



Department of
**Mental Health &
Substance Abuse Services**

Crisis Responder Training

Office of Crisis Services and Suicide Prevention

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What is this Crisis Responder Training and how should it be used?

What?

This Crisis Services Training is a compilation of information originally gathered and composed by a work group of dedicated Department of Mental Health employees for the purpose of meeting the goals covered in the “Why?” section.

Why?

A primary goal of this Crisis Training is to standardize general and basic crisis training for all providers. Another goal of this training is to increase awareness and understanding that a crisis situation is often determined by the perception of the individual experiencing the crisis situation.

Who?

Anyone working in crisis services should successfully complete this training in addition to any population specific, geographic specific, or other specific training that is currently conducted by the individual crisis service providers.

How?

The current Crisis Services Provider Directors and/or their identified Crisis Trainer Designee will be responsible for assuring all of their Crisis Services Staff successfully complete the training according to the time frames listed below.

Where?

The Crisis Training is located on the TDMHSAS website for easy and convenient access. Each Crisis Services staff member will complete the Crisis Training one chapter at a time. There will be a post test at the end of each chapter. After successful completion of a chapter, as evidenced by the passing score of the post test at the end of the chapter, the staff member may continue to complete the succeeding chapters in like fashion.

If any chapter is not successfully completed, as evidenced by not passing the post test, the provider-specific identified crisis trainer will be responsible for working with the individual crisis staff member to gain more understanding of the content and the post test can be re-taken. If technical assistance is needed, contact Morenike Murphy, Director of Crisis Services at 615-253-7306 or Maria Bush, Assistant Director of Crisis Services at 615-532-0407.

When?

This training should be successfully completed by any Crisis Services staff member hired after July 2007 prior to working independently in a crisis situation. A refresher training of this Crisis Training or any subsequent updates shall be taken every three years.

Contributors

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Chapter 1: Mental Health Crisis Services Definitions and Goals

Objectives

- Define a mental health crisis
- Understand the primary components of Tennessee's Crisis Services System
- Review goals of crisis services (Local resources should also be discussed with your trainer/supervisor)

Discussion

In order to best assist an individual during a mental health crisis, it is important to understand the components of a mental health crisis and the goals of providing Crisis Services. In this chapter we will build a foundation of introductory knowledge, upon which we will build and expand throughout this training.

Goals and Services

Crisis services are provided to anyone in the state of Tennessee regardless of whether or not someone has TennCare, Medicare, private insurance, or no insurance. Crisis providers across the state of Tennessee are monitored by Managed Care Companies (MCCs) with oversight from The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS).

The goals of crisis services include, but are not limited to:

1. Promote the safety and emotional stability of individuals with mental illness or emotional crises;
2. Minimize further deterioration of individuals with mental illness or emotional crises;
3. Assist individuals in developing and/or enhancing better coping skills and a natural support system;
4. Help individuals with mental illness or emotional crises obtain ongoing care and treatment; and
5. Encourage services in the least restrictive setting that is clinically appropriate to meet the individual's needs.

The scope of Tennessee's statewide crisis services continuum includes:

- Statewide Toll-Free Crisis Line
- Adult Mobile Crisis Response
- Children & Youth Mobile Crisis Response Walk-In Center Services
- Crisis Stabilization Unit (CSU)
- Crisis Respite Services
- Follow-Up

And Offers:

24/7 Toll-free telephone triage and intervention as needed, Face-to-face services and/or telehealth evaluations including community screenings by a mandatory pre-screening agent, Evaluation and referral for additional services and treatment, Stabilization of symptoms, Mobile services to wherever the crisis is occurring in the community whenever possible, and follow-up services.

What is a Mental Health Crisis?

A **mental health crisis** is any intensive behavioral, emotional, or psychiatric situation that is perceived to be a crisis by the individual/family experiencing the crisis.

We do not want to discourage anyone from seeking crisis services, however, we do want to encourage individuals to engage in the crisis services system if there is any one (or multiple) of the following:

- Threat or imminent risk of suicide
- Threat or imminent risk of harm to others
- Inability to avoid imminent danger or self-harm
- Inability to properly care for self

Note: This definition focuses on the needs of the individual rather than the root cause of the mental health crisis. A crisis is determined by the individual.

How can an individual seek Crisis Services in Tennessee?

Behavioral health crisis services can be activated by a telephone contact or at a walk-in center:

Tennessee Statewide Crisis Line

855-CRISIS-1 (855-274-7471)

The statewide crisis line is a 24/7/365 call system to help anyone experiencing a mental health crisis. All calls are geo-routed to a trained crisis specialist within an individual's area. The service is free.

Note: This number is managed by the Mental Health Cooperative with oversight by TDMHSAS

Post Test

Chapter One: Mental Health Crisis Services Definitions and Goals

1. **A person should seek crisis services if they are experiencing which of the following?**
 - a. Inability to avoid imminent danger or self-harm
 - b. Threat or imminent risk of suicide
 - c. Inability to properly care for self
 - d. Threat or imminent risk of harm to others
 - e. All of the above
2. **What best describes a mental health crisis?**
 - a. An intensive behavioral, emotional, or psychiatric situation
 - b. Only suicidal thoughts
 - c. Only homicidal thoughts
 - d. Someone's perceptions that they are experiencing a crisis
 - e. Both a and d
 - f. All of the above
3. **All of the following are included in Tennessee's Statewide Crisis Services Continuum: Adult and Children & Youth Mobile Crisis Response, Statewide Toll-Free Crisis Line, Crisis Respite Services, Follow-up Services, Crisis Stabilization Units (CSU), and Walk-In Center Services.**
 - a. True
 - b. False
4. **What are some of the goals of crisis services?**
 - a. Promote the safety and emotional stability of individuals with mental illness or emotional crises
 - b. Minimize further deterioration of individuals with mental illness or emotional crises
 - c. Help individuals with mental illness or emotional crises to obtain ongoing care and treatment
 - d. Prevent placement in settings that are more intensive or more restrictive than clinically necessary to meet an individual's needs.
 - e. All of the above

Post Test

Chapter One: Mental Health Crisis Services Definitions and Goals

5. **Which is more important in determining the acuity of a crisis situation?**
 - a. The situation itself
 - b. The person's feelings about/response to the situation
 - c. The age of the person
 - d. None of the above
6. **Which is not a component of crisis services?**
 - a. Triage
 - b. Intervention
 - c. Follow-up services
 - d. Auditing

Chapter Two: Mental Health Crisis Services Components

Objectives

- Identify essential skills in answering crisis calls
- Become familiar with the National Guidelines and Policies for Helping Callers at Imminent Risk

Discussion

In order to best assist an individual during a mental health crisis, it is important to understand the components of a mental health crisis and the goals of providing Crisis Services. In this chapter we will build a foundation of introductory knowledge, upon which we will build and expand throughout this training.

What are crisis telephone answering skills?

The manner in which the agency's crisis telephones are answered sets the tone for each crisis call. All telephone calls are required to be answered in a *uniform, courteous, and professional* manner. All telephone calls are to be answered "live", by a qualified and trained crisis services triage personnel. No answering machines, recordings, or other electronic mechanisms are allowed to field crisis calls.

Normally, crisis services triage personnel are the initial contact a person has with the crisis services system. Within seconds of the first telephone call, the caller is forming an opinion of the people they may interact with and the possible services they may receive. The crisis personnel answering the telephone must ensure the initial contact is a positive one, setting the stage potentially for a successful treatment experience and instilling confidence in the professionalism of the service quality.

1. Every crisis services triage personnel should answer the telephone in a standardized and courteous way. For example, "South Middle Crisis Services, how may I help you?"
2. As soon as possible, secure the caller's name, telephone number, and if possible secure the caller's location. The crisis services triage personnel should state something similar to, "in case we are accidentally disconnected could I have your name, telephone number, and the address from which you are calling." If the caller hesitates to share their location, do not insist they provide the location or address at this time.
3. Do not place a call on hold without the permission of the caller. If a caller is placed on hold, check back with the caller every minute to give him/her feedback regarding the status of the call. If you need to talk to other staff, press the mute button.
4. Do not place the person on speakerphone as this may make them feel there is no privacy in the conversation and may prevent them from telling you important information. Using speakerphone may also compromise the confidentiality of the caller's right to protect their private health information.

Helping Callers at Imminent Risk of Suicide

The following includes excerpts from an Executive Summary from National Suicide Prevention Lifeline

In January 2008, the National Suicide Prevention Lifeline (Lifeline) Standards, Trainings and Practices Subcommittee (STPS) and Steering Committee approved Lifeline's Policy for Helping Callers at Imminent Risk of Suicide.

The *Policy for Helping Callers at Imminent Risk of Suicide* emanates from three underlying values: 1) the need to take all actions necessary to prevent a caller from dying by suicide, 2) active collaboration with the caller to act to secure his/her own safety and 3) collaboration with other community crisis and emergency services that are likely to aid the crisis center towards ensuring the safe, continuous care of the caller at imminent risk.

The policy can be further understood in terms of two central concepts: "active engagement" and "active rescue." These concepts are an integral part of any call center policy that would effectively address caller safety.

Active Engagement:	Active Rescue:	Least Invasive Intervention:
The ability of the crisis center staff to not only adopt an "active listening" approach but requires that they actively engage the individual at risk in a discussion of their thoughts of suicide. This can occur through supporting the individual's experience, exploring strengths and resources, building hope for recovery, and empowering the caller to work towards securing their own safety. While crisis call centers typically seek to "engage" all callers, "active engagement" is distinctive due to its collaborative nature in which the staff member engages the caller at "imminent risk" to collaboratively take steps to prevent his/her suicide.	The need for call center staff to initiate rescue with or without the caller's consent during circumstances in which, despite all efforts at engagement, the call center staff believe that the individual is at imminent risk and unable to participate in securing his/her own safety. Active rescue is distinguished from voluntary rescue in a strict sense; voluntary rescue is predicated on crisis center helper-caller agreement. This component is specific to the helper needing to actively initiate rescue services because the caller is unwilling or unable to do so for him or herself, and, without rescue services, the helper believes that the caller is likely to die by suicide.	Promotes the use of approaches that emphasize cooperation over coercion with callers at imminent risk to secure their safety, with the use of involuntary methods as a last resort. Through actively engaging the caller, the goal is to include the person's own wishes in any plan to reduce risk. In Tennessee we refer to this as utilizing Referral Alternative Services.

Helping Callers at Imminent Risk of Suicide

Updated January 31, 2012 the NSPL Policy for Helping Callers at Imminent Risk of Suicide is as follows:

- Center Guidelines shall direct Center Staff to actively engage Callers and initiate any and all measures necessary—including Active Rescue to secure the safety of Callers determined to be attempting suicide or at Imminent Risk of suicide. Specifically, Center Guidelines shall direct Center Staff to:
 - Practice **Active Engagement** with Callers determined to be attempting suicide or at Imminent Risk of suicide and make efforts to establish sufficient rapport so as to promote the Caller's collaboration in securing his/her own safety, whenever possible.
 - Use the **least invasive intervention** and consider involuntary emergency interventions as a last resort, except for in circumstances as described below.
- Center Staff shall Seek to collaborate with individuals at Imminent Risk
 - Include the individual's wishes, plans, needs, and capacities towards acting on his/her own behalf to reduce his/her risk of suicide, wherever possible.
 - Initiate life-saving services for attempts in progress.
 - To the degree it is evident to Center Staff that a **suicide attempt** is in progress, whether the information is gathered directly from the person at risk or someone calling on his/her behalf, Center Guidelines shall direct Center Staff to undertake procedures to ensure that the individual at risk receives emergency medical care as soon as possible.
 - While Center Staff should make reasonable efforts to obtain the at-risk individual's consent to receive such services wherever possible, Center Guidelines shall not require that the individual's willingness or ability to provide consent be necessary for Center Staff to initiate medically necessary rescue services.
- Center Staff shall initiate **Active Rescue** to secure the immediate safety of the individual at risk, up to and including calling an emergency service provider, if, in spite of the Center Staff's best efforts to engage the at-risk individual's cooperation, he or she:
 - Remains unwilling and/or unable to take such actions likely to prevent his/her suicide; and
 - Remains at Imminent Risk.

2012 NSPL Policy Guidelines continued

- **Third-party callers:** Center Staff shall practice Active Engagement with persons calling on behalf of someone else (“Third-party Callers”) towards determining the least invasive, most collaborative actions to best ensure the safety of the person believed to be in the process of a suicide attempt or at Imminent Risk of suicide (up to and including Active Rescue, as a last resort).
- **Supervisory consultation:** Center Guidelines shall direct Supervisory Staff to be available to Center Staff during all hours of the Center’s operations for timely consultation from Center Staff needing assistance in determining the most appropriate intervention(s), including Active Rescue, for any individual who may be at Imminent Risk of suicide.
 - Center Guidelines shall describe the circumstances under which supervisory consultation shall be sought as well as the process by which Center Staff shall contact Supervisory Staff.
- **Caller ID:** In order to enable its Active Rescue efforts, the Center shall maintain Caller ID or some other method of identifying the Caller’s location that is readily accessible to Center Staff in real time (i.e., during the call).
 - The Real Time Caller ID tool on the Administrator’s Members-Only site may be used in order to fulfill this requirement.
- **Establishing and Maintaining Collaborative Relationships with Local Crisis and Emergency Services:** In cases in which the Center initiates Active Rescue, and in which local emergency service providers are willing and able to provide such confirmation, Center Guidelines shall direct Center Staff to confirm that such emergency services have successfully made contact with the at-risk individual.
 - If the Center reports that local emergency service providers are unwilling or unable to offer confirming information to the Center, the Center shall provide documentation to the Administrator demonstrating its efforts to collaborate with local emergency service providers.
 - To the degree that Center Staff have confirmed that emergency response services initiated by the Center were unsuccessful in making contact with the individual at Imminent Risk, Center Guidelines shall direct Center Staff to take additional steps to address the safety needs of the at-risk individual.
 - The Center shall establish collaborative relationships with one or more emergency service providers in its community and submit proof of said relationships to the Administrator upon its application to the Network or upon request by the Administrator.

National Suicide Prevention Lifeline (NSPL) Suicide Risk Assessment Standards

It is policy that each Lifeline caller be asked about suicidality. An affirmative answer will require that the telephone worker conduct a full suicide risk assessment with the caller consistent with the core principles and subcomponents below. These standards are guidelines for NSPL Centers as to the minimum requirements for the core principles and subcomponents of each Center's suicide risk assessment instrument. The Center can use its own suicide risk assessment instrument as long as all of the core principles and subcomponents are incorporated.

Core Principles & Subcomponents

Suicidal Desire	Suicidal Capability	Suicidal Intent	Buffers/Connectedness
Suicidal Ideation • Killing Self and/or Others	History of suicide attempts	Attempt in progress	Immediate supports
Psychological Pain	Exposure to someone else's death by suicide		Social supports
Hopelessness	History of/current violence to others	Plan to kill self/other • Method Known	Planning for the future
Helplessness	Available means of killing self/others		Engagement with helper • Telephone worker
Perceived burden on others	Currently Intoxicated	Preparatory behaviors	Ambivalence for living/dying
Feeling trapped	Substance abuse		
Feeling Intolerably alone	Acute symptoms of mental illness, for example: • Recent dramatic mood change • Out of touch with reality	Expressed intent to die	Core value/beliefs
	Extreme agitation/rage, for example: • Increased anxiety • Decreased sleep		Sense of purpose

National Suicide Prevention Lifeline (NSPL)

Recommendations for an Approach to Asking Lifeline Callers about Suicidality

Prompt Questions:

Are you thinking of suicide?

Have you thought about suicide in the last two months?

Have you ever attempted to kill yourself?

The NSPL Certification and Training Subcommittee recommends that crisis center workers ask a minimum of three “prompt questions” (listed above) which address current suicidal desire, recent (past two months) suicidal desire, and past suicide attempts. An affirmative answer to any or all of the above will require that the telephone worker conduct a full suicide risk assessment with the caller consistent with the core principles and subcomponents of the Lifeline’s Suicide Risk Assessment Standards (previous slide).

It is important to elicit **current suicidal desire** given the caller is calling the Lifeline now. What is happening in the caller’s life today that motivated him/her to reach out by calling the Lifeline now?

If the caller denies current suicidal ideation, inquiring about recent suicidal ideation (e.g., past two months) may indicate the caller’s emotional instability. In addition, a caller may feel more ready to acknowledge previous thoughts/behaviors rather than to discuss the more immediate situation. Depending on how the crisis center worker responds, discussing previous suicidal desire and/or attempts can increase rapport and trust, leading to disclosure of current suicidal desire if present.

Inquiring about previous suicidal attempts also allows for the telephone worker to engage the caller in a discussion about what happened during and after the attempt, which has the potential to increase awareness of:

- The caller’s coping skills,
- Reasons for living, and
- Awareness of available resources.

Post Test

Chapter Two: Mental Health Crisis Services Components

1. **Which of the following terms best describes the following: “The ability of the crisis center staff to not only adopt an “active listening” approach but requires that they actively engage the individual at risk in a discussion of their thoughts of suicide.”**
 - a. Active rescue
 - b. Least restrictive intervention
 - c. Referral alternative services
 - d. Active engagement
2. **Which of the following terms best describes the following: “The need for call center staff to initiate rescue with or without the caller’s consent during circumstances in which, despite all efforts at engagement, the call center staff believe that the individual is at imminent risk and unable to participate in securing his/her own safety.”**
 - a. Active rescue
 - b. Least restrictive intervention
 - c. Referral alternative services
 - d. Active engagement
3. **All telephone calls are to be answered “live” by qualified and trained crisis personnel.**
 - a. True
 - b. False
4. **Every individual who calls the National Suicide Prevention Lifeline should be asked about suicidality.**
 - a. True
 - b. False
5. **The manner in which a person calls an agency’s crisis lines sets the tone for the crisis call.**
 - a. True
 - b. False

Chapter Three: Early Intervention and Prevention

Objectives

- Define what is involved in the crisis intervention and screening process
- Understand crisis intervention strategies and how they are applied
- Define and role play active listening skills
- Learn minimal encouragements, paraphrasing, reflecting, emotional labeling, validation, and affirmation
- Gain knowledge regarding crisis plans and follow-up measures

Discussion

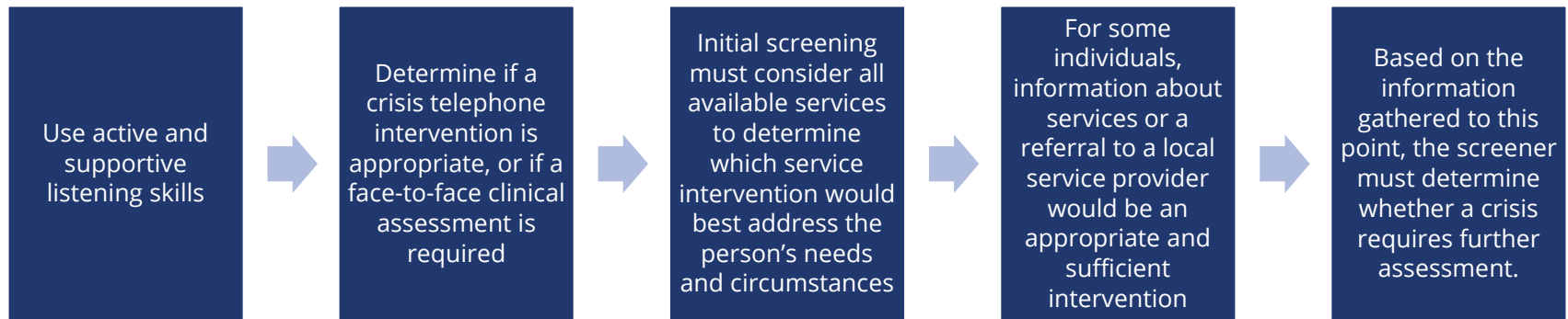
To effectively execute crisis services, certain skills must be acquired or enhanced. This chapter covers many of these skills and explains why they are important to use with an individual in a crisis situation. It will be important to practice these skills so that you can become very familiar with them. Further research on these skills can be conducted as needed.

Intervention Screening

A screening determines the problem and needs of the individual as well as provides guidance for crisis prevention and/or early intervention. Prior to initiating any crisis assessment service, a screening of the potential crisis situation must be conducted. The screening may be formal and occur through a telephone call to a crisis line, an appointment with a case manager, mental health service provider, or telehealth interview, or may be informal through information obtained from a family member or others. Screening information (which may be incomplete or from an untrained person) can help determine if a formal crisis assessment service is warranted.

What is included in a formal crisis intervention screening?

- Gather basic demographic information
- Identify Parties Involved
- Determine whether a crisis situation may exist
- Determine an appropriate level of response



Note: 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?

A crisis assessment evaluates any **immediate** need for emergency services and, as time permits, the person's current life situation, sources of stress and acuity level, mental health problems and symptoms, strengths, cultural considerations, identifiable and realistic support network, drug and alcohol use, current medication use, vulnerabilities, and current functioning.

What are mental health crisis intervention services?

"Mental health 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 person cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the person's baseline level of functioning.* Intervention settings may include the person's home, the home of a friend or family member, a clinic, emergency room, provider office, jail or other community settings. Mental health crisis intervention services must be available 24 hours a day, seven days a week.

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

- Extreme dysphoria**
- Extreme depression
- Suicidal intent
- Homicidal intent
- Acute psychosis²
- Hopelessness
- Helplessness
- Extreme tearfulness
- Extreme detachment or withdrawal/isolation

If the crisis assessment determines that crisis intervention services are needed, the intervention services must be provided as urgent or emergent.

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

****Dysphoria:** *Deep sadness, anxiety, and restlessness*

What is included in a crisis assessment?

Who may conduct a crisis assessment/intervention?

Trained, credentialed and/or approved mental health personnel and professionals who have a licensed psychiatrist or physician experienced in psychiatry available for consultation may conduct crisis assessments. Designated Mandatory Pre-screening Agents, as described further in Chapter Five, may execute an emergency involuntary hospitalization Certificate of Need.

How soon must a crisis intervention plan be developed?

As part of the crisis intervention services, the crisis services provider must develop a crisis intervention plan during the initial face-to-face assessment. The plan must address the needs and problems noted in the crisis assessment and refer to identified services to reduce or eliminate the crisis.

What are mental health crisis stabilization services?

If the crisis service provider determines that the person requires mental health crisis stabilization services, such as 23 hour observation, crisis respite, or crisis stabilization, the crisis services provider must arrange for the provision of these services either directly or through other resources. Mental health stabilization services are individualized mental health services that are provided to a person following a crisis assessment. Crisis stabilization services are designed to assist the person in returning to his or her prior functional level or improved level of functioning, if possible.

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 situation with someone. These stages include the following listed in the chart, (see right) and throughout this chapter.

7 Stages:	
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
7	Follow up measures ³

What is involved in the Crisis Intervention process?

Assessing Lethality and Safety Needs

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? Does the person have means to carry out his or her intentions? These screenings must be done with sensitivity. Some callers are offended if asked questions about suicidal or homicidal intent before they are allowed to 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 (see Chapter Four).

Establishing Rapport and Communication

"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, they 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**. In order to best provide these a responder needs to establish rapport and communication with the person.

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 hopefully accomplish the following with the individual:

- help them make sense of what happened;
- validate their concerns, emotions, and reactions;
- offer perspective from your objective viewpoint;
- provide hope and a sense of direction;
- point out resources they may have forgotten; and
- give them power to make choices, and take action." ⁴

What are active listening skills?

Active listening sounds easy, but it requires skill and practice. Active listening skills are essential for a crisis services provider. Good communication is a solid foundation for any relationship.. Each skill is used concurrently with the others while attempting to remain objective, empathic, and human.⁵ There are a number of components of active listening such as:

- Encouragement
- Paraphrasing
- Reflecting
- Emotional labeling
- Validating
- Reassurance
- Waiting

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.

Paraphrasing

Paraphrasing expresses interest and focuses on the individual and his/her problem. Paraphrasing includes several elements such as repeating the **intent** or **content** of what the person has stated to ensure that the responder understands the meaning of the words the person 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 paraphrased what the mother said in her own words and the mother followed up clarifying what she meant. Simple paraphrasing also opens the door for the person to restate his or her intent in a different way. In order to ensure a shared understanding of the situation, the crisis service provider may want to paraphrase the information to be sure that he or she has understood correctly and has the whole picture.

If further information is needed **clarifying** can be done in a number of ways. By actively seeking clarity, you achieve a shared meaning, avoid misunderstanding, and gain the trust of the person with whom you are speaking.⁶ The crisis service provider can simply say, “I am not clear about what you mean when you say ...” or “Tell me more about that.”

Reflecting

Reflective listening is a special type of listening that involves paying respectful attention to the content and feeling expressed in another person's communication. Reflective listening is hearing and understanding, and then letting the other know that he or she is being heard and understood. It requires responding actively to another while keeping your attention focused completely on the speaker. In reflective listening, you do not offer your perspective by carefully keep the focus on the other's need or problem.

This is quite a bit different than paraphrasing. For instance, if we return to our example of someone telling you that their dog died, the paraphrase was “You lost your pet.” The reflection would be, “You're feeling really alone right now.” A reflection highlights an emotion, and is used frequently to check in to make sure that your empathy statements are on point.

What is validation?

Perhaps the most important support to give to a person in crisis is validation. Validation is conveying that it is okay to feel whatever it is the client is feeling and that he or she is not alone, in that given the same circumstances, others might feel the same way. Affirm their worth and their efforts to cope with the situation. Reassure them that they can get through this crisis, and that they deserve help when things seem intolerable. The most important thing is to convey the idea that the feelings the person is having are normal.⁹

Some examples of validation are listed below:

- “I'd be angry too if that happened to me.”
- “With so many things going on, of course you feel overwhelmed; I think anyone would in your situation.”

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.”¹⁰

What is emotional labeling?

During a crisis situation, feelings are often confusing and hard to define. Helping the person 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 person a chance to clarify and correct the perceptions of the crisis service provider. The following slides cover potential emotional responses that may be exhibited by an individual in crisis.

Emotional Responses

Anxiety is an emotional response that can be expected to manifest in any crisis situation, because there are no answers, and seemingly no resolution. People may become afraid of the unknown or what they fear might happen. This projecting into an unsure future is a normal, natural response to a crisis situation. Anxiety also acts as a motivator to find options, solace, and resolution to problems. Sometimes anxiety can be experienced as free-floating fear or panic.

The following 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

Emotional

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

Behavioral

- 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

Somatic (physical)

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

Cognitive

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

How can you identify a major problem?

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

- 1 What happened to prompt the call?
- 2 What led up to the precipitating event?
- 3 Who is involved in the situation?
- 4 What emotions is the person experiencing?
- 5 Is the person concerned or afraid?

Many of these questions will be answered as the person tells his/her story and rapport is built. ¹¹ The basic information needed is the answer to “Where does it hurt?” and “How can I help?”

How then, can a person who is experiencing specific symptoms or behaviors be assisted? In the next slide, you will learn actions you can take for various behaviors.

Symptom Behaviors:

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

Loss of contact with reality-based personal boundaries

- Support reality-based statements
- Do not encourage out of touch with reality statements
- Be careful with the use of physical touch

Exaggerated response to stimuli

- Reduce exciting stimuli
- Assist the person to find a quiet space
- Use clear, concise questions or statements

Lethargy/Loss of interest

- Help the person set realistic, doable goals

Low self esteem

- Assist person in pointing out his or her own strengths, but if he or she is unable, then the crisis services provider can point out strengths
- Do not discuss past failure or weaknesses unless brought up by the person
- Discuss any weaknesses or past failure the person brings up in a tactful manner
- Help the person problem-solve ways to deal with these perceived weaknesses

Symptom Behaviors:

Difficulty with self-initiated goal directed activity

- Make expectations clear and realistic
- Help the person identify meaningful tasks and break these down into “doable” pieces

Aggressive behavior

- Set limits on behavior
- Be aware of threatening statements and take them seriously

Depression, frustration, loneliness, 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 because the person may perceive this as minimizing the pain
- Help in problem solving and making changes in behavior that will have an impact on the feelings

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
- Hallucinations, delusions, illogical thinking
- Do NOT dispute the person’s reality of experiencing delusions or hallucinations
- Accept that this is what the person truly believes or perceives
- 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

Symptom Behaviors:

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.")

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

Slow response time

- Be patient
- Allow the person time to formulate a response

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

How does a crisis services provider help the person go about exploring possible alternative solutions?

Several questions are pertinent to exploring alternatives. 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. ¹²

1. What does the person believe is the most important issue that he/she is dealing with?	2. What is the person hoping for?	3. What does the person think he/she needs?
4. What has he/she already tried?	5. What has worked in the past?	6. What personal and community resources does this person have to draw on?

What is involved in a crisis plan?

If someone has an active mental health provider, it is possible they may have an existing crisis plan, also referred to as a safety plan or a crisis management plan, they have developed with their mental health provider. If this is the case, it is necessary to try to access the person's current crisis plan.

The plan that is developed should be short-term, clear, doable and developed as much as possible by the person experiencing the crisis situation. Specific activities that will give the person the feeling of empowerment or hope over his/her life should be included. Safety planning is covered in further detail in Chapter Four.

What are follow-up measures?

The follow-up service is a very important part of the crisis intervention services. Follow-up services can be telephone call(s) or face-to-face assessment(s) between crisis staff and the individual, following crisis intervention, respite, or stabilization to ensure the safety of the individual until treatment is scheduled or treatment begins and/or the crisis is alleviated and/or stabilized. Follow-up services can include crisis services staff contacting the individual only one time or can include several contacts a day for several days, as deemed appropriate by crisis staff. Contractual time frames and/or standards for follow-up must be followed.

The Do's and Don'ts of De-Escalating Crisis Situations¹³

- 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 or significant others available as appropriate in defusing a crisis.
- DO give an agitated client time and space to calm down.
- DO encourage medication compliance when appropriate and based on a consultation with a physician, nurse practitioner, or physician assistant.
- DO negotiate temporary solutions where appropriate
- DO be respectful toward the client.
- DO leave a physical escape route for both yourself and the client.

The Do's and Don'ts of De-Escalating Crisis Situations¹³

- 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 a client under the influence of substances.

Post Test

Chapter Three: Early Intervention and Prevention

1. **If a person believes that he or she is experiencing a crisis, it is best to honor that belief.**
 - a. True
 - b. False
2. **Prior to initiating any crisis service, it is assumed that some sort of screening of the potential crisis situation will be conducted.**
 - a. True
 - b. False
3. **The screener must determine if counseling over the telephone is appropriate, or the person requires an on-site face-to face assessment.**
 - a. True
 - b. False
4. **Designated Mandatory Pre-Screening Agents may execute an emergency involuntary hospitalization Certificate of Need.**
 - a. True
 - b. False
5. **Which of the following is not an active listening skill?**
 - a. Paraphrasing
 - b. Emotional labeling
 - c. Reflecting
 - d. Questioning
6. **A crisis responder should attempt to argue with a person that his or her delusional beliefs are inaccurate.**
 - a. True
 - b. False

Post Test

Chapter Three: Early Intervention and Prevention

- 7. Minimal encouragements include which of the following?**
 - a. Activities such as saying “yes” or “go on”
 - b. Asking “what happened next?”
 - c. Non-verbal encouragement such as making eye contact or nodding
 - d. All of the above
- 8. What component(s) is/are included in a follow up service after a face to face contact?**
 - a. A telephone call the next day
 - b. A face to face contact the next day
 - c. A substance abuse screen only
 - d. Both a and b
- 9. Validation is conveying that it is alright for the person to feel how they feel.**
 - a. True
 - b. False
- 10. When conducting a crisis intervention, it is important to be authoritarian and demanding.**
 - a. True
 - b. False

Chapter Four: Harm Assessment and Suicide Prevention

Objectives

- Learn the aspects of suicide prevention including defining risk factors
- Learn the dangers of depression in conjunction with drugs and alcohol
- Discuss some basic guidelines for interacting with a person who is potentially violent
- Discuss the debriefing process following a completed suicide

Discussion

This chapter covers some very important information including defining risk factors and guidelines for interacting with a person who could potentially be violent. Other material in this chapter includes the dangers of depression in conjunction with drugs and alcohol; however, this subject is also discussed in chapter eight of this training. The debriefing process following a completed suicide is discussed with some practical suggestions. Chapter eleven could also be beneficial in this situation because it covers self care for a crisis services provider.

Facts about suicide

National numbers averaged over past 10 years

- 44,000 + people die by suicide yearly
- 123 people die by suicide every day
- Over 1.3 million people attempt suicide each year
- Suicide is the 10th leading cause of death for all age groups
- Suicide is the 2nd leading cause of death for ages 10-24
- Someone dies by suicide every 13 minutes
- 1,110 people died by suicide in 2016 in Tennessee
- Approximately 327,467 people had thoughts of suicide in Tennessee in 2014 (5% of the population)
- Men die by suicide 3.53x more often than females
- Average number of attempts, across the lifespan is 25 per one death by suicide
- Youth: 100-200 attempts per one death by suicide
- Older people: 4 attempts per one death by suicide
- 10 million adults think about suicide each year
- 1.2 million plan a method
- Recent research (Cerel, 2015) suggests that for each death by suicide 115 people are exposed
 - Among those 25 experience a major life disruption (loss survivors)
- Over 1 million loss survivors each year
- Suicide risk is greater in survivors (e.g., 4-fold increase in children when a parent dies by suicide)
- Risk is highest in middle aged adults

Attitudes and opinions about suicide

- Be aware of your beliefs
- Acknowledge your values, attitudes and opinions
- Respect differences
- Be non-judgmental

Our approach: Reaction vs. Response

We all have beliefs, attitudes & past stories

- Beliefs of what is right and wrong
- Attitudes towards situations and groups
- Ideas of why people do what they do
- Past stories that provide insight
- Past stories marked by pain, sadness and anger

Our beliefs, attitudes and past stories at some point will get activated/ triggered/ pulled (however you want to say it) by crisis situations.

- Clients doing things we hold to be deeply wrong.
- Clients belonging to a group with whom we have had negative encounters.
- Clients who remind us of people who have hurt us.

And so we'll have reactions.

Our approach: Reaction vs. Response

The danger:

Acting on unexamined reactions can lead to the Crisis Responder being:

Under-responsive to the crisis situation

- Minimization of the situation
- Withdrawal
- Apathy
- "They're just doing this for attention."



Over-responsive to the crisis situation

- Taking an adversarial approach
- Taking a controlling approach
- Acting out of anger or fear

Which can lead to:

- Missing suicidal ideation
- Triggering suicidal behavior
- Client disengagement

It's not if we should or should not have these reactions, it's about how we **respond** to these reactions.

The Goal:

Our words, non-verbals and decision making be intentional responses to the clients needs and not unexamined reactions to the client/situation.

How we reach the goal

Personal awareness

- Being able to observe your own reactions
- Self-reflection: Learning what can trigger emotional reactions in you

Honest dialogue

- With peers about our reactions
- Professional consultation and support
- Ongoing education

Know yourself, so that your Crisis Response is about the client and what he or she needs, and not about you.

Appraising Underlying Risk Factors

Demographics: male, widowed, divorced, single, white

Psychosocial: lack of social support, unemployed, drop in socio economic status, firearm access, family history, history of abuse/trauma, recent discharge from psychiatric unit, feeling like a burden, contagion

Psychiatric: psychiatric DX, comorbidity especially with A&D

Physical Illness: chronic pain, debilitating illness

Psychological: hopelessness, psychic pain/anxiety, psychological turmoil, decreased self-esteem, fragile narcissism, perfectionism

Behavioral: Impulsive, aggression, severe anxiety/panic attacks, agitation, intoxication, prior suicide attempt

Cognitive: thought constriction, irrational thinking, all/nothing thinking

Childhood trauma: sexual, physical abuse, neglect, loss of parent, lack of stability

Risk factor considerations

Individual/ Personal Level

- Previous suicidal behavior
- Gender (male)
- Mental Illness
- Chronic pain or illness
- Immobility
- Alcohol or other substance abuse
- Low self-esteem
- Low sense of control over life circumstances
- Lack of meaning and purpose in life
- Poor coping skills
- Hopelessness
- Guilt and shame
- Feeling like a burden

Social Level

- Abuse and violence
- Social isolation
- Family dispute, conflict and dysfunction
- Separation
- Bereavement
- Significant Loss
- Peer rejection
- Imprisonment
- Poor communication skills
- Family history of suicide or mental illness

Contextual/Life Environment

- Access to Lethal Means
- Unemployment, economic insecurity
- Financial stress
- Neighborhood violence and crime
- Poverty
- School failure
- Social or cultural discrimination
- Homelessness
- Exposure to environmental stressors
- Lack of social support services
- Geographical isolation

Suicide Risk in Specific Disorders

Condition	% Lifetime Risk
Prior Suicide Attempts	27.5%
Bipolar Disorder	15.5%
Major Depression	14.6%
Mixed Drug Abuse	14.7%
Dysthymia	8.6%
Obsessive-Compulsive	8.2%
Panic Disorder	7.2%
Schizophrenia	6.0%
Personality Disorder	5.1%
Alcohol Abuse	4.2%
General Population	0.72%

Warning Indicators

Behavioral		Physical
Talking about suicide	Sense of hopelessness	Withdrawal from friends, family or society
Making a suicide plan	Feeling trapped (like there is no way out)	Ceasing activities that used to be important
Self harming behavior	Withdrawing from friends and family	Giving away valued possessions
Prior suicide attempt/s	Ceasing activities that used to be important	Increased alcohol and/or drug use
Finalizing affairs, e.g. <i>making a will</i>	Giving away valued possessions	Uncharacteristic or impaired judgment or behavior, e.g. risk taking
Unexplained crying	Increased alcohol and/or drug use	
Uncharacteristic or impaired judgment or behavior, e.g. <i>risk taking</i>		

Protective Factors

Individual/Personal Level		Social Level	Life Environment
Gender	Positive sense of self	Physical and emotional security	Safe and secure living environment
Good mental health and wellbeing	Sense of control over life's circumstances	Family harmony	
Good physical health	Sense of meaning and purpose in life	Supportive and caring family	Financial security
Absence of alcohol and other drug use	Good coping skills	Supportive social relationships	Employment
Positive outlook and attitude of life		Sense of self-determination	
		Good communication skills	Safe and affordable housing
		No family history of suicide or mental illness	

Terminology

Terms that promote stigma

- Committed suicide
- Failed attempt
- Para suicide
- Suicide victim
- Suicide gesture
- Manipulative act
- Suicide threat
- Successful suicide

Preferred Terminology

- Died by suicide
- Suicidal
- Self-directed violence
- Interrupted suicide attempt
- Aborted suicide attempt
- Suicide attempt
- Non-suicidal self-directed violence

Principles that Guide the Assessment Process

Clinical Determination

- Techniques to solicit level of suicidal thinking
- Determining self harm
- Suicidal intent
- Risk formulation
- Disposition
- Safety planning
- Follow-up

Special Considerations

- Military and Veterans
- LGBT
- Bullying
- Schizophrenia
- Personality Disorders
- Intellectual Disability
- TBI
- SUD

Lifespan Considerations

- Youth
- Older adults

At-Risk Populations

These populations are at higher risk than average for suicide:

- Working aged adults are the highest risk age group
- Suicide is the second leading cause of death for men aged 25-44
- American Indian and Alaska Native individuals have the highest rate of suicide
- Survivors of suicide are four time more likely to die by suicide than the general population
- Males complete suicide at a rate four times that of females, but females attempt more often
- African American children under the age of 12 are more likely to die by suicide than white children
- Suicide is the second leading cause of death for ages 10-24
- Other at-risk populations include those who:
 - Are in jail or prison
 - Suffer from chronic pain or illness
 - Have a family history of substance abuse, mental illness, suicide, or violence
 - Are in the LGBTQ+ community
 - Are members of the military or veterans

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", "case review" or "psychological first aid" are terms used by mental health professionals to describe interventions that should be available when a crisis service provider experiences a completed suicide or traumatic event that involves a service recipient. The goal of these interventions is to allow a crisis service provider to express their personal reactions to the event and to identify steps that might relieve stress symptoms related to their exposure to the event. In some cases, emergency mental health interventions may include staff members outside of the crisis service provider. Any of these interventions should be conducted by, or in consultation with, a trained mental health professional in the area of emergency mental health services.

How to work with a person 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.

The following 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
- Triage staff should ask about presence of weapons before dispatching crisis service provider, when applicable
- 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

How does a crisis service provider work with a person who may become violent?

- 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 with which the person may be willing to cooperate. If a potentially dangerous person refuses to give up the weapon, the crisis services provider 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 crisis service provider must have an avenue of escape if the person 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 person's emergency contacts as necessary.

What factors should be considered when assessing a person 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:

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

How can a crisis services provider 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 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. TAKE EVERY THREAT SERIOUSLY, CONSULT OTHERS AS NEEDED. DO NOT STAY IN A DANGEROUS SITUATION.
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 are some of the legal implications of working with suicidal people?

If a person completes suicide after a crisis services provider intervenes, it is possible that the family or friends of the individual may hold the crisis services provider 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 (Did the institution provide a safe environment?), and
3. Suicide following discharge or escape.

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.

Risk management guidelines:

- Documentation- always document, if it is not documented, it did not happen per most outside entities' opinion
- 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
- Preventive preparation

Do's and Don'ts in Suicide Prevention

DO'S	DON'TS
<ul style="list-style-type: none">• Remove opportunities• Receive and accept suicidal communication• Do intrude• Prevent isolation and involve significant others• Transfer rather than refer• Follow-up• Always obtain consultation when unsure• Do know your own value system about suicide• Get precipitant (identify issues, concerns, and/or events that led up to the current crisis)• Use self as instrument of prevention	<ul style="list-style-type: none">• Do not worry about saying the wrong thing• Do not consider suicidal persons as special• Do not assume ability to solve problem(s)• Do not try to talk the person out of committing suicide• Do not engage in abstract discussion about suicide, death, dying• Do not be too accepting of suicide• Do not de-legitimize• Do not give cheap general reassurance• Do not lose confidence (may need more limited goals)

Establish Rapport

- Unconditional positive regard
- Genuine
- Empathy
- Establish trust
- Engage in active listening
- Reflect feelings or thoughts
- Open-ended questions
- Attending behaviors

Safety Plan

- Safety planning is part of the clinical process of assessment
- Engage the client in the process
- The safety plan developed in a crisis situation is time limited
- Safety planning is a 6 step process

Safety Plan

1. Warning signs, ask, "How will you know when this safety plan should be used?" and "what do you experience when you start to think about suicide?"
2. Coping strategies, ask, "What can you do if you become suicidal again?" Use collaboration, and problem solving to help them self define coping strategies.
3. Social Contacts, Who May Distract From the Crisis, work with the client to help him/her understand that if step 2 doesn't work then try step 3, ask, "Who or what social setting help you take your mind off your problems? "Who helps you feel better when you are with them?", Help them identify potential safe places they can go to be around people,(peer support center, coffee shop)Ask the client to identify one or more additional safe places of people incase option one isn't available. The goal of this step is to distract the client from suicidal thoughts.
4. Identify Family or Friends Who Would offer help, ask, "who among your family or friends do you think you could contact for help during a crisis, who do you feel you can talk to when under stress?" Ask for several people and their contact information, ask "May I call them now with you to be sure they feel they can do this?"
5. Professionals and Agencies, ask, " who are the mental health professionals that we should identify to be on your safety plan?" List names contact information, in include crisis response and other supports such as the suicide lifeline.
6. Making the Environment Safe, Ask about lethal means availability, assure there is a plan to restrict access, include family and significant others to assure removal of means. Check with your local LE contact to see if gun locks are provided. If at all possible, conduct a safety sweep of their residence or provide information to family about what to look for and what to do.

Formulating Risk

Intent	Plan & Lethality
<p>Are suicidal thoughts/feelings present?</p> <ul style="list-style-type: none">• What are they?• Are they active/passive?• When did they begin?• How frequent are they?• How persistent are they?• Are they obsessive?• Can the client control them?• What motivates the client to die or to continue living?	<p>How far has the suicidal planning process proceeded?</p> <ul style="list-style-type: none">• Specific method, place, time?• Available means• Planned sequence of events• Intended goal (death, Self-injury, other outcome)• Feasibility of the plan, access to means• Lethality of planned actions• Likelihood of rescue• What preparations have been made• Has the client rehearsed (i.e. rigging a noose, putting gun to the head)• HX of suicidal behavior

Formulating Risk

Immediate Predictions	Low Risk	Moderate Risk	High Risk
Method	Undecided	Decided	Decided
Means	Not present	Easy access	In possession
Time & Place	Not chosen	Tentative	Definitely chosen
Lethality	Low	Moderate	High
Preparation	None made	Some planning	Steps taken
Prior attempts	No	Yes	Yes
Life Events or Conditions			
Trauma	None or mild	One or moderate stress	Several or severe trauma

Disposition

- Weigh the risk and benefits of treatment recommendations
- Not every suicidal individual requires hospitalization
- Utilize the C-SSRS to help guide the decision
- Risk categories, low, medium, high determine the need for hospitalization, use your agencies guidelines to determine hospitalization
- SAFETY Plan and follow-up appointments for the non-hospitalized client
- Not every client that needs hospitalization requires involuntary commitment

Post Test

Chapter Four: Harm Assessment and Suicide Prevention

- 1. Males die by suicide at a rate four times that of females, but females attempt more often.**
 - a. True
 - b. False
- 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. Social Isolation
 - d. Significant loss
 - e. Access to lethal means
- 3. Potential for violence is easily predictable.**
 - a. True
 - b. False
- 4. What component (s) is/are important for suicide prevention?**
 - a. True
 - b. False
- 5. What component (s) is/are important when working with a potentially violent person?**
 - a. Show concern for the person
 - b. Be respectful
 - c. Don't offer any choices
 - d. Both a and b
- 6. You should always stay in a dangerous situation if you think you can be of some help.**
 - a. True
 - b. False

Post Test

Chapter Four: Harm Assessment and Suicide Prevention

7. Which is the best indicator of potential violent behavior?

- a. Person presents with depression
- b. Person presents with psychosis
- c. There is a previous diagnosis of borderline personality disorder
- d. Previous episodes of violent or assaultive behavior

8. Which of the following is a step of safety planning?

- a. Warning signs and Coping Strategies
- b. Social Contacts
- c. Identify Family or Friends Who Would offer help
- d. Professionals and Agencies
- e. Making the Environment Safe
- f. All of the Above

Chapter Five: Tennessee Mental Health Law

Objectives

- Gain knowledge of state mental health law as it pertains to crisis situations
- Gain understanding of how one is admitted to a psychiatric facility

Discussion

On June 23, 2000, the Tennessee Department of Mental Health and Mental Retardation became the Tennessee Department of Mental Health and Developmental Disabilities. July 1, 2012 the name of the department was changed to the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). Title 33 of the Tennessee Code Annotated (T.C.A.) is the mental health and developmental disability law. Comprehensive revisions to Tennessee Code Annotated, Title 33, relative to services and supports for people with mental illness, serious emotional disturbance, and developmental disabilities in Chapter 947 of the Public Acts of 2000 were effective March 1, 2001. The expansion of eligibility to include developmental disabilities became effective March 1, 2002.

The current version of Title 33 is through the State of Tennessee website:

<http://www.lexisnexis.com/hottopics/tncode/> and follow links to Tennessee Code and Constitution to Title 33.

What are the most frequent types of admissions to a psychiatric facility?

The three types of most frequent admissions to an inpatient psychiatric facility under Title 33 are:

- Voluntary
- Emergency involuntary
- Non-emergency involuntary

Even though Regional Mental Health Institutes (RMHIs or state hospitals) admit people in all three categories, private psychiatric hospitals may not. Check with the individual private hospital to determine which categories they serve. Below are brief overviews of the each admission process. Since emergency involuntary admission is the most frequent involuntary admission to a hospital or treatment resource, the process is described in more detail.

Voluntary Admission

T.C.A. § 33-6-201

The following persons may apply for voluntary admission to an inpatient psychiatric hospital, public or private:

- A person who is sixteen (16) years of age or older
- A parent, legal custodian or legal guardian who is acting on the behalf of the child (under the age of sixteen)
- A conservator whom the appointing court has expressly granted authority to apply for the person's admission to a hospital or treatment resource for mental illness or serious emotional disturbance
- A qualified mental health professional acting on the basis of terms of the person's declaration of mental health treatment
- A person's attorney in fact under a durable power of attorney for health care

Voluntary admissions to the Regional Mental Health Institutes are subject to the availability of suitable accommodations (i.e. bed availability) and historically have been infrequent. Voluntary admissions do not require certificates of need.

Emergency Involuntary Admission

T.C.A. § 33-6-401

The following professionals may refer an individual for emergency involuntary admission:

- Licensed physician
- Licensed psychologist with a health service provider designation
- Mandatory pre-screening agent

Emergency involuntary admissions require two certificates of need. The process for emergency involuntary admissions is explained in the next section. Emergency involuntary admissions to the Regional Mental Health Institutes are not subject to suitable available accommodations.

Non-Emergency Involuntary

T.C.A. § 33-6-502

The following professionals may evaluate an individual to determine whether he/she meets criteria for a non-emergency involuntary admission:

- Licensed physician
- Licensed psychologist with a health service provider designation

Non-emergency involuntary admission requires two (2) certificates of need. The two (2) certificates of need for non-emergency involuntary hospitalization under Chapter 6, Part 5 of Title 33 are brought before a judge and at least one of the professionals must testify and then the judge may commit the person for involuntary care and treatment. Non-emergency involuntary admissions to the Regional Mental Health Institutes are subject to the availability of suitable accommodations (i.e. bed availability).

What is the emergency involuntary admission process?

The emergency involuntary admission process in Tennessee requires two evaluations – one in the community, which may result in the first certificate of need, and one at the admitting hospital or treatment resource, which also may result in the second certificate of need. The process and the people involved in the process are described below.

Who may detain?

Crisis service providers 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 or herself or others, the best plan is to give the person the amount of services and intervention that he or she is comfortable with, assisting with connection to other services to the extent that he or she is willing. This is not possible, however, when a person is likely to hurt himself or herself or another person.

In situations like this:

- an officer authorized to make arrests in Tennessee,
- a licensed physician,
- a psychologist with a health service provider designation, or
- a mandatory pre-screening agent

may take the person into custody without a civil order or warrant for immediate examination for certification of need for care and treatment (*T.C.A. § 33-6-402*).

When may these people detain?

T.C.A. § 33-6-410 outlines the circumstance in which detaining an individual may occur:

- A person has a mental illness or serious emotional disturbance, AND
- The person poses an immediate substantial likelihood of serious harm under § 33-6-501 because of the mental illness or serious emotional disturbance.

What are mandatory pre-screening agents?

A Mandatory Pre-screening Agent (MPA) is a qualified mental health professional who has successfully completed a 6-hour MPA training course and has been designated by the Commissioner of the Dept. of Mental Health and Substance Abuse Services. MPAs are certified to write the first “Certificate of Need” after conducting the first assessment for involuntary psychiatric hospitalization.

To be considered for eligibility for designation as an MPA you must be licensed to practice in Tennessee and be a Qualified Mental Health Professional (QMHP). MPA designation is limited to Qualified Mental Health Professionals (QMHP) who are employed to provide crisis services by a state provider.

Qualified mental health professionals:

- Psychiatrist
- Physician with expertise in psychiatry
- Psychologist with health service provider designation
- Licensed psychological examiner
- Licensed senior psychological examiner
- Licensed master’s social worker with two years of mental health experience
- Licensed clinical social worker
- Licensed or certified marital and family therapist
- Licensed professional counselor
- Licensed nurse with a master’s degree in nursing who functions as a psychiatric nurse
- Licensed Physician's Assistant with a master's degree and expertise in psychiatry as determined by training, education or experience

How does a QMHP receive designation as a mandatory pre-screening agent?

To be considered for eligibility for designation as an MPA you must be licensed to practice in Tennessee and be a Qualified Mental Health Professional (QMHP). MPA designation is limited to Qualified Mental Health Professionals (QMHP) who is employed to provide crisis services by a state provider. Before initial designation, professionals are required to attend a 6 hour, in person training and then receive designation by the Commissioner of the Department of Mental Health and Substance Abuse Services. Training is designed to ensure MPAs carefully consider all less drastic alternatives to hospitalization appropriate to meet the needs of the individual.

What is a Certificate of Need for emergency involuntary admission?

To refer an individual for emergency involuntary admission to any psychiatric inpatient hospital or unit for any person, a qualified professional in the community must evaluate the person and complete a certificate of need (CON) in accordance with Title 33, Chapter 6, Part 4 This professional must personally evaluate the individual and must be aware of the rights given to all people under Title 33.

Who may complete a Certificate of Need for emergency involuntary admission?

These are three professionals authorized to complete certificates of need:

- Licensed physicians
- Licensed psychologists with a health service provider designation
- Mandatory Pre-screening Agents

What are the criteria for emergency involuntary admission?

- A person has a mental illness or serious emotional disturbance, and
- The person poses an immediate substantial likelihood of serious harm because of the mental illness or serious emotional disturbance, and
- The person needs care training and treatment because of the mental illness or serious emotional disturbance, and
- All available less drastic alternative to placement in a hospital or treatment resource are unsuitable to meet the needs of the person (*T.C.A. § 33-6-403*)

What is the process to obtain a Certificate of Need for emergency involuntary admission?

Screening by a MPA is required for anyone being referred for hospitalization at a state owned or operated hospital or treatment resource and any publicly funded person being admitted or committed to a private hospital. If a MPA is not available within two (2) hours of the request, then a licensed physician or psychologist with health service provider designation, in consultation with a member of the crisis response service, may provide one of the certificates of need for involuntary hospitalization.

To determine whether the person meets criteria for emergency involuntary admission, the physician or psychologist must consult with his/her local crisis services providers regarding available less restrictive alternatives to hospitalization. The physician or psychologist does not have to accept the recommendation of the crisis services provider for less restrictive alternatives, and may either complete the CON or refer the person to the crisis services provider for follow-up and assistance.

A face-to-face evaluation (including tele-video) of the person by the professional completing the CON is required.

If the person is to be referred to a private facility for admission evaluation, then a licensed physician or psychologist with a health service provider designation may complete the first CON without contacting a mandatory pre-screening agent or the local crisis services provider (unless the private facility has a contractual obligation to use MPA). However, for any evaluation of a certificate of need, all the possible least restrictive alternatives for inpatient hospitalization must first be considered. (Many private hospitals accept the authority of a mandatory pre-screening agent. Please contact the hospital for this information prior to arranging for further evaluation.)

How is someone transported to a hospital for evaluation for an emergency involuntary admission?

Transportation of a person to a hospital or treatment resource for an emergency involuntary admission shall not begin until the mandatory pre-screening agent or licensed physician or psychologist completes the first certificate of need.

All professionals completing the first certificate of need for emergency involuntary admission must be aware of the county appointed transportation agent. Title 33 states that the sheriff is responsible unless county has secondary transportation agent.

If the physician, psychologist or mandatory pre-screening agent who is completing the first CON determines that the person does not require physical restraint or vehicle security, then they may approve one of the following persons to transport at the transporter's expense:

- One or more friends
- Neighbors
- Other mental health professionals familiar with the person
- Relatives of the person
- Member of clergy

What is mandatory outpatient treatment?

The purpose of mandatory outpatient treatment (MOT) is to provide a less restrictive alternative to inpatient care for persons with a mental illness who require continued treatment to prevent deterioration in their mental condition and who will respond to a legal obligation to participate in outpatient treatment.

Mandatory outpatient treatment is not a substitute for hospitalization and always follows involuntary hospitalization.

How does MOT relate to crisis?

Though a small percentage of people with mental illness in Tennessee are under an MOT court order, those who are have certain responsibilities. These responsibilities may include taking medications and attending therapy appointments. If a person in crisis is under a MOT court order, contacting the community mental health center that manages his or her MOT would aid the continuum of care. Also, mandatory pre-screening agents must provide information about a person's MOT status to the receiving hospital, if a CON has been completed. **Individuals must return to the hospital that implemented the MOT if possible.**

How can a crisis provider find out about a MOT status on a particular person?

Each community mental health center has a MOT coordinator and should have information about the person's MOT status.

The state laws governing the use of mandatory outpatient treatment can be found in Title 33, Chapter 6, Part 6 ("Civil MOT") and Title 33, Chapter 7, Part 3 ("303(b) MOT"), Tennessee Code Annotated.

What information is confidential?

T.C.A. § 33-3-103 states that except in compliance with the statute:

"all applications, certificates, records, reports, legal documents, pleadings made and all information provide or received in connection with services applied for, provided under, or regulated under this title and directly or indirectly identifying a person or former service person shall be kept confidential and shall not be disclosed by any person."

When can information be disclosed without consent?

Information that is confidential under Title 33 may be disclosed (*T.C.A. § 33-3-105*) without consent of the person if:

- Disclosure is necessary to carry out duties under this title (Title 33)
- Disclosure may be necessary to assure service or care to the person by the least drastic means that are suitable to the person's liberty and interests
- As a court orders, after a hearing, upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to public interest or to the detriment of a party to the proceedings
- It is solely information as to a residential person's overall medical condition without clinical details and is sought by the person's family members, relatives, conservator, legal guardian, legal custodian, guardian ad litem, foster parents, or friends
- A person moves from one service provider to another and exchange of information is necessary for continuity of service
- A custodial agent for another state agency that has legal custody of the person cannot perform the agent's duties properly without the information

The above section of the law allows physicians, psychologists, mandatory pre-screening agents and crisis workers to refer people in a mental health crisis to an inpatient treatment resource or a less restrictive alternative without obtaining consent from the person.

Who may give consent to release information?

Information about a person that is confidential under Title 33 may be disclosed with the consent of (*T.C.A. § 33-3-104*):

- The person who is sixteen (16) years of age or over
- The conservator of the person
- The attorney in fact under a power of attorney who has the right to make disclosures under the power
- The parent, legal guardian, or legal custodian of a person who is a child
- The person's guardian ad litem for the purposes of the litigation in which the guardian ad litem serves
- The treatment review committee for a person who has been involuntarily committed
- The executor, administration or personal representative on behalf of a deceased person
- The caregiver under title 34, chapter 6, part 3

What is “Duty to Warn”?

The "Duty to Warn" law is found at *T.C.A. § 33-3-206*. The law requires qualified mental health professionals to warn an intended victim if the professional knows that a person has made a specific serious threat of physical violence against a clearly identified person and the person has the apparent ability to commit such act. If the target of the threat cannot be located, the professional may inform the local law enforcement agency.

How may one “discharge” their duty to warn?

Obligations may be discharged by a QMHP by:

- Informing the identified victim of the threat OR
- Admitting the service recipient to a hospital on a voluntary basis OR
- Taking steps to seek involuntary commitment to a hospital OR
- Following your current professional standards to discharge the duty

How can I report abuse, neglect or mistreatment?

To report child abuse in Tennessee: (877) 237-0004

To report elder abuse in Tennessee: (888) 277-8366

Title 33 references three (3) other Tennessee state laws at *T.C.A. § 33-3-108*.

- The Child Abuse Reporting Law, Title 37, Chapter 1, Part 4
- The Child Sexual Abuse Reporting Law, Title 37, Chapter 1, Part 6
- The Adult Protective Services Law, Title 71, Chapter 6

Post Test

Chapter Five: Tennessee Mental Health Law

1. **The State of Tennessee mental health law is found in statute at:**
 - a. 6-103 code
 - b. Title 33
 - c. Constitution of Tennessee
 - d. Policy for Mental Health Emergencies

2. **How much of a person's medical record is considered confidential under state law?**
 - a. Only the sections that specifically mention the diagnosis
 - b. All of it
 - c. Only the last five years of treatment received
 - d. Only that produced after HIPAA came into effect

3. **Which of these professionals may detain under Title 33?**
 - a. Clergy
 - b. Mandatory pre-screening agent
 - c. Licensed psychologist with a health services provider designation
 - d. Licensed physician
 - e. An officer authorized to make arrests in Tennessee
 - f. All except a

4. **How many Certificates of Need are required for emergency involuntary admission?**
 - a. One, if the person is really psychotic and unable to answer questions
 - b. Two
 - c. Three, if the patient objects to the admission
 - d. None

Post Test

Chapter Five: Tennessee Mental Health Law

5. **What are the requirements to be designated as a mandatory pre-screening agent?**
 - a. TDMHSAS training on Community Based Screening
 - b. Five years experience as a crisis team member
 - c. The professional must be a qualified mental health professional
 - d. Reference letter from another mandatory pre-screening agent
 - e. All the above
 - f. Both a and c
6. **If a mandatory pre-screening agent is not available within two hours, who may complete the evaluation for a Certificate of Need?**
 - a. A crisis worker who is not a mandatory pre-screening agent
 - b. Licensed physician who consulted with a crisis team member
 - c. A qualified mental health professionals who is not a mandatory pre-screening agent
 - d. A licensed psychologist with a health services provider designation who consulted with a crisis team member
 - e. Both b and d
 - f. Both a and c
7. **A person may be transported to a treatment resource before the Certificate of Need is completed if the transportation agent arrives and is ready to go.**
 - a. True
 - b. False
8. **Mandatory outpatient treatment is not a substitute for hospitalization and always follows involuntary hospitalization.**
 - a. True
 - b. False

Post Test

Chapter Five: Tennessee Mental Health Law

9. **Title 33 allows for disclosure of health records without consent of the person when the disclosure is necessary to assure service or care to the service recipient by the least drastic means.**
 - a. True
 - b. False
10. **Duty to Warn law requires qualified mental health professionals to warn an intended victim if the professional knows that a person has made a specific serious threat of physical violence against a clearly identified person and the person has the apparent ability to commit such act.**
 - a. True
 - b. False

Chapter Six: Less Restrictive Referral Alternatives

Objectives

- Identify available less restrictive alternatives available in Tennessee
- Gain understanding of how to access the services in a particular area

Discussion

When a person does not meet the criteria for inpatient psychiatric hospitalization, there are options for less restrictive care in Tennessee. While these resources vary throughout the state, it is mandated by Title 33 that all available less restrictive alternatives to hospitalization or treatment resource must be unsuitable to the person needing care, training or treatment before the Certificate of Need for emergency involuntary hospitalization is completed.

What options for less restrictive alternatives to inpatient hospitalization are available in Tennessee?

Home/ natural support system

The term “natural supports” refers to the resources inherent in community environments that can be used for rehabilitative and supportive purposes.

Support services (peer, dual anonymous, alcoholics anonymous, etc.)

Support groups that are usually provided free of charge and with leadership from within the group.

Psychiatric rehabilitation services

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independent as possible on the individual’s recovery journey.

Regular outpatient individual or group therapy (psychiatric and/or alcohol & drug)

Services are usually provided for a fee and people attend sessions on a weekly, bi-weekly or monthly basis. Sessions are structured by a professional group leader who is usually a licensed mental health professional.

Regular and intensive case management services

These are services where mental health professionals check-in with people needing guidance in taking medications, attending appointments, help with a few activities of daily living such as shopping and obtaining medications. The case managers may check-in with the people through telephone calls and/or home visits.

Regular and emergency medication evaluation/assessment

The person is evaluated by a psychiatrist, physician, nurse practitioner or physician's assistant for need of behavioral health medications and prescribes the medications as needed.

Outpatient Therapy (psychiatric and/or alcohol & drug)

A customized therapeutic program provided on an outpatient basis.

Day treatment

From TDMHSAS Rule, Chapter 0904-5-15: Adult day treatment service is a non-residential program that provides a treatment and/or rehabilitation of at least three (3) hours duration per program day for adult persons. The program may be structured and offer community living skills training, vocational training, assistance with interpersonal relationships and be geared toward moving the person on to a more independent and normal lifestyle. The program may also be unstructured and provide socialization and maintenance to persons who might not move on to more independence. TDMHSAS also requires this program to be licensed through TDMHSAS.

Medical and social detox

Medical Detoxification occurs in a hospital inpatient or residential facility that offers comprehensive substance abuse treatment, detoxification, and care.

Crisis Respite Services

This is a voluntary service where the person stays at a specified location with a mental health agency staff person for no more than 2 days. The purpose is to separate the person from the stressor or environment that contributed to the crisis. Minimal behavioral health interventions are provided.

Crisis Walk-In 23 Hour Observation

This offers walk-in services for crisis resolution and treatment monitoring for up to 23 hours for individuals who may otherwise go to the hospital. It is staffed by mental health professionals, psychiatric medication prescribers, and nurses and provides a safe, supportive environment for the individual as he or she resolves the immediate crisis.

Crisis Stabilization Unit

From TDMHSAS Rule, Chapter 0904-5-18: A Crisis Stabilization Unit is a non-hospital facility-based service that offers twenty-four (24) hour intensive mental health treatment. The focus is on short-term stabilization (up to 72 hours) for those persons whose psychiatric condition does not meet the criteria for involuntary commitment to a psychiatric hospital or other treatment resource. If necessary, in order to assure that adequate arrangements are in place to allow for the safe discharge of the person, the length of stay may be extended by up to 24 hours. TDMHSAS also requires these facilities to be licensed through TDMHSAS.

Partial Hospitalization

From TDMHSAS Rule, Chapter 0940-4-33: Partial hospitalization is a non residential medical directed treatment program that offers intensive, coordinated, and structured services for adults and/or children within a stable therapeutic milieu. Partial hospitalization embraces day, evening, night, and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized mental health service approaches. Partial hospitalization is designed to provide intensive services for persons who are able to be voluntarily diverted from inpatient psychiatric hospitalization or require intensive treatment after discharge from an inpatient stay. Programs are designed to serve persons with significant impairment resulting from a psychiatric, emotional or behavioral disorder. Such programs are also intended to have a positive impact on the person's support system.

Partial hospitalization programs may either be free standing or integrated with a broader mental health or medical programs. TDMHSAS also requires these facilities to be licensed through TDMHSAS.

Walk-In Center

A non-hospital, facility-based service located at the Crisis Stabilization Unit that offer twenty-four hour, seven days per week behavioral health treatment to adults 18 years of age and older by providing assessment and evaluation, early intervention, prevention, stabilization, referral, and follow-up services for individuals seeking assistance in obtaining appropriate behavioral health services or linkage of services to achieve and/or improve his/her prior level of functioning following a crisis situation.

How do I find out which alternatives are available in my area?

Residential Treatment Based Programs

From TDMHSAS Rule, Chapter 0940-5-17: Adult residential treatment program is a mental health treatment program that offers 24 hours intensive, coordinated, and structured services for adult persons within a non-permanent therapeutic milieu that focuses on enabling a person to move to a less restrictive environment. TDMHSAS also requires these facilities to be licensed through TDMHSAS.

The local crisis services provider usually either operates the less restrictive crisis alternatives or is aware of the community resources. Also, the managed care organizations or behavioral health organizations that serve the TennCare population will have a list of alternative sources that are available to those with TennCare. For individuals with other health insurance, the individuals' insurance companies can be contacted for resources.

Community mental health agencies also may provide community alternatives. There are a number of community mental health providers in the state that are not crisis services providers, but do provide emergency services for active clients. Some agencies accept public funds and others rely strictly on private payment. In any event, contacting the sources before the alternative is needed is highly encouraged to develop positive relationships.

How do I access the programs?

Knowing the details about the resource and the contact person before the service is needed can help expedite the referral process. Of course, not all resources are appropriate for all people. If you have an idea of the needs of the person and can contact a resource that can best meet those needs, accessing services can be easier and quicker. If the person is an enrollee of a managed care/behavioral health organization, these entities can also be useful to locate local resources.

Who is eligible for less restrictive services?

In order to be eligible for less restrictive services, the person:

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

These services must be available to any adult or child who needs the services.

How are the programs monitored?

Managed Care Organizations and Behavioral Health Organizations monitor the mental health and substance abuse providers in their networks with oversight from TDMHSAS. TDMHSAS also licenses crisis stabilization units, partial hospitalization, and residential treatment based programs.

How will the people I refer benefit from these referral services?

The benefits of the referral services vary from resource to resource. Sometimes, the benefits are as simple as allowing the person to calm down and be away from the stressors of their daily life. Other benefits include:

- Community supports can encourage community tenure
- Receiving support and help with fewer interruptions in the flow of daily life
- Improve coping mechanisms and level of functioning
- Promoting recovery and resilience

Post Test

Chapter Six: Less Restrictive Referral Alternatives

1. **How can someone access information about less restrictive alternatives?**
 - a. Contact the local crisis team
 - b. The Behavioral Health/Managed Care Organization
 - c. Community Mental Health Agencies
 - d. All the above
2. **What is a benefit of a referral service?**
 - a. Gives the person something to do
 - b. Improves coping mechanism and level of functioning
 - c. Both a and b
 - d. None of the Above
3. **When a crisis services provider needs to access a less restrictive alternative to hospitalization, the best way to ensure access is to cold call local providers to see what is available.**
 - a. True
 - b. False
4. **Respite is a voluntary service where the person stays at multiple locations depending on his or her treatment needs.**
 - a. True
 - b. False
5. **A crisis stabilization unit is an involuntary, indefinite placement to 10-bed facility that offers crisis services.**
 - a. True
 - b. False
6. **TDMHSAS provides oversight and monitoring of the less restrictive alternatives in addition to licensing a few of the options.**
 - a. True
 - b. False

Post Test

Chapter Six: Less Restrictive Referral Alternatives

7. **Partial hospitalization is designed to provide intensive services for services recipients who are able to be voluntarily diverted from inpatient psychiatric hospitalization or require intensive treatment after discharge from an inpatient stay.**
 - a. True
 - b. False
8. **The case managers may check-in with the people through telephone calls and/or home visits.**
 - a. True
 - b. False

Chapter Seven: Cultural Identity and Impact on Crisis Intervention

Objectives

- Learn about cultural identity
- Learn how racial or ethnic culture impacts a crisis service provider's response to a crisis
- Learn how racial or ethnic diversity impacts a person's response to a crisis service provider

Discussion

As a nation, the United States continues to grow in diversity; our face, voice, and beliefs are forever changing. Not only are we changing as a Nation, so too is the way health care is being provided, in large part due to the ongoing managed care revolution. Despite the pace at which change in the healthcare marketplace is occurring, in many ways, the Nation's health delivery systems have not kept pace with our growing diversity. A significant disconnect has arisen between health care need and the availability and accessibility of relevant, culturally competent care for people who need it. Perhaps nowhere is the importance of culturally competent care greater than in the delivery of mental health services, where cultural issues and communication between person and provider are a critical part of the services themselves.³³

³³ Introduction as written in the final report from working groups on cultural competence in managed mental health care services, Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups (U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration Center for Mental Health Services)

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.”³⁴ Therefore, every person served by a crisis service provider 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 importance in an intervention situation.

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

As of 2000, the federal government designated 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.

It is projected that by 2050 the U.S. demographic makeup will be 47% non-Hispanic White, 29% Hispanic, 13% Black and 9% Asian. According to the most recent data, approximately 20% of the U.S. population, or a little over 58 million people, speak a language other than English at home, and of that 20%, almost 9% (over 24 million people) have limited proficiency in English which has implications for their proficiency in health and health care. Given the increasing cultural diversity over the last several decades and the rapidly changing landscape of health and health care in the United States there is an increased need for health and health care professionals and organizations to provide effective, high quality care that is responsive to the diverse cultural and linguistic needs of individuals served. 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 includes general and specific information about ethnic, racial, and other minority cultures.

Racial or ethnic culture impact on a response (continued)

Coping with day-to-day problems varies between cultures. In general, the Asian American culture emphasizes 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.

In general, the African American culture tends 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 diversity impact a person's response to a crisis service provider 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 individuals from cultures 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.

Although crisis response services are generally provided at no financial cost to individuals in crisis, concerns about financial cost of the service may be a factor in comfort and use of crisis services for minorities. Funding for services should also be considered when referrals to follow-up services are made.

Clinician bias may also play a role in some minorities' hesitancy to avail themselves of mental health services. Because clinical judgment 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.³⁶

Does a person's sexual identity as homosexual, bisexual, or transgender have an impact on response to a crisis or a crisis service provider?

Some individuals who are lesbian, gay, bisexual or transgender clients may need to utilize crisis services. Studies suggest that up to 30% of adolescents who kill themselves are homosexual.³⁷ Because of this potentially higher suicide rate, crisis service providers must include sexual orientation as a factor when identifying risks for an individual. They must also be sensitive to any issues of shame and family conflict that may arise as a result of sexual orientation.

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

Rural America may represent 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.³⁸

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

- In 2016, the rate of suicide among American Indians/Alaska Natives was 21.39 per 100,000 and among whites it was 18.15. In contrast, the suicide rate among Asian/Pacific Islanders was 7.00; the rate for blacks was 6.35; and the rate among Hispanics was 6.38.
- Suicide rates are higher than the national average for some groups of Asian Americans. For example, the suicide rate among Asian American and Pacific Islanders (AAPI) in the state of California is similar to that of the total population. However, 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.
- The suicide rate is roughly two times higher for black children ages 5-12 compared with white children of the same age group.
- In a survey of students in 192 high schools around the country, the 2017 Youth Risk Behavior Surveillance System found that black students (9.8%) were significantly more likely than white students (6.1%) to have reported a suicide attempt. Among Hispanic students, females (10.5%) were almost twice as likely as males (5.8%) to have reported a suicide attempt. But Hispanic male students (5.8%) were more likely than white male students (4.6%) to report this behavior.³⁹
- In a survey of students in 192 high schools around the country, the 2017 Youth Risk Behavior Surveillance System found that the prevalence of having attempted suicide was higher among gay, lesbian, and bisexual (23.0%) and not sure (14.3%) than heterosexual (5.4%) students.

Guidelines for Increasing the Crisis Services Provider's Multicultural Awareness ⁴⁰

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. Crisis workers should have available the interpreter resources guide e.g. interpreters available to the agency, or information from various health plans receiving federal funds such as TennCare must have available interpreter services.
3. Ask for clarification if you are not clear what the person has said.
4. Do not assume that you understand any nonverbal communication unless you are familiar with the person's culture. Examples: unwillingness to make physical contact or eye contact.
5. Do not impose your personal values.
6. If the person'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.
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
14. Recognize that your lack of familiarity with a person'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 a crisis services provider.

It will also be helpful to become aware of the various diverse groups in the area that the crisis service provider will be covering.

Post Test

Chapter Seven: Cultural Identity of Impact on Crisis Intervention

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. **Which of the following minority group is expected to become the largest minority by 2050?**
 - a. African American
 - b. Asian/Pacific Islander
 - c. Hispanic American
 - d. None of the above
3. **The federal government designates four major racial or ethnic groups in the U.S. They include which of the following:**
 - a. African American
 - b. Asian/Pacific Islander
 - c. Latino
 - d. Native American
 - e. All of the Above
4. **All crisis services providers have a cultural identity that will have an impact on the provision of crisis services.**
 - a. True
 - b. False
5. **Generally, members of ethnic minorities seek services from mental health providers less than members of the larger society.**
 - a. True
 - b. False
6. **If you are not familiar with an individual's culture then you have to use your own culture to judge their verbal and non-verbal responses.**
 - a. True
 - b. False
7. **Asian American culture believes outward expression may disrupt social harmony.**
 - a. True
 - b. False

Chapter Eight: Crisis Intervention with Specific Populations

Objectives

- Learn the definition of serious and persistent mental illness (SPMI) and serious and emotional disturbance (SED)
- Learn the special issues to consider for people who have a mental illness and chemical dependency issue
- Learn the special issues to consider when interviewing an older adult
- Learn about medical disorders that may look like symptoms similar to mental illness
- Learn the special issues to consider for people with mental illness who are incarcerated or at risk of incarceration

Discussion

Crisis service providers will come in contact with a wide variety of people in a wide variety of situations. Individuals with serious and persistent mental illness must have a mental illness that interferes with his or her ability to function without some professional support in the community. People in a mental health crisis may have medical issues, maybe under the influence of a substance that mimics or exacerbates symptoms of mental illness. The older person has an entirely different set of stressors that may lead to a mental health crisis. And people with mental illness may find themselves incarcerated as a result of the symptoms of the mental illness. Recognizing and having knowledge about special populations is very important and can be useful in achieving an efficient and positive outcome for the individual.

Serious and Persistent Mental Illness

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

Serious and persistent mental illness (SPMI) as defined in the contract between TDMHSAS and the BHO/MCO and serious emotional disturbance (SED) as defined in Title 33 require that a person must meet a number of criteria in order to be considered seriously and persistently mentally ill or a child to have a serious emotional disturbance. However, these components basically state 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 a level of crisis for a person with a mental illness.

As with any person experiencing a crisis, the crisis services provider 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/or 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 a Declaration of Mental Health Treatment and/or advance directive, wellness plan or a crisis plan before a crisis occurs.

A Declaration of Mental Health Treatment and an advance directive are legal documents. A wellness plan or a crisis plan are not legal documents but are used by persons and providers to assist them in a crisis situation.

An individualized wellness or crisis plan might include items such as:

- The symptoms the individual experiences at their baseline
- Triggers for increased stress and symptoms
- Early signs that the person is becoming more stressed or moving toward a symptom cycle
- Action steps for de-escalation or coping
- Supportive resources that the person can call on for assistance
- Preferred treatment options including psycho-pharmalogical (e.g. medication allergies)

If a personal wellness or crisis plan is on file with the crisis service provider before a crisis occurs, it saves time and energy for both the person and the crisis provider. The person does not need to relate his/her entire mental health history to the provider. The crisis services provider can better assist in identifying the stressor and can help the person in moving through his or her own wellness or crisis plan rather than developing a new one. If one is not on file the crisis services provider should try to obtain the crisis or wellness plan from the person's mental health provider as applicable.

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

Many people who have a mental illness may also have a co-occurring substance dependency issues. Chemical abuse or dependency 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. In the next slide, review the table that identifies various drugs by classes, symptoms of mental illness and possible effects.

If a person is obviously intoxicated/or under the influence of a substance, to the point a crisis assessment cannot be adequately completed, the crisis service provider may need 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 wellness or crisis plan as well as referral services.

Crisis Responder Training

Mental Illness/ Substance	Signs and Symptoms
Depression	Sleep disturbance, sad mood, low energy, suicidality, guilt, hopelessness, inability to experience pleasure
Alcohol	Euphoria, slurred speech, loose muscle tone, loss of fine motor coordination, staggering gait, loss of judgment. Impairment of balance, vision, hearing and reaction time. At higher BAC: dysphoria, anxiety, restlessness Withdrawal: nausea, sweating, shakiness, anxiety, delirium tremens, hallucinations, seizures
Heroin (<i>smack, H, skag, junk</i>)	Euphoria, warm skin flush, dry mouth, heavy extremities, alternately wakeful and drowsy state Withdrawal: drug craving, restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes (" <i>cold turkey</i> "), kicking movements (" <i>kicking the habit</i> ")
Inhalants (<i>glue, gas, solvents, poppers, bold, rush</i>)	Euphoria, loss of inhibition and control Complications: hearing loss, limb spasms, heart attack, sudden death. Damage to brain, liver, kidney, and bone marrow
Mania	Insomnia, hyperactivity, hypersociability, expansiveness, grandiosity, elation
Cocaine (<i>crack, C, snow, flake, blow</i>)	Euphoria, rapid speech, reduced need for sleep or food, mentally alert, restlessness, irritability, anxiety, paranoia, headache, constricted blood vessels, dilated pupils, nosebleeds, intestinal problems, " <i>tracks</i> ," Increased temperature, heart rate, and blood pressure Complications: intense craving, heart attack, stroke, seizure, respiratory failure. Combined with alcohol can cause sudden death
Methamphetamine (<i>speed, meth, chalk, ice, crystal, glass</i>)	Euphoria, wakefulness, increased physical activity, decreased appetite Complications: shortness of breath, hyperthermia, irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, aggressiveness

Crisis Responder Training

Mental Illness/ Substance	Signs and Symptoms
Prescription drug abuse: stimulants	Increased alertness, attention, increased blood pressure, heart rate, respiration. High doses: irregular heartbeat, fever, heart attack, lethal seizures, hostility, paranoia
Anxiety and panic	Sense of impending doom, intense fear, chest pain, rapid heartbeat, shortness of breath, dizziness, sweating, abdominal distress
Prescription drug abuse: benzodiazepines, barbiturates	Calmness, drowsiness, drug dependence. Combined with other medications can cause: heart attack, respiratory problems. Sudden withdrawal: seizures
Marijuana (<i>pot, herb, weed, grass, widow, ganja, and hash</i>)	Euphoria, relaxation, dry mouth, rapid heartbeat, loss of coordination and balance, slower reaction times, "red eyes". Long-term effects: impairment in memory, thinking, learning and problem solving; distorted perception.
Psychosis	Hallucinations (auditory or visual), delusions, paranoia, social withdrawal, confusion, incoherent or reduced speech, odd movements
LSD (acid)	Intense emotions, delusions, visual hallucinations. Changed sense of time and self, "cross over" sensations, hearing colors, seeing sounds. Physical signs: dilated pupils, fever, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, tremors. Long term effects: flashbacks, schizophrenia, depression.
PCP (<i>angel dust, ozone, wack, rocket fuel. Combined with marijuana: Killer joints, crystal supergrass</i>)	Feeling of strength, power, invulnerability, numbing of the mind, drop in breathing, blood pressure, heart rate, nausea, vomiting, blurred vision, flicking up and down of the eyes, drooling, loss of balance, dizziness, seizures, coma. Psychological effects: craving, hallucinations, delusions, paranoia, disordered thinking, catatonia. Behavior: Violence, suicide attempts. Long term use: memory loss, depression, weight loss.
Opioids	Relaxation, euphoria, drowsiness, confusion, nausea, constipation, slowed breathing, lack of focus, inability to concentrate. Withdrawal: muscle aches, excessive sweating, trouble sleeping, anxiety, abdominal cramping, diarrhea, nausea and vomiting, rapid heartbeat, blurred vision.

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

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

According to the Surgeon General's 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 suicide rate for older Americans has been rising consistently since 2008.
- 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 2011, men accounted for 8 times the number of suicides among persons aged 65 years and older.
- The suicide rate in 2015 among individuals over 65 was 16.7/100,000, which is significantly higher than the overall population rate of 13.3/100,000.
- From 2008-2016, the largest relative increase in suicide rates occurred among people over 85 years of age. The rate in this age group increased from 15.6 per 100,000 to 19.4.
- Firearms are the most common method of suicide by both males and females, 65 years and older, accounting for approximately 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.
- The rate for divorced or widowed men in this age group is 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 is 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 dying by 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:

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."⁴¹

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. Therefore, they are less likely to bring them up to a crisis service provider or to any health professional. The crisis service provider 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 service providers should be aware of this possibility and obtain good information about any medications that a person is taking and consult with medical personnel if concerns about drug interactions or toxicity arise.

Are there medical disorders that look like symptoms similar to mental illnesses?

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.

Medical or Physical Condition	Mental Illness with Similar Symptoms
Cushing's syndrome, brain tumors, drug use, exposure to toxin, medication reaction, delirium	Psychotic episodes, psychosis
Cushing's syndrome, brain tumors, multiple sclerosis, delirium, cocaine or amphetamine use	Manic episodes
Hypothyroidism, stroke, multiple sclerosis, dementia symptoms, drugs such as Inderol	Depression, depressive episodes
Hypothyroidism, cardiac conditions (such as arrhythmia), cocaine, amphetamines, caffeine	Anxiety disorders
Early stages of dementia, Alzheimer's disease, withdrawal from some drugs	Paranoia, delusions

Polydipsia, otherwise known 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.

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 service provider 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.

The crisis service provider should ask questions about new medications or changes in medications that have been made recently. Over the counter medications should be covered as well, as should the use of herbals and vitamins. 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.

Are there special issues to consider for people with mental illness who are incarcerated or at risk of incarceration?

People with mental illness may become involved with the criminal justice system for a variety of reasons. The symptoms of mental illness may result in bizarre or unusual behaviors that are disturbing to other people and result in complaints to law enforcement. This type of contact with law enforcement can lead to arrest.

Crisis service providers should be sensitive to calls received from family members or community persons concerning someone who is exhibiting behaviors related to their mental illness. Occasionally, the crisis service provider will tell the caller to contact the police for intervention which may result in the person being jailed instead of receiving mental health treatment. The crisis service provider should establish policies and procedures that will most likely result in the person accessing mental health services and lessen the unwanted results of inappropriate incarceration.

Crisis service providers need to be aware that suicide rates in correctional facilities are nine times higher than in the general population.⁴²

Those at increased risk in the correctional settings include:

- First time arrestee or arrestee with little or insignificant criminal history
- Arrestee with high status in the community (especially those arrested for high profile offenses)
- Prior suicide by close friend or family member or recent suicide by another inmate
- Same sex rape or threat of rape
- Inmates facing long prison sentences or those who just received a lengthy sentence
- Juvenile offenders

Individuals who are psychotic in a jail setting are also at increased risk for self injurious behaviors and suicide attempts. The psychotic individual is also at increased risk of being harmed by other inmates due to the perception of the individual with mental illness as vulnerable or bizarre.

Crisis service providers will be requested to assess inmates who are in the Department of Correction's custody and are housed in local county jails. Although the crisis services provider may not be able to facilitate referral for hospitalization for the inmate, they can provide vital information to the sheriff in order that appropriate mental health services can be obtained.

Post Test

Chapter Eight: Crisis Intervention with Specific Populations

1. **Serious and persistent mental illness (SPMI) is a diagnostic category which is required for the provision of crisis services.**
 - a. True
 - b. False
2. **Intoxication may mimic symptoms of a mental illness.**
 - a. True
 - b. False
3. **Suicide rates in correctional facilities are 9 times higher than in the general population.**
 - a. True
 - b. False
4. **Crisis service providers are not responsible for responding to crisis calls received from correctional facilities.**
 - a. True
 - b. False
5. **A Declaration of Mental Health Treatment and an advance directive are legal documents.**
 - a. True
 - b. False
6. **Which of these factors may impact 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

Post Test

Chapter Eight: Crisis Intervention with Specific Populations

7. **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. Both b and c
8. **A wellness or crisis plan might include which of the following:**
 - a. Triggers that increase stress or symptoms
 - b. Actions steps for de-escalation or calming
 - c. Suggestive resources that could be contacted for assistance
 - d. All of the above
9. **Which of the following medical disorders may cause symptoms similar to those experienced by someone with a mental illness:**
 - a. Brain tumors
 - b. Multiple sclerosis
 - c. Hypothyroidism
 - d. Dementia
 - e. All of the above

Chapter Nine: Law Enforcement as Partners: Developing Relationships, Clarifying Roles, and Cross Training and Education

Objectives

- Learn the advantages of partnering with law enforcement
- Learn what is involved in role clarification with law enforcement
- Learn the importance of cross training with law enforcement

Discussion

Crisis service providers, police officers and correctional officers have a great deal in common. They work with many of the same people in their respective roles. Police officers are most likely to be the first responder when a person with mental illness is experiencing a crisis in the community. In jails, correction officers supervise inmates on a daily bases who have mental illness. According to the Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers (Ditton, 1999), almost a quarter of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness. Because of these situations, crisis services providers can expect to interact with police officers in the community as well as correctional officers in the jails.

(For the purpose of this section, law enforcement officer includes sheriff personnel, both county road officers and correctional officers, and city police officers.)

What are the advantages of partnering with law enforcement?

The community benefits from law enforcement and crisis service providers partnering together to help people experiencing a mental health crisis. Both professionals bring different but necessary skills to a crisis situation. The law enforcement officers are most often the first responders and are equipped to handle persons who are armed or violent in a manner that a crisis service provider should not attempt to handle. Officers with arresting authority are identified in Title 33 as someone who can detain and transport a person to a medical or mental health facility to be assessed. On the other hand, crisis service provider can often de-escalate a mental health crisis to a point where transportation for further assessment is not necessary.

How can a crisis service provider develop a working relationship with law enforcement?

A successful relationship develops best when contact is made between crisis service providers and law enforcement officers outside a stressful situation (such as responding to a crisis call or when there has been a change in operating procedures). The crisis service provider should contact the head of the local law enforcement agency (police chief or sheriff, etc.) to initiate this relationship and continue regular contact thereafter to build and maintain sound working relationships.

Initial meetings should focus on the benefits to both partners and on clarifying roles, expectations and operational structure. A formal method of communicating with law officers should be developed. Meeting at regular intervals should occur to update each other on any procedural changes, review interventions and continue to clarify roles.

Some crisis service areas may contain many law enforcement jurisdictions. In this situation, the crisis service provider may wish to introduce themselves and/or correspond to all of the jurisdictions but focus majority of the face-to-face relationship building on areas with high population density or high likelihood of frequent calls requiring crisis service response.

What is involved in role clarification with law enforcement?

The crisis service responder should clearly explain the goals and focus of crisis services and how this can be of help to law officers (e.g. providing consultation, responding to callers expressing suicidal ideation, assessing inmates for mental health needs, etc.). Discussions should occur regarding situations when a crisis service provider may need to seek the services of law officers and when law officers may want to involve the crisis service provider. The crisis service provider should identify the limitations of the services they can provide and ask the limitations of the services that law officers can provide. This should also include the limitations the jail may have when someone is incarcerated and experiencing a mental health crisis. Many jails do not have the capability to adequately or safely care for a person who is suicidal or experiencing a psychotic episode. It is important for the crisis service provider to have first hand knowledge of how the county jails are structured, the jail's policies on medication, suicide precautions, and access to medical personnel.

Clarification of who is in charge when both law officers and crisis service providers are at a scene is very important. Usually, when both groups are at a site, crisis service providers act as consultants to the law officers with major decisions being made by the law officer's 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, crisis intervention and Title 33 (Mental Health Law)?

Crisis service providers may wish to offer education/training to local law enforcement officers regarding mental illness and crisis intervention. Like mental health professionals, law officers are required to receive continuing education. Crisis service provider may wish to make any continuing education session that they offer more attractive to law officers by making the session Peace Officers Standards and Training (POST) credit certified. The crisis service provider should work with the law enforcement-training officer to develop appropriate training material that will meet POST certification requirements.

Conversely, crisis service provider must acknowledge that law officers have developed a broad knowledge about the laws and services in the community. Crisis service provider must be willing to learn from their law enforcement partners' expertise. Cross training is very valuable for all professionals.

Training law enforcement officers on the sections of Title 33 that are directly related to the obligation of law enforcement agencies would be most beneficial in preventing mishaps and disagreements in the community.

Suggested Title 33 Sections:

Transportation: Title 33, Chapter 6, Part 4 and 5; Title 33, Chapter 6 Part 9

Emergency Detention: *T.C.A. §33-6-402*

Temporary Detention: *T.C.A. §33-6-902, T.C.A. §33-3-616, T.C.A. §33-6-425*

Post Test

Chapter Nine: Law Enforcement as Partners

- 1. Crisis service providers are encouraged to take charge during a crisis situation when working with the local law enforcement.**
 - a. True
 - b. False
- 2. Relationships with law enforcement officers develop best when not begun in a stressful situation (such as responding to a crisis call).**
 - a. True
 - b. False
- 3. All county jails are equipped to appropriately handle offenders with mental illness who are experiencing a mental health crisis.**
 - a. True
 - b. False
- 4. All county jails are equipped to appropriately handle offenders with mental illness who are experiencing a mental health crisis.**
 - a. True
 - b. False
- 5. Crisis services providers, police officers and correctional officers have a great deal in common.**
 - a. True
 - b. False
- 6. There are no community benefits from law enforcement and crisis service providers partnering together.**
 - a. True
 - b. False
- 7. Law enforcement officers are most often the first responders to a situation involving someone exhibiting symptoms of mental illness.**
 - a. True
 - b. False
- 8. The crisis service provider should clearly explain the goals and focus of the crisis services and how this can be of help to law officers.**
 - a. True
 - b. False

Post Test

Chapter Nine: Law Enforcement as Partners

9. **All jails have the capability to adequately and safely care for a person who is suicidal or experiencing a psychotic episode.**
- a. True
 - b. False

Chapter Ten: Collaboration with Service Providers and Others

Objectives

- Learn the advantages of collaborating with informal and formal supports that a person may have in the community
- Learn how a crisis service provider should collaborate with community services, advocates, potential persons and their families
- Learn the type of collaboration that should occur during a crisis intervention
- Learn the appropriate information that should be shared with family and friends of the person

Discussion

Seeking out and collaborating with persons and agencies that have first hand knowledge concerning a person's mental health history and treatment, as well as knowledge about the current crisis situation, is vital to the success of a crisis services provider's ability to intervene and support the person in a time of crisis.

Building collaborative relationships in the community benefits not only the persons of crisis services, but also the crisis delivery system as a whole. Sharing information and resources among community agencies can improve the crisis service delivery system to be more effective and efficient.

Services and persons that a crisis service provider may wish to collaborate with:

- Family of the person
- Friends of the person
- Landlords of the person
- Employers/co-workers of the person
- Mental Health Clinics
- Mental Health Case Managers
- Mental Health Community Support Programs
- Mental Health Rehabilitation Services Providers
- Peer Support Centers
- Emergency Medical Technicians/Ambulance Companies
- Home Health Agencies
- Law enforcement/Sheriff officers/Juvenile Justice officers
- Court personnel
- General Practitioners/Medical Clinics
- Social Service Agencies
- Schools
- Hospitals/Emergency Departments
- Psychiatrists
- Mental Health Advocates

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

Crisis service providers cannot be all things to all people. They have a role to fill in the community, which is to provide intervention and support to people who are experiencing a mental health crisis. Following this intervention the crisis service provider must be able to transfer the stabilized person to the person's usual support network or specialized support system as needed. As part of this transition, crisis service provider must be willing to work with the person's support network to the extent that the person allows. Sometimes enlisting friends and family to better support the person is appropriate. Depending on the person, involving formal support services such as peer support services or mental health rehabilitation 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 with whom a crisis service provider may wish to collaborate.

At times the crisis service provider's role will be to assist the persons 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 service provider when needed. It is often a lot easier for most of us to seek help from someone we know. Building relationships with advocates, persons, families of persons and community service providers will make the intervention process less stressful for everyone.

How should a crisis service provider go about collaborating with community services, advocates, potential persons and potential persons' families?

One of the best ways to introduce any service is a visit by the people who will provide the service. The crisis service provider may wish to visit local providers such as mental health clinics, community support programs, peer support centers, vocational programs, case managers, home health care agencies and other agencies that may serve people who will utilize the crisis services system. Crisis Services providers should discuss the kind of cooperation that they may need from community providers either during or following a person's crisis, how to make referrals to the community provider and how the community provider would refer someone to crisis services. Crisis Service providers should also discuss the services that they provide and explain the limitations of those services.

Visiting individuals who will actually be assisted by the crisis service provider is another way of introducing the services into the community and building collaborative relationships. There are many ways of connecting with potential persons: visits to family and person operated groups, peer support centers, attend the regional mental health policy and planning council meetings, visit mental health service providers and hospitals, to name a few. **A special emphasis on individualized treatment and least restrictive environment is of particular importance when explaining crisis services to potential persons.**

A follow-up correspondence or contact should be made after the visits. Follow up activities are important to building good collaborative relationships.

What sort of collaboration should occur during a crisis intervention?

The collaboration that occurs when the crisis service provider is intervening in a crisis will depend largely on the person being served. Asking the person about his or her support network is a very important piece of the crisis intervention process. However, a given person 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 person has developed a wellness or crisis assistance plan prior to the current crisis situation and/or has a Declaration for Mental Health Treatment, the crisis service provider should attempt to locate and 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 community provider will request the assessment or intervention. When this is the case, the crisis service provider should get as much information about the situation as possible. 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 rather than focusing 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 the overwhelming stress a crisis situation can cause. They will need some basic information.

Information to share with families and friends:

- Support families and friends for seeking help. *Ex. "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 service provider must be careful not to take these emotional reactions personally. Remember that the family or friends of a person in crisis is experiencing a crisis also.

Post Test

Chapter Ten: Collaboration with Service Providers

1. **Collaboration with Service Providers**
 - 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 person can receive longer term support as appropriate
 - c. Must be able to help the person make connections to longer term supports as appropriate
 - d. All of the above
2. **All of the following is information that the crisis services provider might wish to share with friends and family of a crisis services person 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
3. **Collaboration with other providers will assist in making appropriate referrals for those individuals who will need more support.**
 - a. True
 - b. False
4. **Building relationships with advocates, consumers, families of consumers and community service providers will not aid in the intervention process.**
 - a. True
 - b. False

Post Test

Chapter Ten: Collaboration with Service Providers

5. **The crisis services provider should attempt to locate and follow a person's Declaration for Mental Health Treatment, wellness plan or crisis plan.**
 - a. True
 - b. False
6. **Crisis service providers should discuss with community providers the service that they provide and explain the limitations of those services.**
 - a. True
 - b. False
7. **Collaboration that occurs when the crisis service provider is intervening in a crisis depends largely on the person being served.**
 - a. True
 - b. False
8. **Asking family and friends about patterns, history and other information concerning the person is not helpful in assessing the current crisis.**
 - a. True
 - b. False
9. **It is always appropriate to enlist friends and family to better support the person.**
 - a. True
 - b. False

Chapter Eleven: Crisis Services Provider Boundaries and Self-Care

Objectives

- Gain knowledge regarding professional client boundaries
- How to set reasonable limits with clients
- Strategies to reduce burnout and stress

Discussion

This chapter will explore boundary areas crisis providers may experience during face to face encounters with the client. Examples of possible boundary problem areas will be presented with strategies of how to set limits, all while maintaining a professional clinical role with the client. The second part of the chapter will discuss ways to reduce burnout and stress from the perspective of both the crisis member and of the organization.

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

What are examples of possible crisis provider boundary problem areas?

There are a number of ways to misuse or abuse this power, even unintentionally. It is the crisis service provider's responsibility to manage his or her role and interaction with each client so as to avoid this misuse or abuse. The crisis service provider's role is a professional one. The relationship developed with the client must stay on that level even though the crisis provider will be dealing with very personal information and circumstances. Some examples of boundary problems are listed below.

- **Sharing personal information** can break appropriate boundaries with a client. Though it may help establish rapport to self-disclose a personal life event, great care should be taken to make sure roles are not reversed; that is, that the client isn't taking care of the provider.
- **Probing too deeply** with a client can also be inappropriate. Make sure the information requested is relevant to providing assistance. For instance, knowing the client is a survivor of rape may be important to managing this case. A detailed account of the rape is unnecessary.
- **Providing too much help** is a very common way crisis providers 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 something has been done that the client could have accomplished him or herself. Providing too much help encourages dependence. A crisis services provider should empower the client as much as possible.
- **Sexual relationships are absolutely unacceptable.** A sexual relationship consists of everything from flirting to sexual intercourse.
- **Social interaction** that is not part of the job, like seeing movies together, dinner together, or an invitation to a crisis provider's home is inappropriate. If these things occur, the crisis provider would be establishing a dual relationship, one as a professional and simultaneously as a friend. It is too easy to lose objectivity as someone's friend, and it is confusing and frustrating when limits must be set later on.
- **Boundary issues occur when crisis providers recognize clients from a pre-existing social relationship.** Crisis providers at times may be called upon to provide services to friends, relatives, or acquaintances. If this situation should occur, it is best to consult with your supervisor for advisement.

Boundary issues are always complex and difficult to define in specific cases. In general, rely on consultation with others when there is uncertainty. If a crisis services provider is feeling burnt out, chances are he or she is doing too much. Boundaries should be re-evaluated. Reliance on the behavior of the clients to make the crisis services provider feel good about him or herself, points to boundary issues.⁴³

Crisis services providers will experience situations in which a person requests or expects a crisis provider to overstep boundaries. When this occurs, the crisis provider must set reasonable limits with the person. The following is a guide to limit setting.⁴⁴

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.

⁴³ Charles G. Cook, Crisis Intervention Sample Protocol (Submitted to the Minnesota Department of Human Services, 1995), 8-9

⁴⁴ Maureen Malloy, R.N., Behavioral Emergency Outreach Program

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

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

Effective management

Staff needs 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 the purpose of their organization. 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 persons of the services.

Functionally defined roles

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

Team support

Organizations need to structure settings in which staff members are not competitive with each other but instead encourage and support one another.

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.⁴⁵ In addition, management should encourage time off as needed and assure adequate staffing.

Myths regarding crisis services providers

The following are some myths regarding crisis services providers:

Myth: The crisis services provider must do something besides just listen to the person.

Reality: When listening to a person, something very important is accomplished. Sometimes listening is what the person needs and wants most. Being more directive may not be appropriate.

Myth: The crisis services provider should like all of the people who request services.

Reality: The crisis services provider will not like all persons. This is normal and does not make the crisis provider bad or ineffective. If the crisis service provider dislikes someone enough that he or she cannot work with that person, 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 or her life and may be a point of intervention.

Myth: The crisis services provider must know the information needed.

Reality: Additional information may not help with an intervention. The relationship that is established is a more essential part of helping someone than simply giving information. Information can be sought together with the person.

Myth: The crisis services provider 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 crisis provider’s job is to help the person think through the likely outcomes of the alternatives and choose one that most nearly meets the person’s needs and expectations. Sometimes the person may appropriately decide to do nothing.

Post Test

Chapter Eleven: Crisis Service Provider Boundaries and Self Care

1. **Which of the following is true of good boundaries with persons?**
 - a. A crisis services provider can never give a person too much help
 - b. A little flirting with a person can be used as a tool to put a person at ease
 - c. A crisis responder will not develop a social relationship with a person (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 services worker to share intimate details of his or her personal life with a person
2. **Which of the following is important in limit-setting with a person?**
 - 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 person'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. Use of mood altering chemicals/drugs
 - c. Use of stress reduction strategies
 - d. Self-awareness
4. **Which of the following is not a myth regarding crisis services providers?**
 - a. The crisis provider must do something besides just listen to the person
 - b. The crisis provider must know "the answer" to every situation
 - c. The crisis provider must know the information needed
 - d. Additional information may not help with an intervention

Post Test

Chapter Eleven: Crisis Service Provider Boundaries and Self Care

5. **An organizational approach to reducing staff burnout includes all the following except:**
 - a. Plan for stress management
 - b. Structure settings where members are competitive with each other
 - c. A clear purpose and goal
 - d. Effective management structure and leadership
 - e. Both A and C
6. **Boundary issues are always simple and easy to define in specific cases.**
 - a. True
 - b. False
7. **Crisis services providers will experience situations in which a person requests or expects a crisis provider to overstep boundaries.**
 - a. True
 - b. False
8. **Management should encourage time off as needed by crisis staff to reduce staff burnout.**
 - a. True
 - b. False
9. **Stress can be both productive and instructive.**
 - a. True
 - b. False
10. **A balance between work and home life, physical and mental endeavors, spiritual and practical concerns are essential to remaining centered and resilient.**
 - a. True
 - b. False

This concludes the Tennessee Department of Mental Health and Substance Abuse Services Crisis Responder Training

You will need to review this material every 3 years. Print and fill out your certificate of completion located on the next page before exiting the course.

Certificate of Completion

This Certifies that

Has completed the Crisis Responder Training
from the office of Crisis Services and Suicide Prevention

Attested To By: _____ Date: _____



Department of
**Mental Health &
Substance Abuse Services**