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

TDMHSAS would like to offer a special appreciation to Larraine Pierce with the Minnesota Department of Human Services who authored the Crisis Curriculum, A Mental Health Manual, May 2002 and gave permission for the use of her work.

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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	Social Level	Contextual/Life Environment
• 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	• 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	• 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%**

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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. making a will*	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. risk taking*		

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	Financial security
Good physical health	Sense of meaning and purpose in life	Supportive and caring family	Employment
Absence of alcohol and other drug use	Good coping skills	Supportive social relationships	
Positive outlook and attitude of life		Sense of self-determination	Safe and affordable housing
		Good communication skills	
		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
• 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	• 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-legitimatize • 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
Are suicidal thoughts/feelings present? • 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?	**How far has the suicidal planning process proceeded?** • 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

This concludes the Tennessee Department of Mental Health and Substance Abuse Services Crisis Responder Training: Harm Assessment and Suicide Prevention Chapter

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: Harm Assessment and Suicide Prevention

from the office of Crisis Services and Suicide Prevention

Attested To By: _____ Date: _____

TN Department of Mental Health & Substance Abuse Services