# Optimizing Caregiver Interactions with Crisis Responders (13 Nov 2014)

## Contents

# Introduction

A crisis, especially one which manifests itself suddenly, can be a time of high stress, frustration, and unpredictability (including the risk of creating a danger to the Consumer or those in the vicinity of the Consumer). This document is intended to facilitate more optimal outcomes when the caregiver of a person with a psychiatric emergency calls for help. Hopefully, caregivers, responders, crisis hotline workers, call takers and dispatchers and especially consumers will benefit from the contents of this document.

This document is a work in progress. It has benefited from the input of Responders, Caregivers and Consumers. Over time, it is anticipated that the suggestions made here will become more nuanced according to the specifics of the scenario at hand. It may even become enriched by illustrative anecdotes drawn from actual crisis situations.

The decision to follow any of the suggested actions contained in this document is the responsibility of the individual who is satisfied that the action is in fact the best thing to do and does it. It may at times be more appropriate to forego some of the suggestions made in this document, depending on the assessment of those involved.

Examples of psychiatric emergency which are being considered may include a psychotic episode or severe depression in which suicide is a serious concern. The word “crisis” will be used as a general term for these kinds of psychiatric emergencies.

## Cast of Characters:

Caller: This is the person who, through a dispatcher or call taker in a dispatch center, initiates the mobilization of Responders to the crisis location, typically through a phone call. Most often, but not always, this will also be the Caregiver.

Call Taker: This is the person who receives the call to mobilize Responders to a crisis. Depending on how the Response system is set up, this may be a person covering a special phone number for mental health calls, a 9-1-1 call taker, a Dispatcher.

Caregiver: This is the person most concerned with fostering the best possible outcome for a specific individual who is either at risk of having a psychiatric emergency or is experiencing a perceived psychiatric emergency. Often the Caregiver is a family member who lives with the

person in crisis. It may also be a person at a group home or other non-institutional facility who has responsibility for residents who are known to be at risk of a crisis.

Consumer: This is the person who "consumes" services, the person who is at risk of a crisis or perceived to be in crisis.

Crisis line: This may be a person covering a phone number for providing advice for mental health issues. Typically this person does not have authority to dispatch Responders. Often this person also does not have the capability of forwarding the call to a 9-1-1 call taker or Dispatcher.

Dispatcher: This is the person who directs Responders to a location. The Dispatcher generally will provide additional information to Responders while they are en route.

Psychiatrist: If the Consumer has been prescribed medications for mental illness, the Consumer's psychiatrist may be able to assist the Caregiver during a crisis, especially before the Caregiver calls for assistance from Responders. The psychiatrist may also be able to provide information to Responders or to personnel at a hospital or other facility where the Consumer is taken for treatment.

Responder(s): This may be a single regular police officer, a SWAT team, an experienced and well-trained CIT officer with back-up, a CIT officer accompanied by a social worker or psychologist, or some other configuration of personnel concerned with public safety. This document assumes that, if there is more than one designated Responder to the crisis, there will be a "lead Responder" who provides over-all direction to the team of Responders and also is the person who attempts to de-escalate the situation with the Consumer. There is sometimes no logical necessity, other than availability of resources, for the lead Responder to also be the Responder who engages in de-escalation. There can arise situations where both SWAT and CIT are responding to the same crisis. If this happens, it is important to ensure that a lead Responder coordinate the overall response.

The situation during a crisis response can be quite stressful for Caregivers, Responders and, of course, the Consumer. The Consumer is in a state of volitional, cognitive and/or emotional distress. The Responders are usually coming to an unfamiliar location, dealing with unfamiliar people and having to assess, on-the-fly, the risks of physical danger to themselves and others. The stress on the Caregiver can come from several directions: unfamiliarity with who will be responding, what the Responders will do, whether the Consumer's safety will be in jeopardy.

The behavior of the Consumer may be novel to the Caregiver leading to further confusion and stress. The Caregiver may also be second-guessing the decision to call for crisis intervention assistance. Previous experience with crisis Responders may also influence the Caregiver's stress level, as well as any recent publicized interventions which have come to the Caregiver's attention. There may also be others who are adding to the stress level: having responsibility for very young children or enduring the helpful and not-so-helpful advice and comments from others present at the time.

## Feedback

This document would not be possible without the contributions and critical review of responder trainers, responders, caregivers and consumers. Continued input, suggestions, constructive criticism and illustrative anecdotes will help make future versions even more effective.

If you would like to provide feedback or anecdotes, please contact by email:


Steve Hobart steve.hobart.cit@gmail.com

Or

Ted Isensee ted.isensee@gmail.com


All contributions will be edited to preserve anonymity.

Future versions of this document will eventually appear on the website of the Isensee Foundation for Safe Police Response: http://www.safepoliceresponse.org/

## Before Calling for Crisis Intervention Responders

Obviously, a Caregiver /Caller who has never experienced a crisis will be less prepared to efficaciously participate in the crisis response. A Consumer who has no previous history of severe mental illness will likewise present additional challenges to responders. This part of this document will not be of much use in these cases.

A Caregiver's or Consumer's previous experience with Responders, whether positive or negative, will color the interaction with Responders during the next crisis. For a Consumer deep in the throes of a psychotic episode or presenting a serious threat of suicide, the immediacy of his/her mental state will probably override much consideration about any previous encounters with Responders.

Prior to calling 9-1-1 or an equivalent emergency number, there are things which the Caregiver can do to promote a more optimal outcome. There is a progression in the Caregiver's assessment of a psychiatric crisis, outlined as "stages":

1. Pre-crisis
2. Suspected prodromal
3. Suspected crisis
4. Convinced of crisis
5. Decision to call for assistance

### Pre-crisis

In this stage, the Caregiver does not sense an impending crisis, but is aware that someday in the indeterminate future, a crisis may occur. Only 10-20% of people who experience a psychotic episode never have another one. It is prudent, therefore, to be prepared for a future episode, while at the same time fostering recovery which reduces the frequency and risk of future episodes.

#### Helpful

1. Becoming educated about resources available in the event of a crisis.
    a. Educational resources: NAMI, MHA, others?
    b. Responder resources
        i. Who to call? Phone number? – not necessarily 9-1-1.
        ii. Who will respond?
    c. Medical resources
        i. Where will Consumer receive help?
        ii. What are the potential insurance complications?

iii. Will the psychiatrist be available on an emergency basis?
iv. Does psychiatrist have admitting privileges at a local hospital?
v. What local hospitals have psychiatric beds?

2. Become acquainted with potential responders
3. Notifying Law Enforcement to flag the address as a residence of someone at risk of crisis.
4. Learn about diagnosis and potential triggers.
5. Learn about what is normal behavior so that abnormal behavior can be identified. Sometimes difficult with adolescents who are undergoing physical, hormonal, social, and philosophical adjustments.
6. Encourage continued recovery: medications, socialization, employment, personal responsibility, therapy, etc.
7. Keep weapons and knives in a locked location.
8. Develop a crisis plan with the Consumer and Psychiatrist
    a. Crisis Kit
    b. Psychiatric Advance Directive
    c. Medical Power of Attorney
    d. Etc.
9. Testing the crisis plan with a dry run (within reason)

### Harmful

1. Wishful thinking that a crisis will never happen
2. Not researching local resources
3. Not accessing local resources
4. Not being alert to Consumer's behavior

## Caregiver Suspects Imminent Crisis

At this stage, the Caregiver has a heightened concern that a crisis may occur. There may be prodromal symptoms, known triggers or expressions of suicidal thoughts. Crisis planning at this stage is going to be suboptimal compared to planning when everything is stable and the Consumer is likely to be more cooperative in formulating a crisis plan. It is too late to begin taking full advantage of the educational resources offered by the community. It is probably too late to get a medical power of attorney or psychiatric advance directive.

There may be a crisis line or hotline that can offer advice. Generally, such community services do not link directly with Responders or Dispatchers for Responders. However, a crisis line or

hotline may be able to provide to Caregivers advice, such as is contained in this document, which would facilitate a more optimal crisis resolution.

### Helpful

1. Call a mental health crisis line, hotline or the psychiatrist.
2. Review relevant educational materials
3. Put together a rudimentary crisis kit – Crisis hotline worker may be able to offer advice as to what to include in a crisis kit.
4. Address, if possible, anything which may be triggering or aggravating the suspected crisis
5. Being attentive to Consumer (moodiness, triggers, change in habits (e.g. social, eating, hygiene, sleep)) – Crisis hotline worker may be able to suggest looking for indicators of Consumer distress that can be articulated to a Call Taker / Dispatcher / Responder.

### Harmful

1. Leaving the scene – Crisis hotline worker can counsel the Caller / Caregiver to remain calm and wait for the Responders to arrive, should the decision be made to call for help.
2. Using the prospect of calling the police as a threat to induce better behavior or taking of medications – Crisis hotline worker advises against saying anything which could place potential Responders in the position of adversaries, perhaps even suggesting that the Caregiver not mention to the Consumer that calling for help is being considered.
3. Becoming highly emotional or confrontational with the Consumer.

## Caregiver Convinced of Crisis

At this point the Caregiver is convinced that a crisis situation has arisen, but has not determined that a call for assistance is warranted. Again, a crisis line or hotline may be able to provide useful coaching to Caregivers who are unsure about what to do next, assuming that there is no immediate physical danger to be attended to. Most of the advice pertaining to “Imminent Crisis Suspected” also applies here; however, there is now a heightened sense of urgency to “do something”. Again, the most pressing decision facing the Caregiver is whether to call for assistance, while being attentive to the Consumer’s condition, especially if the behavior is on a trajectory of creating a risk of harm to anyone.

### Helpful

1. Stay calm
2. Review NAMI “Family-To-Family” or similar materials pertaining to crisis situations
3. Call a mental health hotline, crisis line or psychiatrist
4. Ensure that nothing which could be used as a weapon is accessible

### Harmful

1. Raising the stress level in the Consumer
    a. Threats and ultimatums
    b. Panicking
    c. Activating “triggers”
2.

## Caregiver Decides to Call for Assistance

The Caregiver has decided that the crisis is sufficiently serious that assistance is needed. The Consumer may be too unpredictable, agitated, resistant or violent to risk an attempt to get the Consumer to treatment without help.

### Helpful

1. Prepare information for call taker/Dispatcher (see next section)
2. Stay calm
3. Coordinate with others (family members or other concerned parties)
    a. That only one person calls for help.
    b. That someone continue to monitor the Consumer

# While Caregiver is Engaged with 9-1-1 or Dispatcher/Call Taker

The Caregiver should take note that the personnel at a Crisis Line or Hot Line generally do not have authority to dispatch responders. It should also be noted that the initial call to 9-1-1 may not immediately connect with the person who actually does dispatch responders. It may be a shared 9-1-1 system which will transfer the call to an appropriate call taker or Dispatcher. In some systems, the call taker and Dispatcher are not the same person, but rather may be part of a "dispatch center" wherein the call taker passes information to the Dispatcher.

It would seem that better outcomes would be facilitated if the information flow be bi-directional. Not only should the caller be providing information to the Call Taker / Dispatcher, but the likelihood of a successful response may be enhanced if the Caller / Caregiver is provided with useful information in the course of the call. If the Caller is not treated supportively, professionally and with respect, cooperation during this crisis and future crises may be impaired.

## Helpful

1. Provide the information requested by the Call Taker / Dispatcher. Additional information, listed below may also be useful, even if not requested by the Call Taker / Dispatcher.
    a. Information about the Consumer
        i. Location – the Responders need to know where to go. In addition, the location may be in a different jurisdiction than that covered by the Call Taker / Dispatcher. Calls to 9-1-1 using cellular telephone or voice over internet protocol (VOIP) technologies have sometimes been problematic for Call Takers / Dispatchers, necessitating confirmation of the address to which Responders will be sent.
        ii. Dangerous situation? (If yes: tell caller to stay on the line as response is dispatched)
            1. Dispatcher needs to know the urgency of the response in order to keep resources properly allocated
            2. Dispatcher needs to communicate to Responders the details of any present dangers
            3. Have any specific threats been made?
        iii. Identifiers
            1. Name used by people familiar to Consumer – Responders can use the same familiar name
            2. Age, height, weight, race, color of hair – helps Responders recognize the Consumer, and who is not the Consumer

3. Clothing – also helps Responders recognize the Consumer, and who is not the Consumer

iv. Current condition
   1. Psychiatric diagnosis, if any – helps Responders tailor response and de-escalation to the situation at hand
   2. Active psychosis details – also helps Responders tailor their response
   3. Triggers – Responders want to avoid triggers which escalate the situation
   4. Present activity (specifics, especially those which justify the call)
   5. Access to weapons (kitchen, toolshed) – Responders will use appropriate caution
   6. Medical – this information may at times also be helpful to the Responders
      a. Type and dosage of all prescribed medications
      b. Any non-prescribed drugs, especially psychoactive drugs or alcohol
      c. Physical impairments or chronic conditions, e.g. diabetes, deafness

v. Relevant history – key word is relevant
   1. Past violent behavior – Responders may find this useful as a baseline for tailoring their approach
   2. Past psychoses and/or delusions – Likewise, this could be useful baseline information
   3. What situations/topics raise or lower anxiety? – information useful for de-escalating
   4. Psychiatrist – if available, may be an additional resource for information about the consumer
   5. How has Consumer responder to crisis responders in the past?
   6. Is there a means to communicate with the Consumer? – de-escalation requires communication: e.g. talking face-to-face, through a door, over a cell phone, texting.

2. Caller info
   a. Location (same as Consumer?) – Responders may need additional information from the Caregiver. It is probably a good idea to confirm the second-hand information passed on from the Dispatcher: Caregiver / Caller may have misspoke, Call Taker / Dispatcher may not have accurately received what the Caregiver /Caller attempted to communicate,
   b. Caller's name
   c. Caller's relationship to Consumer
   d. Will caller be available when responders arrive?
      i. How to visually recognize caller
3. Information about the location

a. Are there any animals present? – especially dogs or others which could be a nuisance, distraction or obstacle to an effective crisis response. If there is a therapeutic animal present or otherwise involved, this needs to be communicated to Responders. (e.g. therapy dogs, mental health service dogs, emotional support dogs and skilled companion dogs).
b. Are there any physical hazards inherent in the location, apart from any uncertainty about safety created by the Consumer.

For the Caregiver/Caller (who may not think to ask), the following information may be useful, even if not volunteered by the Call Taker / Dispatcher.

1. Who will be the lead Responder? – A Responder who is not the lead Responder may not have the requisite training to deal with a mental health crisis. Such a Responder, though well-intentioned, may not communicate to the lead Responder all the relevant information shared by the Caregiver. If the lead Responder has not arrived, the entire response team has not yet arrived and a less coordinated response may be inappropriately initiated
2. Is the lead Responder trained in crisis intervention? – If not, a Responder in the role of a Law Enforcement Officer on the scene will generally take responsibility for ensuring everyone's safety, especially the safety of other officers. If the lead Responder is not trained in crisis intervention, the Caretaker should explicitly ask the Call Taker / Dispatcher to send such a trained officer. If the Call Taker / Dispatcher cannot assure that an officer trained in crisis intervention will be the lead Responder, the Caregiver may want to re-evaluate the risks in having untrained people responding to a mental health call. The Dispatcher may decide to send Responders, even if the Caregiver decides that the present risk of untreated mental illness is not as dangerous as having untrained Responders. A Caregiver with crisis experience may be put in a position of having to diplomatically coach the untrained Responder. (Good luck!)
3. When will the lead Responder arrive? – If other Responders arrive first, it may be a good idea to ask them to wait for the lead Responder, unless there is an active threat of physical harm which needs to be contained.
4. Caregiver should request that the Lead Responder consult with the Caregiver on arrival. This will provide the opportunity for both the Caregiver and Responder to confirm the information exchanged with the call to 9-1-1 (or other appropriate emergency number).
5. Caregiver should request that the Call Taker / Dispatcher relay to all the Responders that this is a mental health call and that a CIT officer be present. If the Responders are police who do not understand the nature of the call, and the proper response, tragic misreadings of the situation may occur once they arrive.
6. How many will be in the Response Team? – A small army of armed police is generally not conducive to de-escalation. It may be required if there is an active threat of physical harm, however.
7. Caregiver should ask for a call-back phone number. In the event that the situation changes, the Responders will need to know. If the call is being handled by a Dispatch center, a transferred 9-

1-1 response, or near a shift change, a prompt response to the Caregiver's update may make a difference in the outcome.

The Call Taker / Dispatcher is in a position to help reduce the anxiety of the Caller / Caregiver. This is also an opportunity to provide some coaching to facilitate an optimal outcome. It may help to facilitate a better outcome if the Caller's stress level is reduced through various forms of reassurance:

1. Repeating back the information provided. – Ensures that the Caller has been understood and that the specific concerns of the Caller are going to be addressed.
2. Maintaining a calm, courteous and respectful demeanor and tone of voice.
3. Assurances regarding the compassion and training of the Responders.
4. Provide the Caller / Caregiver with a direct call-back number. – If something changes, before the Responders arrive, the Caller / Caregiver should communicate it.

## Harmful

1. Caretaker losing self-control – Coach controlled breathing. Reassurance that appropriate help will be on the way. Coach Caller to speak slowly and clearly. Model the kind of voice which facilitates a good exchange of information. Confirm any information that could have been unclear.
2. Caretaker shouting at, or arguing with, the Call Taker / Dispatcher – Stay professional with an even, respectful, courteous tone of voice. Encourage the Caller to do the same.
3. Blaming Call Taker / Dispatcher for difficulties or unavailability of resources.
4. Hanging up prematurely, leaving the scene – explicitly coach the Caller to stay on the line and to remain at the scene until Responders arrive. Coach Caregiver / Caller what to do until Responders arrive – see next section

# After the Call and Before Responders Arrive

At this point, Responders are on their way. The Call Taker / Dispatcher will convey at least some of the information provided by the Caregiver to the Responders. There very likely will be no opportunity to coach the Caregiver during this phase. The Call Taker / Dispatcher may, if there is no exigent circumstance, stay on the line with the Caller / Caregiver to provide coaching; however, this may not always be feasible. During this phase, the Caregiver may decide to call a Crisis Helpline, NAMI, fellow Caregiver or a trusted advisor. Hopefully, if the Caregiver does call someone during this phase, sound counsel will be given.

Caregiver attitudes during this phase can vary widely, depending on previous experience and the situation facing the Caregiver:

1. Hopeful – because the Caregiver expects experienced, professional Responders to stabilize the situation and help get appropriate treatment.
2. Fearful – because the Consumer presents an active threat to the safety of the Caregiver
3. Confident – because the Caregiver has previous positive experience with the Responders, is adequately prepared for this crisis and has been given reassurances by the Call Taker / Dispatcher.
4. Apprehensive/anxious for the safety of the Consumer (likely a loved one), especially if there is a perception of the tendency of armed Responders to resort to lethal force if they become surprised, alarmed or concerned about sustaining any kind of injury.

### Helpful

1. Stay calm and deliberate
2. Ensure there is no access to anything which could be a weapon
3. Ensure third parties, children and animals are out of the way
4. Continue to monitor activities and demeanor of Consumer. Call with any significant updates.
5. Ensure that the consumer has no access to potential weapons
6. Retrieve or assemble a crisis kit
7. Watch for arrival of Responders
8. Turn on all the lights if the Consumer is likely to be indoors. – Responders may experience stress induced by occupationally conditioned hyper-vigilance if they are unable to see the entirety of their environment. Dispatcher / Call Taker will hopefully phrase this rationale differently.
9. The Lead Responder may be able to communicate with the Caller / Caregiver while en route. Establishing rapport, allaying fears, coaching the Caregiver, learning more about the Consumer and the present crisis.
10. All persons present with the Caller /Caregiver should agree on having a single spokesperson, preferably the primary Caregiver, to the Responders. Multiple parties trying to communicate at

the same time with the Responders can lead to chaos, confusion and, potentially, Responders not giving heed to what anyone on the scene is trying to say.

### Harmful

1. Triggering emotional stress in the Consumer: screaming, threatening, hysteria, engaging in a power struggle, etc.
2. Leaving the scene, unless safety requires it
3. Allowing Consumer to raise stress level in Caregiver by pushing emotional buttons.
4. It may be harmful for the Caregiver to try to de-escalate the situation prior to the rrival of more experienced CIT personnel.

## Initial Contact with Responders

This is the most critical time. The majority of avoidable tragedies during mental health calls seem to occur within just a few minutes after the arrival of Responders or of a late-arriving Responder.

One of the first tasks of the Responders is to assess the situation for immediate dangers. Ideally, the Caregiver and Lead Responder will consult and verify the information each has received from the Dispatcher / Call Taker. They can also provide additional information to one another that was not conveyed during the call for assistance. This could include any changes in the situation or additional details about the Consumer's current state or relevant history. The more information that is gathered by the Lead Responder, the better understanding he/she will have as to the potential risks and as to a de-escalation approach. In addition, a fuller understanding of the situation will facilitate the formulation of a plan to best execute the intervention.

In the absence of a clear and immediate danger, the initial contact between the Responders and the Caregiver provides an opportunity for each to assess how much assistance the other will be able to provide.

If there is a sworn police officer on the scene (most CIT Responders come from the ranks of sworn police officers), the officer legally has authority over any non-police officers present. If the Responder thinks he/she is wearing a "Law Enforcement" hat, as opposed to a "CIT Responder" hat, he/she may be assuming that "command presence" and verbal commands should be sufficient, short of physical force, to obtain compliance from the Consumer. Depending on the specific nature of the mental health crisis, this may indeed be the case, but often it is not. The "Law Enforcement" officer who attempts to apply physical force and encounters resistance has, absent any accommodation for the fact that he/she is dealing with a mentally ill person, grounds for persisting in applying and escalating whatever force is necessary to effect an arrest (for "resisting arrest", among related charges such as obstruction of an officer in the conduct of his duties and public disturbance). The "CIT Officer", on the other hand, will adapt to the specific of the situation, as informed by the Caregiver and Dispatcher, to patiently de-escalate the situation with a tailored approach to the Consumer.

Just as Caregivers may have concerns about how the crisis response will play out, so do Responders, especially if they are not familiar with the location or the person in crisis. Having incomplete information about what awaits them on arrival, their primary inclination is to be

alert to any potential threats to the safety of everyone present, especially themselves. The reasoning for “especially themselves” is that if the trained protectors, are not protected, then those who they protect may have inadequate protection. The more information that is made available to the Responders, there will be less unwarranted apprehension about the crisis response.

## Helpful

1. Having a single Caregiver calmly greet the first arriving Responders. If the Caregiver is also the person who called for assistance, this should be said up front. Getting the names of the Responders can foster a more interpersonal working relationship.
2. The Caregiver should truthfully answer all questions presented by the Responders, even if the answers are embarrassing. Misinformation can potentially sabotage what would otherwise have been a successful, minimum stress, intervention.
3. The Caregiver should inform the Responders if other family members are available to answer questions or volunteer information. The Responders may want additional perspectives or observations, but only as they determine it to be useful.
4. Along the same lines as the previous point, the Responders may find it useful to have contact information for others who are involved in the affairs of the Consumer, e.g. psychiatrist, case manager.
5. The Caregiver should expeditiously comply with commands and requests from the Responders. Failure to do so may not only result in arrest is the Responders include police officers, but it can also undermine the efficacious execution of the intervention. The Responders may perceive that the presence of the Caregiver contributes to the distress of the Consumer. On the other hand, the Responders may perceive that the Caregiver may make an active contribution to the de-escalation process. It is advantageous for the Responders to be able to access the Caregiver as needed.
6. While answering all questions and complying with all commands is useful, this is not to imply that the Caregiver should be completely passive. The following proactive actions may lead to a more satisfactory outcome.
    a. Verifying the information given to the Dispatcher can be useful to ensure that the Caregiver and the Responders “are on the same page”. Garbled radio traffic, typos into the CAD system, misunderstandings by the Call Taker / Dispatcher can all contribute to unfortunate assumptions as to what the Responders are expected to accomplish and how they go about it. See the extensive list of potentially helpful information in the preceding section “While Engaged with the 9-1-1- Dispatcher / Call Taker”.

b. "Getting on the same page" also entails that the Caregiver communicates to the Lead Responder what outcome is desired, e.g. transport to a mental health treatment facility.
c. If the demeanor of the Responders suggests a "Law Enforcement" mentality (e.g. being in an unwarranted hurry, not consulting with the Caregiver) as opposed to a "CIT" mentality, the Consumer is at heightened risk of danger. The most helpful thing the Caregiver can do is to diplomatically offer the Responders, especially the one who seems to be in charge, information that can help them execute the mental health call. E.g. call out "Officer, I may have information which can help with your mental health call." Questioning the competency of the Responders or calling for a supervisor to send someone else is not likely to be successful.

7. Building trust and rapport with the Responders will facilitate remaining engaged as part of the Response team. Support and hospitality can help in this regard.
8. On the other hand, Responders who keep the Caregiver in the loop, calmly explaining what is likely to happen next, will also alleviate anxiety and foster a more productive working relationship with the Caregiver.
9. Attaining a consensus on the plan of action. Agreed upon cooperation.
10. Asking the Responder-in-charge "What do you want me to do?" and then following instructions.
11. Keeping pets, family members and others out of the way.
12. A well-meaning, but inexperienced, Caregiver would likely benefit from extra coaching as to the most helpful actions to take during the crisis response.

## Harmful

1. Running up to the Responders is likely not a good idea. It may convey an undue sense of urgency about the situation. Instinctually, any unfamiliar thing approaching someone is regarded as a potential threat until established to be otherwise. Responders are already arriving with a state of mind that the situation they are about to confront may contain unknown hazards. Unnecessarily adding to that cognitive/emotional load is likely to be counter-productive.
2. Distracting the Responders with unnecessary information, questions or observations may impede the ability of the Responders to address the crisis.
3. Getting overly excited or dramatic. The less the Responders are concerned with the Caregiver's state of mind and emotions, the more they can focus on the Consumer.
4. Similarly, interrupting, arguing with or criticizing the Responders may well result in the Caregiver being escorted to a location more remote from where the Responders are working. Need to trust the professionals' training, experience and concern for the Consumer.
5. Withholding information or downplaying or exaggerating the situation.

6. Assuming that the Call Taker / Dispatcher relayed to the Responders everything that the Caregiver told them.
7. Failure of the Caregiver and Responder's to reach a consensus on the course of action will undermine cooperation and could result in a complaint and/or lawsuit should unilateral action by the Responder cause harm to the Consumer.

# While Responders Engage with Person in Crisis

Once the Responders have adequate information, they will proceed to execute a plan to resolve the crisis, preferably through de-escalation. The role of the Caregiver should be whatever role is assigned by the crisis Responder-in-charge.

## Helpful

1. Being wherever the Responder says to be. This may involve considerations of safety, accessibility and the Responder's plan for engaging the Consumer (e.g. facilitating de-escalation, avoidance of emotional triggers, etc.)
2. Not saying anything unless queried or directed by a Responder. The verbal interaction between the crisis Responder and the Consumer should not be interrupted by any third parties.

## Harmful

1. Caregiver or others interfering with the Responder's interaction with the Consumer.
2. Caregiver not following Responder's instructions.

# At Resolution of Response

At this stage, the crisis is not necessarily over, but the role of the crisis Responder is coming to an end. There are multiple possible scenarios:

1. De-escalation has resolved the crisis such that the behavior which prompted the intervention of crisis Responders has ceased. The Responders will leave the Consumer in place.
2. The Consumer is to be transported to a facility for appropriate treatment and care.
3. The Consumer's behavior has been deemed to include violations of the law such that the Responders feel obligated to involve the Consumer in the criminal justice system. In other words, the Consumer will be taken to jail or diverted to treatment prior to going to jail.
4. The Consumer / Responder interaction resulted in significant physical injury to the Consumer. The Consumer will be transported to a hospital.

Depending on the Caregiver's perspective, the resolution of the Responder's role in the crisis can produce various attitudes.

1. The Caregiver may be relieved and grateful that the prospect of danger to the Consumer and others has been removed.
2. The Caregiver may be anxious about what happens next in the treatment process. Every consumer has a first crisis. The Caller / Caregiver may be unfamiliar with the process and available options and services. Coaching the Caregiver at this stage will facilitate appropriate continued involvement in promoting the treatment and recovery of the Consumer.
3. The Caregiver may be angry about how the Responders handled the situation. This may be unjustified if a consensus plan was followed, but nevertheless resulted in harm or potential harm to the Consumer or others. A perceived lack of respect on the part of Responders to the Consumer, Caregiver or other family members at any point can poison the atmosphere, resulting in reduced cooperation and less satisfactory outcomes.
4. If the Consumer had been perceived as presenting a physical danger to the Caregiver or others, but is not taken into custody by the Responders, feelings of hopelessness, frustration and fear may arise.

## Helpful

1. Having a crisis kit, including copies of assembled documents, ready to go with the Consumer if the crisis response results in the Consumer being transported elsewhere: treatment, hospital, jail.
2. Following any instructions or advice given by the crisis Responders.
3. Prepare to assist in the Consumer's recovery. Education, support, access to services, etc.
4. The Caregiver may have questions about what happens next. Responders can offer some assistance in this area.

5. An “after action review” may be fruitful. Reviewing what went right and what could have been done better can lead to better crisis response in the future.

## Harmful

1. Arguing with Responders – They are trained and doing their job. Patience, cooperation and diplomacy will accomplish more.

## Elements of a Crisis Plan

Individual/Family Information:

| | | | |
|---|---|---|---|
| Person's Name: | D.O.B. | Diagnosis(s) | Date of Plan: |
| Medications: | Dosage: | Physician Name / number | Pharmacy Name / Number |
| Support Contact Name: | Phone(s) | Support Contact Name: | Phone(s) |

Description of immediate needs:

Safety Concerns:

Treatment Choices:

Interventions preferred:

Interventions that have been used:

Interventions that should be avoided:

Professional involvement:

| | | | |
|---|---|---|---|
| Psychiatrist Name / Phone: | Therapist Name / Phone: | Work Contact / Phone: | Case Mgr Name / Phone: |
| Crisis Team Phone: | Doctor Name / Phone: | Hospital Name / Phone: | Other: |

Supports to use in crisis resolution:

| | | | |
|---|---|---|---|
| Name / Phone: | Name /Phone: | Name /Phone: | Name /Phone: |

Resources:

| | | | |
|---|---|---|---|
| Advocacy Group: | Support Group: | MH Agency: | Other: |

Credit NAMI Minnesota: http://www.namihelps.org/Crisis-Booklet-Adults.pdf

## Crisis Kit (for Consumer and Caregiver)

- Physical:
  - Toiletries,
  - Comfortable change of clothes
  - Reading material and/or music with earphones
  - Other medications, snacks (consider shelf life)
- Documentation:
  - Medical and psychiatric records
  - Prescription history
  - Insurance documents
  - Medical (or full) power of attorney or guardianship papers,
  - Psychiatric Advance Directive
  - HIPAA (and state) release forms
  - Crisis plan notes and documents
  - Copies of previous mental health warrants or other legal matters
  - Certificate of Medical Examination
  - Partially filled-out mental health warrant