LAW ENFORCEMENT RESPONSE TO SUICIDAL EMERGENCIES

INCLUDING PREPARATION FOR COLUMBIA SUICIDE SEVERITY RATING SCALE ASSESSMENT 2-YEAR CERTIFICATION FOR LEOs

HYBRID COURSE VERSION

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INTRODUCTION

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HOUSEKEEPING ANNOUNCEMENTS

NATIONAL CRISIS INTERVENTION TRAINING INSTITUTE, INC.

Critical Response and Training Divisions

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Formerly served as Chief of Police, Northwestern Oklahoma State University Police Department.

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Veteran Detective , Norman (OK) Police Department. Specialized in investigation of crimes against children and covert child pornography investigations.

Former Director of the Department of Crimes Against Children for Children's Rights of America, Inc., and the National Child Abuse Task Force. Concurrently served as Director of the National Youth Crisis Hotline.

Former Sergeant – Special Investigations / Victim's Advocate / CIT Officer, Mid-America Christian University Police Department.

Veteran Paramedic, Addiction Counselor, and Crisis Intervention Counselor.

Doctoral Researcher – currently on hiatus (PhD – All but Dissertation) – Research Interests: Addictionology, Predator Psychology, Victimology, Survival Psychology, and Detection of Deception.

Has provided Training, Technical and/or Direct Case Assistance to FBI, US Postal Inspectors, US Depart of Justice Office of Juvenile Justice and Delinquency Prevention, Royal Canadian Mounted Police, Honolulu (HI) PD, Maui (HI) PD, Hawaii Department of Human Services, and many other agencies and organizations.

Author / Instructor of 38 law enforcement training courses, currently accredited by the State of Oklahoma Council on Law Enforcement Education and Training.

Parental Survivor – January 8, 2009 to Present.

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TOPICS TO BE COVERED

SESSION ONE:

- "Crisis" and other suicide-related terms defined and described.
- Stinkin' thinkin.'
- Why people are curious or concerned about suicide.
- Suicide Myths and Facts.
- Precursors to suicidality.
- Suicide risk factors.
- Suicide danger signs.
- Why people in crisis sometimes don't feel comfortable talking about their problems.
- Soft Skills.
- Other desirable First Responder traits and skillset.

SESSION TWO:

- My story.
- What NOT to say to a suicidal person.
- Tips for friends of suicidal persons.
- Responding to Surviving Parents and Loved Ones.
- MACU PD "Response to Suicidal Emergencies" protocols.
- C-SSRS-A Certification.
- Practical Skill Evaluation and Written Post Test.

SESSION ONE

“CRISIS” DEFINED AND DESCRIBED

WHAT IS A CRISIS?

(BOYD, 1991; JAMES & GILLILAND, 2001; JOHNSON & BOGAN, 1986, 1988; JOHNSON, 2007)

Any event or series of circumstances which threatens a person's well-being and interferes with his or her routine of daily living.

IN CRISIS, PEOPLE TEND TO SUFFER FROM SENSORY OVERLOAD. IT'S HARD TO LISTEN WHEN YOU'RE EARS ARE POUNDING.

HOW IS THIS RELEVANT?

IN A CRISIS

(JOHNSON & BOGAN, 1986, 1988)

- **Weight of the problem** is greater than weight of assets/awareness of assets.
- The person feels **out of control**, uncomfortable, helpless, hopeless, depressed, guilty, confused, sad, overwhelmed, etc.
- The person wants **change** and relief.
- The person is facing a **turning point**.
- Decision-making ability is often **impaired**.
- Outcome can be **constructive or destructive**.
- Sensory perception (especially hearing) may be **impaired or distorted.**

REMEMBER THE DIFFERENCE IN A CRISIS AND A PROBLEM
(BOYD, 1981; LOOS, 1993-1994)

- ***Crisis:***

  the weight of the problem outweighs the suffering person's resources and assets, and/or his/her awareness of those resources and assets.

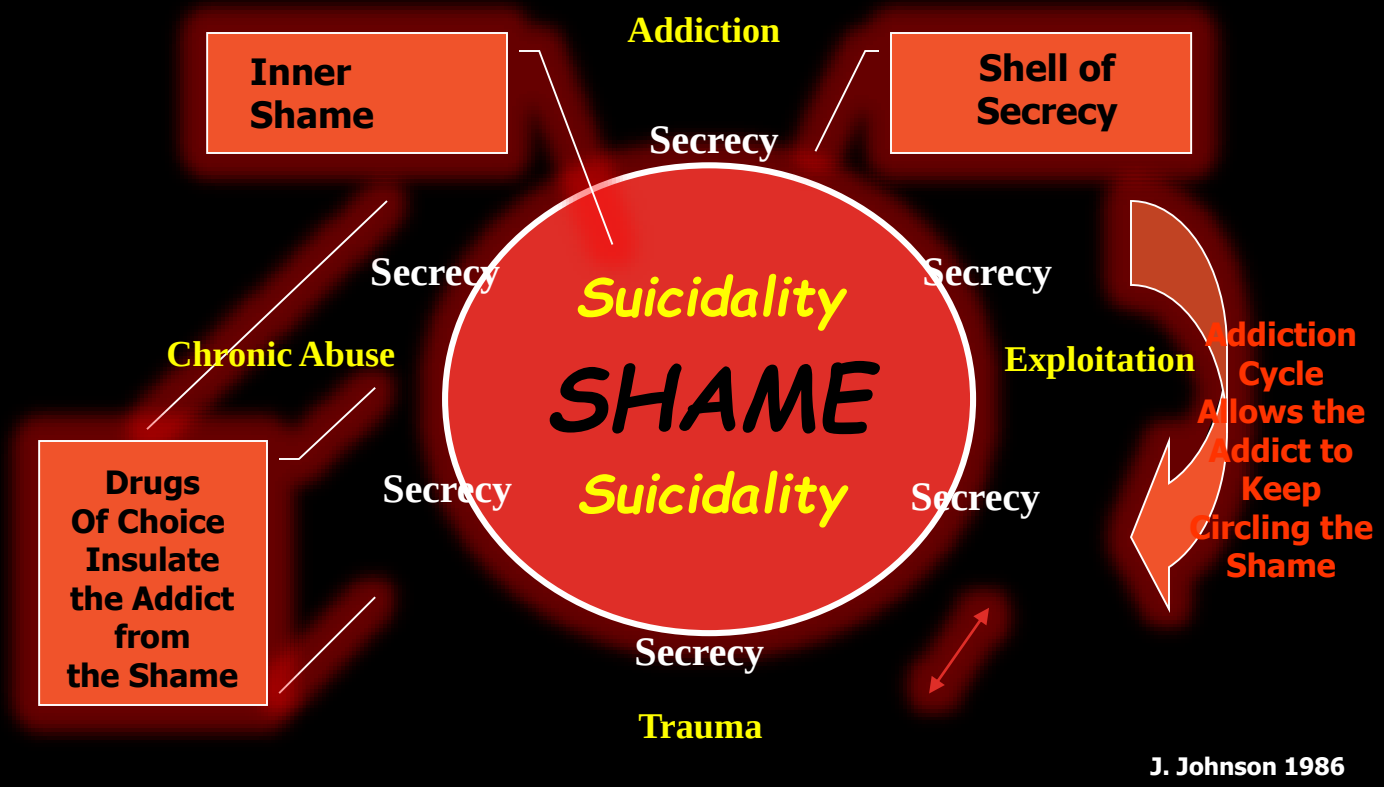
- ***Problem:***

  the suffering person is aware, and accesses, adequate support and resources to allow him or her to deal with the problem.

“STINKIN’ THINKIN’”
AND OTHER PRECURSORS TO SUICIDALITY

SECRECY, SHAME, AND SUICIDE

(JOHNSON, 1996, 2005, 2007, 2014)



COMMON PRECEDENT, SHAME-BASED, CO-MORBIDITY FACTORS
(ABC NEWS, 2008; JOHNSON & BOGAN, 1986, 1988)

- History of chronic abuse , neglect, exploitation, and other forms of acute trauma .
- History of substance abuse / addiction.
- Pervasive pattern of escape-related coping mechanisms.

TYPICALLY, THESE SUFFERING PEOPLE ARE IN SUSTAINED STATES OF "*CHRONIC CRISIS MODE*." THEY'RE LIKELY TO HAVE PROBLEMS COMMUNICATING THEIR FEELINGS. THEN (JOHNSON, 2005, 2007, 2014A,B; JOHNSON & BOGAN, 1986, 1988)

- They often find their **old ways don't work**.
- They get **more afraid and frustrated**. This makes them feel **more out of control**.
- They're at **high risk** of "shutting down."
- They turn to **old habits**.
- In other words, they **do what they have trained to do** – AVOID AND ESCAPE.

INSTRUCTOR'S THEORY:

ACTIVE AVOIDANCE AND ESCAPE ARE LEARNED, CONDITIONING-TYPE BEHAVIORS

Suicide is the ultimate act of avoidance and escape.

PERVASIVE PATTERN OF AVOIDANT BEHAVIORS

(JOHNSON, 2014)

("Dress Rehearsals Revolving Around the Final Performance")

REMEMBER WHAT THEY TAUGHT US IN POLICE ACADEMY:

In a critical incident, people do what they are trained to do; not what they are taught or told to do!

INSTRUCTOR'S THEORY:

"*AVOIDANT PERSONALITY-TYPES*" HAVE BEEN TRAINING, CONDITIONING, AND REHEARSING FOR YEARS…

LEADING UP TO A FINAL SUICIDAL PERFORMANCE

PERHAPS WITHOUT EVER CONSCIOUSLY THINKING ABOUT SUICIDE!

WHEN THE SUFFERING PERSON ENTERS INTO A "***STUCK STATE,***" OFTEN **DESPAIR, HOPELESSNESS, ISOLATION,** AND **SUICIDAL IDEATIONS AND BEHAVIORS** EMERGE

SUICIDALITY IS THE QUINTESSENTIAL EXAMPLE OF *"STUCK STATE"* AND *"STINKIN' THINKIN'."*

WHEN A PERSON IS TRULY SUICIDAL, DESPAIR AND HOPELESSNESS OVERWHELM RATIONAL THINKING.

OTHER SUICIDE-RELATED TERMINOLOGY

"NON-SUICIDAL SELF-INJURIOUS BEHAVIOR"
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"Engaging in behavior purely (100%) for reasons other than to end one's life."

KEY POINTS

- Either to affect an internal state (feel better, relieve pain, et cetera)…such as "self mutilation (e.g. "Cutting").
- External circumstances (get sympathy, attention, make angry, et cetera).

"SUICIDAL IDEATION" (COLUMBIA LIGHTHOUSE PROJECT, 2018; JOHNSON, 2005, 2007, 2014)

"Recurrent, sometimes pervasive thoughts of suicide."

FIVE LEVELS OF SUICIDAL IDEATION

- Wish to die.
- Active thoughts of killing oneself.
- Associated thoughts of methods.
- Some intent.
- Plan and intent.

INTENSITY OF IDEATION

Once determine types of ideation, few follow-up questions about most severe thought:

Frequency.

Duration.

Controllability.

Deterrents.

Reasons for ideation.

ALL THESE ITEMS SIGNIFICANTLY PREDICTIVE OF COMPLETED SUICIDE / MINIMUM AMT INFO NEEDED

SPECIAL NOTE:
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

BEHAVIOR IS "EVER" (CAPTURE ALL LIFETIME OCCURRENCES)

FOR IDEATION AND INTENSITY OF IDEATION, LISTEN FOR STATEMENTS ABOUT THE TIME(S) THE PERSON IN CRISIS FELT THE MOST SUICIDAL

"SUICIDAL INTENT" (COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A willful and cognitive desire to die."

KEY POINTS

- Accurate inference is vitally important! E.g. Intent can sometimes be inferred clinically from the behavior or circumstance.
- e.g. If someone denies intent to die, but they thought that what they did could be lethal, intent can be inferred.
- "Clinically impressive" circumstances may be present, such as highly lethal acts where no other intent but suicide can be inferred (e.g. gunshot to head, jumping from a window of a high floor or story, setting self on fire, or taking 200 pills).
- "Clinically less-impressive" circumstances may be present, such as ingesting five pills and a can of beer. This may be transposed to "Clinically impressive" status if it becomes clear that the "means" was thought to be highly lethal by the Person in Crisis.

"SUICIDE ATTEMPT" (COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A non-fatal, self-inflicted, potentially injurious behavior with any intent to die, as a result of the behavior,"

--or--

"A self-injurious act committed with at least some intent to die, as a result of the act."

KEY POINTS

- There does not have to be any injury or harm; just the potential for injury or harm (e.g. gun failing to fire).
- Any "non-zero" intent to die – does not have to be 100%.
- Intent and behavior MUST be linked.
- A suicide attempt begins with the first pill swallowed or scratch with a knife.

"INTERRUPTED ATTEMPT" VERSUS "ABORTED ATTEMPT"
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

INTERRUPTED ATTEMPT

"When a person starts to take steps to end their life, but someone or something stops them (e.g. bottles of pills in hand, but someone grabs it; on ledge, poised to jump)."

ABORTED ATTEMPT

"When a person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior." (e.g. a man plans to drive his car off the road at high speed, at a chosen location. On the way to the destination, he changes his mind and returns home; Man walks up to the roof to jump, but changes his mind and turns around; Woman has a gun in her hand, but then puts it down).

"PREPARATORY ACTS OR BEHAVIOR" (COLUMBIA LIGHTHOUSE PROJECT, 2018)

"Any other behavior (beyond saying something) with suicidal intent."

EXAMPLES

- Collecting or buying pills.
- Purchasing a gun.
- Writing a will or a suicide note.

"LETHALITY / MEDICAL DAMAGE" (COLUMBIA LIGHTHOUSE PROJECT, 2018)

" The extent to which actual physical injury was inflicted ."

(Assess only in attempts or fatality)

SCALE

0 – No physical damage or very minor physical damage (e.g. surface scratches).

1 – Minor physical damage (e.g. lethargic speech; first degree burns; mild bleeding; sprains).

2 – Moderate physical damage (medical attention needed (e.g. conscious but sleepy; somewhat responsive; second degree burns; bleeding of major vessel).

3 – Moderately severe physical damage; medical hospitalization; likely intensive care required (e.g. comatose with reflexes intact; third degree burns less than 20% of body; extensive blood loss, but can recover; major fractures).

4 – Severe physical damage; medical hospitalization with intensive care required (e.g. comatose without reflexes; third degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).

5 – Death.

LETHALITY OF THE ATTEMPT (COLUMBIA LIGHTHOUSE PROJECT, 2018)

Might require additional open-ended questions in order to better determine the potential lethality of the attempt (NOT a FORMAL PART OF THE LEO C-SSRSA PROCESS, BUT MAY BE HELPFUL IN WRITING INCIDENT REPORT NARRATIVE):

EXAMPLES

- *"What happened?"*
- *"Can you show me where you were hurt?"*
- *"Were there any injuries or physical damage?"*
- *"Did it bleed a little bit or a lot?"*
- "Did you have to put on a Band-aid or bandage, or do anything to stop the bleeding?"

SUICIDE
MYTHS AND FACTS

SUICIDE MYTHS AND FACTS
(JOHNSON 2005, 2007, 2014)

- **MYTH**: If someone tries suicide and lives, there is a much smaller chance they will make another attempt.
- **FACT**: Approximately 80% of completed suicides were preceded by at least one suicide attempt.

- **MYTH**: Once a person is suicidal, they will remain suicidal.
- **FACT**: While suicide is sometimes appropriately described as a "permanent, catastrophic solution to a temporary problem," it is common for a person to make successful transition from a suicidal state to a state of survival. However, the less a person sees their earthly plight as a "temporary problem," the more likely they are to experience recurrent suicidal thoughts, ideations, and impulses.

SUICIDE MYTHS AND FACTS (CONT'D)
(JOHNSON 2005, 2007, 2014)

- **MYTH**: Utilizing "mood/mind-altering substances" to escape your problems reduces the risk of suicide by taking a person's mind off his/her problems.
- **FACT**: Any escape-based pattern of behavior, such as habitual intoxication, establishes a pervasive pattern of trying to "escape pain." People who abuse alcohol and other forms of mood/mind-altering substances have a much greater likelihood of becoming suicidal than the general population. Why? Their "drug of choice" is not a problem; it's a "solution that kills." So is suicide.

- **MYTH**: Suicidal people always want to die.
- **FACT**: Sometimes. However, some people are at a point where they no longer feel they can live with their pain. When they are at that point, they are often considering suicide as an option. When they want (and plan) to die, they have selected suicide as THE option.

SUICIDE MYTHS AND FACTS (CONT'D)
(JOHNSON 2005, 2007, 2014)

- **MYTH**: You should not bring up the topic of suicide with someone you think may be suicidal.
- **FACT**: Bringing up the subject of suicide is a powerful way of giving the suicidal person permission to feel, and permission to discuss those feelings.

- **MYTH**: If a person who has been suicidal seems to feel better, it probably means the crisis has passed.
- **FACT**: Once the decision to die has been made, many suicidal people experience a sense of relief, and an uplifting of spirits. They've made their decision; they're choosing suicide as an option.

SUICIDE MYTHS AND FACTS (CONT'D)
(JOHNSON 2005, 2007, 2014)

- **MYTH**: People who talk about suicide are merely letting off steam or seeking attention. They aren't as serious a threat as someone who isn't "Crying for help."
- **FACT**: Most people who attempt or commit suicide talked about it to someone (often several people) prior to taking their life (or attempting to).

- **MYTH**: Young people are at highest risk of suicide.
- **FACT**: While males between ages 18-24 are at the highest rate of growth among suicidal populations, older males are at highest risk of suicide.

WHY PEOPLE ARE CURIOUS OR CONCERNED ABOUT SUICIDE

KEY REASONS WHY PEOPLE ARE INTERESTED IN FINDING OUT MORE ABOUT SUICIDE

(JOHNSON, 2005, 2007, 2014)

- They know someone who they **suspect is thinking** about it.
- They know someone whom they **know is thinking** about it.
- They know someone who **has tried it**, either "half-heartedly" or "seriously."
- They know someone who **committed suicide.**
- They fall into one of the above **categories themselves.**
- They **want to help**.
- They **want help.**

INCIDENCE OF SUICIDE IN UNITED STATES

SUICIDE: A MAJOR PUBLIC HEALTH CRISIS IN THE U.S.

(COLUMBIA LIGHTHOUSE PROJECT, 2018)

- Suicide is a preventable public health problem: Prevention efforts depend upon appropriate identification and screening.
- Every 15 minutes someone dies by suicide in U.S.
- 2nd leading cause of death in children.
- Bully victims 2-9x more likely to consider suicide.
- 3rd leading cause of death in adolescents.
- 10% of high school students attempt suicide each year. (???)
- 4th leading cause of death in adults.
- Rate doubled for African American males 1980-1996.
- #1 cause of injury mortality in U.S.
- More people die by suicide than motor vehicle crashes.
- Majority of suicide decedents see their doctor prior to their death.
- 45% in the month prior to their death.
- 80% in the year prior.
- Excellent opportunity for prevention.
- 2nd Leading cause of death in law enforcement officers.
- In 2012, nearly as many police persons died by suicide as were killed in the line of duty.
- Rate comparable to that in US Army.
- Most common cause of death in incarcerated individuals.
- Suicide rates 3x general population.
- 60% of inmate suicides have no psychiatric illness and no clear warning signs.

SUICIDE RISK FACTORS

SUICIDE RISK FACTORS
(JOHNSON, 2005, 2007, 2014; JOHNSON & BOGAN, 1986, 1988; SAMSHA CONTRIBUTORS, 2018)

- Mental disorders, especially mood disorders, schizophrenia, schizotypal disorder, schizoaffective disorder, anxiety disorders, and certain personality disorders, especially Borderline Personality Disorder.
- Ostracized by family, community, or society in general.
- Shame re: "secret life."
- Recent scandal which brought public ridicule, loss of social status, or loss of respect.
- Sense of condemnation for who they are, lifestyle, sexual preferences, et cetera.
- Gender dysphoria.
- History of pervasive avoidant behaviors (covered in detail later).
- History of trauma or abuse.
- Major physical or chronic illnesses; chronic physical pain.
- History of suicide thoughts, ideations, gestures, or attempts.
- Family history of suicide.
- Recent catastrophic events.
- Recent loss of significant relationships.
- Easy access and familiarity with lethal means.
- Local clusters of suicide.
- Lack of social support and sense of isolation.
- Stigma associated with asking for help or showing "weakness."
- Certain cultural or religious beliefs, which view suicide as honorable.

SUICIDE RISK-RELATED CO-FACTORS AND CO-MORBIDITY FACTORS

- Mental health history.
- Past / current medications or medical problems.
- History of maladaptive coping patterns.
- Rx/ETOH or dual diagnosis issues.
- Involvement in the occult.
- History (personal and / or family) or suicide thoughts, ideations, gestures or attempts.
- History of pervasive treatment resistance (example given: Treatment-resistant occupational stress disorder / law enforcement "burnout").
- History of child abuse and/or neglect (e.g. Montreal Study).
    - Suicide victims who were abused as children show changes in brain.
    - Changes found in 18 out of 18 suicide victims with confirmed histories of childhood abuse and neglect.
    - Neglect can cause biological effects.
    - Changes are in ribosomal RNA, not genes.
    - Changes were in genetic material that makes proteins that in turn makes cells function.
- History of substance abuse / addiction.

SUICIDE DANGER SIGNS

SUICIDE DANGER SIGNS
(JOHNSON, 2005, 2007, 2014; JOHNSON & BOGAN, 1986, 1988 SAMSHA CONTRIBUTORS, 2018)

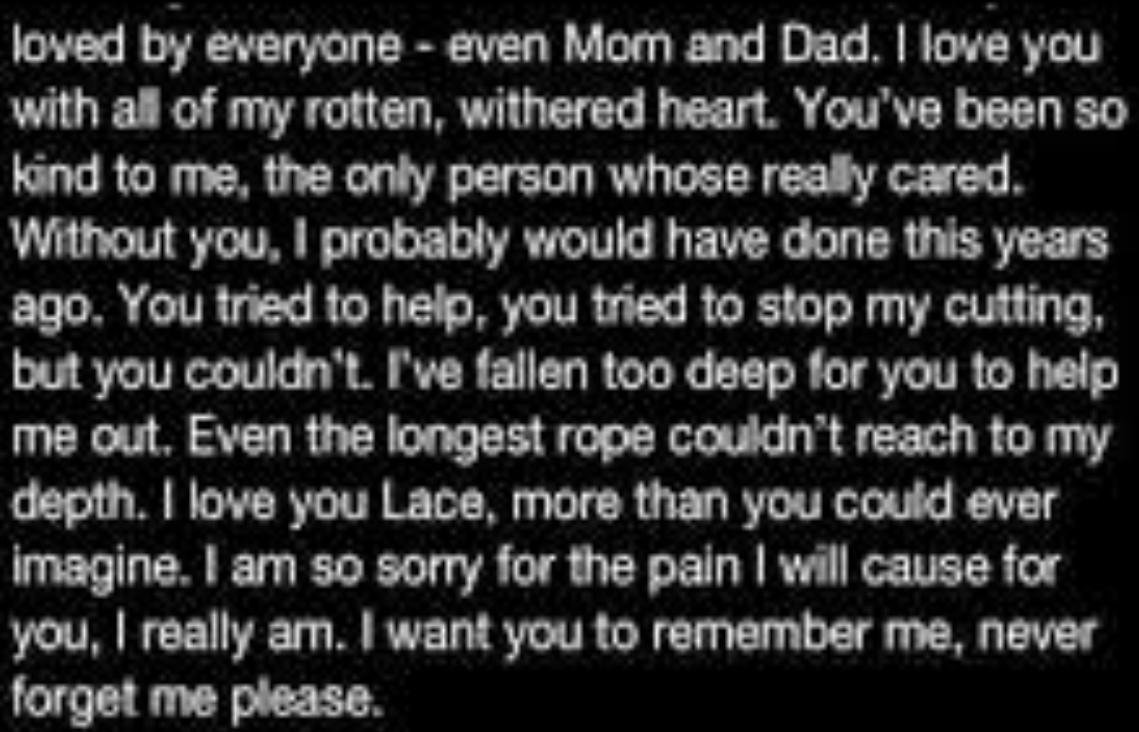
- Specific and/or detailed suicide plan.
- Extremely lethal plan.
- Hiding "*means,*" or keeping "means" readily available.
- Hint re: "*friend*" who is contemplating suicide.
- Drop in grades or school attendance.
- Loss of appetite.
- Complaints of depression.
- Online research of suicide methodology.
- Remarkable disregard for "*boundaries.*"
- Statements re: hopelessness and having "*no purpose.*"
- Sleeping too little or too much.
- Preoccupied w/death or suicide of a friend or classmate.
- Exaggeration of closeness of relationship to a person who has died.
- "*They'll be sorry.*"
- History: personal or family.
- Frequenting assisted suicide websites.
- Reckless and/or death-defying behavior.
- Real or imagined "*abandonment issues.*"
- Sexually provocative behavior toward people in positions of trust and authority.
- Withdrawing or increased isolation.
- Rage or seeking revenge.
- Preoccupation with mass spree killings and homicide/suicide incidents.

SUICIDE DANGER SIGNS (CONT'D)

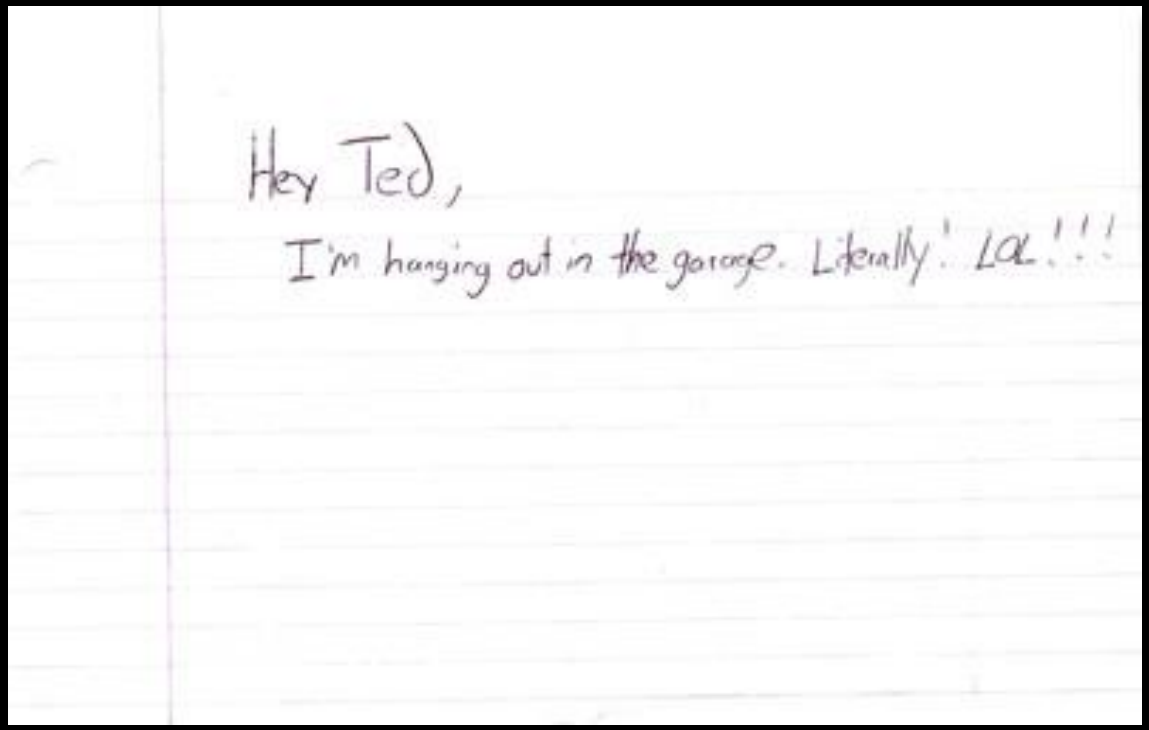
(JOHNSON, 2005, 2007, 2014; JOHNSON & BOGAN, 1986, 1988; ROBERTS, 2000; SAMSHA CONTRIBUTORS, 2018)

- Pervasive pattern of avoidant behaviors.
- *"Tying up loose ends."*
- Apparent relief or lift in spirits w/no apparent problem resolution.
- Sudden giving away of valuables and possessions.
- Depression escalating to euphoric state.
- Little insight into permanence of death.
- Expressions of abandonment.
- Self-mutilating behavior (especially *"cutting")*.
- Statements re: pain never ending.
- Increased substance abuse.
- Frequent / exaggerated apologies.
- Body modification with death and suicidal themes.
- Alluding to being reunited with deceased loved ones.
- Preoccupation w/occult, death themes, or separation by death.
- Preoccupation w/relief of pain.
- Hopelessness re: abuse ending.
- Eating disorders.
- Frequenting assisted suicide or death-related websites.
- Flattened affect or increased lability / extreme mood swings.
- Highly unstable and reckless sexual behavior.
- Statements re: being a burden to others.
- Frequently *"testing the waters"* with people who have said they care.

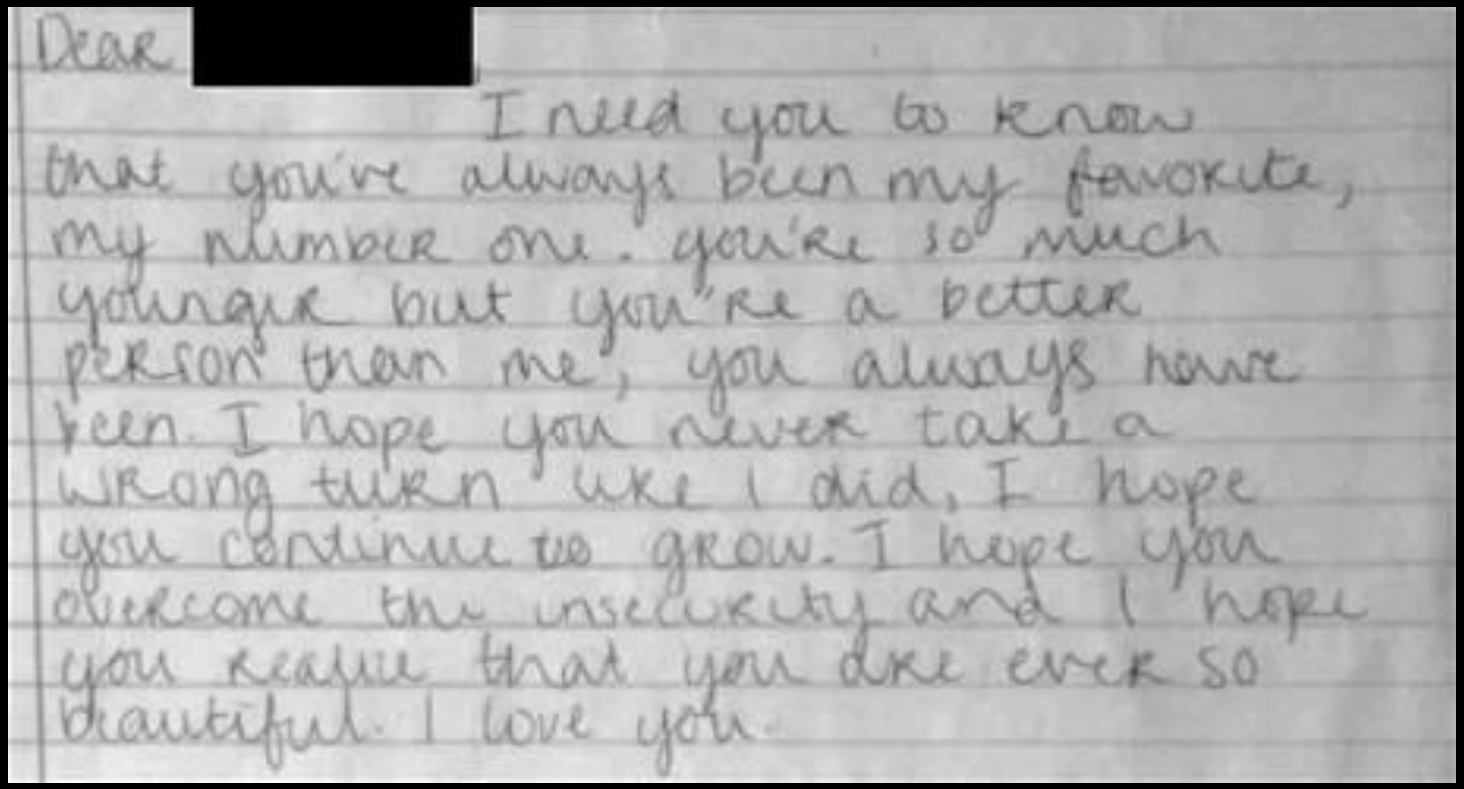
WATCH FOR SUICIDE NOTE!
(HANDLE THEM AS IMPORTANT PHYSICAL EVIDENCE)


loved by everyone - even Mom and Dad. I love you with all of my rotten, withered heart. You've been so kind to me, the only person whose really cared. Without you, I probably would have done this years ago. You tried to help, you tried to stop my cutting, but you couldn't. I've fallen too deep for you to help me out. Even the longest rope couldn't reach to my depth. I love you Lace, more than you could ever imagine. I am so sorry for the pain I will cause for you, I really am. I want you to remember me, never forget me please.

WATCH FOR "*HUMOROUS DEFLECTION*"



WATCH FOR "*OUT OF THE BLUE TRIBUTES*"


Dear [redacted]

I need you to know that you've always been my favorite, my number one. you're so much younger but you're a better person than me, you always have been. I hope you never take a wrong turn like I did. I hope you continue to grow. I hope you overcome the insecurity and I hope you realize that you are ever so beautiful. I love you.

WATCH FOR "*FORESHADOWING MESSAGES*" IN POETRY, LYRICS, ESSAYS, ET CETERA

Hushabye, baby, you're almost dead.
You have no pulse & your pillow is red.
You're family hates you & your friends let you bleed,
Sleep tight with a knife because that's all you need.
Rockabye baby, broken & scarred,
You didn't know life would be this hard.
Time to end the pain that you hid so well,
& down will come baby,
straight back to hell.

Slit your wrist and cut your thighs. Fake a smile and dry your eyes. Hate yourself and hate your life. Welcome to my world of lies.

WHY PEOPLE IN CRISIS SOMETIMES DON'T FEEL COMFORTABLE TALKING ABOUT THEIR PROBLEMS

PEOPLE IN CRISIS ARE OFTEN RESISTANT TO COMMUNICATION DUE TO (JOHNSON, 2005, 2007, 2014, 2017; JOHNSON & BOGAN, 1986,1988)

- *Shame.*
- Feeling threatened.
- Fear of getting into trouble.
- Fear of being locked up.
- Fear of being looked upon as weak or sick.
- Weariness.
- Mistrust.
- Something to hide.
- Misunderstanding.
- Shock / being stunned.

…OR…
(JOHNSON, 2005, 2007, 2014, 2017; JOHNSON & BOGAN, 1986,1988)

- Coercion.
- Having broken rules.
- Desire to protect.
- Trauma.
- Clinician's approach.
- Jargon / confusion.
- Our ignorance of their developmental level.
- Persons present.
- Lack of support.
- *WHY?* questions.
- Tradition / History.

SOFT SKILLS

HOW CAN WE "COMMUNICATE WITH SUFFERING PEOPLE" IN ORDER TO FACILITATE TRUST AND COMMUNICATION?

(JOHNSON, 2014; JOHNSON & BOGAN, 1986, 1988)

- **DO** validate the suffering person's feelings.
- **DON'T** ask "*Why?*" questions.
- **DO** Listen for true messages. **DON'T** focus on codes.
- **DO** empathize. **DON'T** show pity or sympathy.

CONT'D

(JOHNSON, 2014; JOHNSON & BOGAN, 1986, 1988)

- **DO** make a promise you can keep immediately.
- **DON'T** lie to a suffering person or make promises you can't keep.
- **DO** be genuine, and willing to admit mistakes.

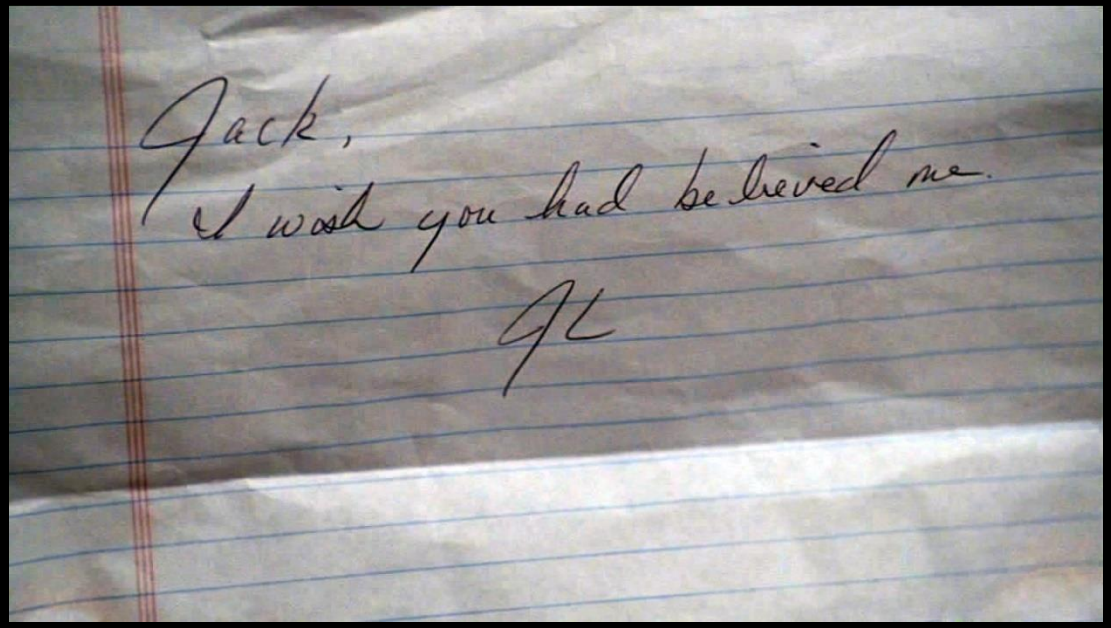
EMPOWER THE SUFFERING PERSON

PIERCE THROUGH THEIR SENSE OF ISOLATION

COUNTER THEIR SENSE OF DIS-COURAGEMENT WITH EN-COURAGEMENT

As Believers, We Are All
"Called to Encouragement."

AND LISTEN!!!



Sometimes people want to die simply because they feel no one will listen to them.

DISCUSSION

How would you respond to a person who asks you, *"Do you believe that suicide is the unpardonable sin?"* Or *"Do you believe that a person will go to hell for committing suicide?"*

HINT: NEVER ANSWER THAT QUESTION WITH AN ANSWER. HERE'S WHY

(JOHNSON, 2005, 2014, 2017)

- **If you answer *"yes,"*** and the person has a loved one who has already committed suicide, you've just told him/her that it's your opinion that the person is now in hell.
- **If you answer *"no,"*** and the person is considering suicide, you may have just removed the one obstacle that has kept them from committing suicide.

SUGGESTED RESPONSE FOR FIRST RESPONDERS

(JOHNSON, 2005, 2007, 2017; JOHNSON & BOGAN, 1986, 1988)

"I'm glad you felt comfortable enough to ask me that question. Why? Because I have had many, many young people ask me that very same question…and none of them were asking it because they were doing a book report on suicide. Each and every time, they either had a loved one who had committed suicide, or they themselves were considering suicide. Does either of those situations apply to you? Can you tell me why you asked the question?"

SUGGESTED RESPONSE FOR FRIENDS AND FAMILY MEMBERS

(JOHNSON, 2014)

"A friend of mine [that's ME, folks]

who has worked with lots of kids who have either dealt with suicidal feelings, or who had someone they loved commit suicide told me that of the hundreds of kids he's talked to who asked that question…all of them either were thinking about suicide, or someone they loved had committed suicide. Are you concerned that _____ went to hell? Have you been thinking about suicide?"

LET'S LOOK AT SOME OTHER ROADBLOCKS TO COMMUNICATION
(GORDON, 1975; JOHNSON, 2005, 2006)

- Solution-oriented statements.
- Put-downs.
- Other inferior methods of communicating.
- Inhibiting factors unique to customer.
- Our general approach.
- Reinforced powerlessness (Enabling).
- Anxiety / crisis mode.
- *"Why," "Should,"* and *"Ought."*

MORE ABOUT ROADBLOCKS TO COMMUNICATION

(GORDON, 1975; JOHNSON, 2005, 2006)

Solution-oriented

- Ordering.
- Threatening.
- Moralizing.
- Advising.
- Lecturing.
- Criticizing.
- Directing.

Put-Downs

- Flattering / False Praise.
- Name-Calling.
- Reassuring.
- Advising.
- Probing.
- Diverting / Humoring.
- Interrupting.
- Challenging and Confronting.

OTHER POTENTIAL PROBLEMATIC CO-FACTORS

(JOHNSON, 2005, 2006, 2014; JOHNSON & BOGAN, 1986, 1988)

- Disregarding inhibiting factors unique to person in crisis.
- Our general approach.
- Co-Factors which may be influencing the person's behavior.

REMEMBER THE OTHER INFERIOR METHODS OF COMMUNICATING
(GORDON, 1975)

- Parroting.
- Paraphrasing.
- You-messages.
- Monologue.
- Excluding / Ignoring.

IN ADDITION TO

the actual words, the way we say them and how we act when we say them can help to build trust / rapport and a level of comfort with the needful customer. Also, how far apart we are physically.

BE CONSCIOUS OF THE "FOUR P'S"

(INBAU, ET AL, 2001; JOHNSON, 2005, 2014)

- Posture.
- Para-linguistic (tone, volume, cadence, inflection, et cetera)
- Precipitating co-factors and co-morbidity factors.
- Proxemics.

PROXIMITY ZONES (PROXEMICS)

(INBAU, ET AL, 2001)

- **Public Zone** (Over 5 f t)
- **N/A**
- **Social Zone** (3-5 f t)
- **Start Here**
- **Personal Zone** (1 – 3 fee
- **Work Closer**
- **Intimate Zone** (0-1 foot)
- **Be Sure Before Getting Into Intimate e**







VERBAL DE-ESCALATION SKILLS AND GUIDELINES

(GORDON, 1975; JOHNSON, 2005, 2006)

- I-Messages.
- Positive Confrontation.
- Active Listening.

COMPONENTS OF I-MESSAGES

Describe Behavior: *"When you interrupt me and tell me to 'not feel that way'… "*

Describe How it Makes You Feel (in Realistic, Non-inflammatory Terms): *"It makes me even more frustrated and angry, like you don't want to allow me permission to feel…"*

Describe Tangible Consequences (or Benefits) to You, and/or to Your Relationship: *"That causes me to shut down, not be honest and open, and that hurts our relationship, which is very important to me."*

COMPONENTS OF YOU-MESSAGES

Label the Person: ***"You're an inconsiderate jerk who never listens to me. You don't love me…you think I'm stupid!"***

Describe How it Makes You Feel (in Inflammatory and/or Exaggerated Terms): ***"That makes me want to rip off your head and spit down your neck!"***

Cite Either Non-realistic Consequences or Share No Consequences to You or To the Relationship: ***"Maybe if I was dead and couldn't talk at all, you'd be happy."***

I-MESSAGES VERSUS YOU-MESSAGES

(GORDON, 1975; JOHNSON, 2005, 2006, 2010, 2014)

- I-Messages validate feelings, lessen risk of damage to the relationship, and are more difficult to argue with.
- You-Messages have much higher risk of damaging the relationship.
- I-Messages facilitate clarification, honesty, and open communication.
- You-Messages cause people to shut down, and stuff anger.
- I-Messages are excellent first-steps to discussing and solving problems.
- You-messages shut down communication and impede problem solving.

POSITIVE CONFRONTATION
(JOHNSON, 2014)

- Positive confrontation techniques are designed to facilitate change in behavior, and/or reinforce behavior, by addressing the elements covered in an "I-message" (describing behavior, sharing non-inflammatory emotions, and describing clear, concrete benefits or consequences of the person's behavior.

- Positive confrontation focuses on changing behavior at little no risk of damaging the relationship between the person attempting to facilitate change, and the person to whom the positive confrontation is addressed.

- Positive confrontation, when properly executed, brings favorable results without damaging the relationship.

CO-FACTORS WHICH MAY BE INFLUENCING THE PERSON'S BEHAVIOR

(INBAU, ET AL, 2001; JOHNSON, 2005, 2006, 2010, 2014)

- Importance of the issue.
- Self-Image.
- How the person views others.
- How the person views the interviewer.
- Relationship with the interviewer.
- Previous contact with law enforcement.
- Prior treatment for various mental disorders.
- Mental state of the individual.
- Transference.
- Response to Counter-transference.
- What person has to gain or lose.
- Environment.
- Audience.
- Threats or promises by another person (present or not present).
- Methods and tactics used by the interviewer.
- Physical state of the individual.

EFFECTIVE LISTENING LEVELS

(GORDON, 1975; JOHNSON, 2005, 2006)

- **Analytical** = for information / to categorize.
- **Directed** = to answer specific questions.
- **Attentive** = for general information.
- **Exploratory** = because you're interested.
- **Appreciative** = for esthetic pleasure.
- **Courteous** = because you feel obligated.
- **Passive** = overhearing, but not attentive.

YES, WE CAN RESPOND WITH

- **Parroting** - repeating the exact words the person said.
- **Paraphrasing** - putting what they said in your own words.
- Of the two, **paraphrasing is better** than parroting, **but not the best** alternative.

AND THEN THERE'S ACTIVE LISTENING
(GORDON, 1975; JOHNSON, 2005, 2006, 2010, 2014; JOHNSON & BOGAN, 1986, 1988)

- We speak in **codes** and **messages**.
  - **Codes**: the words we say.
  - **Message**: what we really mean.

- **Process**:
  - **Listen** to code.
  - **Interpret** code into apparent message.
  - **Relay** back message to speaker.
  - **Allow** and **respond** to feedback.

ADVANTAGES OF ACTIVE LISTENING (GORDON, 1975; JOHNSON, 2005, 2006, 2010, 2014; JOHNSON & BOGAN, 1986, 1988)

- Better than parroting or paraphrasing, because it relays your message.
- Makes the person in crisis feel better about the conversation.
- Tells the person in crisis that you're listening.
- Insures that you are interpreting accurately and/or allows the person in crisis to correct you if you're reading them wrong.
- Therefore, it renders more accurate information which will help you in helping the person in crisis.

HELPFUL HINTS

- **Remove** the words **"WHY," "SHOULD,"** and **"OUGHT"** from your customer service vocabulary.
- **"Why"** tends to sound accusatory and may place the listener "on the defensive."
- **"Should"** and **"ought"** are autocratic, solution-oriented terms which tend to say **"You're dumb."**

EXAMPLE

"What was going on that prevented you from TELLING SOMEONE ABOUT WHAT WAS GOING ON?"

As opposed to

"Wow, Bill. Why didn't you SAY SOMETHING SOONER! IF YOU HAD, WE MAY HAVE BEEN ABLE TO HELP YOU MORE. NOW, I'm JUST NOT SURE WE CAN."

FACILITATE COMMUNICATION VIA (JOHNSON, 2005, 2006, 2010, 2014, 2014A, 2014B)

- Rapport-building exercises.
- Encouraging person to give their version of event in narrative form; uninterrupted.
- Utilizing active-listening and I-message skills.
- Avoiding "why" questions.
- Avoiding put-downs and solution-oriented communication techniques.
- Strategically and carefully utilize leading questions which do not compromise integrity of investigation.
- Team-building and trust-building exercises.

FACILITATING RAPPORT AND COOPERATION

- Be patient.
- Don't push.
- Don't stereotype.
- Offer respect.
- Be observant to needs.
- Give choices.
- Facilitate supportive and autonomous decision-making.
- Empower.
- Connect with survivors.

RECOMMENDED VERBAL APPROACHES

- *"Cindy, I'm not asking you to trust me. After all you've been through, you'd be crazy to trust a total stranger, or even one who has been nice to you. I'm just asking you to watch me, and when you're ready, to make a decision on whether or not I've earned your trust."*
- *"I'll meet with you as many times as it takes for you to feel more comfortable talking to me. My main goal isn't to get information; it's to help you."*
- *"You're in control: you don't have to tell me anything you don't want to. I want you to feel free choosing what we talk about, and how much or how little you wish to share with me."*
- *"If you say you're done for the day, the interview's over. I know it can be very tiring talking about things that are painful and scary. Just take your time. Do you feel the need to take a little break right now?"*
- *"Don't worry about not remembering everything right now. When you're hurt really bad inside, it sometimes affects your memory. Don't worry about not getting everything right, or in the exact order that things happened. It will come back to you. I'm here to give you a safe place to remember those things, and to sort them out."*

MORE RECOMMENDED VERBAL APPROACHES

- *"You've survived for a long time by making yourself numb. It's how you endured the trauma, the abuse, and the humiliation. Those bad things are over, and now you're learning to feel again. That can be scary, and sometimes uncomfortable. But numbness isn't the same as being well, and sometimes healing hurts, but it is worth it. It's kind of like when your leg goes to sleep, and then when the circulation comes back, you feel those little needles. I hate those; but they always remind me that my leg is coming back to life, and that if my leg had stayed numb, I might have lost it."*
- *"You're experiencing some scary things right now that are caused by your memories. But those things aren't real any more. You're in a safe place, where you have permission to feel, and where you are protected. I'm here to help you through those feelings and memories as much as I can, but we also have special people who are experts in helping you do that. You're not by yourself anymore. I promise."*
- *"Even though you'll be working with other people to help you through this, I promise I'll be there to check in on you regularly, and will not forget about you."*
- *"Why am I being patient with you? Because you're worth it, and because the most important thing to me isn't the information you have; it's for you to be safe, and okay, and to get beyond this and on to a happy, fulfilled life. I promise you that's possible, and that we are here to help you to start that new life."*

OTHER DESIRABLE FIRST RESPONDER TRAITS AND SKILLSET

EFFECTIVE CRISIS INTERVENTIONISTS

help to turn a crisis into a solvable problem or challenge.

Effective friends help suffering people get the help they need.

OFTEN, THEY DON'T FEEL COMFORTABLE

- **Acknowledging** painful feelings.
- **Admitting** that they've done something wrong.
- **Telling someone** that they're thinking about doing something self-destructive.
- **Asking** for help.

DON'T HESITATE TO ASK THEM WHY THEY WANT TO KNOW ABOUT SUICIDE…EVEN IF YOU'RE AFRAID TO ASK.

WHY ARE WE SOMETIMES HESITANT TO DISCUSS SUICIDE WITH A SUFFERING PERSON?

(JOHNSON, 2005, 2007, 2014, 2017)

- **We don't think** we should because it's a scary subject.
- **We don't think** it applies to us or anyone we know.
- **We don't think** we should, because if we talk about it, it will put the thought in someone's mind.

SOMETIMES, THAT'S THE PROBLEM.

WE DON'T THINK!

OTHER TIMES, THOUGH, WE'RE AFRAID

- that if we say the wrong thing it will **make it worse.**
- that **we don't know** what we're doing.
- that **it will embarrass** them or us.
- that our person will **get into trouble**.
- that just thinking about it will **magically make it happen.**

WHEN, IN FACT

- **Practically everyone knows someone** who has thought, or is thinking about suicide.
- Giving a friend **permission to feel**, and to express their feelings can really help.
- **We don't have to be a perfect counselor**, as long as we're accessible.
- Chances are, if we're that concerned, **the person already has thought about suicide**, or is maybe planning suicide.

AND LIKE ANY JOB, BEING A CRISIS INTERVENTIONIST HAS RESPONSIBILITIES AND LIMITATIONS. WE ARE SUPPOSED

(JOHNSON, 2005, 2007, 2014, 2017)

- To **watch** for signs of trouble.
- To **be available** to **listen.**
- To **offer support** and **encouragement.**
- To **refer** to people that can help further.
- To **report** abuse and other danger to life.
- To **respect** confidentiality.
- To **set a good example** for the suffering person.
- To **practice** our skills with the suffering person.
- To **know** our **limitations**.

AS A SUPPORTIVE LISTENER, WE COMMUNICATE WITH PEOPLE IN CRISIS IN ORDER TO

(JAMES & GILLILAND, 2001; JOHNSON, 2005, 2007, 2014, 2017; LOOS, 1993-1994)

- Establish **trust and rapport**.
- Find out **information**.
- Determine **risk of lethality**.
- **Relay pertinent information** to a professional, or interested party.
- Make **referrals**.
- Get the suffering person to a **safe place**.
- *Give **encouragement and support***.

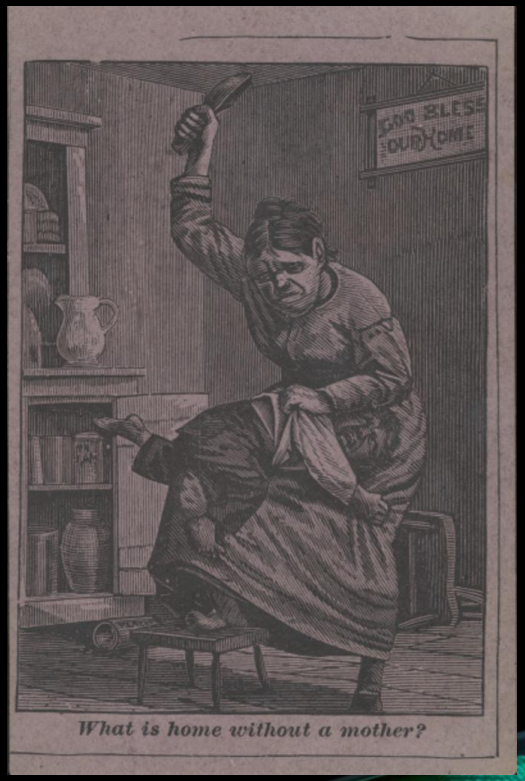
IF WE SAY THINGS THE WRONG WAY
(JOHNSON, 2005, 2007, 2014, 2015; LOOS, 1993-1994)

- We **may not see** the desired **results.**
- The suffering person **may not be convinced** that we know or care how they feel.
- We **may make matters** worse.
- We can make our client **feel more like a victim.**

WE ARE ***NOT*** SUPPOSED TO BE
(JOHNSON & BOGAN, 1986, 1988; LOOS, 1993-1994)

- **Giving advice (typically).**
- **Doing definitive therapy for suicide risk.**
- **Keeping secrets**. (which is very different from "confidentiality.")
- **Investigating.**
- **"Co-signing"** our suffering person's problematic behavior.
- Making their **problems worse.**
- **Enabling** the suffering person to stay in trouble.

SO, IN MOST CASES, IT'S IMPORTANT TO LEARN TO BE SUPPORTIVE AND INFORMATIVE



What is home without a mother?

NOT INSTRUCTIVE

ALSO, TRY TO BE

- **Clear**, concise and organized.
- **Accessible**.
- **Down to earth**.
- **Relaxed** and unhurried.
- **Supportive** and willing to listen.
- **HUMAN**.
- A **trustworthy** person.

HELPFUL HINT: TRY TO AVOID GIVING ADVICE

(JOHNSON & BOGAN, 1986, 1988; LOOS, 1993-1994)

- Advice-giving is a **no-win** proposition.
- It's a **set-up**.
- It's a **bummer** in the long run. Take my advice: Don't give advice. (Just kidding.)
- It **weakens the suffering person** by making them more dependent, and less able to solve their own problems.

WHY?

(JOHNSON & BOGAN, 1986, 1988; LOOS, 1993-1994)

- The suffering person learns to **rely on us too much** for answers, rather than learning how to find answers.
- The suffering person has **information we don't have**.
- The suffering person may be made to **feel stupid**.
- Advice giving **makes us use three dirty words**: "Why," "ought," and "should."

SOMETIMES, THOUGH, THEY'RE SO LOST AT SEA THAT THEY NEED DIRECTION TO SURVIVE

HOWEVER, MY ADVICE IS, IN GENERAL, WHENEVER POSSIBLE

DON'T GIVE ADVICE!

THE **KEY** TO ARTFUL ADVICE-GIVING IS TO GET OUT OF THE ADVICE-GIVING BUSINESS JUST AS QUICKLY AS YOU POSSIBLY CAN.

THERE ARE A NUMBER OF CONTRIBUTING CO-FACTORS THAT WILL INCREASE A PERSON'S LIKELIHOOD OF ATTEMPTING SUICIDE. HERE ARE A FEW (JOHNSON & BOGAN, 1986, 1988)

- Mental health history.
- Past / current medications or medical problems.
- Hx of maladaptive coping patterns.
- Rx/ETOH or dual diagnosis issues.
- Involvement in the occult.
- History (personal and / or family) or suicide thoughts, ideations, gestures or attempts.

SESSION TWO

MY STORY

HOW I BECAME AN EXPERT

My Beloved Son, Adam Joshua Johnson
July 31, 1984 --- January 8, 2009

"FOR YEARS, I HAD BEEN CALLED UPON AS A 'EXPERT' IN VARIOUS AREAS PERTAINING TO VICTIMIZATION OF CHILDREN, ADDICTION, CRISIS INTERVENTION, ET CETERA. AS A VETERAN POLICE DETECTIVE, PARAMEDIC, CRISIS INTERVENTIONIST, AND ADDICTIONS COUNSELOR,…AND HAVING DEALT WITH LITERALLY THOUSANDS OF ENDANGERED AND ABUSED YOUTH AND THEIR FAMILIES… I THOUGHT I HAD A PRETTY GOOD IDEA OF WHAT PARENTS EXPERIENCE AFTER LOSING A CHILD TO SUICIDE OR HOMICIDE.

However, until January 8, 2009, I didn't have a clue."

…Joel Johnson, Co-Director…

National Crisis Intervention Training Institute

YOU'RE POSSIBLY HERE BECAUSE YOU WANT TO HELP. YOU WANT TO KNOW WHAT TO DO AND HOW TO DO IT. THANK YOU!

Let's start off by talking about what NOT to do.

The following are statements that have been made to me in the last several years by people who are supposed to know what to do and how to do it.

TOP TEN THINGS

THE TOP-TEN THINGS TO NEVER SAY TO A SUICIDAL PERSON

(JOHNSON, 2005, 2007, 2015, 2017)

#10

"YOU NEED TO JUST SNAP OUT OF IT!" PICK YOURSELF UP AND GO ON! IF I WERE YOU, I'D JUST FORGET ABOUT IT AND GET ON WITH MY LIFE!"

RESPONSE

TRY THIS. STAND UP. BEND OVER. GRAB YOUR BOOTS OR SHOES. NOW PICK YOURSELF UP OFF THE FLOOR AND CARRY YOURSELF ACROSS THE ROOM. WHAT? CAN'T DO IT? CAN'T DEFY GRAVITY?

NEITHER CAN A CLINICALLY-DEPRESSED CLIENT, WHOSE PROBLEMS SEEM TO MASSIVE TO HANDLE; TOO HEAVY TO BEAR. ALSO, TO "FORGET ABOUT IT" MAY FOSTER SECRECY AND SHAME, AND PERPETUATE AN ABUSIVE SITUATION.

#9

"YOU SHOULDN'T FEEL LIKE THAT! TRUST ME. YOU'LL FEEL BETTER TOMORROW."

RESPONSE

ONE OF THE MOST PRECIOUS GIFTS WE CAN GIVE TO A PERSON IN CRISIS IS PERMISSION TO FEEL.

DON'T ROB THE SUFFERING PERSON OF THAT GIFT. OH, AND BY THE WAY…WHEN THINGS DON'T FEEL BETTER OR GET BETTER TOMORROW, YOU'LL HAVE LOST CREDIBILITY WITH HIM/HER.

#8

"IS THAT ALL THAT'S BOTHERING YOU? THAT'S NOTHING! LOTS OF PEOPLE HAVE PROBLEMS WORSE THAN YOURS."

RESPONSE

OH, GREAT. MAKE THEIR CRISIS SEEM TRIVIAL. IT MAY NOT SEEM BIG TO YOU, BUT IT SEEMS ENORMOUS TO THE SUFFERING PERSON WHO, AT LEAST TEMPORARILY, LACKS THE TOOLS TO DEAL WITH THEIR PROBLEM.

#7

"I HOPE YOU'RE NOT THINKING ABOUT HURTING YOURSELF. ARE YOU? THAT WOULD BE A STUPID THING TO DO." (NOTE: THIS IS VERY DIFFERENT THAN ASKING "HAVE YOU BEEN THINKING ABOUT SUICIDE?")

RESPONSE

NO ONE WANTS TO, OR LIKES, FEELING STUPID. THIS TYPE OF STATEMENT MAKES THE SUFFERING PERSON FEEL HESITANT TO SHARE. TO STUNT THEIR WILLINGNESS TO TALK ABOUT THEIR PROBLEM MULTIPLIES THE ODDS THAT THEY WILL CHOOSE SUICIDE.

#6

"DON'T SAY THAT! I'M SURE YOUR PARENTS LOVE YOU VERY MUCH!"

RESPONSE

MAKE SURE YOU HAVE YOUR FACTS STRAIGHT BEFORE SAYING SOMETHING LIKE THIS. SOMETIMES WE DON'T KNOW WHAT'S REALLY GOING ON IN THE CHILD'S HOME.

AND BESIDES…LOVE IS POSSIBLY NOT BEING EXPRESSED IN A WAY THAT IS MEANINGFUL TO THE SUFFERING PERSON WHO IS DEPRESSED. AND, "DON'T SAY THAT!" ISN'T THE BEST WAY TO GET THE PERSON TO TALK TO YOU.

#5

"IF I WERE YOU, I'D _____."

RESPONSE

YOU'RE NOT. AND YOU DON'T HAVE ALL THE FACTS.

#4

"IF YOU ARE WANTING TO GET ATTENTION, YOU ARE CERTAINLY GOING ABOUT IT THE WRONG (OR RIGHT) WAY!"

RESPONSE

TO ASSUME THAT A "CRY FOR HELP" IS MERELY AN ATTENTION-ATTRACTING TACTIC CAN BE A DEADLY MISTAKE. SUICIDAL PEOPLE ARE ANGRY. IN FACT, DEPRESSION ITSELF IS OFTEN DESCRIBED AS "ANGER TURNED INWARD."

THEY MIGHT JUST DO IT AFTER HEARING SOMETHING LIKE THAT. AND REMEMBER, IT'S A DOCUMENTED FACT THAT MOST PEOPLE WHO COMMIT SUICIDE, COMMITTED PRECEDING SUICIDAL GESTURES OR ATTEMPTS.

#3

"YOU OUGHT TO BE ABLE TO THINK OF A BETTER WAY TO DEAL WITH THIS THAN SUICIDE. WHY HAVEN'T YOU TRIED _____?"

RESPONSE

YOU MIGHT AS WELL JUST GO HANG A "DUMMY" SIGN AROUND THEIR NECK AND GET IT OVER WITH. "OUGHT" NEEDS TO BE THROWN IN THE DUMPSTER…ALONG WITH "SHOULD" AND "WHY."

#2

"IF YOU REALLY WANT TO SLASH YOUR WRISTS, AND DO IT RIGHT, YOU SHOULD DO IT VERTICALLY INSTEAD OF HORIZONTALLY."

RESPONSE

I CAN'T BELIEVE PEOPLE SAY STUFF LIKE THIS, BUT THEY DO. LET'S SEE….WHY WOULDN'T I WANT TO GIVE A SUICIDAL PERSON A "HOW TO" LESSON. HMMMM. LET ME THINK.

AND NOW……FOR THE NUMBER ONE THING TO NEVER SAY TO A SUICIDAL PERSON……

#1

"CHEER UP! YOU HAVE YOUR WHOLE LIFE AHEAD OF YOU!"

RESPONSE

IF THEY ARE IN MISERY, AND SEE NO END IN (OTHER THAN SUICIDE), YOU'VE JUST TOLD THEM THEY HAVE A LIFE SENTENCE OF PAIN UNTIL THEY STOP BREATHING.

RECOMMENDATIONS FOR TALKING TO FRIENDS OF SUICIDAL PEOPLE

IT IS ALWAYS OKAY TO ASK "*HAVE YOU BEEN THINKING ABOUT SUICIDE?*"

Just don't try to sell them on the idea.

ENCOURAGE THE CONCERNED PERSON TO NOT WORRY ABOUT THE SUFFERING PERSON BEING MAD, OR BEING LABELED A "SNITCH."

(JOHNSON, 2005, 2007; JOHNSON, 1986, 1988)

- People don't stay mad forever. They do, however, stay dead forever.
- If the threat is real, the alternative is the death of the person in crisis.
- The professionals who clinically intervene you have the responsibility to respect confidentiality.

REMEMBER, *YOU ARE ETHICALLY RESPONSIBLE TO REFER AND REPORT SUSPECTED SUICIDAL RISK.*

IT'S MORE THAN OK TO BRING UP THE TOPIC OF SUICIDE. BELIEVE ME, YOU WON'T BE "*PUTTING THE THOUGHT IN THEIR HEAD*." IF YOU'RE CONCERNED ENOUGH TO ASK, THE THOUGHT IS MOST LIKELY ALREADY THERE.

…TRY TO NOT ASK IT IN A WAY THAT WILL CAUSE THE SUFFERING PERSON TO THINK YOU DISAPPROVE OF THEM ADMITTING TO HAVING THOUGHT ABOUT SUICIDE.

BY BRINGING IT UP, YOU ARE GIVING THE PERSON PERMISSION TO TALK ABOUT SOMETHING THAT IS ALREADY ON HIS OR HER MIND.

MACU POLICE DEPARTMENT SUICIDE EMERGENCY RESPONSE PROTOCOLS

(NOTE: USAGE OF THE C-SSRS QUESTIONAIRE IS CURRENTLY UNDER CONSIDERATION)

NOTE:
MACU PD CURRENTLY-CERTIFIED CRISIS INTERVENTION TEAM (CIT) OFFICERS

Tim Gibson, Chief of Police*

Joel Johnson, Police Officer / Instructor

Chief Gibson is to be contacted by First-Responding Officers, in cases of suicidal emergencies, unless Officer Johnson has been designated as the CIT Officer on Call.

UPON BEING NOTIFIED OF A POSSIBLE SUICIDAL EMERGENCY

- If call or verbal report is received by a CSO, the Police Officer on duty, and/or Chief of Police on call or on duty is to be immediately notified.
- The Responding Police Officer will respond to the location of the Person in Crisis, and notify the Chief of Police or Designated CIT Officer by phone, as soon as possible.
- Upon contact, the Police Officer or Chief of Police will enter the room occupied by the person in crisis, ascertain whether or not the "scene is safe," or secure the scene for personal safety.
- If any weapons or items comprising "lethal means" are present and accessible, the Responding Police Officer will secure those items and separate the Person in Crisis from them.
- The Responding Police Officer(s) will then conduct a preliminary Lethality Assessment, utilizing the *Columbia Suicide Severity Rating Scale*, as described in the following slides, and make notification to the Director of Student Life by phone, as soon as possible.

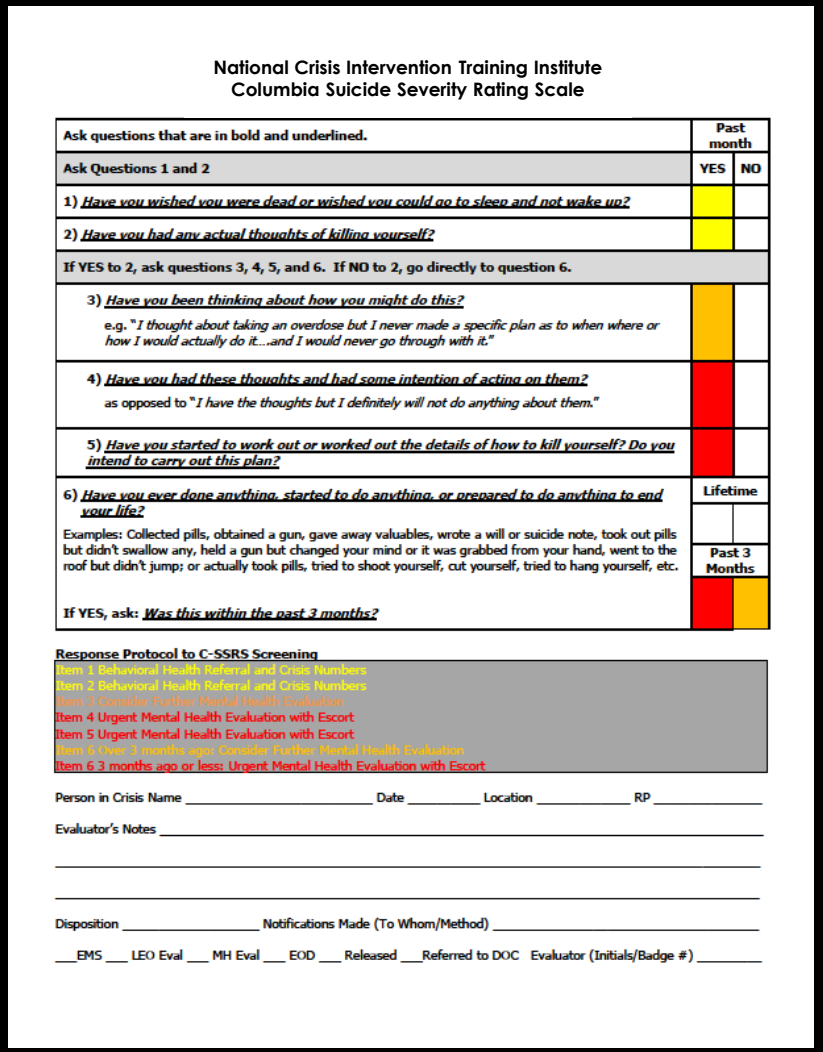
WHAT SHOULD THE FIRST-RESPONDING POLICE OFFICER DO WHEN PERFORMING AN INITIAL LETHALITY ASSESSMENT

- Ascertain if there is an immediate threat, and if there are environmental issues that need to be addressed immediately (removal or separation from the preferred "means" of self-injury, and other lethal or self-harmful items).
- Ensure that persons present are helpful (not antagonistic) members of the person in crisis' support system, and that the Person in Crisis wants them to be present.
- Protect Person in Crisis' privacy and dignity, and, If necessary, remove parties from scene who may be detractors.
- Establish or enhance relationship of trust and rapport.
- Recognize and identify any apparent suicide danger signs, as well as verbal, para-linguistic, and non-verbal indicators of suicidality.
- Exhibit open, relaxed, and friendly non-verbal and para-verbal behavior.
- Verbally administer the Columbia Suicide Severity Rating Scale questionnaire.
  - Ascertain desire to not live with the pain, versus decision to die (C-SSRSA QUESTION #1).
  - Ascertain actual thoughts of suicide (C-SSRSA QUESTION #2). IF "Yes" to #1 and #2:
  - Pre-thoughts about Plan and Intent? (C-SSRSA QUESTIONS #3 and #4)
  - Specific Plan and Intent? Lethal means?" (C-SSRSA QUESTION #5).
  - Suicidal behavior? Means gathered and immediately available? (C-SSRSA QUESTION #6).

COLUMBIA SUICIDE SEVERITY RATING SCALE ASSESSMENT

NCITI VERSION

(Columbia Lighthouse Project, 2018; NCITI, 2018)



National Crisis Intervention Training Institute
Columbia Suicide Severity Rating Scale

Ask questions that are in bold and underlined.	Past month	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it."*		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to *"I have the thoughts but I definitely will not do anything about them."*		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***	Lifetime	
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Past 3 Months	
If YES, ask: ***Was this within the past 3 months?***		

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral and Crisis Numbers
Item 2 Behavioral Health Referral and Crisis Numbers
Item 3 Consider Further Mental Health Evaluation
Item 4 Urgent Mental Health Evaluation with Escort
Item 5 Urgent Mental Health Evaluation with Escort
Item 6 Over 3 months ago: Consider Further Mental Health Evaluation
Item 6 3 months ago or less: Urgent Mental Health Evaluation with Escort

Person in Crisis Name _____ Date _____ Location _____ RP _____

Evaluator's Notes _____

_____

_____

Disposition _____ Notifications Made (To Whom/Method) _____

___EMS ___ LEO Eval ___ MH Eval ___ EOD ___ Released ___Referred to DOC Evaluator (Initials/Badge #) _____

C-SSRS ASSESSMENT – LAW ENFORCEMENT KEY QUESTIONS

(COLUMBIA LIGHTHOUSE PROJECT, 2018)

1. *"Have you wished you were dead, or wished you could go to sleep and not wake up?"*
2. *"Have you had any actual thoughts of killing yourself?"*

   (If "No" to Questions 1 and 2, go directly to question 6).
3. *"Have you been thinking about how you might do this?"*
4. *"Have you had these thoughts and had some intention of acting on them?"*
5. *"Have you started to work out, or worked out the details of how to kill yourself?" "Do you intend to carry out this plan?"*
6. *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?* **(If "Yes"),** *"Was this within the last three months?"*

NYPD OFFICER ADMINISTERS THE C-SSRS (QUESTIONS 1-2, 6)

RESPONSE PROTOCOLS TO C-SSRS ASSESSMENT (PURSUANT TO "YES" RESPONSES TO QUESTIONS 1-6)

(COLUMBIA LIGHTHOUSE PROJECT, 2018)

- Question #1 and/or #2 ONLY: Behavioral Health and Director of Counseling referrals, and Crisis Numbers given.
- Question #3: Consider immediate mental health evaluation at Designated Medical Facility (after hours) and make phone notification to Director of Student Life.
- Question #4: Transport to Designated Medical Facility for evaluation /Notify Director of Student Life via Phone.
- Question #5: S/A.
- Question #6 (less than 3 months ago): S/A.
- Question #6 - ONLY (but OVER 3 months ago): Consider transport to Designated Medical Facility for evaluation.

IF CIRCUMSTANCES AND VERBAL RESPONSE TO THE C-SSRS QUESTIONNAIRE DO INDICATE AN EOD EXAMINATION IS NECESSARY, THE FIRST RESPONDER SHALL

- Notify a Departmental CIT Officer (if not already present). At time of this training, the two certified Crisis Intervention Team officers on staff with MACU PD are:
  - Tim Gibson, Chief of Police.
  - Joel Johnson, Police Officer / Instructor.
- Call the Student Life Director AS SOON AS POSSIBLE, to notify him of the situation, as well as the identity of the Person in Crisis.
- The Student Life Director will immediately contact a Licensed Professional Counselor (LPC) on call, requesting that he or she respond.
- The Student Life Director and/or LPC will communicate with the Person in Crisis, seeking to Identify that person's support system, and the Person in Crisis' willingness to access and utilize those resources.
- When warranted, the Student Life Director or LPC assist by communicating with various facilities, in order to find an available bed for the Person in Crisis.
- If warranted, the First Responding Police Officer will transport the Person in Crisis to Community Hospital, located at 3100 SW 89th Street, OKC, OK.
- Provide the Designated CIT Officer with findings and observations, in order to determine co-morbidity factors which may call for formal protective intervention (to pass on to professionals providing definitive evaluation and care).

IF CIRCUMSTANCES AND VERBAL RESPONSE TO THE C-SSRS QUESTIONNAIRE DO NOT INDICATE AN EOD EXAMINATION IS NECESSARY, THE FIRST RESPONDER SHALL

- Notify a Departmental CIT Officer (if not already present). At time of this training, the two certified Crisis Intervention Team officers on staff with MACU PD are:
  - Tim Gibson, Chief of Police.
  - Joel Johnson, Police Officer / Instructor.
- Call the Student Life Director to notify him of the situation, as well as the identity of the Person in Crisis…and follow any instructions given by the Student Life Director.
- The Student Life Director will immediately contact a Licensed Professional Counselor (LPC) on call, in order to facilitate counseling and other follow-up services for the Person in Crisis.
- The Student Life Director and/or LPC will communicate with the Person in Crisis, seeking to Identify that person's support system, and the Person in Crisis' willingness to access and utilize those resources.
- Regardless of whether or not the Responding Police Officer gathers enough information to warrant transportation for an EOD examination, the Student Life Director and/or LPC may at any time determine that an EOD examination is warranted. If so, they will complete a 3rd Party Affidavit, instruct the Police Officer to whatever hospital has an available bed (ascertained by the Student Life Director).

SPECIAL INSTRUCTIONS PERTAINING TO EMERGENCY TRANSPORT

- If the incident occurs during regular business hours, and there is no indication of a need for medical screening (such as possible ingestion of medication, self-inflicted injuries, et cetera), the Police Officer on Duty shall take the Person in Crisis into protective custody, and, upon receiving instruction from the Director of Student Life, shall transport the Person in Crisis to the Designated Mental Health Facility, for evaluation.
- If for any reason the Person in Crisis needs to be medically screened, or if the precipitating incident occurs outside regular office hours, the on-duty Police Officer shall transport the Person in Crisis to the Designated Medical Facility, unless the Person in Crisis needs to be transported by Ambulance, for medical reasons.
- During any emergency transport via police vehicle, for personal safety purposes --unless otherwise deemed appropriate by instructions of the Chief of Police-- the Person in Crisis shall be physically restrained with handcuffs, and secured by seat belt and shoulder harness, in the front seat of the police vehicle during transportation. If a third party, such as the Director of Student Life, Head RA, or another party), is accompanying the Police Officer and Person in Crisis, that Third Party) shall be instructed to ride in the back seat on the passenger side, immediately behind the Person in Crisis.
- NOTE: The Transporting Police Officer shall make every effort to exercise gentleness, patience, discretion, and respect when applying physical restraints, explaining that the policy and procedures are designed for the protection of the Person in Crisis. Every effort should be made to protect the privacy and dignity of the Person in Crisis.
- The On-duty Police Officer shall remain in attendance during the evaluation, and, if it is clinically determined that the Person in Crisis does not need to be transported to the Designated Mental Health Facility , the Police Officer shall transport the Person in Crisis back to the University property (e.g. dormitory). Return transportation to the University may be conducted without the Person in Crisis being restrained for safety purposes. Follow-up notification shall be made to the Director of Student Life.

SPECIAL INSTRUCTIONS SURROUNDING EMERGENCY TRANSPORT(CONT'D)

- Once transported to the Designated Medical Facility, the Officer in attendance shall give a verbal report to the hospital personnel, and determine whether or not the Person in Crisis presents an elopement risk. If so, the Police Officer in Attendance shall remain at the hospital Emergency Room during the medical and psychological screening, until the Person in Crisis is either released, or transported to a secure psychiatric facility for mental health evaluation
- Pursuant to the medical/legal EOD process, the attending Police Officer shall write a *Law Enforcement Officer's Affidavit*, or facilitate a *Third Party Affidavit* written by a credible, authorized person (e.g. parent, guardian, adult relative, or other credible adult person) who is providing information directly related to the Person in Crisis' suicidal or homicidal risk. Either of those documents shall be turned over to the medical personnel at the Designated Medical Facility, to be reviewed by hospital personnel, and included in documentation to be forwarded to the Designated Mental Health Facility.
- If the Person in Crisis is taken into Emergency Protective Custody, and/or is subject to an Emergency Order of Detention, the details of the emergency intervention shall be documented in a *Confidential Incident Report*, and assigned a case number. That report shall be held in a secure MACU Police Department file in the Office of the Chief of Police. For confidentiality reasons, any and all Personal Identifying Information (PII) contained in the Incident Report shall be redacted from any copy of a report, when copies made accessible to any authorized third parties.

SAMPLE LAW ENFORCEMENT EOD EOD AFFIDAVIT FORM

National Crisis Intervention Training Institute, Inc.

PEACE OFFICER'S AFFIDAVIT FOR EMERGENCY DETENTION

IN RE: THE PROTECTIVE CUSTODY OF:

(Subject's Name) – _____
Last First MI

I, the undersigned Peace Officer, being first duly sworn, declare: I am a member of a law enforcement agency within the State of Oklahoma; that on the _____ day of _____, 20_____, I observed (Subject's name) _____ at (location)_____ _____in (county)_____, Oklahoma, and that at _____ o'clock ___ m, this person was taken into protective custody.

I swear or affirm that the basis for taking this person into protective custody was: (Describe the activity of incident personally observed by the officer which formed the basis for the officer's opinion and action. If based on an affidavit of a third person, instead of personal observation, so state:)

_____
_____
_____
_____
_____
_____
_____
_____

That upon such basis, I am the opinion that this person is a person requiring treatment to a degree that immediate emergency action is necessary, and should be held in emergency detention, as provided by The Mental Health Law of the State of Oklahoma.

_____
Signature of Peace Officer

_____
Name of Law Enforcement Agency

Subscribed and sworn before me on this
_____ day of _____, 20 _____.

_____
Notary Public

My Commission expires: _____.

SAMPLE EOD THIRD PARTY AFFIDAVIT FORM

National Crisis Intervention Training Institute, Inc.

THIRD PARTY AFFIDAVIT FOR EMERGENCY DETENTION

IN RE: THE PROTECTIVE CUSTODY OF:

(Subject's Name) _____
Last First MI

I, the undersigned adult person, declare: that on the _____ day of _____, 20_____, I observed (Subject's name) _____ at (location)_____ City _____in _____ (County)_____, Oklahoma, and that at _____ o'clock ___ , do and/or state the following (describe activity or incident personally observed, and material statements made by Person taken into Emergency Protective Custody):

_____

_____

_____

_____

_____

_____

_____

_____

_____

That upon such basis, I am the opinion that this person is a person requiring treatment to a degree that immediate emergency action is necessary, and should be held in emergency detention, as provided by The Mental Health Law of the State of Oklahoma. I understand that any intentionally false statement made to the Officer by me regarding this activity or incident constitutes a misdemeanor crime in the State of Oklahoma, and that I may be prosecuted for making such false statement.

_____ _____
Signature of Third Party Relationship to Person Taken Into Protective Custody

_____ _____
Printed Name of Third Party Street Address

_____ _____ _____
City State Zip Code

_____
Phone Number

_____ Mid-America Christian University Police Department
Signature / Badge # of LEO Witness

SUMMARY
CLASS DISCUSSION

CASE STUDY EXAM PREPARATION

SUICIDE ATTEMPT, YES OR NO?
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"The student is feeling pressured by school, and wants to drop out. However, she doesn't know how to convince her parents she is serious. She researched lethal doses of ibuprofen. She took 6 ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die; only to escape from all the pressure of school. After being discovered by her roommate, she was taken to the Emergency Room where her stomach was pumped, and she was admitted to a psychiatric ward."

1. Yes.
2. **No.**
3. Not Enough Information.

SUICIDE ATTEMPT, YES OR NO?
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A junior business major living in a dormitory, following a fight with her boyfriend, felt like she wanted to die. She took a kitchen knife from the cafeteria, returned to her room, and made a superficial scratch to her wrist. Before she actually punctured the skin or bled, however, she changed her mind and stopped."

1. **Yes.**
2. No.
3. Not Enough Information.

SUICIDE ATTEMPT, YES OR NO?
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A freshman student was feeling ignored by her friends and family. While home on a weekend visit, she went into the family kitchen where mother and sister were talking. She took a knife out of the drawer and made a cut on her arm. She denied that she wanted to die at all ('not even a little'). But just wanted them to pay attention to her."

1. Yes.
2. **No.**
3. Not Enough Information.

SUICIDE ATTEMPT, YES OR NO?
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A female student cut her wrists after an argument with her boyfriend."

1. Yes.
2. No.
3. **Not Enough Information.**

SUICIDE ATTEMPT, YES OR NO?
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A married student, living in the dormitory, had a big fight over the phone with her ex-husband about her stepson. She took 15-20 imipramine tablets and went to bed. sleeping all night, until 4:00 pm the nest day. Her roommate returned from class, and the married student told her that she couldn't stand up or walk. EMS was called, and she was taken to ER, where she told what she had done, and was made to drink charcoal. She was admitted to hospital for medical observation. She was unable to verbalize clear intent, but states she was well aware of the dangers of TCA overdose and the potential for death."

1. **Yes.**
2. No.
3. Not Enough Information.

TYPE OF ATTEMPT?
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A student stated that she experienced heartbreak over the 'loss of a guy,' a week before being interviewed by a campus police officer, after telling her best friend over the phone that she had taken four clonazepam, and "cried it out" while on the phone. She was dismissive of the seriousness of the attempt, but indicated that she wanted to die at the time she took the overdose."

1. **Suicide Attempt.**
2. Interrupted Attempt.
3. Aborted Attempt.

TYPE OF ATTEMPT?
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"During a pill count, a student living in the dorm discovered that an unknown quantity of tablets ("at least ten") were missing from her medication bottle. Upon questioning, her roommate admitted that she had been taking her roommate's medication, two or three pills at a time, and was saving them up so she could take them all together at a later time, in order to kill herself."

1. Suicide Attempt.
2. Interrupted Attempt.
3. **Preparatory Behavior.**

FURTHER CASE EXAMPLE
(COLUMBIA LIGHTHOUSE PROJECT, 2018)

"A male student seeing the school Counselor reported that he first started thinking about killing himself when he was 12 years of age. He thought about how easy it would be to pretend to fall in front of a bus before it was able to stop, so that it would look like an accident. Although he thought about it often, he said he did not have the courage to do it."

1. Preparatory Behavior.
2. Suicidal Ideation with Plan.
3. **Suicidal Ideation with Method.**

COLUMBIA SUICIDE SEVERITY RATING SCALE ASSESSMENT CERTIFICATION

THE COLUMBIA LIGHTHOUSE PROJECT

IDENTIFY RISK. PREVENT SUICIDE.

- Mission: To "light the way to ending suicide."
- Message: "Just ask. You can save a life."
- Formed under auspices of Columbia University to disseminate the Columbia-Suicide Severity Rating Scale.
- C-SSRS Assessment is a key to ending suicide: A devastating, but preventable, worldwide public health crisis.
- Goals and Functions:
  - Get the right stylized scale to the End-User.
  - Provide training on how to use the Scale.
  - Advocate for worldwide use of the Scale to save lives.
  - Speak to your group or organization about the Scale, and its necessity and value.
  - Address fears and dispel misconceptions that people may have about asking someone about suicide.
  - Direct End-Users to resources that can bolster their suicide prevention efforts.
  - Identify risk. Prevent suicide. Make a difference.

C-SSRS ASSESSMENT CERTIFICATION VALID FOR TWO YEARS

Certificate of Learning

This is to certify that

_____

has successfully completed the educational course on

The Columbia- Suicide Severity Rating Scale

Date Completed: __/__/__

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

Kelly Posner, Ph.D.
Director, The Columbia Lighthouse Project
Columbia University College of Physicians and Surgeons

C-SSRS-A IS USED BY (COLUMBIA LIGHTHOUSE PROJECT, 2018)

- Family, Friends, and Neighbors.
- Law Enforcement.
- Mental Health Professionals and Para-Professionals.
- Emergency First Responders.
- Governments.
- Pre-hospital Healthcare.
- In-Hospital Healthcare.
- Chaplains.
- Military.
- Schools – Educators, Coaches, Bus Drivers, Paraprofessionals, etc.
- Corrections.
- Researchers.
- Center for Disease Control.
- Peer Counselors.

C-SSRS…DEPRESSED SUBJECTS… ALL OF THESE BEHAVIORS ARE PREVALENT (ONLY 13% ARE ATTEMPTS)

(MUNDT, ET AL, 2011)

- No behavior: 28,303 (98.6%)
- Actual attempt: 70 (0.2%)
- Interrupted attempt: 178 (0.6%)
- Aborted / Self-interrupted attempt: 223 (0.8%)
- Preparatory behavior: 71 (0.2%)
- Non-suicidal self-injury: 45 (0.2%)

- Only 1.7% had any worrisome answer.
- Only 0.9% with circa 50,000 administrations.
- 472 interrupted, aborted/self-interrupted, preparatory.
- Versus 70 actual attempts.

ALL PREDICTIVE: Multiple Behaviors = Greater Risk

KEY ADVANTAGES TO C-SSRS-A METHODOLOGY & CERTIFICATION

- Evidence-based, therefore, widely recognized, respected, and accepted.
- Uniformity…allows for consistent response to suicide-related emergencies.
- Method and process is brief, concise, and easy to follow.
- Time-saving when time counts the most.
- Protocols compatible with NWOSU PD Policies and Procedures, and Oklahoma Statutes pertaining to Emergency Protective Custody procedures.
- Greatly reduces legal liability, if adhered to, for the above-five reasons.
- Documents LEO's competence and qualifications to conduct emergency assessments for EOD process.
- Contiguous with Emergency Notification protocols, and communication with Counselors on call.
- Compatible, recognized, and accepted by Medical and Clinical Personnel conducting formal assessments.
- Provides information and key phrases necessary for Law Enforcement Officer's Affidavit and Incident Report narratives.

KEY ADVANTAGES (CONT'D)

- Rapid administration time: Average less than one minute.
- Reduced manpower and financial cost burden in clinical settings.
- Extremely sensitive and specific.
- Excellent patient satisfaction record.
- Used internationally: 103 language versions.
- May be used with Alzheimer's, OBS, Autistic, and other cognitively-impaired individuals.
- No advanced mental health training required.
- Among 812 nurses trained: 99% reliability independent of mental health training.
- Allows for provision of data coming from multiple sources.
- Facilitates and provides operationalized criteria for next steps or referral for longer-term management of the emergency.

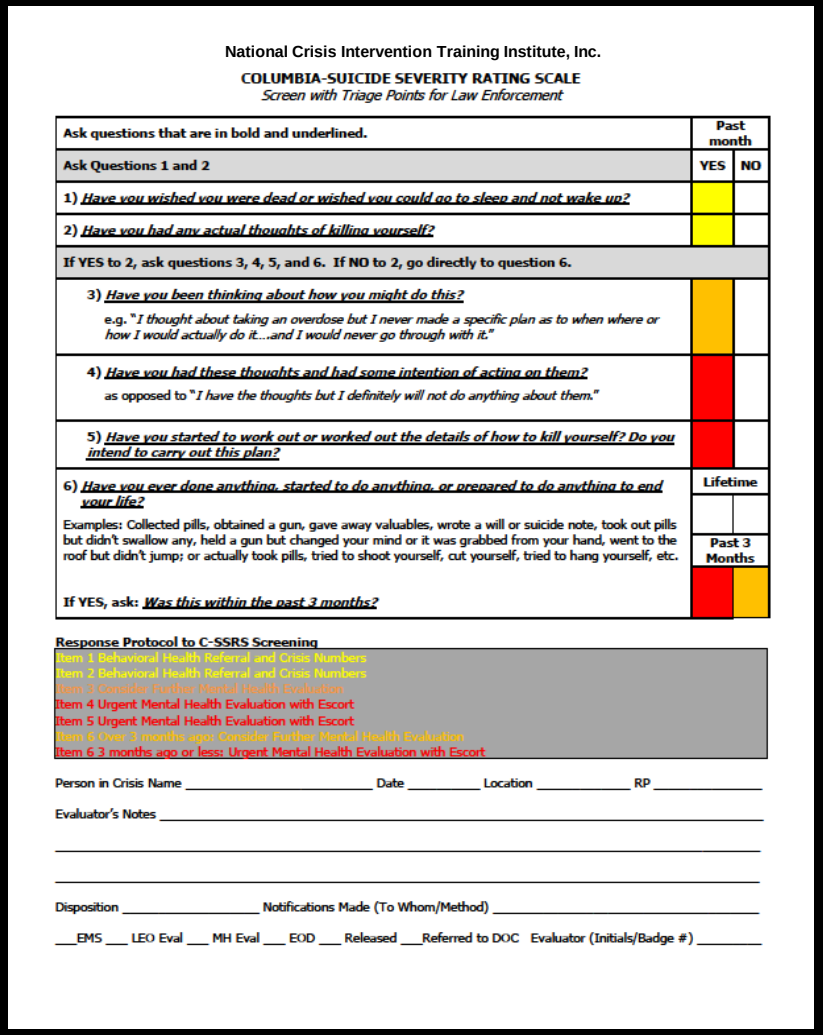
"[USING THE C-SSRS] MAY ACTUALLY BE ABLE TO MAKE A DENT IN THE RATES OF SUICIDE THAT HAVE EXISTED IN OUR POPULATION, AND HAVE REMAINED CONSTANT OVER TIME….THAT WOULD BE AN ENORMOUS ACHIEVEMENT IN TERMS OF PUBLIC HEALTH CARE AND PREVENTING LOSS OF LIFE."

JEFFREY LIEBERMAN, M.D.
PRESIDENT-ELECT OF AMERICAN PSYCHIATRIC ASSOCIATION

COLUMBIA SUICIDE SEVERITY RATING SCALE ASSESSMENT - REVISITED

NCITI VERSION

(Columbia Lighthouse Project, 2018; NWOSU PD, 2018)



National Crisis Intervention Training Institute, Inc.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen with Triage Points for Law Enforcement

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***	**Lifetime**	
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Past 3 Months**	
If YES, ask: ***Was this within the past 3 months?***		

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral and Crisis Numbers
Item 2 Behavioral Health Referral and Crisis Numbers
Item 3 Consider Further Mental Health Evaluation
Item 4 Urgent Mental Health Evaluation with Escort
Item 5 Urgent Mental Health Evaluation with Escort
Item 6 Over 3 months ago: Consider Further Mental Health Evaluation
Item 6 3 months ago or less: Urgent Mental Health Evaluation with Escort

Person in Crisis Name _____ Date _____ Location _____ RP _____

Evaluator's Notes _____

_____

_____

Disposition _____ Notifications Made (To Whom/Method) _____

___EMS ___ LEO Eval ___ MH Eval ___ EOD ___ Released ___Referred to DOC Evaluator (Initials/Badge #) _____

TO COMPLETE ONLINE C-SSRS CERTIFICATION COURSE

- Go to www.cssrs.Columbia.edu.
- Click on "Training," then "Training for Communities and Healthcare."
- Scroll down to "Certificates," then click on "Training Campus."
- Click on "Register" (upper right corner), then complete registration information fields. Follow instructions on the page. Once registered, you will automatically be led to the "RFMH" page.
- Once at RFMH Page, Click on "My Activities," and sign up for the FREE "Blue Cloud" program. Click on "Sign Up," then under "Blue Cloud Educational Network," click on "Columbia Suicidality Scale (C-SSRS)." This will lead you back to the "RFMH" page. Again, click on "My Activities." (NOTE: It may take a few minutes to open, depending on the current level of activity on the site).
- Once the various courses appear, click on "Enroll Now," for "RFMH-101-The Suicide Scale C-SSRS – English USA." You will then go to a page that shows you enrolled in that course. Click again on "RFMH-101-The Suicide Scale C-SSRS," and then again on "RFMH-A002a – The C-SSRS Training – English-USA-V.1.1 – Initial training,"
- View the PowerPoint presentation by clicking on the blue right arrow on the right side of the page. You may click on "Large" (on top of the PowerPoint field) to enlarge the screen.
- Once you have completed the PowerPoint, click "Yes – I am ready to move onto the sample case studies!"
- Follow the instructions as you proceed through the case studies. These must be completed in order to get your certificate. The Case Studies correspond to the sample case studies presented in the C-SSRS PowerPoint, as well as the ones in this course.
- Once you have generated your completion certificate, print it out and give a copy to the head administrator for your agency, or your agency's Training Coordinator, for it to be placed in your training file.
- Your certification will expire in in two years from your completion date.

CONCLUSION

HERE'S A PORTION OF A SECOND LETTER FROM ONE OF YOUR INSTRUCTOR'S "*SATISFIED CUSTOMERS*" ON THE NATIONAL YOUTH CRISIS HOTLINE

…and believe me, the first letter I got was a LOT more rude and hostile.

"I NEVER CUT MYSELF WITH GLASS BEFORE. I'VE DONE OTHER THINGS BUT NOTHING THAT HURT THAT MUCH. I JUST THOUGHT THE HURT ON THE INSIDE WOULD STOP IF THERE WAS SOMETHING ELSE TO THINK ABOUT. THE HURT IN THE INSIDE IS STILL THERE, THOUGH…IT DIDN'T MAKE A DIFFERENCE."

"…IT GETS HARD, BUT YOU ARE THERE. JUST LIKE YOU SAID YOU WOULD BE. THANKS."

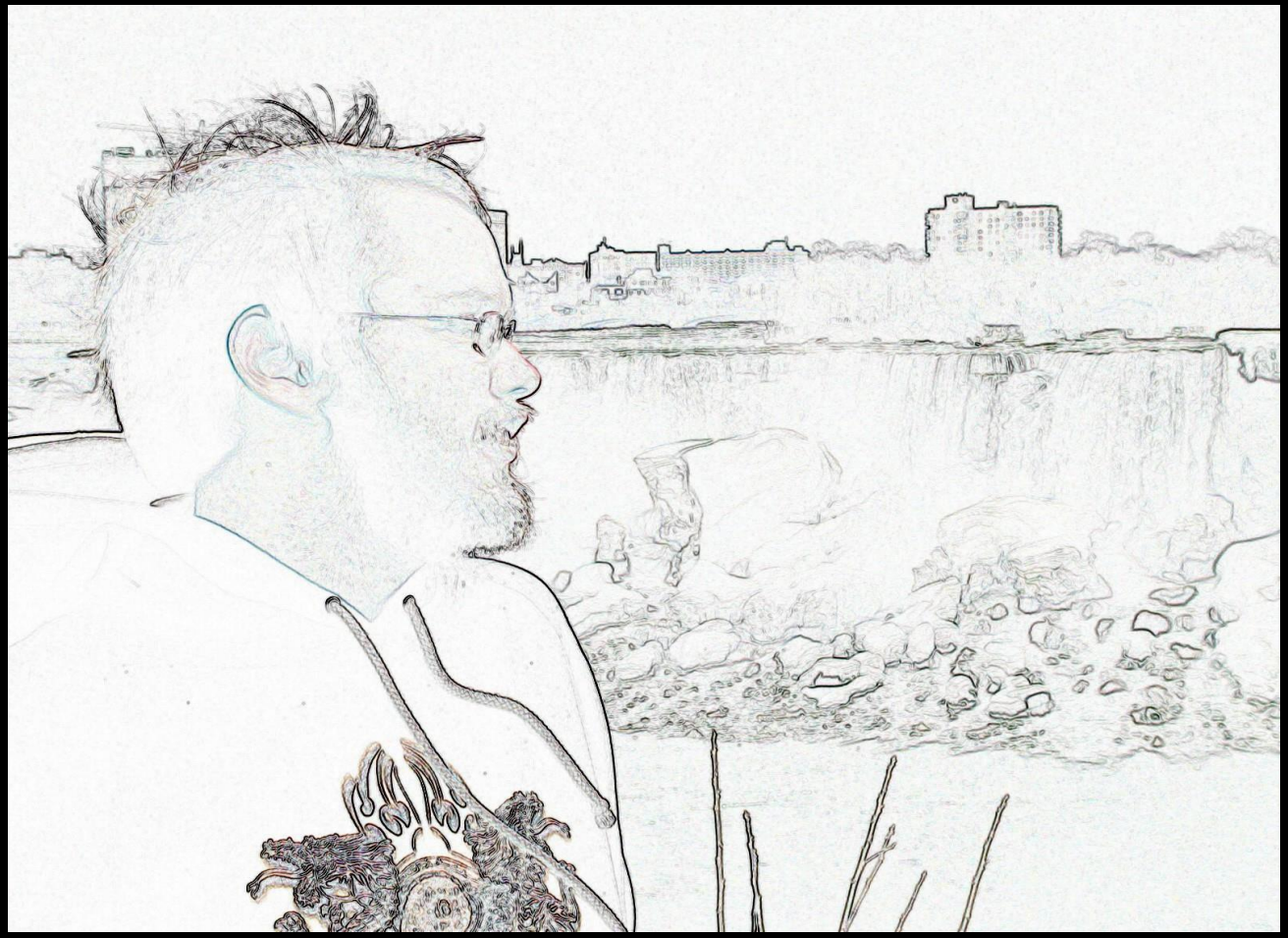
…CASSANDRA, AN 18 YR.-OLD HOTLINE CALLER
(JOHNSON & BOGAN, 1988)

THIS TRAINING WAS PREPARED IN HONOR AND LOVING MEMORY OF

ADAM JOSHUA JOHNSON

JULY 31, 1984 – JANUARY 8, 2009

"Son, your smile is our melody, your heart is our harmony;
And the lyrics of your life, they make us strong.
Our love for you will stay, and will never go away,
For we are The Notes of Adam's Song."



I love you, my Son.

QUESTIONS?

ROLE PLAY & PRACTICAL SKILLS EVALUATION

WRITTEN POST-TEST

FOR ADDITIONAL RESOURCES, VISIT

WWW.NCITI.ORG

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