Assessing Risk in Crisis Situations

- Slide 2: Who came to this session today looking for "the answer" to who is at risk and who is not at risk to harm themselves or others?
  - Unfortunately, we cannot possibly identify and eliminate risk entirely
  - Complex, complicated issue w/ many factors
  - BUT we can do things as crisis clinicians to ensure that we explored, mitigated, and minimized the risk as much as possible
- Slide 3: Today we will go over 3 areas- Review
- Slide 4: Start w/ Basic Definitions
- Slide 5:
  - Practice and Tools- 1st Area
    - Acknowledge fluidity of risk: struggle for our field. Combination of tools, assessment, formulation, collateral that leads to clinical judgement.
    - Knowing Populations: Give relevant stats/trends about risk in TN. Example of deaths by suicide in CSUs- white males in 50s, relational and financial issues, denying SI
    - C-SSRS- only a tool to be combined with other information to help formulate a clinical judgement. Discuss P&P importance.
    - AMSR- Use the "What" of getting the right information. Although developed for Suicide Risk, we gather info for all types of risk in much the same way. Briefly discuss Vulnerability vs. Volatility
    - Considerations Include:
      - LACK of SLEEP
      - A&D
      - Spirituality
      - Supports
      - Coping
      - Insight
      - Impulse Control
      - MH Factors
      - Trauma
      - Mindset/Thinking
      - Personality Disorders
      - Engagement/Belonging
    - Risk Factors and Protective Factors: Briefly discuss some less likely ones
    - Collateral: Think outside the box- past provider, who spends the most time w/ ct.
    - Consultation: Each and every time with the respect it deserves

- Slide 6: The KEY
  - Attitudes/Beliefs
    - Emotions:
      - Fear (may encourage person to think about ____, person will do _____, lawsuit)
      - Anger- irritation, resentment, disgust, hate. May arise when clinician feels helpless
      - Helplessness- self-doubt, inadequacy a/b capacity to assess and formulate risk or be helpful. May feel vulnerable especially if have experienced a tragic outcome.
      - Hopelessness for ct. leads to difficulty est or maintaining empathic understanding or basic respect
    - What happens if our emotions are left unacknowledged or unchecked?
      - Under response or over response
  - Insight
    - Therapy, processing, our own stuff
  - Counter-Transference- Ask for examples. What do you do with that?
  - Mental Well Being or Burn out
    - How do you recognize this?
    - Does your team look out for each other in this way?
  - HOW DOES THE ABOVE IMPACT OUR RISK ASSESSMENTS???
  - Is the above an expectation for yourself, from your peers, and leadership?
  - If it is a particularly rough case or triggered something, how do you get support? Professionally and personally?
  - Health of the Team- Briefly review Family Systems Theory
  - Supervision-opportunity to process
- Slide 7 Improvements/ Enhancements
  - Training: AMSR, any type of mental health/addiction focused training
  - Role Playing: Helps clinicians be more competent in their skills, info sharing
  - Communication: ALWAYS can improve. Many players involved, can be hectic. Communication of plan w/ client and all parties involved.
  - Knowing latest trends/stats/ and literature
    - Give recs on literature
  - Being present and being curious are keys to making sure you are covering and uncovering all pertinent info
  - Consistently assessing and re-assessing your approach. Try to create checks and balances.