THE RECOVERY
ACADEMY

RECOVERY ACADEMY

Coping with Crisis

FACILITATOR GUIDE

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Recovery Academy Program Goal

The Champlain Recovery Academy provides a range of educational and skill building opportunities, using a recovery based approach, so that students may:

- become experts in their own self care ,
- recognize and develop their personal resourcefulness: and

for families, friends, and service providers to:

- better understand mental health conditions and addictions
- learn how to support people with lived mental health experience and or addictions in their journey to well-being.

Student Population: Individuals who may be experiencing a crisis, family members and supporters, and care providers. *

Learning objectives: Introductory Session ~ Coping with Crisis

At then end of the 2 hr. session, students will:

1. Understand four stages of crisis
2. Identify cues signifying risk of crisis
3. Know at least one de-escalation technique

The 4 Cornerstone Concepts of the Introductory Session- Coping with Crisis

There are four key cornerstones facilitators will be expected to cover in the lecturette using a bike accident analogy:

1. Crisis
2. Behavioural Cues or signs and the benefit of early intervention???
3. De-escalation techniques while maintaining personal safety
4. The importance of planning and practice

If student-needs drive the necessity for a specific unit of additional **content**, this can be added within the time frame set out. i.e a discussion about what planning means.

Learning Principles and Styles

Working with adult learners differs from teaching. As facilitators, we adjust our facilitation style to meet the needs of participants. We are there to facilitate a process of interactive learning not merely to present content. A few important Adult Learning Principles to keep in mind are:

Students:

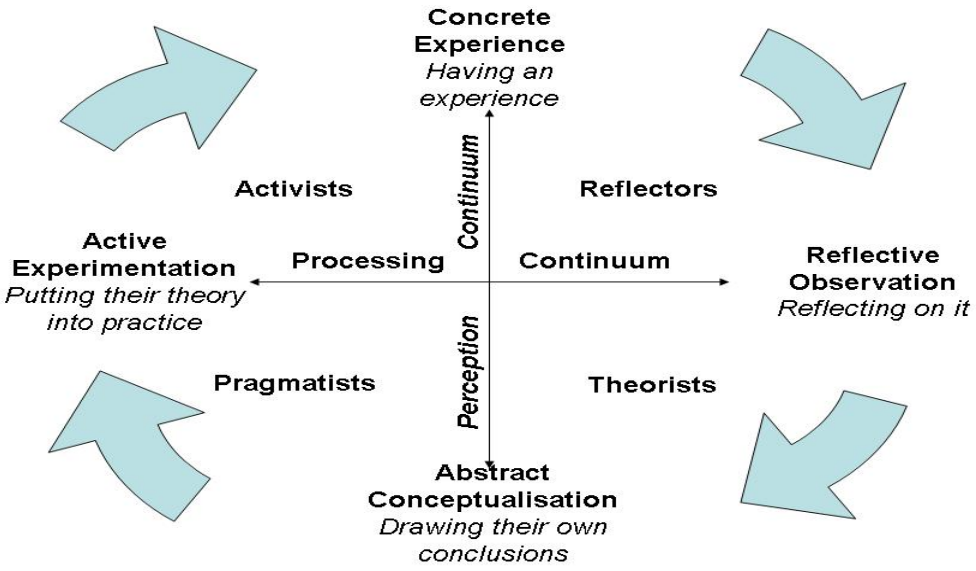
1. Are self directed and motivated to learn
2, Bring their life experience and knowledge with them
3. Have goals and expectations
4. Seek relevance for immediate applicability
5. Are practical and engage in problem solving and planning
6. Wish to be treated with respect and as equals.

Learning styles may be best described succinctly in NLP Terms Visual, Auditory and Kinesthetic. As such, we need to offer and be sensitive to all three styles within the session.

Participants engage by **experiencing, reflecting, thinking and acting.**

- **Experiencing:** learning in real time what is relevant to their current situation.
- **Reflecting:** exploring different perspectives, being open to new ideas and concepts, looking for meaning
- **Thinking:** analyzing ideas, visualizing how to apply the concepts of the learning experience in a practical way, planning how these can be applied in their life situation.
- **Acting:** showing the ability to apply the concepts, being willing to take risks, planning how they will proceed.

EXPERIENTIAL LEARNING CYCLE and LEARNING STYLES



- **Reflector -** Prefers to learn from activities that allow them to watch, think, and review (time to think things over) what has happened. Likes to use journals and brainstorming. Lectures are helpful if they provide expert explanations and analysis.
- **Theorist -** Prefer to think problems through in a step-by-step manner. Likes lectures, analogies, systems, case studies, models, and readings. Talking with experts is normally not helpful.
- **Pragmatist -** Prefers to apply new learnings to actual practice to see if they work. Likes laboratories, field work, and observations. Likes feedback, coaching, and obvious links between the task-on-hand and a problem.
- **Activist -** Prefers the challenges of new experiences, involvement with others, assimilation and role-playing. Likes anything new, problem solving, and small group discussions.

Coffield, F., Moseley, D., Hall, E., & Ecclestone, K. (2004). *Learning styles and pedagogy in post-16 learning: A systematic and critical review.* www.LSRC.ac.uk: Learning and Skills Research Centre. Retrieved January, 15, 2008:http://www.lsda.org.uk/files/PDF/1543.pdf

Experiential Learning Methodologies

Emphasizes group work and participation in interactive exercises from which learners extract general principles and as well as immediate practical applications to their own situation. Examples: are story telling, scenarios or case studies, role-plays, simulations, chair techniques, work dyads or tryads, teamwork assignments etc .

Creating a safe learning environment in a recovery context.

It is important to recognize the vulnerability of students. Individuals with mental health and/or addictions issues, their supporters and service providers all experience stigma. Myth, misunderstanding and negative experiences in and out of crisis situations can create a natural hesitancy on the part of students. No pressure should be felt to disclose status.

An important part of the facilitators' role is to create the most relaxed environment as possible. The more relaxed students are the more open to learning, sharing and enquiry.

Room set up: Easy access for students to the washroom and the exit . Where possible set chairs in curves, half circles or circles (depending on size of group) avoid straight rows or set ups that impair movement or easy conversation. Leave space between chairs.

Be welcoming. Smile, let them know about seat choice, where to put coats, ask anything you need before we start. Etc

Clearly outlining the Session this lets students know what to expect for the session.

Use positive nonverbal communication
Nonverbal messages are an essential component of communication in the teaching process. It is not only what you say to your students that is important but also how you say it. An awareness of nonverbal behavior will allow you to become a better receiver of participants' messages and a better sender of signals that reinforce learning.

Some areas of nonverbal behaviors to explore include:

- **Eye contact:** Facilitators who make eye contact open the flow of communication and convey interest, concern, warmth and credibility.

- **Facial expressions:** Smiling is a great way to communicate friendliness and warmth

- **Gestures:** A lively and animated facilitating style captures students' attention, makes the material more interesting, and facilitates learning. Head nods also communicate positive reinforcement that you are listening.

- **Posture and body orientation:** Standing erect, but not rigid, and leaning slightly forward communicates that you are approachable, receptive and friendly. Speaking with your back turned or looking at the floor or ceiling should be avoided, as it communicates disinterest.

- **Proximity:** Cultural norms dictate a comfortable distance for interaction with participants. Look for signals of discomfort caused by invading participants' space, which include rocking, leg swinging, crossed arms, tapping and gaze aversion.

- **Para-linguistics:** Tone, pitch, rhythm, timbre, loudness and inflection in the way you speak should be varied for maximum effectiveness.

- **Humor:** Develop the ability to laugh at yourself and encourage participants to do the same. Humor is often overlooked as a teaching tool. It can release stress

and tension for both instructor and student and foster a friendly classroom environment that facilitates learning. www.literacyonline.

Address common fears:
State: There are no stupid questions.
When asked a question or referring to questions on post it, model responses to questions that positively reinforce the message.

"I was hoping some one would ask that"

"That's a helpful question"

"That's an interesting question"

State: Letting us know what hasn't worked is a useful tool for learning (no judgment) you might mention something you tried that didn't work

Housekeeping: washrooms - where they are located and if there will be a break, cell phones- please put on vibrate, if you need to take a call, feel free to take it outside the room and rejoin us when you can , if you need to leave please indicate to us with the royal wave.

(Comfort agreement) Code of Conduct For Facilitators

- Provide you with a safe, warm and friendly learning environment in which everyone is treated with dignity and respect
- Handle your questions in a friendly and professional manner
- Respectful communication provide examples and model this
- Use of "I statements"
- Speak for yourself
- Listen respectfully
- Confidentiality personal information:
- Celebrate diversity and difference.

Model learning about diversity
Mark Kiselica, a psychologist who conducts multicultural training, stresses the importance of teachers self-disclosing their own journey in becoming more culturally sensitive and knowledgeable. Kiselica states that "the process of developing multicultural awareness and sensitivity is a journey marked by fears, painful self-reflection, and joyful growth," and students can learn from an

instructors who share their mistakes, incidents that led to their learning, and what they have gained from the process.

Role as a facilitator There is a fine line for teachers between presenting oneself as a learner on a journey toward greater diversity awareness and self-awareness and an expert who has reached expert status on issues of diversity and multiculturalism.

Students often react favorably to the first, almost always negatively to a person who wants to be seen as the authority on these issues.

Maintain a focus at all times on learning rather than treatment or care

For students

- Make the most of your time with us, enjoy being a student and be prepared to learn
- Celebrate diversity and difference
- Ask us for clarification if there is anything that you are not sure about
- Be considerate by treating everyone with dignity and respect

Participation for each section Remind students the variety of ways in which they can participate, all is acceptable. Their choice Etc. post it notes for questions, for the tree or to give to facilitator, non participation in exercises is an acceptable choice, we may ask you to be a time keeper etc.

Confidentiality need only identify yourself by first name and only if you are comfortable, let us know why you are here, verbally or written on post it note.

Needs identification- ongoing : It is important to identify that all needs (questions) are important, however the facilitators are facing limits of time, intensity, and diversity so all questions (needs) may not be met during this particular, session. Make an effort to assist In identifying a option or alternative pathway.

Use icebreakers to allow the students to create connection outside of their connection to mental illness and or addiction. For example, if you are using a known scenario (bike accident) to bridge to your learning objectives you might ask who has ridden a bike as a child, as a teenager, as an adult for recreation or transportation.
Or

Who has taken a first aid course?

Identify pre-existing relationships if it is a group of less than 25 people.

Be transparent, it is okay not to know the answer, we are well resourced and can reach out for help

Share part of your own story (be vulnerable) within the context of the session

Potential Triggers
An offhand comment in a session that seems inoffensive to many people can cause an individual to feel diminished, threatened, discounted, attacked, or stereotyped. This "trigger" is an emotional response; while the individual does not feel personally threatened, an aspect of the person's social identity (or the social identity of members of another social group) feels violated.

A word, phrase, or sentence that seems harmless to some people may trigger an emotional reaction in others. Examples of phrases that could be triggers are:

• "I don't see differences; people are just people to me."
• "If everyone just worked hard, they could achieve."
• "I think people of color are just blowing things out of proportion."

One's emotional response can include anger, confusion, hurt, fear, surprise, and embarrassment.

There are a number of responses to triggers, some of which are more effective and more appropriate than others, depending on the situation.
Responses to triggers include:

• **Avoidance-** Avoiding future encounters and withdrawing emotionally from people or situations that trigger us.

• **Silence-** Not responding to the situation although it is upsetting, not saying or doing anything.

• **Misinterpreting-** Feeling on guard and expecting to be triggered, we misinterpret something said and are triggered by our misinterpretation, not the words.

• **Attacking-** Responding with the intent to lash back or hurt whoever has triggered us.
• **Internalization-** Taking in the trigger, believing it to be true.

• **Confusion-** Feeling angry, hurt, or offended, but not sure why we feel that way or what to do about it.

• **Naming-** Identifying what is upsetting us to the triggering person or organization.

• **Confronting-** Naming what is upsetting us to the triggering person or organization and demanding that the behavior or policy be changed.

• **Surprise-** Responding to the trigger in an unexpected way, such as reacting with constructive humor that names the trigger and makes people laugh.

• **Discretion-** Because of the dynamics of the situation (power imbalances, fear of physical retribution), deciding not to address the trigger at this time but at some way at some other time.

http://www.uww.edu/learn/diversity/safeclassroom.php

Media: FC, writing materials – paper or index cards, post it notes, name tags, pens. CD player, DVD Player, computer.

Administration: Contact perspective students 2 to 3 weeks ahead, by phone or email, confirm their participation in writing, call 3 days before the workshop to remind them. Provide date, time and address and room number. Room set up ~ a circle of chairs of a maximum # of…. Provide access to fresh water.

Facilitators' Tools: Facilitator Guide, Roller Coaster to Recovery, Recovery Academy Syllabus, list of attendees, a flipchart & easel, markers – various colours, cd player, dvd player? + cd 's and DVD's, note pad, Workshop Evaluation Questionnaire.

Facilitator Guide: lays out the time frame, the workshop exercise and content, and any AV aids or tools required.

Facilitators' Notes: Provides back ground reading or scripts required to cover the intended leaning objectives and content. **SEE Appendix B**

Evaluation: the evaluation questionnaire is a simple to complete on page sheet that will also be posted on the website, ask students at the beginning of this session to give you feedback, in addition to complete it. pager, **Appendix A**

Fs invite verbal feedback in the group as part of the closing, link back the feedback to their questions and expectations as expressed in the opening. Demonstrate the link.

Facilitators post session Feedback:

Fs discuss their learning's, opportunities for improvement and provide feedback and recommendations to the Program Coordinator.

TIME	CONTENT and EXERCISES	TOOLS
	WELCOME **F**acilitators welcome each student as they enter the workshop. **Students** choose their seats and may complete name cards until it starts (optional)	Tent cards and markers
1 min	**F**acilitators open with welcoming remarks (you are in the right place)	
2.5 min	**F** describes the RA as whole and links this with the 3 specific **Learning Objectives** for this session. Invite any clarifying questions or concerns	Prospectus? POSTED
2.5 min	**F** provides **Outline of the Session** (fluid) how we are going to share this time together (learning methodologies). Invite any clarifying questions or concerns	POSTED
2 min **T: 8 min**	**F** covers **Housekeeping Items**. Invite any clarifying questions or concerns	
	INTRODUCTIONS **Student** introductions start with Facilitators (model) *I am (first name) and I am here because…or* *Hi, I'm here because…* **F** Invite students to introduce themselves. Then,	
5 min	**F** provides a few minutes for students to write their question(s) or area of interest on a post it note to be placed on the tree.	POST IT NOTES and MARKERS

TIME	CONTENT and EXERCISES	TOOLS
5 min **T: 10 min**	**NEEDS IDENTIFICATION EXERCISE** **F**acilitators read out posted questions and paraphrase their understanding of the questions, checking back with participants **F** use this opportunity to adjust the session based on Identified Needs **F** Clarify what will be covered and identify what might be outside of the scope of the session while identifying other options if available. Take note of the need in a visible way.	TREE Post it notes Parking lot FC
5 min	**COMFORT AGREEMENT** (ground rules) **F** propose group guidelines and invite students to add to the list	POSTED
10 min **T: 10 min**	**CLIMATE SETTING EXERCISE** (a.k.a. icebreaker or sociometry) Group finds connection with each other through an exercise e.g. pet owners: dog, cat, other, or none. Or use The Hunt is On! or other icebreaker exercise Link the Ex. to what we choose & choices - Recovery	
5 min 5 min **T: 10 min**	**STORY – Service Provider** Linked to coping with crisis and learning objectives **STORY – Peer** Linked to coping with crisis and learning objectives this story needs to include : what led up to crisis such as triggers, early warning signs , things breaking down and the crisis point. It also includes messages of reaching a point of seeking/asking for help and the turn around towards recovery.	

TIME	CONTENT and EXERCISES	TOOLS
10 minutes **T Time: 10**	**LETURETTE: using a scenario** Using an analogy like an auto or bike accident … Explore and highlight all of the concepts that are within the following learning objectives" from the perspective of the individual in crisis, a family member or supporter, and care provider. • Crisis – define it - many faces • Behavioural cues or signs • De-escalation techniques for self or others (maintain personal safety • Planning -next steps - post crisis, prevention and creating a crisis plan	**F notes**
5 min 15 min **T Time: 20**	**GROUP EXERCISE –** **F** divide the participants into subgroups according to their choices. Students self select *which piece of the scenario they wish to explore as a subgroup*. Or, if they wish, divide up according to the 3 different perspectives working though each scenario phase. Ask participants as a subgroup to explore their phase of the scenario and identify examples of Crisis, Behavioural Cues or signs, De-escalation techniques, and Planning. Ask them to be prepared at the end of the Exercise to discuss in the main group how these <u>apply to themselves</u> right now (if they are comfortable) Prompt students to share from the individual, family or support or care provider perspective.	Hand Out of Scenario and Instruction sheet
10 min	**WRAP UP the - EXERCISE IN PLENARY** One **F** facilitates a group discussion, while the **2nd F** flipcharts the group learning: (validates **Students' input**) see next page.	FC

TIME	CONTENT and EXERCISES	TOOLS
T time : 10	Coping with Crisis - pull together the 4 cornerstones, three learning objectives & link these to the scenario. • Current situation – where am I/We right now? • What Crisis is ….. (**A**ttitudinal Shift) • What do I need to consider re. my situation right now? – reflecting , thinking, analyzing **S**kills • What are my options? - Problem solving **S** • What do I choose to do right now? – Decision-making **S** • Am I open to learning de-escalation techniques? • How will the planning meet my needs – Needs Identification **S** What do I need to consider doing as my next step in post crisis, in crisis prevention and crisis planning--Planning **S**kills	Point out the skills and attitudes they demonstrated at the closing of the grp discussion by adding these in a coloured marker
T 17 min	**FOLLOW-UP EXERCISE** (reinforcement)* if applicable **F** introduces a Flow Chart or other choice-making tool using the scenario to bring it home to their choices about their next steps. (Needs Identification and Planning.) **ALTERNATIVE EXERCISE #1** Assess need. Offer a 'grounding or centering' meditation. Facilitate a guided meditation. **ALTERNATIVE EXERCISE #2-** My Story – a Care Provider' s View Care providers give a talk what 'experience with crisis, what worked what didn't and example of a crisis plan for loved one and for self.	POST CHART Participant Hand out CD

TIME	CONTENT and EXERCISES	TOOLS
5	**CLOSING - THE QUESTIONS** **F** links back the session to the Student Questions identified on the Tree **F** asks: *"To what extent was your question or area of interest covered in this session?" If not answered, where can individuals find answers.*	
5	**NEXT STEPS - OPPORTUNITIES ~ RA or other Needs identification** • Self - Now • Family members - Now • Service providers - Ongoing	
5	**EVALUATION** **F** hands out 1 page questionnaire and asks for their input to improve the Coping with Crisis Workshop. Ask Students for quick feedback in group, FC their responses for all to see. Offer alternative ways of evaluating and providing feedback.	Questionnaire FC: " + / Δ " Website and email address
Total Time 115 Minutes	**SIGN Ups** Facilitators have sign up sheets for other workshops or RA resources. And are available to answer questions.	RA Prospectus
	FACILITATOR DEBRIEF their session – strengths building approach and suggestions for improvement	

APPENDIX "A"

WOKSHOP EVALUATION QUESTIONNAIRE

1. The workshop objectives were clear and understandable.

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

2. I was invited to express my needs and /or questions.

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

3. The facilitators covered the concepts as posted.

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

4. I had an opportunity to explore the concepts and engage with other participants.

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

5. The learning exercises were helpful and relevant.

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

6. The pace and amount of time allowed was appropriate.

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

7. The highlight of the workshop for me was _____

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

8. **I have ideas I can apply and that are relevant and practical. Please give an example_____**

Strongly agree	moderately agree	disagree	strongly disagree
1	2	3	4

9. **I recommend the following changes _____**
(Areas for improvement)

_____

10. **I'm interested in taking: _____**
(Name of workshops)

Name (optional)_____

APPENDIX "B"
Facilitators Background Notes

RECOVERY -

- A recovery approach to mental disorder or substance dependence (and/or from being labeled in those terms) emphasizes and supports a person's potential for recovery.
- Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning.
- Recovery is a common experience.
- Recovery is coming to terms with the mental illness and having a life for yourself.
- Recovery is a deeply and intensely personal, unique process of adjusting or changing one's attitudes, values, feelings, perceptions, beliefs, skills, roles and goals in life.
- Recovery is a deeply emotional process.
- Recovery is not just recovery from the illness.
- Recovery is seeing yourself, treating yourself and responding to others as a person rather than as an illness.

What is recovery and what it is not.
The difference between therapy and education.

THERAPY	EDUCATION
- Focuses on problems, deficits and dysfunctions; -Strays beyond formal therapy sessions and becomes the over-arching paradigm, -Transforms all activities into therapies – work, gardening, etc…; - Problems are defined, and - the type of therapy, by the professional 'expert'; - Maintains the power imbalances and reinforce the belief that all expertise lies with the professionals.	- Helps people recognize and make use of their talents and resources; - Assists people in exploring their possibilities and developing their skills, - Supports people to achieve their goals and ambitions; - Staff becomes coaches who help people find their own solutions; - Students choose their own courses, work out ways of making sense of (and finding meaning in) what has happened and become experts in managing their own lives.

Individual Crisis Plan ~ Handout

- When I am feeling well, I am (describe yourself when you are feeling well)

- The following signs indicate that I am no longer able to make decisions for myself, that I am no longer able to be responsible for myself or to make appropriate decisions.
- When I clearly have some of the above signs, I want the following people to make decisions for me, see that I get appropriate treatment and to give me care and support:
- I do not want the following people involved in any way in my care or treatment. List names and (optionally) why you do not want them involved:
- Preferred medications and why:
- Acceptable medications and why:
- Unacceptable medications and why:
- Acceptable treatments and why:
- Unacceptable treatments and why:
- Home/Community Care/Respite Options:
- Preferred treatment facilities and why:
- Unacceptable treatment facilities and why:
- What I want from my supporters when I am feeling this badly:
- What I don't want from my supporters when I am feeling this badly:
- What I want my supporters to do if I'm a danger to myself or others:
- Things I need others to do for me and who I want to do it:
- How I want disagreements between my supporters settled:
- Things I can do for myself:
- Indicators that supporters no longer need to use this plan:
- I developed this document myself with the help and support of:

Facilitators Background Notes
CRISIS

Crisis Situations

What counts as a crisis?

Definition: "any event that is, or expected to lead to, an unstable and dangerous situation affecting an individual or group" http://en.wikipedia.org/wiki/Crisis

What does this mean to individuals and families and clients?
Something happens that leads to concerns about safety for the individual, caregivers, or others (overwhelmed, panic attack, distressed, collapse, prolonged isolation a threat of suicide, sudden bizarre or dangerous behavior, hearing voices, etc.)

How does a crisis develop?

Poor self care, low self esteem, substance abuse, untreated physical illness
Poor daily routine and maintenance
Lack of support and or isolation
Communication gaps or breakdowns in communication with others
Missed cues or signs of triggers, early warning signs or things breaking down,
Lack of access to community resources, lack of personal resources including
Knowledge and education on the A and or MH one 's own challenges
Cultural differences, language barriers, socio economic , etc,

What can I do to prevent a crisis

Following my daily maintenance plan which keeps me well
Using all the tools in my recovery tool box
Building a support system
Identifying my triggers and how they happen & using my triggers plan
Catching the early warning signs and using my recovery tools & plan
Reaching out for support when the signs are recognized
Using my recovery tools when things are breaking down
Taking corrective action with the help of my family and or supporters to prevent a crisis

FAMILY and SUPPORTERS, and CARE PROVIDER PERSPECTIVE

How does a crisis develop?

Four stages of a crisis situation
- Prodromal: risk cues or signs that potential crisis can emerge
- Crisis breakout: triggering event with resulting damage
- Chronic: lingering effects of crisis
- Resolution: crisis no longer a concern to stakeholders

Fink, S. (1986). Crisis management planning for the inevitable.

Crisis situation in Mental Health and Addictions (2nd phase of crisis)

(story)

Because of mental health and or addictions we might expect
- Reduced insight
- Less control
- Lack of judgment
- Dis-inhibition
- Greater emotional liability

Crisis - Including aggression or threat of suicide

Behavioural Cues for Aggression:

First and foremost assess the situation
Safety first
Is there an obvious trigger?
What is the person doing or how are they acting?
What is the person saying and how are they saying it?

Verbal cues
What is being said

Para-verbal cues
How something is expressed
- Volume of speech
- Too loud or too quiet
- Talking quickly
- No longer talking

- Who is being addressed
- Self, others or someone who isn't there?

Behavioral cues

What the person is doing

- Pacing
- Fidgeting
- Yelling
- Cursing
- Name calling
- Posturing
- Sweating

De-escalation Techniques

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a person from causing harm to us, themselves or others

It is NOT:

- A teaching opportunity (although it is a chance to LEARN)
- A guarantee that bad behaviors will stop
- Something you will only ever have to do once

Three main factors to consider when confronted with a de-escalation situation:

- **Self control -** being aware of your own responses
- **Physical presence -** taking a supportive stance
- **The de-escalating conversation** - the strategies you employ

De-escalation Techniques: Self-control

- Appear calm, centered and self-assured -even if you don't feel it
- Anxiety can make the patient feel anxious and unsafe which can escalate aggression
- Use a modulated, low monotonous tone of voice
- Do not be defensive
- Even if the comments or insults are directed at you, they are not about you
- Be aware of available back-up resources
- Know that you have the choice to leave or call for help if de-escalation does not work
- Be respectful even when firmly setting limits or calling for help
- The agitated person is still sensitive to feeling shamed and disrespected

De-escalation Techniques: Physical presence

Stance -

- •Know where the door is and stand between it and the individual (do not block their access to it)
- •Stay at the same eye level
- •Sit and encourage the individual to be seated -if he stands, you stand, too
- •Allow extra physical space between you
- •Allow yourself at least three feet in between yourself and the individual
- •Stand at an angle so you can sidestep away if needed
- •Allow yourself and the individual to look down or away
- •Keep hands out of your pockets, up and available to protect yourself –this also demonstrates that you are not concealing anything
- •Give choices and empower the individual

Do NOT turn your back for any reason

- • Stand fully in front of the individual
- • Maintain constant eye contact

Physical presence – Facial expression

Constant eye contact can come off as a challenge

Do NOT smile - This can look like mockery or anxiety

Physical presence – Gestures

•Do NOT touch the individual –even if some touching is generally something you do when talking It is far too easy for an agitated person to misinterpret reaching out as hostile or threatening

•Do NOT point or shake your finger

•Do NOT argue or try to convince

De-escalation Techniques: Communication

- •Remember the intent is to calmly bring the level of arousal to a safer place
- •Do not get loud and try to yell over a screaming person
- •Wait until the individual takes a breath, then talk
- •Speak calmly and at an average volume
- •Respond selectively
- •Answer all informational questions, no matter how rudely asked
- •Ex: “Why do I have to fill out these (expletive) forms?”
- •This is a real, information-seeking question

•Do NOT answer abusive questions
•Ex: "Why are you being such an (insult)?"
•This question should get no response whatsoever
•Explain limits and rules in a firm but respectful tone
•Give choices where possible in which both alternatives are safe ones
•Ex: "Would you like to calmly continue this conversation now or would you prefer to stop and discuss it later when we can be more relaxed?"
•Empathize with feelings but NOT with the behavior
•Ex: "I understand that you feel angry, but it is not okay for you to yell at me."
•Do NOT argue or try to convince
•Suggest alternative behaviors where appropriate
•Ex: "Would you like to take a break from this discussion to have breakfast? We can continue after we are done."
•Give the consequences of inappropriate behavior without threats or anger
•Ex: "If you do not stop yelling at me, I will not continue this discussion."

De-escalation Techniques: What NOT to do T.A.C.O.S.

If the goal is to de-escalate, **DO NOT**:

- **T**hreaten the individual
- **A**rgue or contradict the individual
- **C**hallenge the individual
- **O**rder or command the individual
- **S**hame or disrespect the individual

Maintaining Personal Safety

•Trust your instincts
•You will know fairly quickly if it's beginning to work
•If you think that de-escalation is not working, STOP!
•Make sure you are safe
•Leave the situation
•Call for assistance
•Call the police
•Use physical means **ONLY** as a last resort

Adapted from: "Verbal De-Escalation Techniques for Defusing or Talking Down an Explosive Situation", *Skolnik-Acker, E* (2008)

Crisis Situation possible Suicide Risk

Untreated mental illnesses—specifically depression, bipolar disorder, schizophrenia, and substance abuse—are the leading contributory causes of suicide in young adults (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). These disorders are common among youth (Shaffer et al., 1996; King, 1997). Progress has been made in the scientific understanding of suicide, mental disorders, and substance abuse, as well as in developing interventions to treat these disorders.

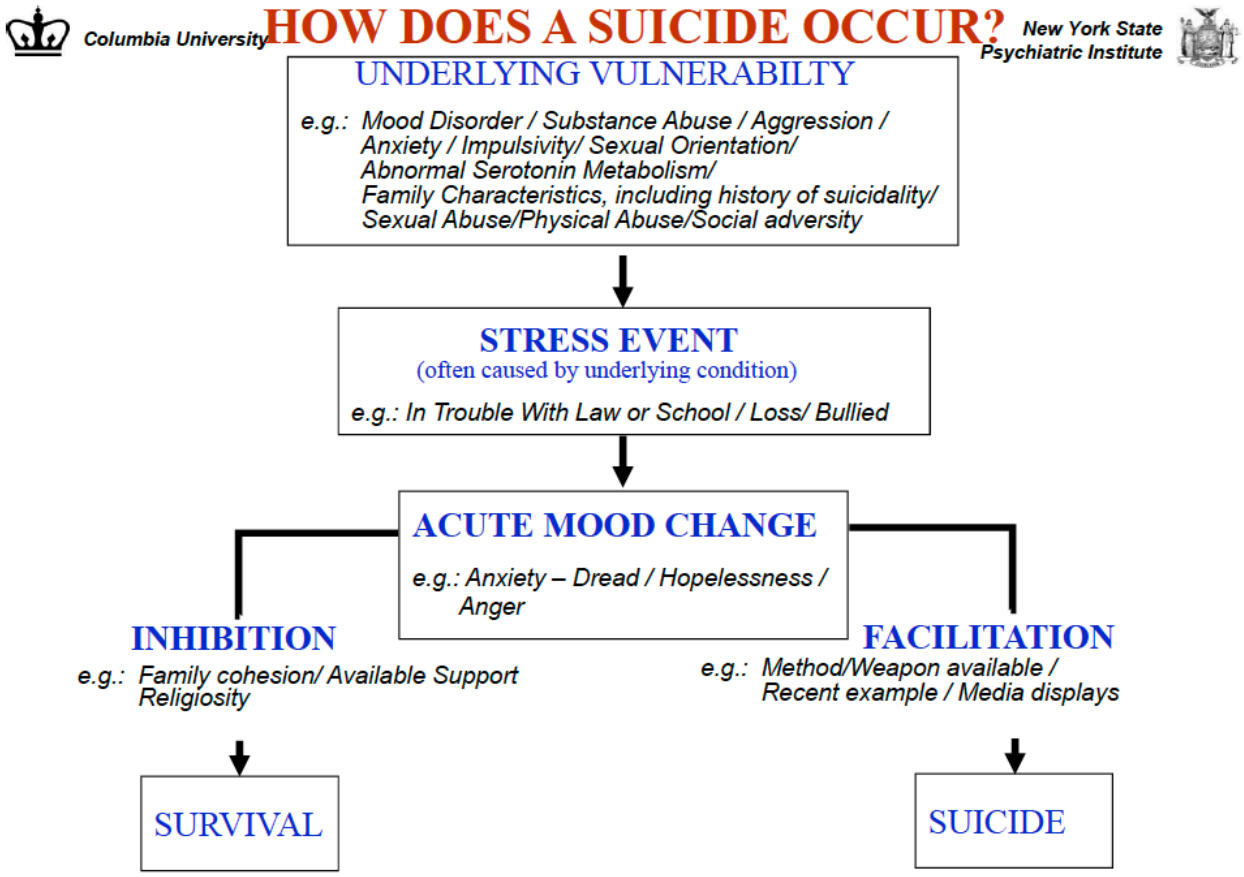
Efficacy and Effectiveness of Specific Strategies

There is limited information about the efficacy and effectiveness of suicide prevention strategies. There have been no specific treatment outcome studies that enroll only college and university students. However, most treatment research studies do include subjects in this age group. Current research indicates that certain interventions have been shown to be effective for the treatment of psychiatric disorders often seen among college-age students, including depression—which is the most common psychiatric disorder associated with suicide—bipolar disorder, schizophrenia, and eating disorders.

These Interventions also have been demonstrated effective for generalized anxiety disorders, including PTSD. Promising interventions fall into two categories:

- Somatic interventions, including SSRIs, Lithium, and Clozapine
- Psychosocial interventions, including dialectical behavioral therapy (DBT),
- Cognitive behavioral therapy (CBT), and interpersonal therapy (IPT).
- These treatments and the evidence for their effectiveness have been reviewed extensively in two major publications:
- Practice guidelines for the assessment and treatment of patients with suicidal behaviors. (2003). *American Journal of Psychiatry*, *160*(Suppl. 11), 1–60.

Practice parameters for the assessment and treatment of children and adolescents with suicidal behavior. (2001). *Journal of the Academy of Child and Adolescent Psychiatry*, *40*(Suppl. 7), 4S–23S



Risk Factors

Suicide & Substance Abuse

- Between 40-60% of those who die by suicide are intoxicated at the time of death.
- Alcoholics are at higher risk if they also suffer from depression – at the time of death by suicide, 50-75% of alcohol-dependent individuals are suffering from depression.
- 20% of those who die by suicide have used cocaine in the days prior to death.

Source: Substance Abuse & Mental Health Service Administration, 2004. *From Herrmann & Lang*

PERSONALITY/COGNITIVE FACTORS

- Hopelessness
- Poor interpersonal problem solving ability
- Aggression/Impulsivity

Serotonin Disregulation

- low serotonin associated with excitable, impulsive, and violent behavior
- serotonin lower in males, after alcohol intake and in the elderly

Genetic Factors

-genes that play role in the regulation of serotonin

Most Common Family Risk Factors

- Family history of suicidal behavior
- Parental psychopathology
- Parent-child relationships – *conflict*
- *poor communication*
- Parental divorce

MOST COMMON STRESSFUL LIFE EVENTS

- Interpersonal losses
- Legal/disciplinary crises

(averaged Brent et al., 1999 and Gould et al., 1996)

SUICIDE AND PHYSICAL ABUSE

Association between physical abuse and suicide completion *(Brent et al., 1994)*

§ Childhood physical abuse associated with increased risk of suicide attempts in late adolescence or early adulthood, even after adjusting for demographic, child psychiatric and parental characteristics.

(Johnson et al., 2002)

SUICIDE AND SEXUAL ABUSE

§ No evidence of association between sexual abuse and suicide completion *(Brent et al., 1994)*

§ 33% of sexually abused children are suicidal at ages 16 to 18 *(Fergusson et al. 1996)*

§ Individuals with history of sexual assault are 6 times more likely to report a suicide attempt, controlling for demographic characteristics, PTSD and depression *(Davidson et al., 1996)*

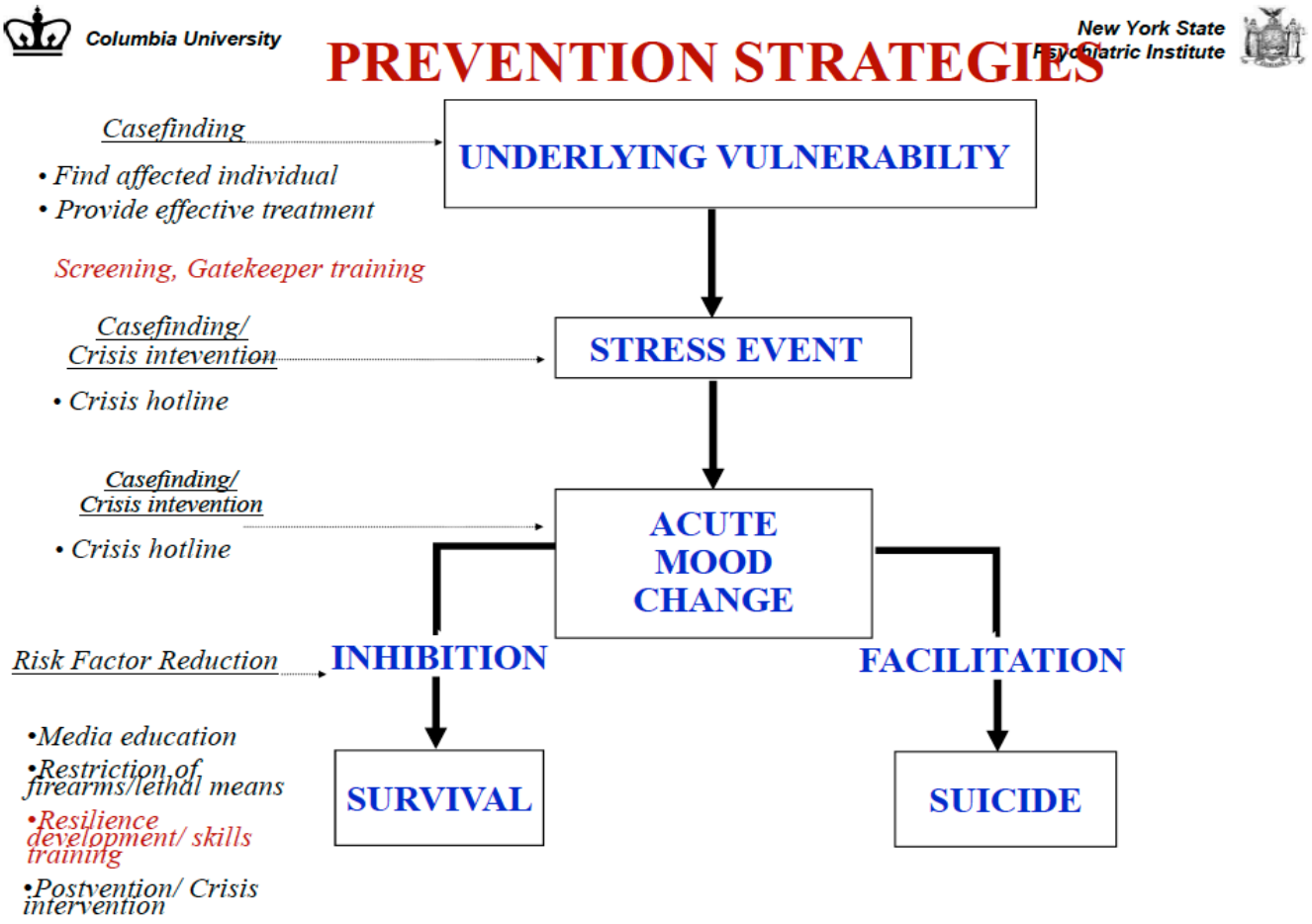
(Compiled by Greenberg and Gould, 2002)

Bullying Media Messages

• Typical media message: bullying causes suicide.
• This does not tell the full story.
• Suicide risk may be substantially mediated by other factors.
(Gould et al. 2003, Shaffer et al., 1996; Brent et al., 1993).

SUICIDE CONTAGION

Process by which knowledge of one suicide facilitates the occurrence of a subsequent suicide.
Viewed within the larger context of behavioral contagion or social learning theory



Reduce or Eliminate access to Method

Resilience development/skills training

• Prevent suicide through the enhancement of problem-solving, coping, cognitive skills, and help-seeking behaviors.

• Enhance protective factors to “immunize” students against suicidal feelings.
• These skills may prevent suicide risk factors such as depression, hopelessness and drug abuse

Screening:
Suicidal adolescents are under-identified
• Potent risk factors can identify at-risk youth
• Youth suicide occurs in the context of an active, often treatable mental illness

Youth Suicide:
Epidemiology and Prevention Strategies
Madelyn S. Gould, Ph.D., M.P.H.
Columbia University/
New York State Psychiatric Institute
Texas Suicide Prevention Symposium
San Marcos, TX
August 1, 2012

Chart found on page 13 of **From Rollercoaster to Recovery.**

	HEALTHY	REACTING	INJURED	ILL
Mood	Normal mood fluctuations. Calm & takes things in stride	Irritable Impatient Nervous Sad Overwhelmed	Anger Anxiety Pervasively sad Hopeless	Angry outburst/aggression Excessive anxiety/panic attacks Depressed/suicidal thoughts
Attitude and Performance	Good sense of humour. Doing their best at school. In control mentally	Displayed sarcasm Procrastination Forgetfulness	Negative attitude Drop in grades/or always doing school work Poor concentration Poor decisions	Breaking rules/law Can't or won't do school work. Out of control behavior Can't concentrate
Sleep	Normal sleep patterns. Few sleep difficulties	Trouble sleeping Intrusive thoughts Nightmares	Restless disturbed sleep Recurrent images/nightmares	Can't fall asleep or stay asleep Sleeping too much or too little
Physical Symptoms	Physically well Good energy level	Muscle tension Headaches Low energy	Increased aches and pains Increased fatigue	Physical illness Constant fatigue
Social Behaviour	Physically and socially active	Decreased activity/ Socializing	Avoidance Withdrawal	Not going out or answering the phone
Alcohol, Drugs and Cigarettes	No use/small amounts of alcohol	Regular but controlled use	Increased use hard to control with negative consequences	Frequent use with severe consequences

Crisis Planning ~ Checklist for Crisis Plan

Some of the questions you may want to talk over with your supporters to develop a plan when you are well that helps them advocate for you in a crisis.

Describe how you feel when you are feeling well. This will help your supporters notice when you are starting to have symptoms.

What are the stressors/situations in your life that may cause you to become unwell?

What are the symptoms that indicate you are having difficulty making decisions for yourself, the ones that indicate you may no longer be responsible for yourself or can make appropriate decisions.

- Who are the people you don't want to have involved in any way in your care or treatment.
- List names and if comfortable relationship and (optionally) why you do not want them involved:

- When you clearly have some of the above symptoms, who are the people you would like to be asked to make decisions for you, see that you get appropriate treatment and to give you care and support:
- When you are experiencing these symptoms what do you want from your supporters?
- What do you not want?
- What do you want your supporters to do if you are a danger to yourself or others?
- Things you need others to do for you and who you want to do it: eg take care of a pet
- How do want disagreements between your supporters settled:
- Things you can do for yourself:
- Do you give permission for your supporters to talk with each other about your
- symptoms and to make plans on how to assist you.
- Indicators that supporters no longer need to use this plan:
- Preferred medications and why:
- Acceptable medications and why:
- Unacceptable medications and why:
- Acceptable treatments and why:
- Unacceptable treatments and why:
- Home/Community Care/Respite Options:
- Preferred treatment facilities and why:
- Unacceptable treatment facilities and why:

From Roller Coaster to Recovery: a Guide for Individuals and Families
Crisis and Risk of Suicide

People who talk about suicide usually do not really want to die, but are desperate for support.
It is extremely important to take any mention of suicide seriously, particularly if they have been showing signs of other behaviours you are concerned about.
Sometimes when there is a mental illness present, the person will hear voices telling them they should die.
If you think the person is in danger of attempting suicide, ask them directly.
Don't be afraid to discuss it openly—it will not increase the chances of the person dying by suicide.
Try to make a verbal contract or agreement with the person to not carry out their plan at least until a specified time (maybe 2 hours from that point).
Assure them that you will not judge them, that you are there to support and get them through this rough time.

Talk about the things they feel overwhelmed about—listen, don't try to give too much advice or minimize their concerns.
Once the person is calm, talk about calling the Distress Line and/
or the family doctor to explore what options could be made available.
This could make the process of hospital admission or further
involvement with the mental health system feel more within the person's control.
Thoughts of suicide can stem partly from feelings of helplessness and hopelessness.
As much as is possible and safe, it is best not to take away the options and potential for decision-making in a person's life.

IF THE PERSON WON'T ACCEPT HELP AND SAYS THEY WILL COMMIT SUICIDE, CALL 911

STEPS FOR PREVENTING CRISIS:

Educate Yourself. For instance, attend a family education group or program related to mental health and the mental health system. Research has shown that family education is one of the most important variables in reducing the frequency of hospitalization.

Reduce Stress at home. Try to lower the emotional voltage in your interactions with the individual. Learn to recognize patterns that cause stress
and conflict for you and your family member. Re-evaluate your expectations of them and stop doing what is not working. This is a good opportunity to choose your battles.

Reach out for Help both for you, the individual who is struggling with mental illness and for the rest of the family who will be affected. Don't try to manage things all on your own. There is no shame in admitting someone has a mental illness in the family, or in admitting that you might need some help to manage.

Be Aware of Relapse Symptoms and patterns that you have observed in the individual. Get help sooner rather than later. If possible, you want to avoid the stress and trauma that can be involved in hospitalization, which can sometimes seem like the only option in the midst of a full-blown crisis. It is very unusual for someone to become suddenly and severely ill—the process of relapse usually takes about a week. Keep your eyes open.

Have Your Family's "Toolbox" Ready
It can be an incredibly frightening experience to see the person in crisis or in the middle of a psychotic episode. It is important to prepare yourself and your family for this possibility. Included in your 'toolbox' are all the things you
need when faced with a mental health crisis.

Here are some examples of tools you can have ready:

- A list of people you can trust and who you can call in a difficult time—family, friends, your family doctor, etc. Have this list ready and posted so that if you aren't around, someone else will still be able to find it.
- A list of ways to behave that will help to create calm in a stressful situation, such as speaking in a soft voice, keeping your body language subdued and reducing the amount of noise or extra stimulus in the environment if possible.
- Try not to challenge what the person is saying or experiencing - don't say things like "its not that bad", or I don't see why you are so upset."