



Crisis Intervention Techniques

And Call Handling Procedures for Public Safety Telecommunicators

APCO Candidate ANS 1.120.1-2021

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FOREWORD

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EXECUTIVE SUMMARY

For decades public safety agencies across America have implemented policies and procedures to reflect current times, needs, and environments. Most recently there has been a push within Emergency Communication Centers to improve education, understanding and consequent job performance around the handling of calls involving behavioral health issues. Behavioral health covers a wide breadth of signs and symptoms experienced which could include, but are not limited to, behavioral challenges, emotional difficulties, substance use, developmental disabilities, diagnosable conditions, mental health, and age-specific characteristics associated with generalized behavioral health. This standard will review primarily poor behavioral health, but it should be noted that behavioral health can also be positive and healthy. Current research suggests that between 7-10% of calls for service involve a component of behavioral health, most often a crisis.¹ As the rates of impact continue to rise, Emergency Communications Centers are updating policies and procedures in order to appropriately manage and respond to individuals in crisis. Updated responses include, but are not limited to, identifying training requirements for handling calls involving an individual in crisis, procedures for effectively recognizing and communicating with the caller, highlighting nationally available resources, and continued forward thinking responses to provide quality services.

Public Safety Telecommunicators (PSTs) are typically the first layer of response to crisis-based calls and can serve as the initial layer of de-escalation attempts. PST's must manage a wide range of emergency calls, often involving a variety of behavioral health disorders and conditions. Throughout Emergency Communications Centers there is a demand for skills associated with handling such calls in an appropriate, calming, and professional manner. To reflect the requests and needs for such improvement, APCO has published this standard: Crisis Intervention Techniques & Call Handling Procedures for PSTs, which provides a fundamental tool for PSTs. In practice, this standard is written to provide fundamental strategies and responsibilities for the agency, a brief understanding of behavioral health, PST responsibilities, and stress management for the PST. This standard provides procedures and techniques for improved responses for PSTs while handling a call involving a person in crisis.

Historically, many of us are accustomed to using the term "mental health" when referring to a person in crisis. However, we'd like to challenge you throughout this standard to utilize the phrase "behavioral health". This is a simple transition which permits for a wider breath and scope, allowing us to encompass all the material noted in this standard, and then some. It is important to remember the language is still interchangeable, therefore, as a PST you should strive to modify language to reflect what is used in this standard, while remembering the phrase "mental health" may be used by the caller themselves.

We'd like to give you an example of how the two (mental health and behavioral health) work together in a scenario which could be applicable to public safety. Say you, as a PST, receive a call from an individual who has severe anxiety. They would likely be calling due to panic attacks, suicidal thoughts, fear of leaving their home, etc. While you wait for responding units to arrive on scene, the caller might also disclose to you that they have had poor appetite, hard time sleeping, work disturbances, and low social life. In a different situation, but with the same type of caller, they might be calling after getting into a car accident or into a domestic with their partner as a result of their anxiety. Although the anxiety itself is a diagnosable condition and what could be listed as straight mental health, all the behaviors which surround the anxiety, both directly and indirectly, are impacting their overall

¹ Mental Health First Aid. (2019). *Mental Health First Aid USA Public Safety* (18). Retrieved from www.mentalhealthfirstaid.org/.

functioning and consequently their call for help. This is the behavioral health piece. This is how we view behavioral health – the overall health, and in a PST’s world, generally that behavioral health is in poor condition.

Due to the nature of behavioral health, it is difficult to provide concrete responses and strict expectations for a PST. Similarly, it is challenging to provide specific expectations when handling a caller experiencing a crisis. The intended goal of this standard is to guide an educated response and suggest some possible options for response in different situations. Not all responses will work the same for the variety of calls the PST will receive; the PST shall understand the uniqueness of each call and the need for variation in responding as such. Despite this, the PST shall attempt to always use compassion, empathy, strong active listening skills, and calm responses to make informed decisions to all incoming calls involving or directly related to behavioral health issues.

To achieve successful handling of behavioral health related calls, the PST shall use the information they receive from the call to guide a response to the caller and to relay relevant information to responding units.

Chapter One

INTRODUCTION

SCOPE

This chapter provides a basic introduction to the definitions and concepts found within this standard

1.1 Definitions

- 1.1.1 Active Listening:** Demonstrating an interest and understanding of what is being said through staying focused, asking questions, listening for the main point, and listening for the rationale behind what is being said.²
- 1.1.2 Burnout:** A state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. It occurs when one feels overwhelmed and unable to meet constant demands. As stress continues, one begins to lose the interest or motivation leading them to take on a certain role in the first place.³
- 1.1.3 Calling Party:** Refers to an individual requesting response from a designated responder (Police/Fire/EMS) regarding an emergency. Regarding a behavioral health crisis, the calling party could be the person in crisis, or a secondary party requesting help for the person having the crisis. Sometimes referred to as the reporting party.
- 1.1.4 Compassion Fatigue:** A state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree it is traumatizing for the helper.²
- 1.1.5 Computer Aided Dispatch (CAD):** A computer-based system assisting PSTs with activities such as call input, dispatching, call status maintenance, event notes, field unit status and tracking, and call resolution and disposition.¹
- 1.1.6 Crisis:** An event which may or may not exceed an individual's coping strategies resulting in disturbances, reactions, or impairments in cognition, affect, and/or behavior.⁴

² Association of Public Safety Communications Officials (APCO). *Public Safety Telecommunicator 1, Seventh Edition Training Manual*.

³ Rigden, K. (2017, Dec). *Stress Management: Stress and the 911 Dispatcher*. Retrieved from aedrjournal.org/.

⁴ Kassam, K. S., & Mendes, W. B. (2013). The effects of measuring emotion: physiological reactions to emotional situations depend on whether someone is asking. *PLoS one*, 8(7), e64959; NAMI (2018). Retrieved from www.nami.org/; Watson, A., Compton, M. & Draine, J. (2017). The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice?. *Behavioral Sciences & The Law, Special Issue*, 35 (5-6).

- 1.1.7 De-escalation:** Attempting to bring down the intensity level of emotions to redirect behavior so it can be controlled within safe boundaries.⁵
- 1.1.8 Emergency Medical Services (EMS):** A type of emergency service dedicated to providing out-of-hospital acute medical care, transport to definitive care, and other medical transport to patients with illnesses and injuries preventing the patient from transporting themselves.
- 1.1.9 Empathy:** The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner.⁶
- 1.1.10 Public Safety Telecommunicator (PST):** An individual employed by a public safety agency as the first of the first responders whose primary responsibility is to receive, process, transmit, and/or dispatch emergency and non-emergency calls for service for law enforcement, fire, emergency medical, and other public safety services via telephone, radio, and other communication devices.⁵
- 1.1.11 Responder:** Public emergency response personnel identified as responding in person to crisis, including but not limited to police, fire, EMS, on-site clinician, etc.
- 1.1.12 Veteran:** A person who served in the active military, naval, or air service and was discharged or released under conditions other than dishonorable.⁷

1.2 Understanding Concepts Related to Behavioral Health

- 1.2.1 Anosognosia:** To not know a disease, or to lack insight of one's own condition; often combined with psychosis or mania. It is often hard for people without diagnosable illness to relate to a person's lack of insight.⁸
- 1.2.2 Behavioral Health Trained Officer:** Standardized curricula have been developed on a national scale to train first responders including law enforcement officers, PSTs, emergency medical technicians/paramedics, fire department staff and others to identify, understand, and respond appropriately to behavioral health crises. Training opportunities and engagement varies based on state, location, and department size. Some examples of such training are as follows:

⁵ Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Jr, Zeller, S. L., Wilson, M. P., Rifai, M. A., & Ng, A. T. (2012). *Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup*. *The western journal of emergency medicine*, 13(1), 17–25.

⁶ Empathy. (n.d.). *Merriam-Webster Dictionary*.

⁷ Veterans Association. (2020). *What is a Veteran? The Legal Definition*. Retrieved from www.va.org/.

⁸ National Alliance of Mental Illness (NAMI). (2020). *Anosognosia*. Retrieved from www.nami.org/.

1.2.2.1 Crisis Intervention Team (CIT): A 40-hour, empirically studied, peer-reviewed model, it is an innovative first-responder model that includes police-based crisis intervention training to help persons with mental disorders and/or addictions access treatment rather than place them in the criminal justice system due to illness-related behaviors; teaches responders knowledge of psychiatric treatment, recognition of psychiatric emergencies, de-escalation skills, self-efficacy, transportations to treatment and behavioral health centers, and strategies in order to decrease use of force. It also promotes officer safety and the safety of the individual in crisis.

1.2.2.2 Mental Health First Aid (MHFA): 8-hour training with various specialty modules tailored for Public Safety/EMT and Firefighters. MHFA curriculum covers fundamentals of identifying, understanding, and responding to behavioral health crises.⁹

1.2.2.3 Other behavioral health training curricula for law enforcement, EMTs, and firefighters may be more common on a regional or local level.

1.2.3 Co-occurring Disorders: The condition in which an individual has a co-existing mental illness and substance use disorder. Compared to individuals who have a single disorder, those with a combination of disorders may experience more severe medical and behavioral health challenges and may require longer periods of treatment.¹⁰

1.2.4 Involuntary Treatment: A process through which an individual is determined, by an authoritative source, to be exhibiting signs and/or symptoms consistent with the individual being unsafe to themselves, others, or unable to make safe decisions. Processes will vary state-by-state but will ultimately require psychiatric evaluation.

1.2.5 Medication Treatment: One or a combination of prescription medication(s) used to help treat behavioral health or subdue symptoms associated with diagnoses. Medication compliance can be complex, and compliance can influence overall symptoms and expressions of such symptoms. PSTs shall remember that medications frequently have multiple purposes/uses; PSTs should ask the caller to confirm medications used for those purposes.¹¹

1.2.5.1 See Appendix A: Medications Commonly Used to Treat Mental Illness

1.2.6 Person in Crisis: An individual demonstrating signs and/or symptoms of poor behavioral health or generalized higher acuity (severity) of signs and/or symptoms than of a normal time for the individual; the individual may benefit from administration or referral to treatment services.

⁹ Mental Health First Aid. (2020). *Research & Evidence Base*. Retrieved from www.mentalhealthfirstaid.org/.

¹⁰ Foundations Recovery Network Dual Diagnosis. (2020). *The Most Common Co-Occurring Disorders*. Retrieved from www.dualdiagnosis.org/.

¹¹ NAMI. (2016, October). *Mental Health Medications*. Retrieved from www.nimh.nih.gov/.

- 1.2.7 Sign of Poor Behavioral Health:** Any objective evidence of a condition observed by others (e.g. changes in sleeping or eating habits, social withdrawal, etc.).
- 1.2.8 Stages of Change:** Behavioral change can be categorized in a progression of six stages, each with various engagement markers. A person's current stage will impact their willingness to engage in treatment and conversation around change/help.¹²
- 1.2.9 Stigma:** When someone is viewed in a negative way due to a distinguishing characteristic or personal trait that is thought to be, or is, a disadvantage. Negative attitudes toward people with behavioral health conditions are common, and can result in harmful consequences such as:¹³
- 1.2.9.1 Reluctance to seek help or treatment
 - 1.2.9.2 Lack of understanding by family, friends, co-workers, or others
 - 1.2.9.3 Fewer opportunities for work, school or social activities or trouble finding housing
 - 1.2.9.4 Bullying, physical violence or harassment
 - 1.2.9.5 Belief one will never succeed at certain challenges or one cannot improve one's situation
 - 1.2.9.6 Negative perception which may impede an individual from receiving/seeking treatment
- 1.2.10 Suicide by Cop:** Behavior in which an individual who is experiencing suicidal ideations deliberately acts in a threatening/aggressive/violent fashion, with the goal of provoking a lethal response from a law enforcement officer, such as being shot to death.¹⁴
- 1.2.11 Symptom of Poor Behavioral Health:** A subjective description only apparent to the patient (e.g. complaints of aches and pains, feeling excessively sad, suicidal ideation, etc.).
- 1.2.12 Voluntary Treatment:** An individual actively seeking and willing to engage in behavioral health treatment.

¹² Australian Government Department of Health. (2004). *3.3 The Stages of Change Model*. Retrieved from www.health.gov/.

¹³ Centre for Addiction and Mental Health (CAMH). (2020). *Addressing Stigma*. Retrieved from www.camh.ca/.

¹⁴ APCO. *Crisis Negotiations for Telecommunicators Training Manual*.

Chapter Two

Understanding Behavioral Health

SCOPE

This chapter provides the PST with a basic understanding of behavioral health and the various reasons a person may be experiencing a behavioral health crisis. Additionally, this chapter will assist the PST in recognizing common signs and symptoms of a person experiencing a behavioral health crisis and the different ways diagnosable disorders can affect how a person feels, thinks, and interacts with society.

2.1 What is Behavioral Health?

2.1.1 Behavioral health is an umbrella term that includes the intersections of emotional, psychological, mental, physical, and social well-being. It affects how one thinks, feels, and acts. It also helps determine how one handles stress, relates to others, and makes choices. Behavioral health challenges may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day. Behavioral health includes not only a diagnosis, at times, but also the subsequent behaviors directly or indirectly related to that diagnosis.¹⁵

2.1.2 Treatment is either voluntary or involuntary.

2.2 Who is Affected by Behavioral Health Challenges?

2.2.1 Poor behavioral health is not something which an individual chooses to experience but can choose to treat and maintain. This occurs across all ages, sexes, genders, races, cultures and amongst any subcategory including identities such as veterans, elders, and children. Behavioral health does not discriminate and impacts all populations.¹⁷

2.2.2 A person experiencing a behavioral health crisis does not have to have a previous diagnosis. A person in crisis can just be a person whose normal coping mechanisms are temporarily overwhelmed and in need of assistance. Everyone, at some point in their life, has experienced different facets of emotional, psychological, and social stress (i.e., depression, anxiety).¹⁶

2.2.3 Societal and cultural norms can contribute to much of the stigma associated with behavioral health disorders and can lead to a person not wanting or seeking treatment.¹⁷

¹⁵ Centers for Disease Control and Prevention. (CDC). (2018). *Learn About Mental Health*. Retrieved from www.cdc.gov/.

¹⁶ NAMI. (2018). *Navigating a Mental Health Crisis, A NAMI Resource Guide for Those Experiencing a Mental Health Emergency*. Retrieved from www.nami.org/.

¹⁷ U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services.

2.2.4 Family and friends are impacted by behavioral health due to caregiver impacts and challenges associated with chronic behavioral health. Family and friends likely will be initiating calls for service on behalf of their loved ones.¹⁸

2.2.5 Veterans are more susceptible to PTSD and challenges with reacclimating to “normal” living after tours of duty.

2.2.6 Behavioral Health Facts:

2.2.6.1 It is estimated that 1 in 5 Americans over age 18 experience a mental illness; of those, 1 in 25 Americans over age 18 have serious mental illness (significant impairment in function and limits to major life activities).¹⁹

2.2.6.2 17% of children experience behavioral health disorder.¹⁹

2.2.6.3 50% of all chronic mental illness begins by age 14 and 75% begins by age 24.¹⁸

2.2.6.4 Highest prevalence of mental illness are found within lesbian, gay, and bisexual adults (37% of all diagnosed).¹⁸

2.2.6.5 The average delay between symptoms onset and treatment is 11 years.¹⁸

2.2.6.6 Approximately 10% of police contacts with the public in America involve persons with serious mental illness; most police contacts with persons with behavioral health signs and symptoms do not involve major crimes or violence.²⁰

2.2.6.7 More than 1.7 million Veterans received behavioral health services at a Veterans Affairs facility in 2018.²¹

2.3 Impacts of Behavioral Health Disorders

2.3.1 Suicide is often associated with symptoms of behavioral illness.

2.3.1.1 Suicide is the 10th leading cause of death in the US.²²

2.3.1.2 In 2018, 48,344 Americans died by suicide (reported), on average there are 132 suicides per day.²³

2.3.1.3 Men die 3.56 times more often than women, however; women are more likely to attempt suicide at a rate 3 times as often as men. This is due to men using more lethal means (firearm, hanging) whereas women use less lethal means (poisoning, overdose).²⁴

¹⁸ NAMI. (2019). *Mental Health by the Numbers*. Retrieved from www.nami.org/.

¹⁹ CDC. (2020, June). *Children’s Mental Health*. Retrieved from www.cdc.gov/.

²⁰ Watson, A. C., & Wood, J. D. (2017). *Everyday police work during mental health encounters: A study of call resolutions in Chicago and their implications for diversion*. *Behavioral sciences & the law*, 35(5-6), 442–455.

²¹ U.S. Department of Veterans Affairs. (2020). *Mental Health*. Retrieved from www.mentalhealth.va.gov/.

²² American Foundation for Suicide Prevention. (2020, March). *Suicide Statistics*. Retrieved from www.afsp.org/.

²³ Hedegaard, H. M.D., Curtin, S. C., M.A., & Warner, M., Ph.D. (2020, April). *Increase in Suicide Mortality in the United States, 1999-2018*. Retrieved from www.cdc.gov/.

²⁴ American Foundation for Suicide Prevention. (2020, March). *Suicide Statistics*. Retrieved from www.afsp.org/.

2.3.1.4 Among individuals who die by suicide, 54% had a known behavioral health condition. Increased risk factors include family history of suicide; substance use; intoxication; access to firearms; serious or chronic medical illness; history of trauma or abuse; prolonged stress and recent tragedy or loss.²⁶

2.3.1.5 PTSD increases risk of death by suicide; this is particularly relevant to active military and Veterans.²⁵

2.3.1.6 In 2018, 113 Firefighters/EMTs and two PSTs died by suicide; the Firefighter Behavioral Health Alliance estimates that only 60% of first responder suicides are reported.²⁶

2.3.1.7 In 2018, there were 174 Law Enforcement Officer reported deaths from suicide that outnumbered the 145 reported Line of Duty Deaths.²⁷

2.3.2 Mood disorders (depression, bipolar, etc.) are the third most common cause of hospitalization.²⁸

2.3.3 Isolation and withdrawal from supports due to variations in viewpoints of signs and symptoms.²⁸

2.3.4 An individual's behavioral health will likely fall onto a continuum of awareness and acceptance, often referred to as stages of change. This will impact the individual's ability and/or willingness to engage appropriately with first responders and PSTs.

2.4 Potential Causes of Behavioral Health Disorders

2.4.1 There is no single cause which can concretely be tracked to the root of a development of a behavioral health disorder or crisis. Like any other part of the body, the brain can be influenced by multiple factors which can contribute to increased risk factors for developing signs and symptoms of behavioral health disorders and crisis. They can include isolation/loneliness, alcohol/drug use, biological factors (genes, chemical imbalances in brain), early adverse life experiences (i.e.: trauma or abuse), and experiences related to other chronic medical conditions.²⁹

2.5 Categories of Behavioral Health Disorders

2.5.1 Mood Disorders: Prolonged and persistent periods of emotions which are either heightened or lowered to a point that “typical” life is disrupted. Disturbances can be observed in relationships, work, and daily functioning. Characteristics can include nervousness, irritability, or problems with sleep and concentration.³⁰

2.5.1.1 Examples include: Bipolar Disorder, Depressive Disorders

²⁵ National Center for PTSD. (2017). *PTSD and Death from Suicide*. PTSD Research Quarterly, 28(4). Retrieved from www.ptsd.va.gov/.

²⁶ Firefighter Behavioral Health Alliance. (2020). *Suicide Reporting*. Retrieved from www.ffbha.org/.

²⁷ Blue H.E.L.P. (2020). *Officer Suicide Statistics*. Retrieved from www.bluehelp.org/.

²⁸ CDC. (2018). *Learn About Mental Health*. Retrieved from www.cdc.gov/.

²⁹ CDC. (2011). *Mental Health Awareness*. Retrieved from www.cdc.gov/.

³⁰ APA. (2017). *Bipolar and Related Disorders, Depression*. In DSM-5 (pp. 123-188). Washington, DC.

2.5.2 Anxiety Disorders: Experienced when anxiety symptoms are overwhelming and constant, often impairing everyday living. Characteristics can include stress that is out of proportion to the impact of the event, inability to set aside a worry, and restlessness.³¹

2.5.2.1 Examples include: Generalized Anxiety Disorder, Phobia Disorders, Panic Disorder

2.5.3 Thought Disorders: Disorders that affect the way a person thinks and organizes thoughts. Main characteristics can include disorganized thinking, disturbed perceptions, delusions and hallucinations, disorganized or abnormal motor control.³²

2.5.3.1 Examples include: Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Catatonia

2.5.4 Personality Disorders: Disorders that affects a person's way of thinking, feeling and behaving that deviate from the expectations of the culture, causes distress or problems functioning, and lasts over time.³³

2.5.4.1 Examples include: Borderline Personality Disorder, Obsessive-Compulsive Disorder, Antisocial Personality Disorder, Narcissistic Personality Disorder

2.5.5 Psychotic Disorders: Psychosis is characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what is not.³⁴

2.5.5.1 Examples: Schizophrenia, Schizoaffective Disorder, Delusional Disorder

2.5.6 Trauma and Stressor Related Disorders: Exposure to one single occurrence or cumulative exposures over time in relation to traumatic and stressful experiences to include: exposure to actual or threatened death, physical or emotional violence or pain, including abuse, neglect or family conflict. Characteristics can include withdrawn behavior/avoidance, irritability, angry outbursts, hypervigilance, negative mood, depression, flashbacks/distressing memories.³⁵

2.5.6.1 Examples include: Post Traumatic Stress Disorder, Acute Stress Disorder

2.5.7 Neurodevelopmental Disorders: These types of disorders typically become noticeable early in childhood development and are most often first seen as developmental delays. These types of developmental deficits affect personal, social, academic, or occupational functioning. A person could have several co-occurring disorders of this type.³⁶

2.5.7.1 Examples include: Autism spectrum disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), Attention-Deficit Disorder, Intellectual Disability, Learning Disorders, Tourette's

³¹ APA. (2017). *Anxiety Disorders*. In *DSM-5* (pp. 190-234). Washington, DC.

³² APA. (2017). *Schizophrenia Spectrum and other Psychotic Disorders*. In *DSM-5* (pp. 87-122). Washington, DC.

³³ APA. (2017). *Personality Disorders*. In *DSM-5* (pp. 645-684). Washington, DC.

³⁴ APA. (2017). *Psychotic Disorders*. In *DSM-5* (pp. 87-122). Washington, DC.

³⁵ APA. (2017). *Trauma and Stressor Related Disorders*. In *DSM-5* (pp. 265-290). Washington, DC.

³⁶ APA. (2017). *Neurodevelopmental Disorders*. In *DSM-5* (pp. 31-86). Washington, DC.

2.5.8 Neurocognitive Disorders: This category encompasses the group of disorders in which the primary clinical deficit is in cognitive function, and that are acquired rather than developmental. These disorders are many times co-occurring and often present with other mental disorders.³⁷

2.5.8.1 Examples: Delirium, Traumatic Brain Injury, Hypoxia, Alzheimer’s disease, Parkinson’s Disease, drug and alcohol-related conditions, infections

2.5.9 Substance Use Disorders: Occurs when the recurrent use of alcohol and/or drugs cause significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.³⁸

2.5.9.1 Examples: Alcohol Use Disorder, Cocaine Use Disorder, Opioid Use Disorder, Stimulant Use Disorder, Sedative Use Disorder, etc.

Note: While there are many different medical diagnoses, PSTs are not permitted to diagnose mental illness, but should be knowledgeable as to how mental illness can affect a person in crisis. Many of these associated disorders can cause higher risk for suicidal ideations and suicide attempts. It is very important for PSTs to try and ascertain suicidal ideations, potential plans, and history of suicide attempts during the call taking process.

2.6 Possible Signs and Symptoms of Behavioral Health Crises

2.6.1 Anger

2.6.1.1 Examples: Prolonged or strong feelings of irritability, anger, or aggressiveness; unable to cope with interruptions, engaging in threatening behavior for no obvious reason, frequent temper tantrums, disobedience among children, defiance of authority.³⁹

2.6.2 Anxiety/Nervousness

2.6.2.1 Examples: Fear or suspiciousness of others or a strong nervous feeling, paranoid beliefs, difficulty concentrating, easily distracted or on edge, increased worry or stress.⁴⁰

2.6.3 Confusion

2.6.3.1 Examples: Problems with concentration, memory, or logical thought and speech that are hard to explain, disorientation, difficulties with speech, slurred words or difficulty

³⁷ APA. (2017). *Neurocognitive Disorders*. In *DSM-5* (pp. 591-644). Washington, DC.

³⁸ APA. (2017). *Substance Use Disorders*. In *DSM-5* (pp. 481-590). Washington, DC.

³⁹ NAMI. (2017). *Warning Signs and Symptoms*. Retrieved from www.nami.org/; National Institute of Mental Health (NIMH) (2018). *Disruptive Mood Dysregulation Disorder*. Retrieved from www.nimh.nih.gov/; Mental Health America (MHA). (2020). *Mental Illness & The Family: Recognizing Warning Signs and How to Cope*. Retrieved from www.mhanational.org/.

⁴⁰ APA. (2020). *Expert Q&A: Anxiety*. Retrieved from www.psychiatry.org/; World Health Organization. (2006). *K6+ Self-Report Measurement*. Retrieved from www.hcp.med.harvard.edu/; NAMI (2017). *Anxiety Disorders*. Retrieved from www.nami.org/; NIMH (2018). *Anxiety Disorders*. Retrieved from www.nimh.nih.gov/; National Policing Improvement Agency (2013). *Synopsis of Causation: Generalized Anxiety Disorder*. Retrieved from www.gov.uk/government/; MHA. (2020). *Quick Facts and Statistics About Mental Health*. Retrieved from www.mhanational.org/; SAMHSA (2020). *Understanding Anxiety Disorders Young Adult*. Retrieved from www.samhsa.gov/.

with pronunciation, difficulties with conceiving information, confusion about time and place, difficulties with remembering personal details and events, repeating information, sensory overload.⁴¹

2.6.4 Delusions/Illogical Thinking

2.6.4.1 Examples: Unusual or exaggerated beliefs about personal powers to understand meanings or influence events, illogical or “magical” thinking, irrational behavior, talking about seeing or hearing things which cannot be seen or heard by others, removing clothing for no clear reason, obsessive thoughts or compulsive behavior.⁴²

2.6.5 Depression/Helplessness

2.6.5.1 Examples: Persistent sadness or feelings of hopelessness, general neglect of self, worthlessness, feeling disconnected, flat tone of voice or having trouble expressing positive emotions, growing inability to cope with daily problems and activities.⁴³

2.6.6 Mood Changes

2.6.6.1 Examples: Rapid or dramatic shifts in emotions or depressed feelings, impulsiveness, uncontrollable ‘highs’ or feelings of euphoria, hyperactive behavior among children.⁴⁴

2.6.7 Physical Ailments

2.6.7.1 Examples: Aches, pains or digestive ailments without obvious causes, changes in sleeping habits or feeling tired and low energy, threatening, or engaging in self-harm, increases in breathing/heart rate.⁴⁵

2.6.8 Previous Behavioral Health Treatment

2.6.8.1 Examples: Mentions of a psychiatrist, therapist, psychologist, case manager, adult foster care home, guardian, recovery coach, or medication

⁴¹ APA. (2020). *Help with Posttraumatic Stress Disorder*. Retrieved from www.psychiatry.org/; NAMI (2017). *Warning Signs and Symptoms*. Retrieved from www.nami.org/; NIMH (2018). *Panic Disorder: When Fear Overwhelms*. Retrieved from www.nimh.nih.gov/; MHA. (2020). *Mental Illness & The Family: Recognizing Warning Signs and How to Cope*. Retrieved from www.mhanational.org/; Policy Research Associates, Inc. (2005). *Brief Jail Mental Health Screen*. Retrieved from www.prainc.com/; SAMHSA. (2020). *Warning Signs & Risk Factors for Emotional Distress*. Retrieved from www.samhsa.gov/.

⁴² APA. (2020). *APA Dictionary of Psychology*. Retrieved from www.psychiatry.org/; NAMI (2017). *Psychosis*. Retrieved from www.nami.org/; NIMH (2018). *Fact Sheet; First Episode Psychosis*. Retrieved from www.nimh.nih.gov/.

⁴³ NAMI. (2017). *Depression*. Retrieved from www.nami.org/; NIMH (2018). *Depression*. Retrieved from www.nimh.nih.gov/; SAMHSA. (2020). *Understanding Depression in Young Adults*. Retrieved from www.samhsa.gov/; World Health Organization. (2006). *K6+ Self-Report Measurement*. Retrieved from www.hcp.med.harvard.edu/.

⁴⁴ APA. (2020). *Mindfulness and Mood Disorders in The Brain*. Retrieved from www.psychiatry.org/; NAMI (2017). *Beyond Growing Pains: Children and Mood Disorders*. Retrieved from www.nami.org/; NIMH (2018). *Any Mood Disorder*. Retrieved from www.nimh.nih.gov/; MHA. (2020). *Mood Disorders*. Retrieved from www.mhanational.org/.

⁴⁵ NAMI. (2017). *Eating Disorders*. Retrieved from www.nami.org/; NIMH (2018). *Chronic Illness & Mental Health*. Retrieved from www.nimh.nih.gov/; MHA. (2020). *Is Mental Illness Physical or Mental?* Retrieved from www.mhanational.org/; SAMHSA. (2020). *Physical Health Conditions Among Adults with Mental Illness*. Retrieved from www.samhsa.gov/.

2.6.9 Social Withdrawal

2.6.9.1 Examples: Recent social withdrawal and loss of interest in activities previously enjoyed, avoiding friends and social activities, difficulties understanding or relating to people, being unresponsive to others.⁴⁶

2.6.10 Substance Use

2.6.10.1 Examples: Excessive smoking, drinking, or using drugs, including prescription medications.⁴⁷

2.6.11 Suicidal Ideation

2.6.11.1 Examples: A wish to be dead, thoughts of killing one's self, a plan of killing one's self, putting oneself in danger (e.g. walking into the path of moving traffic), preparatory acts of behavior (e.g. giving things away, writing a suicide note), an actual, interrupted, or aborted attempt at killing one's self, poor/no future oriented plans, leading vague statements (e.g.: "just not worth it anymore", "I can't go on"), re-homing valuables (e.g.: "my animals are safe with my sister").⁴⁸

Note: Examples/behaviors of above signs and symptoms can (and at times do) mimic a medical emergency. PSTs shall ask questions regarding pertinent medical history and behavioral health history, based on agency protocols, to better classify the call and send appropriate units.

For additional or more detailed explanations regarding diagnosis, signs, and symptoms, reference the Diagnostic and Statistical Manual of Mental Health Disorders⁴⁹ (DSM-5) (or most up to date version).

⁴⁶ APA. (2020). *The Risks of Social Isolation*. Retrieved from www.psychiatry.org/; NAMI (2017). *The Social Isolation Effects on Mental Health*. Retrieved from www.nami.org/; NIMH (2018). *Research on Biopsychosocial Factors of Social Connectedness and Isolation on Health, Wellbeing, Illness, and Recovery*. Retrieved from www.nimh.nih.gov/; MHA. (2020). *The Role of Peer Support in Ending Social Exclusion and Loneliness*. Retrieved from www.mhanational.org; SAMHSA. (2020). *Taking Care of Your Behavioral Health – Tips for Social Inclusion*. Retrieved from www.samhsa.gov/v.

⁴⁷ NAMI. (2017). *Substance Use Disorders*. Retrieved from www.nami.org/; NIMH (2018). *Substance Use and Mental Health*. Retrieved from www.nimh.nih.gov/.

⁴⁸ NAMI. (2017). *The Social Isolation Effects on Mental Health*. Retrieved from www.nami.org/; NIMH (2017, September). *Learning More About Suicidal Ideation*. Retrieved from www.nimh.nih.gov/; MHA. (2020). *Preventing Suicide in Older Adults*. Retrieved from www.mhanational.org; The Research Foundation for Mental Hygiene, Inc. (2008). *Columbia-Suicide Severity Rating Scale (C-SSRS)*. Retrieved from www.cssrs.columbia.edu; SAMHSA. (2020). *Suicide Prevention*. Retrieved from www.samhsa.gov/.

⁴⁹ American Psychological Association (APA). (2020). *DSM-5: Frequently Asked Questions*. Washington, DC. Retrieved from www.psychiatry.org/.

2.7 Behavioral Health National Resources

- 2.7.1 American Foundation for Suicide Prevention www.afsp.org
- 2.7.2 APA – American Psychological Association www.apa.org
- 2.7.3 BJMHS – Brief Jail Mental Health Screen www.prainc.com
- 2.7.4 CDC – Centers for Disease Control and Prevention www.cdc.gov
- 2.7.5 Crisis Text Line www.crisistextline.org (text HOME to 741741)
- 2.7.6 C-SSRS – Columbia-Suicide Severity Rating Scale www.cssrs.columbia.edu
- 2.7.7 DSM-5 – Diagnostic and Statistical Manual of Mental Disorders
- 2.7.8 HHS – U.S. Department of Health & Human Services www.hhs.gov
- 2.7.9 K6 – Kessler Psychological Distress Scale www.hcp.med.harvard.edu
- 2.7.10 MHA – Mental Health America www.mhanational.org
- 2.7.11 NAMI – National Alliance on Mental Illness www.nami.org
- 2.7.12 National Suicide Prevention Lifeline 1-800-273-TALK
- 2.7.13 NIH – National Institute on Drug Abuse www.drugabuse.gov
- 2.7.14 NIMH – National Institute of Mental Health www.nimh.nih.gov
- 2.7.15 NPIA – National Policing Improvement Agency
- 2.7.16 SAMHSA – Substance Abuse and Mental Health Services Administration www.samhsa.gov
- 2.7.17 Suicide Prevention Resource Center www.sprc.org

Chapter Three

Agency Responsibilities to the PST

SCOPE

This chapter outlines the agency's responsibilities in preparing the PST to handle crisis incidents and ensuring the PST's skills remain current.

3.1 General Agency Responsibilities to the PST

3.1.1 The agency shall develop and provide policies and procedures for handling crisis calls and the unique challenges associated with them.

3.1.1.1 The agency shall ensure the policies and procedures regarding the handling of crisis calls remain up to date; the agency should consider collaborating with local, state, and/or national behavioral health agencies for applicable policies and procedures.

3.1.1.2 The agency shall ensure PSTs have access to policies and procedures regarding the handling of crisis calls.

3.1.2 Initial training for newly hired PSTs for handling crisis calls shall include at a minimum but not limited to:

3.1.2.1 General knowledge of behavioral health.

3.1.2.2 General knowledge of stress/stress management to include the definition of stress, the difference between good and bad stress, resilience, coping mechanisms, mindfulness, burn out/compassion fatigue, and when to ask for help.

3.1.2.3 General knowledge of local, state, tribal or federal statutes as applicable.

3.1.2.4 Understanding of both industry and in-house terminology that may include stigma, behavioral health, crisis, peer support, burn out, and compassion fatigue.

3.1.2.5 Understanding privacy laws that impact callers, patients, and the agency.

3.1.2.6 Understanding of call taking techniques for handling crisis calls to include active listening, calming, and de-escalation skills.

3.1.3 The agency shall provide continuing education which maintains a level of current education that is relevant to crisis intervention and PSTs.

3.1.3.1 Continuing education should include:

3.1.3.1.1 Updates to agency policies and procedures.

3.1.3.1.2 Advancements in behavioral health as it relates to CIT, MHFA, or other applicable training(s).

3.1.3.1.3 Advancements in call taking and dispatching.

3.1.3.1.4 Other information as it pertains to the processing and dispatching of high-stake calls involving aspects of behavioral health.

3.1.3.2 Continuing education shall count towards hours required for recertification, where necessary.

3.1.3.3 The frequency and amount of continued education provided shall be determined by the individual agency and in accordance with local and/or state requirements.

3.1.4 The agency shall provide information to the PST about resources available to help the PST manage stress. Such resources may include Employee Assistance Programs (EAP), CISM/Peer Support, Chaplain, community resources, and wellness initiatives. *(See Chapter 5.3 for more information).*

3.1.4.1 The agency should consider establishing an early warning/intervention system or protocol to help identify PSTs who may benefit from (or require) stress management efforts.

3.1.5 The agency should maintain an active list of local behavioral health resources that is available to the PST.

3.1.6 Quality Assurance should be performed to ensure the PST is appropriately handling crisis calls; feedback should be provided to the PST regarding their performance.

Chapter Four

PST Responsibilities

SCOPE

This chapter provides the PST with the recommended minimum steps and decision-making processes for the handling of calls for service involving a person in crisis.

4.1 General PST Responsibilities

Note: The information listed in this chapter of the standard is basic recommendations. The PST should always follow agency policies and procedures.

4.1.1 The PST shall maintain a working knowledge of current agency policies and procedures for handling calls involving a person in crisis.

4.1.1.1 The PST shall know where to locate and access current agency policies and procedures for handling calls involving a person in crisis.

4.1.2 The PST shall actively participate in all training, to include initial and continued education, related to persons in crisis as provided by the agency.

4.1.3 The PST shall understand general concepts and definitions as it relates to crisis incidents.

4.1.4 The PST shall understand and adhere to confidentiality laws set forth by local, state and federal agencies regarding the release of information to the public, media, or others. Such information should include but is not limited to:

4.1.4.1 Information obtained while processing a call for service

4.1.4.2 Information in violation of HIPAA laws

4.1.4.2.1 HIPAA does not prevent PSTs from relaying personal health information to responding units, as needed, for person in crisis care, responding unit safety, and general public wellbeing.⁵⁰

4.1.4.2.2 PSTs should be familiar with their local and state specific rules and exceptions.⁵¹

⁵⁰ U.S. Department of Health & Human Services. (2021). *Health Information Privacy*. Retrieved from www.hhs.gov/hippa/.

⁵¹ The Office of the National Coordinator for Health Information Technology. (2021). *HIPPA versus State Laws*. Retrieved from www.healhtit.gov/.

4.1.4.3 Referral Services as appropriate

4.1.5 The PST shall understand public records laws in their respective states and how they apply to their daily operations to include:

4.1.5.1 Messages relayed through email, mobile data terminals, interoffice data communications, two-way radio and any other method of call broadcast

4.1.5.2 Information relayed to the public

4.1.5.3 Information documented in the event notes

4.1.6 The PST shall adhere to all local, state, tribal or federal statutes as applicable.

4.1.7 PST shall be familiar with local and state laws in association with involuntary treatment for behavioral health crisis.

4.2 The PST's Responsibilities During Call Taking

4.2.1 The PST shall follow standard call taking procedures, as determined by the agency to include:

4.2.1.1 Obtain and verify the location where the incident is occurring.

4.2.1.2 Properly classify the incident as a behavioral health crisis related classification, as assigned by the agency, if the information provided by the caller indicates such.

4.2.1.3 Determine if there are any injuries, hazards, and/or dangers requiring additional resources (i.e., Fire, EMS, HAZMAT, etc.).

4.2.1.4 Gather necessary information to determine proper prioritization.

4.2.1.5 Verify and document if there are any weapons involved and, if so, the type and location of weapon(s).

4.2.1.6 Verify and document who is involved to include the name and physical description.

4.2.1.7 Verify and document if the involved person(s) is/are under the influence of alcohol, drugs and/or prescription medications.

4.2.1.7.1 Verify and document if the involved person(s) takes prescribed medication(s) and is currently taking as prescribed or abusing this medication.

4.2.1.8 Determine if anything like this current situation has occurred before and if so, is the person in crisis currently engaged with treatment providers.

4.2.1.9 Obtain the name and call back number of the caller unless the caller wishes to remain anonymous.

Note: The order in which the above information should be obtained from the caller should be done according to agency policy and procedure.

4.2.2 The PST shall recognize the need to reclassify the incident as a behavioral health crisis related classification, as assigned by the agency, when appropriate, as updated information is received from the caller or responder.

4.2.2.1 See Appendix B: Behavioral Health Call Types/Common Terminology to Recognize

4.2.3 The PST should be able to recognize signs and symptoms displayed by an individual possibly experiencing a behavioral health crisis when information is provided either by the person in crisis or a third-party caller that indicates such. The PST shall not assume the individual is experiencing a behavioral health crisis versus a medical issue.

4.2.4 The PST shall display appropriate prioritization procedures to include:

4.2.4.1 Processing calls in a timely manner.

4.2.4.2 Stay on the line with the caller, as needed, until responders are on scene.

4.2.4.3 Make proper notifications to other PSTs, supervisors, and chain of command that may impact public or responder safety.

4.2.4.4 Always ensure that public and responder safety is a priority.

4.2.5 If a caller disconnects, the PST shall attempt to re-contact the caller until responders arrive on scene.

4.2.6 The PST shall be familiar with established jurisdictional boundaries and relay incidents outside of their jurisdiction to the appropriate agency.

4.2.7 The PST shall provide referral services as appropriate.

4.3 Techniques for De-Escalation⁵²

4.3.1 The PST shall utilize de-escalation techniques when speaking to a caller in crisis. De-escalation techniques may include, but are not limited to:

4.3.1.1 Use of a clear and compassionate tone of voice (how the PST says something, not what the PST says).

4.3.1.2 Use of calming techniques to include compassion, patience, and maintaining a calm and controlled tone of voice, such as:

⁵² Department of Criminal Justice Services. (2011, September). *Essential Elements for the Commonwealth of Virginia's Crisis Intervention Team Programs (CIT)*. Retrieved from www.dcjs.virginia.gov/; DuPont, R., Cochran, S., Pillsbury, S. (2007, September). *Crisis Intervention Team Core Elements*. Retrieved from www.cit.memphis.edu/.

4.3.1.2.1 Brief and to-the-point questions and directions.

4.3.1.2.2 Ask one question or give one direction at a time.

4.3.1.2.3 Use a polite tone of voice, at an appropriate volume, and be mindful of the rate of speech.

4.3.1.2.4 Express concern and desire to get the caller help.

4.3.1.2.5 Provide empathy to the caller's situation.

4.3.1.2.6 Remain engaged and provide reassurance and validation to the caller.

4.3.1.2.7 Remind the caller that you, as the PST, are there with them, not going to hang up until help arrives, and/or have responsibility to help them.

4.3.1.2.8 Use appropriate historical and personal knowledge that the PST confidently knows could help de-escalate the caller (if the PST has had previous contact with caller).

4.3.1.2.9 Attempt to find some common ground with the caller to help build a connection (PST shall avoid oversharing in this technique).

4.3.1.2.10 Utilize open-ended questions (questions that cannot be answered "yes" or "no") while assessing the situation.

4.3.1.2.11 Ask follow-up questions to seek further clarity but acknowledging "I want to understand more".

4.3.1.2.12 Encourage caller to share their story; "Please tell me more about what is going on/what happened so I can best help you".

4.3.1.2.13 Advise the caller when help is on the way and what type of emergency service has been dispatched. The PST should use best judgement when considering advising the caller of what type(s) of emergency service(s) have been dispatched, being mindful to not escalate the situation by informing.

4.3.1.3 The PST shall avoid:

4.3.1.3.1 Making interpretations.

4.3.1.3.2 Being judgmental.

4.3.1.3.3 Controversial topics.

4.3.1.3.4 Phrases such as “I know what you’re going through” or “I know what it’s like” (this typically will escalate emotions/reactions rather than minimize) even if PST has personal experiences with caller’s crisis or similar type of situations.

4.3.1.3.5 Oversimplification of presenting problem.

4.3.1.3.6 Minimizing caller’s problems/concerns.

4.3.1.3.7 “Why” questions as the caller may become defensive with these types of questions (if the caller knew the “why” they most likely wouldn’t be in crisis).

4.3.2 The PST shall be honest. Do not make false promises; do not tell the caller only what you think they want to hear (this will complicate treatment/help once the PST has discontinued the call).

4.3.3 The PST shall not argue with nor agree with delusions and/or hallucinations a caller may be experiencing.

4.3.4 The PST shall not challenge a caller’s thoughts/beliefs associated with their delusion and/or hallucination.

4.3.5 The PST shall use active listening skills to include:

4.3.5.1 Use of verbal cues to remind the caller that you’re listening (examples: “uh-huh”, “ah”, “then?”, “and?”).

4.3.5.2 Repeating what the caller said before commenting or moving on to inform the caller you heard them.

4.3.5.3 Reminding the caller about positives they have previously mentioned and encourage them to elaborate on the good.

4.3.6 Verbal strategies to utilize or avoid if caller is experiencing suicidal thoughts/ideations:

4.3.6.1 The PST shall complete outlined requirements in 4.2.1 and should continue to use above techniques and tools.

4.3.6.2 Additional questions/comments to consider asking/stating (if appropriate):

4.3.6.2.1 Ask direct questions such as “are you thinking about killing yourself?” or “have you thought about suicide?”

4.3.6.2.2 Ask if there is a plan and/or means.

4.3.6.2.3 What has been going on that makes you feel this way?

4.3.6.2.4 What is one thing you have to live for? (can be small or large - a pet cat, a sibling, a work deadline, etc.).

4.3.6.2.5 Is anyone currently there with you?

4.3.6.2.6 Express concern and give examples from the caller's narrative. Examples include: "I am concerned about you. It seems like you're not doing some of the things you used to enjoy"; "I am worried about you. I hear you saying you've been giving away things that mean a lot to you".

4.3.6.3 If the caller is not alone, include the bystanders (if positive influences) in your conversation and guide them to help with de-escalation and safety containment until first responders arrive.

4.3.6.3.1 Examples: "Can you stay with (caller's name) until help arrives?"; "Can you tell your friend/family member something which you love about them?"; "Can you remind (caller's name) that you're there with them and aren't leaving?".

Note: The caller for an individual experiencing suicidal ideations will likely either be one of two people: the individual themselves (threatening to complete suicide or stating they are in the process of completing suicide) or a third party (reporting that someone has attempted or threatened to complete suicide).

4.3.7 The PST shall notify responding units if the caller discloses suicide by cop comment(s).

4.3.8 If resistance is met, the PST will need to re-evaluate the situation and consider utilizing a different tactic to approach the situation.

4.3.9 The PST shall recognize that every call is different and techniques/tools successful for one caller may irritate and escalate another caller. The PST shall make every call unique and use best judgements to determine how to handle and respond with their verbal responses.

4.4 The PST's Responsibilities During Dispatching

4.4.1 The PST shall recognize incidents classified as involving a person in crisis and dispatch those incidents in order of priority.

4.4.2 The PST shall dispatch the appropriate resources, as per individual agency policy and procedure, to include any or all the following:

4.4.2.1 Law Enforcement

4.4.2.2 Fire Department

4.4.2.3 Emergency Medical Services

4.4.2.4 CIT

4.4.2.5 Department embedded clinician/support team

4.4.2.6 Mobile crisis unit

4.4.3 The PST shall relay all pertinent information to responding units to include:

4.4.3.1 Incident location.

4.4.3.2 Incident type.

4.4.3.3 Injuries or hazards involved.

4.4.3.4 Time frame of occurrence.

4.4.3.5 Any weapons involved including type and location of weapon.

4.4.3.6 Who is involved to include the name and physical description.

4.4.3.7 If drugs and/or alcohol are a known factor.

4.4.3.8 What type of behavioral health crisis is occurring.

4.4.3.9 Premise alerts and/or alerts on subjects involved.

4.4.3.10 Call history for the location that may relate to the current incident (i.e., prior call history of a behavioral health crisis involving the same person).

4.4.4 The PST shall update all responding units with pertinent information or changes relating to the incident as it becomes available.

4.5 The PST's Responsibilities Post-Dispatch

4.5.1 The PST shall request additional resources when appropriate.

4.5.2 The PST shall make proper notifications to other PSTs, supervisors and chain of command of any incidents that may impact public or responder safety.

4.5.2.1 Notifications shall be done in accordance with agency policies and procedures and may include telephone, email or electronic notifications.

4.5.3 The PST shall monitor the safety of all units on scene and conduct status checks on all responders.

4.5.4 The PST shall make notification as needed to CISM/Peer Support team, if available and when appropriate.

4.5.5 All notifications made shall be documented by the PST in accordance with agency policies and procedures.

Chapter Five

Stress Management

SCOPE

This chapter outlines stress including its definition, identifying stress, managing stress, and resources that may be available to the PST.

5.1 Stress

5.1.1 Stress as it relates to the PST

5.1.1.1 Stress is the body's reaction to any change in its "normal" state. Stress can have a positive or negative impact depending if the body is experiencing eustress (good stress) or distress (bad stress). This reaction can be physical, emotional, or mental.⁵³

5.1.1.2 PSTs experience a variety of stressors daily throughout their shifts. There are constant positive outcomes (e.g. CPR save is eustress) and negative outcomes (e.g. imperfect feedback review can cause distress). In addition to this daily stress roller coaster, a career as a PST will also take its toll.

5.1.2 Recognizing stress

5.1.2.1 Recognizing Individual Stress: Self-awareness of the signs of stress can be difficult to recognize. Self-monitoring is important in maintaining self-awareness.

5.1.2.2 Recognizing Stress in Others: Watch for signs and symptoms of stress and share your observations with the individual or a supervisor in an empathic, understanding manner.

5.1.3 Signs of Stress⁵⁴

5.1.3.1 Behavioral such as:

5.1.3.1.1 Change in eating habits (more or less)

5.1.3.1.2 Change in sleeping habits (more or less)

5.1.3.1.3 Withdrawal from others

5.1.3.1.4 Increased use of drugs or alcohol to relax

⁵³ NIMH. (2020). *5 Things You Should Know About Stress*. Retrieved from www.nimh.nih.gov/.

⁵⁴ Mayo Clinic. (2019, April). *Healthy Lifestyle Stress Management*. Retrieved from www.mayoclinic.org/.

5.1.3.1.5 Nervous habits such as pacing, nail biting and fidgeting

5.1.3.1.6 Neglecting responsibilities

5.1.3.1.7 Decreased performance at work

5.1.3.1.8 Self-neglect / change in appearance

5.1.3.1.9 Uncharacteristic risk-taking activities

5.1.3.2 Cognitive such as:

5.1.3.2.1 Lack of or inability to concentrate

5.1.3.2.2 Negativity

5.1.3.2.3 Constant worrying

5.1.3.2.4 Anxious thoughts

5.1.3.2.5 Problems with memory

5.1.3.2.6 Poor judgment

5.1.3.2.7 Easily distracted

5.1.3.3 Emotional such as:

5.1.3.3.1 Moodiness / mood swings, irritability or anger

5.1.3.3.2 Loneliness and isolation

5.1.3.3.3 Depression or other behavioral health problems

5.1.3.3.4 Anxiety

5.1.3.3.5 Agitation or frustration

5.1.3.3.6 Anger

5.1.3.3.7 Lack of motivation

5.1.3.3.8 Extra sensitive to situations

5.1.3.4 Physical such as:

5.1.3.4.1 Aches and pains

5.1.3.4.2 Diarrhea or constipation

5.1.3.4.3 Nausea

5.1.3.4.4 Chest pain or rapid heartbeat / high blood pressure

5.1.3.4.5 Loss of energy or sex drive

5.1.3.4.6 Exacerbation of health issues

5.1.3.4.7 Frequent colds / infections / flu

5.1.3.4.8 Panic attacks

5.2 Stress Management Techniques

5.2.1 Preventing stress is a key element of managing stress. Techniques to prevent stress include:⁵⁵

5.2.1.1 Getting an adequate amount of sleep, typically 7 to 8 hours a night, allows the body and mind to recover from stress as well as be more resilient to future stress.

5.2.1.2 Eating a proper diet with nutritious foods helps limit the body's stress response. Food high in fats, refined sugars, processed foods, and caffeine naturally elevate the body's stress response.

5.2.1.3 Limiting alcohol intake. If the PST feels the need to cope with stress by drinking, the PST should seek assistance through resources available (see 5.3).

5.2.1.4 Developing proper coping skills before stress happens will limit the negative effects when it does occur. Proper coping skills include:

5.2.1.4.1 Maintaining a positive outlook focused on what can be controlled

5.2.1.4.2 Having a thorough understanding of expectations

5.2.1.4.3 Using relaxation techniques such as meditation and mindfulness

5.2.1.4.4 Writing in a journal

5.2.1.4.5 Developing self-kindness

5.2.1.4.6 Developing effective time-management skills

5.2.2 Reducing and managing acute stress⁵⁶

⁵⁵ CDC. (2019, September). *Coping with Stress*. Retrieved from www.cdc.gov/.

⁵⁶ NAMI. (2019, January). *7 Tools for Managing Traumatic Stress*. Retrieved from www.nami.org/.

5.2.2.1 Frequent breaks, especially after high stress situations, can allow the PST to employ appropriate coping skills.

5.2.2.2 Combat breathing is an effective tool to use when stress is occurring. Breathe in for the count of four, hold for the count of four, exhale to the count of four. Do this several times until acute signs of stress have diminished.

5.2.2.3 Focus on positive outcomes, no matter how small.

5.2.2.4 Debriefing after a critical incident will help the PST process the incident logically with a focus on the positive aspects of the response.

5.2.3 If at any time acute stress surpasses prevention and reduction techniques, PSTs should use resources available to them, as listed in 5.3. It should be noted that some PSTs may be hesitant to seek help because their ability to perform their job may be questioned.

5.3 Resources for PST Stress Management

5.3.1 Critical Incident Stress Management (CISM): An approach used to mitigate the potential long-term stress caused by significant incidents that employees may find themselves working. A specially trained team provides support through post-incident defusing, debriefing, and follow up. CISM teams promote the continuation of productive careers while building healthy stress management behaviors and acknowledging that normal people have normal reactions to abnormal events.

5.3.2 Peer Support: Peer support is a formal support provided by trained supporters that share a common experience, such as seasoned and specially trained dispatchers providing support to other dispatchers. Having a shared experience helps build trust and allows for a deeper understanding of the challenges one presents. The peer supporter can provide guidance in coping strategies, options, and other available resources.

5.3.3 Chaplain: The chaplain is a person who helps those in public service in any stressful event, such as an injury, line of duty death, or other critical incident. They can assist with grief counseling, spiritual counseling, or help with other personal stress with a goal to aid, comfort, and assist public servants.

5.3.4 Employee Assistance Program (EAP): An employee benefit (EAP) is an employee benefit program that assists employees with personal issues and/or work-related issues that may impact their job performance, health, and mental well-being. Typically, the EAP provides referrals to such services as counseling, medical professionals, legal assistance, and/or financial guidance, among others. EAPs can vary from agency to agency.⁵⁷

⁵⁷ U.S. Office of Personnel Management. (2020). *What is an Employee Assistance Program (EAP)?* Retrieved from www.opm.gov/.

Appendix B: Behavioral Health Call Types/Common Terminology to Recognize

Emergency type	Key Dispatch Words/Phrases
Behavioral Health Issue	<ul style="list-style-type: none"> • Possible behavioral health subject • Mention of behavioral health issue: <ul style="list-style-type: none"> ○ History of diagnosable condition ○ Dementia/Alzheimer's ○ Hallucinations • "MH" = Mental Health/PST request • "BH" = Behavioral health/PST request • Off medication • Mental/Emotional • CIT officer request • Having an episode
Substance Use Related	<ul style="list-style-type: none"> • Narcotics involved • Person intoxicated (only if there is mention of history with substances or addiction) • Under the influence of narcotics • Overdose
Attempted Suicide/Self-Harm	<ul style="list-style-type: none"> • Suicidal • Engaged in self-harm
Check the Welfare	<ul style="list-style-type: none"> • Mention of behavioral health issue • Mention of substance use history
Frequent Utilizer of Emergency Services	<ul style="list-style-type: none"> • Officer/Dispatch/Clinician recognizes address • Call history in CAD indicates behavioral health issue
Domestic Violence	<ul style="list-style-type: none"> • Mention of behavioral health issue • "Mom vs. Son; son off meds" • "She's intoxicated"
Homeless	<ul style="list-style-type: none"> • Any mention of a homeless individual

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