremor, fast pulse, fever, delirium, seizures, and even death. Withdrawal from barbituates (Phenobarbital, Miltown or Placidyl) can also provoke similar symptoms. Withdrawal from cocaine, or amphetamines can result in depression-like symptoms.

Polydipsia, otherwise know as water intoxication, can cause a myriad of symptoms that may appear to be mental illness symptoms. People who engage in polydipsia drink enormous quantities of water every day and essentially dilute the chemicals that carry the nerve impulses in their bodies. Symptoms resulting from polydipsia may include agitation, delusions, hallucinations, etc. Seizure, coma, and death can occur in severe cases.

The crisis responder should ask questions about new medications or changes in medications that have been made recently. Over the counter medications should be covered as well. If a person is exhibiting psychotic, manic, or depressive symptoms and has no past history of a mental illness, a medical examination may be in order to rule out a cause other than a mental illness. Questions about the amount of water that the person usually drinks in a day or asking if the person has been unusually thirsty may give some indication of the likelihood of water intoxication. If a crisis responder has concerns that the person in crisis may be suffering from drug interactions or water intoxication, health professionals who can assess this area should be contacted.

10
HOLDS

Members of crisis response teams will likely be involved in situations where an individual is unwilling to accept intervention or services due to the nature of his or her mental illness. If the person is not an imminent danger to himself/herself or others, the best plan is to give the person the amount of services and intervention that he/she is comfortable with, assisting with connection with other services to the extent that he/she is willing. This is not possible, however, when a person is likely to hurt themselves or another person.

In situations like this, two key groups of people can be essential. The first is a health officer. Many (but not all) crisis responders will fit into this group. A health officer is defined as a person who is a licensed physician, licensed psychologist, licensed social worker, psychiatric or public health nurse, or a formally designated member of a prepetition screening unit.* If a crisis responder is a health officer and has reason to believe that the person is mentally ill and in imminent danger of injuring self or others if not immediately restrained, the health officer may take that person into custody and transport him or her to a licensed physician or treatment facility. The health officer's assessment of dangerousness must be based on direct observation of the person's behavior, or upon reliable information of the person's recent behavior, and knowledge of the person's past behavior or psychiatric treatment.

Following transportation to a physician or treatment facility, the health officer must make **written application for admission** of the person to the facility. This application must include the health officer's reasons and circumstances that led to the person being taken into custody. At this point, the physician or mental health professional at the treatment facility must assess the extent of the recipient's crisis. The physician or mental health professional decides whether the recipient requires hospitalization or other services.

Crisis responders who are not health officers may need to seek assistance from the other key group of people: peace officers. The term "peace officer" includes any sheriff or municipal or other local police officer or state patrol officer when engaged in the authorized duties of office. The peace officer may also transport a person to a physician or treatment facility. Like the health officers, they must base their decision regarding whether to transport the person on their assessment of the dangerousness of the person in question. This assessment must be based on the direct observation of the person's behavior or upon reliable information of the person's recent behavior, and knowledge of the person's past behavior or psychiatric treatment. The crisis responder can be instrumental to the peace officer in making this decision by providing information about the person's behavior and/or psychiatric treatment. Upon arrival at the facility, the peace officer has the responsibility of requesting admission to the treatment facility in writing. Again, the physician or mental health professional at the treatment facility decides whether the recipient requires inpatient hospitalization or other services.

*Prepetition screening unit: Professionals identified by a county to review, process, and initiate commitment hearings for people who have a chemical dependency, mental retardation, or mental illness and are thought to be a danger to themselves or others.

Mental Health Holds

Michael Pattison, LICSW,[63] developed the following information as a means of giving an overview of the various "holds" that exist and identifying the differences among them.

Peace/Health Officer Hold (*commonly called "Transportation Hold"*): Gives designated officer authority to take a person into custody and bring that person to a facility where they can be assessed for a 72-hour medical hold. There must be belief and evidence that the person represents an imminent risk of harm to self or others because of mental illness, intoxication or mental retardation. This hold has no stated time limit, but standard practice usually limits this hold to several hours or overnight. Can only be discontinued by a qualified medical examiner or court order. (MSA 253B.05, subd. 2)

12-Hour Notice: Used in psychiatric units. A voluntary patient requesting discharge must give a written notice, and must be assessed within 12 hours by a qualified examiner to determine if they are safe to be discharged or if they should be placed on a 72 hour medical hold. (MSA 253B.04, subd. 2)

72-Hour Medical Hold: Hold placed by a qualified examiner (MD or LP licensed at the doctoral level (formerly LCP)) for a period of 72 hours, excluding weekends and holidays. The person must "represent a risk of harm to self or others" because of mental illness, intoxication or mental retardation. The 72 hours provides necessary time to pursue a court order to continue holding the individual. Can only be discontinued by a qualified examiner or court order. (MSA 253B.05, subd. 1,3)

> **Exception:** Individuals placed in a detoxification facility are usually not held to the 72-hour expiration. The assumption is that an intoxicated person is not capable of maintaining safety. Once detoxified, this condition no longer exists. This is why detoxification units make reference to 24 – 48 hour holding periods.

Apprehend and Hold Order (*also referred to as "Probate Court Hold"*): Signed judicial order placing a person into custody for 72 hours, excluding weekends and holidays, after a finding that serious physical harm to self or others is likely. A "Probable Cause" or "Preliminary Hearing" is set. If hearing is "waived" or cause is found, the person will remain in custody up to 14 days, including weekends and holidays, from the time the apprehend and hold order was issued. Discontinued by court order. (MSA 253B.07, subd. 6 – 7)

Commitment: Signed judicial order placing a person in the custody of a treatment facility director or designee for a period not to exceed 6 months. Terminated by facility intentionally or by failure to meet reporting requirements. Can be extended by court at the end of six months. (MSA 253B.09, subd 1,5)

*Prepetition screening unit: Professionals identified by a county to review, process, and initiate commitment hearings for people who have a chemical dependency, mental retardation, or mental illness and are thought to be a danger to themselves or others.

[63] Michael Pattison, e-mail message, Feb. 8, 2002.

Child Welfare Holds

36-Hour Detention Hold: Hold placed by law enforcement to take a minor into custody and place him/her in a detention facility because of criminal behavior. This hold excludes weekends and holidays and there must a hearing within the specified 36 hours or the minor must be released. (MSA 260.165, subd. 2(b))

72 Hour Health and Welfare Hold: Hold placed by law enforcement to take a minor into custody and place him/her in a protective setting for 72 hours excluding weekends and holidays. There must be evidence that a minor is in need of protective custody because of reasonable belief their health or welfare is or will be endangered. Can only be discontinued by law enforcement personnel or court order. Law enforcement personnel commonly make the decision in concert with social services. (MSA 260.165, subd. 2(d))

Child in Need of Protection or Services (*commonly referred to as a "CHIPS Petition"*)**:** Signed judicial order which might place a minor into a treatment facility or order services in the home for an unspecified period of time with multiple hearing and reporting requirements. A juvenile court CHIPS order has precedence over a family court custody order when they are in conflict. (MSA 260.131/133/135; 260.145)

11

Law Enforcement as Partners: Developing Relationships, Clarifying Roles, and Mutual Education

What are the advantages of partnering with law enforcement?

As with any partnership, the advantages of a partnership between law enforcement and crisis responders go both ways. Law officers are equipped to handle recipients who are armed or violent in a manner that a crisis responder could not and should not. Law officers are identified as "peace officers" who can transport a person to a medical or mental health facility to be assessed. On the other hand, crisis responders can often deescalate a mental health crisis to a point where transportation holds are not necessary.

How can a crisis response team develop a working relationship with law enforcement?

As with most relationships, those between crisis responders and law officers develop best when not begun in a stressful situation (such as responding to a crisis call.) The crisis response team leader may wish to contact the head of the local law enforcement agency (police chief or sheriff, etc.) upon the development of the team and regularly thereafter. Initial meetings should focus on the benefits to both partners and on clarifying roles and expectations. Some teams have developed a formal method of communicating with law officers when responses have involved police and crisis responders. Others meet at regular intervals to review interventions and continue to clarify roles.

Some crisis responder service areas will contain many law enforcement jurisdictions. In this situation, the team may wish to send letters to all of the jurisdictions but focus their face-to-face relationship building on areas with high population density or high likelihood of frequent calls requiring mobile response.

What is involved in role clarification with law enforcement?

The lead crisis responder should clearly explain the goals and focus of the response program and how this can be of help to law officers. (Providing consultation, responding to callers expressing suicidal ideation, etc.) Discuss situations when a crisis responder may need to seek the services of law officers and when law officers may want to involve the crisis response team. The crisis responder should identify the limitations of the services that the team can provide and ask the limitations of the services that law officers

can provide. Clarification of who is in charge when both law officers and crisis responders are at a scene is very important. Usually, when both groups are at a site, the crisis responders act as consultants to the law officers with major decisions being made by the law officers' commanding officer. Any confusion about roles and responsibilities should be discussed and cleared up on an ongoing basis as the situations arise.

What about educating law officers about mental illness and crisis intervention?

Crisis response teams may wish to provide education to local law enforcement officers regarding mental illness and crisis intervention. Like crisis responders, law officers are required to receive continuing education. The Minnesota Board of Peace Officer Standards and Training (POST Board) coordinates a system of licensing for all peace officers in the state. Any person employed as a peace officer by a Minnesota law enforcement agency must hold a POST Board license. In order to continue this license in the State of Minnesota, peace officers and part-time peace officers must successfully complete 48 hours of continuing education every three years. The POST board must approve continuing education for law officers.

Crisis responders may wish to make any continuing education session that they offer more attractive to peace officers by making the session POST credit certified. In order to be accepted for POST credit, the classes must:

- be law enforcement related,
- promote professional peace officer competence, and
- be related to the knowledge, skills, and abilities necessary to perform peace officer duties.

Conversely, crisis responders must acknowledge that law officers have developed a broad knowledge about the laws and services in the community. Crisis responders must be willing to learn from their law enforcement partners' expertise as well as to teach.

12
Collaboration with other Service Providers: Formal and Informal Support Systems, Service Providers, and Advocacy Organizations

Services that a crisis response team may wish to collaborate with
Family of the recipient
Friends of the recipient
Landlords of the recipient
Employers/co-workers of the recipient
Mental Health Clinics
Mental Health Case Managers
Mental Health Community Support Programs
Mental Health Rehabilitation Services Providers
Emergency Medical Technicians/Ambulance Companies
Home Health Agencies
Law enforcement
General Practitioners/Medical Clinics
County Social Service Agencies
Hospitals
Rule 36 Facilities (Rule 36 facilities: Short-term residential treatment facilities for individuals who have a serious and persistent mental illness. Rule 36 refers to the former designation of the state Department of Human Services rule that governs the facilities.)
Psychiatrists
Minnesota Mental Health Consumer/Survivor Network
NAMI-MN* and local branches (National Association for Mental Illness-Minnesota)
Minnesota Mental Health Association

What are the advantages of collaborating with the informal and formal supports that a recipient may have in the community?

Crisis responders, like all of us, cannot be all things to all people. The team has a role to fill in the community. This role is to provide intervention and support to people who are experiencing a mental health crisis or emergency. Following this intervention the crisis responders must be able to hand off long-term or specialized support of a stabilized recipient to the person's usual support network. As part of this transition, crisis responders must be willing to work with the recipient's support network to the extent that the recipient allows. Sometimes enlisting friends and family to better support the recipient is appropriate. Depending on the recipient, involving formal support services such as Consumer Support Program (CSP) services or mental health rehab services may be an option. Ideally the person will be able to receive support as needed through a number of avenues. The list above is a partial listing of people and organizations that a crisis responder may wish to collaborate with.

At times the crisis responder's role will be to assist the recipients in developing or extending their support network. Collaboration with other providers will assist in making appropriate referrals for those individuals who will need more support or a more specialized support than their current network can provide.

Collaboration with community providers and individuals in the community can have a very positive effect on willingness to enlist the help of the crisis response team when needed. It is often a lot easier for most of us to seek help from someone we know. Building relationships with community providers, advocates, recipients, and families of recipients will make the intervention process less stressful for everyone.

How should a crisis response team go about collaborating with community services, advocates, potential recipients and potential recipients' families?

One of the best ways to introduce any service is a visit by the people who will provide the service. The crisis responder team may wish to visit local providers such as mental health clinics, community support programs, vocational programs, case managers, home health care agencies and other agencies that may serve people who will make use of the crisis response services. The team should present the services that they can provide and the limitations of those services. They should also discuss the kind of cooperation that they may need from the providers either during or following a recipient's crisis, how to make referrals to the community provider and how the provider would refer someone to the crisis team.

Visiting the people who will actually be served by the team is another way of introducing the services into the community and building a collaborative relationship. There are many ways of connecting with potential recipients: visits to CSP programs, visits to consumer/Survivor Network meetings, visits to the local mental health advisory council, visits to day-treatment programs and hospitals, to name a few. A special emphasis on the individualized, non-institutional focus of the service is of particular importance when explaining the crisis response service to potential recipients.

A follow-up letter should be sent after the visits. This letter should again list the services provided, the limitations of the services, how to receive services and whom to contact if questions arise.

What sort of collaboration should occur during a crisis intervention?

The collaboration that occurs when the crisis team is intervening in a crisis will depend largely on the recipient being served. Asking the recipient about his or her support network is a very important piece of the crisis intervention process. However, a given recipient may not wish to involve family, friends, or service providers at the time of the crisis. He or she may not wish to involve others at all, or it may be something that he/she chooses after the crisis has stabilized. Others may wish to have family or friends directly involved.

If a recipient has developed a crisis assistance plan prior to the current crisis, the crisis response team should attempt to follow the plan to the extent possible, including bringing in those people identified to assist with the plan.

In some instances, the family, friends, or service provider will be the assessment or intervention requestor. When this is the case, the crisis responder should get as much information about the situation as possible from the requestor. Ask the family and/or friends about patterns, history and other information that may be helpful. Often families or friends are concerned with the immediate issue and need to be focused on patterns of behavior that have lead up to the crisis situation.

What sort of information should be shared with families?

When family members call because a loved one is in crisis, they are also experiencing a great deal of stress. They may have no experience with or understanding of mental illness or the effects of overwhelming stress. They will need information about some basics.

Information to share with families and friends:

- Support families and friends for seeking help. ("You did the right thing by calling.")
- Tell families and friends that they and their loved one deserve to feel better and be healthy.
- State that mental illness is a medical illness, treatments exist, and family or friends did not cause it.
- Share basic information regarding mental illness if appropriate. (Could be handouts, etc.)
- Emphasize that families, friends, and the person in crisis do not need to cope with this situation alone. Support organizations exist for families, friends, and the individual experiencing the crisis.
- Give contact information on local organizations providing support and treatment.

Other families or friends may be well informed about mental illnesses but will likely be working through one of the five stages of grief. A family may approach the crisis provider with confusion, anger, sadness, bargaining, acceptance, or any combination of these emotions — and others. The crisis provider must be careful not to take these emotions as a reaction to the crisis provider personally. Remember that the family or friends of a person in crisis is experiencing a crisis also.

13
Responder Boundaries and Self-Care

"Boundaries are the limits that define appropriate behavior. The client/helper relationship is rife with opportunities to overstep your boundaries. There is an inherent power differential between you and your client. The fact that an individual has come to you for help puts you in a one-up position. You have the power to accept or deny this person as a client. You will be seen as more powerful because you have control over resources needed by this person requesting services.

"There are a number of ways to misuse or abuse this power, even unintentionally. It is your responsibility to manage your role and your interaction with each client so as to avoid this misuse or abuse.

"Your role as a staff member is a professional one. The relationship you develop with your clients must stay on that level even though you will be dealing with very personal information and circumstances. Some examples of boundary problems are listed below.

*"***Social interaction that is not part of the job**, like seeing movies together, dinner together, or an invitation to your home is inappropriate. You will be establishing a dual relationship, one of professional helper and simultaneously as a friend. It is too easy to loose objectivity as someone's friend, and it is confusing and frustrating when limits must be set later on.

*"***Sharing personal information** can break appropriate boundaries with your client. Though it may help establish rapport to self-disclose an event in your life, great care should be taken to make sure roles are not reversed; that is, that the client isn't taking care of you.

*"***Probing too deeply** with a client can also be inappropriate. Make sure the information you request is germane to your needs in providing assistance. For instance, knowing your client is a survivor of rape may be important to managing this case. A detailed account of the rape is unnecessary.

"Sexual relationships are always inappropriate. A sexual relationship consists of everything from flirting to sexual intercourse.

*"***Providing too much help** is a very common way helpers go beyond the professional limits in this type of work. How much is too much can only be determined by the specific case. Too much help has been provided when you have done something that the client could have accomplished him/herself. Providing too much help encourages dependence upon you and others. Think of yourself as a caregiver, not a caretaker.

"Boundary issues are always complex and difficult to define in specific cases. In general, rely on consultation with others when you are not sure. If you are feeling burnt out, chances are you are doing too much, look at boundaries between you and clients. If you are reliant on the behavior of the clients you deal with to feel good about yourself or your work, there are boundary issues."[64]

"Crisis responders will experience situations in which a recipient requests or expects a responder to overstep boundaries. When this occurs, the responder must set reasonable limits with the recipient. The following is a guide to limit setting. [65]

Limit Setting

1. Listen to the person.
2. Try to understand what the person is communicating
3. State the limit simply.
4. Set the limit in a firm way.
5. Set the limit in a kind way.
6. Give the person a reason for the limitation.
7. Encourage the person to express feelings about the limitation.
8. Accept the person's feelings about the limitation.
9. Be consistent.
10. Evaluate the limit in terms of what the limit accomplishes.

[64] Charles G. Cook, *Crisis Intervention Sample Protocol* (Submitted to the Minnesota Department of Human Services, 1995), 8 – 9.
[65] Maureen Malloy, R.N., Behavioral Emergency Outreach Program.

This worksheet may be helpful in determining need for better limit setting and assessment of personal boundaries.

WHEN A RECIPIENT IS	I OFTEN FEEL	AND MY USUAL RESPONSE IS	CHANGE PLANNED?
ANXIOUS			
ANGRY			
HOSTILE			
AGGRESSIVE			

What can an organization do to encourage healthy crisis response staff and discourage burnout?

An organizational approach to reducing staff burnout includes the following elements:

- Effective management structure and leadership

  Staff need to be clear about who is in charge — who sets and enforces policies. This reduces ambiguity about organizational relationships and subsequently relieves stress. Additionally, leaders in the organization need to model stress management techniques that they expect their employees to follow.

- Clear purpose and goals

  Staff members need to know what the purpose of their organization is. If the organizational role and goals are clear, it is easier to determine what services can and should be provided. This is helpful in understanding and setting reasonable limits and boundaries with recipients of the services.

- Functionally defined roles

  Staff roles need to be clearly set out. This reduces conflict and encourages support.

- Team support

  Organizations need to structure settings/ways in which staff members can support each other.

- Plan for stress management

  One role of management staff is to be aware of the stress levels of the staff providing direct services and cue staff members to address their own stress when they seem to be unaware of it. Management also needs to be including stress reduction activities into the milieu of the organization.[66]

What can an individual responder do to reduce burnout and stress?

The following elements are important in reducing stress and preventing burnout:

- Management of workload
  In this era of being asked to do more and more with fewer and fewer staff and less and less time, being able to prioritizing essential versus less important tasks is a necessary skill for every person.

- A balanced lifestyle
  A balance between work and home life, physical and mental endeavors, spiritual and practical concerns are essential to remaining centered and resilient.

- Stress reduction strategies
  Everyone has a number of stress reduction strategies that he or she engages in. These vary from reading to playing sports to socializing with friends. Those people who experience stress as somatic — body oriented — can benefit from activities that

[66] Adapted from information provided by Maureen Malloy, Maureen Malloy, R.N., Behavioral Emergency Outreach Program.

reduce muscle tension — exercise, massage, etc. Those who find stress effecting them primarily mentally can benefit from mentally distracting interventions such as reading, listening to music, arts and crafts, etc. Most people are a mixture of both types and respond to all of these interventions to a greater or lesser degree. Every person must find the stress relievers that work best for him or her.

- Self-awareness
  OK, everyone gets stressed. Stress can be both productive and destructive. The destructive aspects of stress occur when a person's stress level is too high or has been high for too long. Knowing your own thresholds for destructive stress and ways to intervene is essential.[67]

In addition to knowing one's stress limits and interventions, it is important for a crisis responder to be aware of his or her preconceived ideas about crisis intervention and his or her own abilities and limits. The following are some myths regarding crisis responders:

Myth: The crisis responder must do *something* besides just listen to the recipient.
Realities:
When you are *listening* to a person, you are doing something very important. Sometimes listening is what the person needs and wants most. Being more directive may not be appropriate.

Myth: The crisis responder should like all of the people who request services.
Realities:
You will not like all of the recipients that you work with. This is normal and does not make you a bad or ineffective intervener. If you dislike someone enough that you cannot work with him/her, request that a team member work with that person. This is one of the benefits of having a team. If team members also have a strong negative reaction to the individual, these reactions are likely the response that the person is getting in other areas of his/her life and may be a point of intervention.

Myth: The crisis responder must know the information needed.
Reality:
Additional information may not help with an intervention. The relationship that you establish is a more essential part of helping someone than simply information. Information can be sought together with the recipient.

Myth: The crisis responder must know "the answer" to every situation.
Reality:
Answers are created, not discovered. There are many "answers" to any situation. Some may be better than others are, but none is "right" or "wrong," and no one person has all of them. Some alternatives may have better outcomes than others. The responder's job is to help the recipient think through the likely outcomes of the alternatives and choose one that most nearly meets the recipient's needs and expectations. Sometimes the recipient may appropriately decide to do nothing.

[67] Ibid.

Post Test

Chapter One Post Test

1) A person is experiencing a mental health crisis. What are the possible outcomes if the person does not receive crisis response services?
   A) Reduced ability to function on a day-to-day basis
   B) An emergency situation
   C) Placement in a hospital or other more restrictive setting
   D) Any of the above

2) What is the difference between a mental health crisis and a mental health emergency?
   A) A crisis is more severe than an emergency
   B) An emergency requires immediate mental health intervention.
   C) A crisis is easier to deal with
   D) Only people with mental illnesses have mental health emergencies.

Chapter Two Post Test

1) Which of the following is a mobile crisis intervention service as defined here?
   A) A police officer convincing a person not to jump from a bridge.
   B) A licensed clinical social worker providing support to a person in an inpatient hospital ward who has expressed suicidal intent.
   C) A specially trained mental health practitioner traveling to a drop-in center to provide crisis assessment and intervention to a person who is experiencing significant auditory hallucinations.
   D) None of the above

2) Where can crisis stabilization services be provided?
   A) The same places that mobile crisis intervention services may (recipient home, home of friend or family member, emergency room provider office, or other community setting.)
   B) The same places a mobile crisis intervention plus short-term supervised licensed residential programs.
   C) Only in the recipient's home.
   D) Only in a licensed, short-term residential setting.

3) A mobile crisis team must include at least two mental health professionals or one mental health professional and]
   A) One mental health practitioner with specialized training in crisis response services who is supervised by a mental health professional
   B) One mental health rehabilitation worker
   C) One RN
   D) A, B, or C

4) True or False
Mobile crisis intervention services must always include both members of the team in a face-to-face intervention with the recipient.

Chapter Three Post Test

1) Which of the following is not an active listening skill?
   A) Paraphrasing
   B) Emotional labeling
   C) Reflecting
   D) Questioning

2) True or False
A crisis responder should attempt to persuade a person that his or her delusional beliefs are inaccurate.

3) True or False
A crisis treatment plan must be written.

Chapter Four Post Test

1) True or False
Men comprise approximately 80% of suicide deaths.

2) All of the following should be considered to be risk factors when assessing suicide potential, except:
   A) Previous suicide attempt
   B) Low IQ
   C) Impulsive or aggressive tendencies
   D) Significant loss
   E) Access to lethal methods
   F) All of the above

3) True or False
Parasuicide and self-injurious behavior refer to self-inflicted damage or injury where death is not the intended outcome.

4) True or False
Potential for violence is easily predictable.

Chapter Five Post Test

1) True or False
A person is only considered to be a vulnerable adult if they live in a facility licensed by the Minnesota Department of Human Services.

2) The "Duty to Warn" law:
   A) Requires specified professional to warn vulnerable adults of their rights to be free of abuse or neglect.
   B) Requires specified professionals to warn an individual if a family member is being released from a hospital or other institution.
   C) Requires specified professionals to warn an intended victim if the professional knows that a patient has made a specific serious threat of physical violence against a specific person.
   D) Requires patients to warn specified professionals regarding any threats that the patient has received.

Chapter Six Post Test

1) True or False
   A crisis team should provide assessment and intervention services in a recipient's home under any circumstances if the recipient requests this.

2) True or False
   It is important for the crisis team to find out if a person has a crisis plan or advance directive on file with the team before they go out on the call.

Chapter Seven Post Test

1) Crisis stabilization services may be provided by:
   A) a mental health professional
   B) a mental health practitioner with specialized training under the supervision of a mental health professional
   C) a mental health rehabilitation worker with specialized training under the supervision of a mental health professional
   D) all of these

Chapter Eight Post Test

1) Cultural identity includes all of the following *except:*
   A) Gender
   B) Age
   C) Academic ability
   D) Language of origin
   E) Religious or spiritual beliefs

2) True or False
   All crisis responders have a cultural identity that will have an impact on their provision of crisis services.

Chapter Nine Post Test

1) True or False
   Serious and persistent mental illness (SPMI) is a diagnostic category which is required for the provision of crisis services.

2) True or False
   Intoxication may mimic symptoms of a mental illness.

3) Which of these factors may impact on providing crisis services to older adults?
   A) Older adults tend to report the irritability or physiological symptoms of depression rather than the sadness.
   B) Older adults experience increased sensitivity to medications.
   C) Older adults have a higher suicide rate than other groups.
   D) All of the above

4) It is possible for another factor such as illegal drug use, prescription drug use, or medical conditions to look like symptoms of a mental illness. If a crisis responder believes that the person may be experiencing one of these, the responder should:
   A) Contact the police
   B) Consult with a medical professional
   C) Ask the person or family or friends of the person whether this is a possibility.
   D) B&C

Chapter Ten Post Test

1) True or False
   A health or peace officer hold requires that the person be held in a hospital for assessment for 72 hours.

2) Which of the following apply to a 72-hour hold?
   A) Any mental health professional can place a 72-hour hold on an individual.
   B) A 72-hour hold can be discontinued only by a court order or a qualified examiner.
   C) A 72-hour hold includes weekend and holidays.
   D) A 72 hour hold can only be placed on someone who has a mental illness.

Chapter Eleven Post Test

1) True or False
   Crisis responders are encouraged to take charge during a crisis situation when working with local law enforcement.

2) Law officers are:
   A) Also "peace officers"
   B) Are able to receive POST credit for any mental health training that is offered in the community
   C) Able to transport a person to a medical facility to be assessed if the officer has reason to believe that the person is potentially dangerous to his or herself or to others.
   D) A& C

Chapter Twelve Post Test

1) The crisis response team:
   A) Has the role of providing intervention and support to people who are experiencing a mental health crisis or emergency.
   B) Needs to be aware of support services where the recipient can receive longer term support as appropriate.
   C) Must be able to help the recipient make connections to longer term supports as appropriate.
   D) All of the above

2) All of the following is information that the crisis response team might wish to share with friends and family of a crisis services recipient *except*:
   A) Mental illness is a weakness of character or the result of poor parenting.
   B) Families, friends and the person in crisis do not have to cope with this situation alone – support is available.
   C) Mental illness is a medical illness, treatments exist and family and friends did not cause this illness.
   D) Contact information for local support and treatment organizations.

Chapter Thirteen Post Test

1) Which of the following is true of good boundaries with recipients?
   A) A crisis responder can never give a recipient too much help.
   B) A little flirting with a recipient can be used as a tool to put a recipient at ease.
   C) A crisis responder will not develop a social relationship with a recipient (i.e. they will not participate in social activities such as visiting each other's homes, attending social events together, etc.)
   D) It is always a good idea for a crisis responder to share intimate details of his or her personal life with a recipient.

2) Which of the following is important in limit setting with a recipient?
   A) Making sure that the limit has a time-frame attached to it.
   B) Stating the limit clearly, simply and in a firm yet kind way.
   C) Refuting the recipient's concerns about the limit.
   D) Insuring that everyone (family, friends, etc.) involved with the person is aware of the limit

3) All of the following are important elements of stress management except:
   A) A balanced lifestyle
   B) Abstinence from all mood altering chemicals/drugs
   C) Use of stress reduction strategies
   D) Self-awareness

Post Test with Answers

Chapter One Post Test

1) A person is experiencing a mental health crisis. What are the possible outcomes if the person does not receive crisis response services?
   A) Reduced ability to function on a day-to-day basis
   B) An emergency situation
   C) Placement in a hospital or other more restrictive setting
   D) Any of the above

   Correct Answer is D. Any of the above are possible outcomes of a mental health crisis as defined by statute.

2) What is the difference between a mental health crisis and a mental health emergency?
   A) A crisis is more severe than an emergency
   B) An emergency requires immediate mental health intervention.
   C) A crisis is easier to deal with
   D) Only people with mental illnesses have mental health emergencies.

   Correct Answer is B. An emergency requires an immediate mental health intervention. A is incorrect. An emergency is defined as needing immediate intervention while a crisis may only result in decreased functioning. C is incorrect. A crisis may be just as difficult or complicated to intervene in as an emergency. D is incorrect because anyone may experience a mental health emergency.

Chapter Two Post Test

1) Which of the following is a mobile crisis intervention service as defined here?
   A) A police officer convincing a person not to jump from a bridge.
   B) A licensed clinical social worker providing support to a person in an inpatient hospital ward who has expressed suicidal intent.
   C) A specially trained mental health practitioner traveling to a drop-in center to provide crisis assessment and intervention to a person who is experiencing significant auditory hallucinations.
   D) None of the above

   Correct Answer is C. A is incorrect because a police officer would not be considered a member of the mobile crisis team. B is incorrect because mobile crisis services cannot be provided in an inpatient hospital.

2) Where can crisis stabilization services be provided?
   A) The same places that mobile crisis intervention services may (recipient home, home of friend or family member, emergency room provider office, or other community setting.)
   B) The same places a mobile crisis intervention plus short-term supervised licensed residential programs.
   C) Only in the recipient's home.
   D) Only in a licensed, short-term residential setting.

   Correct Answer is B.

3) A mobile crisis team must include at least two mental health professionals or one mental health professional and]
   A) One mental health practitioner with specialized training in crisis response services who is supervised by a mental health professional
   B) One mental health rehabilitation worker
   C) One RN
   D) A, B, or C

   Correct answer is A. A mental health practitioner may be the other mobile crisis response team member is they have received 30 hours of training in crisis response services and are supervised by a mental health professional. Mental health rehabilitation workers cannot provide either crisis assessment or crisis intervention.

4) True or False
   Mobile crisis intervention services must always include both members of the team in a face-to-face intervention with the recipient.

   Correct answer is False. Either team member may provide mobile crisis assessment and intervention services as long as the mental health professional is available for consultation.

Chapter Three Post Test

1) Which of the following is not an active listening skill?
   A) Paraphrasing
   B) Emotional labeling
   C) Reflecting
   D) Questioning

   Correct Answer is D. Questioning is not included as an active listening skill here.

2) True or False
   A crisis responder should attempt to persuade a person that his or her delusional beliefs are inaccurate.

   Correct answer is false. A crisis responder should not try to argue a person out of their delusional thinking.

3) True or False
A crisis treatment plan must be written.

Correct answer is true.

Chapter Four Post Test

1) True or False
Men comprise approximately 80% of suicide deaths.

Correct answer is true. Women attempt more often than men but men are more successful in completing suicide.

2) All of the following should be considered to be risk factors when assessing suicide potential, except:
A) Previous suicide attempt
B) Low IQ
C) Impulsive or aggressive tendencies
D) Significant loss
E) Access to lethal methods
F) All of the above

Correct answer is B.

3) True or False
Parasuicide and self-injurious behavior refer to self-inflicted damage or injury where death is not the intended outcome.

Correct answer is true.

4) True or False
Potential for violence is easily predictable.

Correct answer is False. Even trained professionals can accurately predict only one out of 3 episodes of violent behavior.

Chapter Five Post Test

1) True or False
A person is only considered to be a vulnerable adult if they live in a facility licensed by the Minnesota Department of Human Services.

Correct answer is False. A vulnerable adult may be any person who due to mental or physical impairment is unable or unlikely to report abuse or neglect.

2) The "Duty to Warn" law:
   A) Requires specified professional to warn vulnerable adults of their rights to be free of abuse or neglect.
   B) Requires specified professionals to warn an individual if a family member is being released from a hospital or other institution.
   C) Requires specified professionals to warn an intended victim if the professional knows that a patient has made a specific serious threat of physical violence against a specific person.
   D) Requires patients to warn specified professionals regarding any threats that the patient has received.

   Correct answer is C. Specified professionals must warn a potential victim if a patient/client of theirs makes threats or plans to harm that potential victim.

Chapter Six Post Test

1) True or False
   A crisis team should provide assessment and intervention services in a recipient's home under any circumstances if the recipient requests this.

   Correct answer is False. A crisis responder must use professional judgment about providing services in settings that are unfamiliar or potentially dangerous. A crisis responder may suggest an alternative site to provide intervention and should never stay in a situation that may be dangerous.

2) True or False
   It is important for the crisis team to find out if a person has a crisis plan or advance directive on file with the team before they go out on the call.

   Correct answer is true. The crisis team must attempt to follow crisis plans or advance directives to the extent possible in a crisis situation and should, therefore, review the plan before responding if possible.

Chapter Seven Post Test

1) Crisis stabilization services may be provided by:
   A) a mental health professional
   B) a mental health practitioner with specialized training under the supervision of a mental health professional
   C) a mental health rehabilitation worker with specialized training under the supervision of a mental health professional
   D) all of these

   Correct answer is D.

Chapter Eight Post Test

1) Cultural identity includes all of the following *except:*
   A) Gender
   B) Age
   C) Academic ability
   D) Language of origin
   E) Religious or spiritual beliefs

   Correct answer is C.

2) True or False
   All crisis responders have a cultural identity that will have an impact on their provision of crisis services.

   Correct answer is true. All people have a cultural identity. Becoming aware of personal cultural biases is a step toward increasing multicultural awareness.

Chapter Nine Post Test

1) True or False
   Serious and persistent mental illness (SPMI) is a diagnostic category which is required for the provision of crisis services.

   Correct answer is false. SPMI is a set of criteria developed for the Minnesota Comprehensive Mental Health Act. A person does not have to have an SPMI in order to be eligible to receive MA reimbursable crisis response services.

2) True or False
   Intoxication may mimic symptoms of a mental illness.

   Correct answer is true.

3) Which of these factors may impact on providing crisis services to older adults?
   A) Older adults tend to report the irritability or physiological symptoms of depression rather than the sadness.
   B) Older adults experience increased sensitivity to medications.
   C) Older adults have a higher suicide rate than other groups.
   D) All of the above

   Correct answer is D. All of these are complicating factors when working with older adults.

4) It is possible for another factor such as illegal drug use, prescription drug use, or medical conditions to look like symptoms of a mental illness. If a crisis responder believes that the person may be experiencing one of these, the responder should:
   A) Contact the police
   B) Consult with a medical professional
   C) Ask the person or family or friends of the person whether this is a possibility.
   D) B&C

   Correct answer is D. A crisis responder should gather as much information regarding the causes of the symptoms as possible and consult with a medical professional.

Chapter Ten Post Test

1) True or False
   A health or peace officer hold requires that the person be held in a hospital for assessment for 72 hours.

   Correct answer is False. A health or peace officer hold only allows the officer to transport the person to a physician or treatment facility where the officer must make written application for admission to the facility. The health or peace officer does not determine whether a person is admitted to the facility.

2) Which of the following apply to a 72-hour hold?
   A) Any mental health professional can place a 72-hour hold on an individual.
   B) A 72-hour hold can be discontinued only by a court order or a qualified examiner.
   C) A 72-hour hold includes weekend and holidays.
   D) A 72 hour hold can only be placed on someone who has a mental illness.

   Correct answer is B. Only MDs or Psychologists licensed at the doctoral level are identified as “qualified examiners” and can place or discontinue a 72-hour hold. Hold orders can be placed on people who are at risk of harm to self or others because of mental illness, intoxication or mental retardation.

Chapter Eleven Post Test

1) True or False
   Crisis responders are encouraged to take charge during a crisis situation when working with local law enforcement.

   Correct answer is False.

2) Law officers are:
   A) Also "peace officers"
   B) Are able to receive POST credit for any mental health training that is offered in the community
   C) Able to transport a person to a medical facility to be assessed if the officer has reason to believe that the person is potentially dangerous to his or herself or to others.
   D) A& C

   Correct answer is D. POST credits are only available on POST approved classes.

Chapter Twelve Post Test

1) The crisis response team:
   A) Has the role of providing intervention and support to people who are experiencing a mental health crisis or emergency.
   B) Needs to be aware of support services where the recipient can receive longer term support as appropriate.
   C) Must be able to help the recipient make connections to longer term supports as appropriate.
   D) All of the above

   Correct answer is D.

2) All of the following is information that the crisis response team might wish to share with friends and family of a crisis services recipient *except*:
   A) Mental illness is a weakness of character or the result of poor parenting.
   B) Families, friends and the person in crisis do not have to cope with this situation alone – support is available.
   C) Mental illness is a medical illness, treatments exist and family and friends did not cause this illness.
   D) Contact information for local support and treatment organizations.

   Correct answer is A. The crisis team should not reinforce these long disproved fallacies about character weakness or poor parenting.

Chapter Thirteen Post Test

1) Which of the following is true of good boundaries with recipients?
   A) A crisis responder can never give a recipient too much help.
   B) A little flirting with a recipient can be used as a tool to put a recipient at ease.
   C) A crisis responder will not develop a social relationship with a recipient (i.e. they will not participate in social activities such as visiting each other's homes, attending social events together, etc.)
   D) It is always a good idea for a crisis responder to share intimate details of his or her personal life with a recipient.

   Correct answer is C. All of the other answers are representative of boundary issues.

2) Which of the following is important in limit setting with a recipient?
   A) Making sure that the limit has a time-frame attached to it.
   B) Stating the limit clearly, simply and in a firm yet kind way.
   C) Refuting the recipient's concerns about the limit.
   D) Insuring that everyone (family, friends, etc.) involved with the person is aware of the limit

   Correct answer is B.

3) All of the following are important elements of stress management except:
   A) A balanced lifestyle
   B) Abstinence from all mood altering chemicals/drugs
   C) Use of stress reduction strategies
   D) Self-awareness

   Correct answer is B.

BIBLIOGRAPHY

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.* Washington, DC: American Psychiatric Association, 1994.

The Behavioral Technology Transfer Group, *DBT in a Nutshell,* 2002, January 11, 2002,

Blumenthal, Stephen and Lavender, Tony. *Violence and Mental Disorder: A Critical Aid to Assessment and Management*. United Kingdom: Zito Trust, 2000.

Cook, Charles G. *Crisis Intervention Sample Protocol*, Unpublished manuscript, 1995.

Cook, Charles G. *Crisis Management, Assessment and Intervention Training Manual*. Unpublished manuscript, 1995.

Greenstone, James L. and Leviton, Sharon C. *Elements of Crisis Intervention: Crises and How to Respond to Them, 2nd Edition*. Pacific Grove, CA: Brooks/Cole, Thomas Learning, 2002.

Hyman, Steven E. and Tesar, George E. *Manual of Psychiatric Emergencies 3rd Edition.* Boston: Little, Brown, and Company, 1994.

Minnesota Department of Human Services. *Social Services Manual*, "Chapter XVI: Adult Protective Service." Aug. 1, 1999.

Roberts, Albert R.. *Crisis Intervention and Time-Limited Cognitive Treatment*. Thousand Oaks, CA: Sage Publications, Inc., 1995.

Zealberg, Joseph J. and Santos, Alberto. *Comprehensive Emergency Mental Health Care*. New York: W. W. Norton and Company, 1996.

Web sites

2000 Census Web site, December 2001, Retrieved December 2001, <http://204.29.171.80/framer/navigation.asp?charset=utf-cc=US&frameid=1565&lc=en-us&providerid=262&realname=Census+2000&uid=1747697&url=http%3A%2F%2Fwww.census.gov%2Fdmd%2Fwww%2F2khome.htm>.

Minnesota Department of Health. *Suicide Prevention Fact Sheet*. Jan. 22, 2001. Nov. 14, 2001. <www.health.state.mn.us/facts/suicide.pdf>.

The National Clearinghouse for Alcohol and Drug Information, Drugs of Abuse, Retrieved Feb. 8, 2002. <http://www.health.org/govpubs/rpo926/>.

National Institute of Mental Health, *The Numbers Count: Mental Disorders in America,* Jan. 1, 2001, Retrieved Jan. 11, 2002, <www.nimh.nih.gov/publicat/numbers.cfm>.

Noesner, Gary W. and Webster, Mike; *Crisis Intervention: Using Active Listening Skills in Negotiations;* FBI Publications – Law Enforcement Bulletin, August 1997. Retrieved Dec. 11, 2001, <www.fbi.gov/publications/leb/1999/aut974.htm>.

United States Public Health Service, Department of Health and Human Services, *The Surgeon General's Call to Action to Prevent Suicide.* 1999. Nov.14, 2000 <www.surgeongeneral.gove/library/calltoaction/calltoaction.htm>.

United States Public Health Service, Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Nov. 14, 2000. <www.surgeongeneral.gov./library/mentalhealth/home.htm>

Individuals

Jobes, Dr. David, Associate Director, Counseling Center, Catholic University, Worksheet adapted by Northern Pines Mental Health Center Crisis Program, Brainerd Minnesota.

Malloy, Maureen, Behavioral Emergency Outreach Program, Hennepin County Medical Center, Minneapolis, MN, DHS Crisis Advisory Group Meeting, Jan. 30, 2002

WORKSHEETS and FORMS

LETHALITY ASSESSMENT WORK SHEET

	{LOW LETHALITY				HIGH LETHALITY}
PLAN	Vague, indeterminate plan	Clear thoughts, philosophical	Some specifics	Note & or will thought out, written	Note written, time, place, method chosen
METHOD	Method undecided	Method: pills, cutting	Method: CO, oven gas, car	Method: Hanging, Jumping	Method: Gun
AVAILABILITY	Method unavailable	Can acquire easily	Some effort required to prepare	Method ready, in the home	Method in hand
TIME	No time specified	Specified vaguely, within weeks	Day and time chosen, within a week	Plan to complete today	Plan in progress
PREVIOUS ATTEMPTS	No Previous attempts	1 or 2 gestures	Hx of many threats, attempts	Hx of highly lethal attempt	Over 2 serious attempts
DEPRESSION	Feeling low or blue	Mild depression	Chronic depression	Major depression	Major depression, hopeless
RECENT LOSSES	No specific stress or loss	1 minor conflict or loss	Several concurrent stressors	Major loss or conflict	Several significant losses/changes
HEALTH	Physically healthy	Transitory illness	Disability or chronic health problems	Severe illness or injury, Recent Dx	Terminal illness, Recent Dx
ISOLATION	Others present and supportive	Roommate/SO there	Others close by	Alone, at home, no help nearby	Alone, rented room or car, isolated
COMORBIDITY	No presence of predictors listed below	1 predictor present	More than 1 factor present, comorbidity	Long term existence of several factors	Suicidal careers

Common single predictors of suicide listed in order*

1. Depressive illness, mental disorder
2. Alcoholism, drug abuse
3. Suicide ideation, talk, religion
4. Prior suicide attempts
5. Lethal means
6. Isolation, living alone, loss of support
7. Hopelessness, cognitive rigidity
8. Older white males
9. Modeling, suicide in family, genetics
10. Work problems, occupation, economics
11. Marital problems, family pathology
12. Stress, life events
13. Anger, aggression, irritability, 5-HIAA
14. Physical illness
15. Repetition and comorbidity of factors 1-14, suicidal careers

*(Excerpted from "Suicide and Life Threatening Behavior," volume 21, number 1, The Guilford Press, New York, New York, Introduction by Ronald W. Maris, Ph.D., University of South Carolina).

REGIONAL MENTAL HEALTH CRISIS SERVICES
SUICIDE ASSESSMENT[68]

Client: _____D.O.B._____Age_____

Y/N Presenting request is for suicide assessment?
Y/N Client acknowledges suicide ideation?

Current suicide ideations_____
-frequency of thoughts: _____
-intensity of thoughts: _____
-duration of thoughts: _____

Y/N **Suicide Plan?** Firearms/hanging/cutting/overdose/other _____
Y/N **Access to means?** _____
Y/N **Preparatory behavior?** _____
Y/N **Recent suicide threat?** _____
Y/N **Recent suicide related behavior?** _____

Y/N **Recent suicide attempts?** With injury? Without injury? _____

Y/N High-risk behaviors? _____

RISK FACTOR ASSESSMENT

Y/N **Family/friend suicide history?** _____
Y/N **Suicide attempts history?** _____
Y/N **Substance abuse?** _____
Y/N **Multiple Stressors?** _____
Y/N **Impulsiveness?** _____
Y/N **Health Problems?** _____
Y/N **Psychopathology?** Mood disorder/thought disorder/personality disorder_____

Date_____ Client_____Staff: _____

[68] Developed by Dr. Jobes *Adapted by Northern Pine Mental Health Center Crisis Program

REGIONAL MENTAL HEALTH CRISIS SERVICES
SUICIDE ASSESSMENT

Rating is according to how I believe my client feels right now.

1. **Rate PSYCHOLOGICAL pain{hurt, anguish, misery -not stress or physical pain}**
   Low Pain 1 2 3 4 5 High Pain

2. **Rate STRESS {general feelings of being pressured, overwhelmed}**
   Low Pain 1 2 3 4 5 High Pain

3. **Rate AGITATION {emotional urgency to take some action}**
   Low Pain 1 2 3 4 5 High Pain

4. **Rate HOPELESSNESS {expectation things will not get better no matter what they do}**
   Low pain 1 2 3 4 5 High Pain

5. **Rate SELF-HATE {general feeling of disliking self, poor self-esteem and self respect}**
   Low Pain 1 2 3 4 5 High Pain

6. **Rate Overall RISK OF SUICIDE Low Risk 1 2 3 4 5 High Risk**

Client agrees to maintain safety as per crisis plan Yes_____ No _____
Ability to maintain client safety in the community Yes_____ No_____
Clear and Imminent Danger of Suicide? Yes_____ No _____

CRISIS PLAN AND DISPOSITION:

Date:_____Client:_____Staff:_____

Suicide Status Form (Client)

This form is completed by all clients at the counseling center who are currently thinking about suicide. It is intended to help gather assessment information so that appropriate and helpful treatment decisions can be made. Please try to be as honest as possible in answering this form.

Please rate and fill our each item according to how you fell right now.

1) **RATE PSYCHOLOGICAL Pain (***hurt, anguish, or misery in your mind, not stress, not physical pain):*
   Low Pain: 1 2 3 4 5 :High Pain

   What I find most painful is _____

2) **RATE STRESS** *(your general feeling of being pressured or overwhelmed):*
   Low Pain: 1 2 3 4 5 :High Pain

3) **RATE AGITATION** *(emotional urgency; feeling that you need to take action:* ***not*** *irritation;* ***not*** *annoyance):*
   Low Pain: 1 2 3 4 5 :High Pain

4) **RATE HOPELESSNESS***(your expectation that things will not get better no matter what you do):*
   Low Pain: 1 2 3 4 5 :High Pain

5) **RATE SELF-HATE** *(your general feeling of disliking yourself; having no self-esteem; having no self-respect):*
   Low Pain: 1 2 3 4 5 :High Pain

6) **RATE OVERAL RISK OF SUICIDE:**
   Extremely Low Risk: 1 2 3 4 5 :Extremely High Risk
   (will not kill self) (will kill self)

This section is going to help give your counselor an understanding of your reasons for living and dying. For many suicidal people there is a struggle between wanting to live and wanting to die. This section will help your counselor to understand what some of those considerations might be for you.

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance. (1-5)

Rank	Reasons for Living	Rank	Reasons for Dying

Suicide Status Form (Client –page 2)

Some people who are suicidal are very focused on the suffering they feel inside themselves. Alternatively others who are suicidal are very focused on pain associated with their relationships with others. For yet other people there is a mixture of both. These ratings will help give your counselor a sense of what it is like for you. Please circle the number that most closely describes how you feel.

1) How much is being suicidal related to <u>you?</u>
   Not at all: 1 2 3 4 5 :Very Much

2) How much is being suicidal related to <u>other people?</u>
   Not at all: 1 2 3 4 5 :Very Much

The one thing that would make me no longer suicidal would be:_____

The items below inquire about how you see yourself. Each item consists of a pair of contradictory characteristics (i.e., you cannot be both at the same time). The letters form a scale between the two extremes. You are to circle the letter that describes where you fall on the scale.

Not at all independent	A	B	C	D	E	Very Independent
Not at all emotional	A	B	C	D	E	Very emotional
Very passive	A	B	C	D	E	Very active
Difficult to devote self completely to others	A	B	C	D	E	Easy to devote self to others
Very rough	A	B	C	D	E	Very gentle
Not at all helpful to others	A	B	C	D	E	Very helpful to others
Not at all competitive	A	B	C	D	E	Very competitive
Not at all aware of others' feelings	A	B	C	D	E	Very aware of others' feelings
Can make decisions easily	A	B	C	D	E	Has difficulty making decisions
Gives up easily	A	B	C	D	E	Never gives up
Not at all self-confident	A	B	C	D	E	Very self-confident
Feels very inferior	A	B	C	D	E	Feels very superior
Not at all understanding of others	A	B	C	D	E	Very understanding of others
Goes to pieces under pressure	A	B	C	D	E	Stands up to pressure well

I AGREE TO MAINTAIN MY SAFETY AS DISCUSSED WITH MY COUNSELOR: YES____ NO_____

Client signature:_____ Date:_____

CRITICAL ITEM SUICIDE POTENTIAL ASSESSMENT[69]

This tool should be used in assessing the risk of suicide for clients.

I. PRIMARY RISK FACTORS: If any **one** of the following is present, the client should be considered a high risk for potential suicide, which should be given serious consideration in placement decisions.

A. **Attempt:**

___ 1) Suicide attempt with lethal method (firearm, hanging/strangulation, jumping from heights, etc.).
___ 2) Suicide attempt resulting in moderate to severe lesions/toxicity.
___ 3) Suicide attempt with low rescuability (no communication prior to attempt, discovery unlikely because of chosen location or time, no one nearby, active prevention of discovery, etc.).
___ 4) Suicide attempt with subsequent expressed regret that it was not successful and continued expression of intent or unwilling to accept treatment.

B. **Intent:** (as expressed directly by client or by another based on their observations)

___ 1) Intent to commit suicide **immediately**.
___ 2) Intent with lethal method selected and readily available.
___ 3) Intent with post-mortem preparations (disposal of personal property, writing a will, writing a suicide note, making business and insurance arrangements, etc.).
___ 4) Intent with planned time, place and opportunity.
___ 5) Intent without ambivalence or inability to see alternatives.
___ 6) Command hallucinations to kill self regardless of expressed suicidal intent.
___ 7) Intent with active psychotic symptoms, especially affective disorder or schizophrenia.
___ 8) Intent or behavior indicates intent, but client unwilling to cooperate in adequate assessment.

II. SECONDARY RISK FACTORS: An individual's risk increases with the presence of the following factors. If over half of the following factors are present, consider the person a high risk for potential suicide in making placement decisions.

___ 1) Expressed hopelessness.
___ 2) Recent death of significant other.
___ 3) Recent loss of job or severe financial setback.
___ 4) Significant loss/stress/change event (victimization, threat of prosecution, pregnancy, severe illness, etc.).
___ 5) Social isolation.
___ 6) Current or past major mental illness.
___ 7) Current or past chemical dependence/abuse.
___ 8) History of suicide attempt(s).
___ 9) History of family suicide (including recent suicide by close friend).
___ 10) Current or past difficulties with impulse control or antisocial behavior.
___ 11) Significant depression (clinical or not) especially with feelings of guilt, worthlessness or helplessness.
___ 12) Recent separation or divorce.
___ 13) Rigidity in adapting to change.

[69] Adapted from the CISPA form used at the Hennepin County Crisis Intervention Center, Minneapolis., MN

SAMPLE
Crisis Prevention Plan

Name	
Street Address	
City/County	
Phone #:	
Date prepared/updated	
Emergency Contact	
Name	
Phone#	
Primary Physician	
Name	
Phone#	
Case Manager	
Name	
Phone	
County/Agency	
Psychiatrist	
Name	
Phone #	
Medications Prescribed	
Outpatient Therapist/CSP Worker/ Other support person	
Name	
Phone #	
Name	
Phone #	

What things (events, situations, people, etc.) cause me stress?
What symptoms let me know I am stressed?
What can I do to manage stress?
What can others do to help? What has worked in the past?
Friend or an escort that I will call **Name:**
Phone Number:
My strengths and reasons to succeed.

This worksheet may be helpful in determining need for better limit setting and assessment of personal boundaries.

WHEN A RECIPIENT IS	I OFTEN FEEL	AND MY USUAL RESPONSE IS	CHANGE PLANNED?
ANXIOUS			
ANGRY			
HOSTILE			
AGGRESSIVE			