

Assessment and Intervention in Crisis: an Application of the Six-Step Model and Triage Assessment System

Samsiah Mohd Jais
Faculty of Education and Human Development,
Sultan Idris Education University, 35900 Tanjong Malim, Perak, Malaysia

Abstract: All people are vulnerable to experiencing a crisis state but some people more readily go into a crisis state than others. A crisis state occurs when the traumatic event is perceived as overwhelming by the individual. The individual in crisis state is characterized as being in the state of disequilibrium (cognitive and emotional instability) and immobility (behaviour instability). Thus, crisis state is an acute and unstable state because it may lead to long-term and severe psychological dysfunction or abnormal psychological growth. In this regard, rapid and adequate assessment of a client paper presents a narrative about how we can apply the six-stage crisis intervention model and the triage assessment system together with other aspects of assessment (such as the use of suicide/lethality risk assessment) in responding to the client in crisis. Constant and rapid assessment of the client's state of equilibrium will dictate what we will do in the next few minutes as the crisis unfolds. The six-stage crisis intervention model and the Triage Assessment System (TAS) are among crisis intervention models that provide fast and efficient methods for obtaining a real-time estimate of what is occurring to the client. This study will discuss a narrative about how we can apply the six-step crisis intervention model and the triage assessment system together with other aspects of assessment (such as the use of suicide/ lethality risk assessment). Apart from that, this paper outlines some of the resources from our local community upon which we can draw assistance in getting the client through his or her crisis as well as assist him or her with long-term counselling. These resources are from community groups, government services, telephone help or support lines, religious groups and counselling services.

Key words: Six-stage crisis intervention model, triage assessment system, suicide/lethality risk assessment, religious, Malaysia

INTRODUCTION

Defined as “a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms” (James and Gilliland, 2005), crises are a normal part of life with nearly 90% of adults experiencing a traumatic event, or crisis, over their lifetime. Roberts (2005), defines a crisis as “a period of psychological disequilibrium, experienced as a result of a hazardous event or situation that constitutes a significant problem that cannot be remedied by using familiar coping strategies”. Crisis intervention skills, therefore are an essential tool for professionals working with clients who are experiencing traumatic or overwhelming life events.

Front-line shelter staff including counsellor will need to address the level of distress and impairment in crisis by responding in a logical and orderly manner. Training in the use of a standardized model for intervening in crisis situations can help the counsellor to be aware of the elements of an effective response to crisis and to

intervene in a way that appropriately supports a client through the crisis which assists him or her to maintain ownership of the problem and be empowered toward self-determination (Roberts, 2005). As such, this study provides detailed descriptions of the crisis case narratives, six-step crisis intervention model and the assessment of crisis using triage assessment system, together with other aspects of assessment (such as the use of suicide/ lethality risk assessment). Crisis intervention thus provides opportunities for clients to learn new coping skills while identifying, mobilizing and enhancing those they already possess. These detailed procedural steps inform the reader on how to act immediately, make appropriate assessments of crises, conduct successful interventions and make referrals.

The six-step model of crisis intervention: Even though, human crises are never simple, we have found that it is desirable for the counsellor or crisis worker to have a relatively straight forward and efficient model of intervention. The six steps described here can be used as

such a model (James and Gilliland, 2005; Samsiah, 2008). The steps are designed to operate as an integrated problem-solving process. The entire six-step process is carried out under an umbrella of assessment by the counsellor. The first three steps of defining the problem, ensuring client safety and providing support are more listening activities than they are actions. The final three steps of examining alternatives, making plans and obtaining commitment to positive action are largely action behaviors on the part of the counsellor, even though, listening is always present along with assessment as an overarching theme. The model involves the following steps.

Step 1: Defining the problem to understand the issue from the client point of view. This requires using core listening skills of empathy, genuineness and acceptance.

Step 2: Ensuring client's safety. It is necessary to continually keep client's safety at the forefront of all interventions. This means constantly assessing the possibility of physical and psychological danger to the client as well as to others. Assessing and ensuring safety are a continuous part of the crisis intervention process.

Step 3: Providing support by communicating care for the client and giving emotional as well as instrumental and informational supports.

Acting strategies are used in steps 4, 5 and 6. Ideally, these steps are implemented in a collaborative manner, but if the client is unable to participate, it may be necessary to become more directive in helping client mobilize his or her coping skills. Listening skills are an important part of these steps and the counsellor will mainly function in nondirective, collaborative or directive ways, depending on the assessment of the woman.

Step 4: Examining alternatives which may be based on three possible perspectives:

- Supporting the client to assess his or her situational resources or those people known to him or her in the present or past who might care about what happens to him or her
- Helping the client to identify coping mechanisms or actions, behaviours or environmental resources that she might use to help her get through the present crisis
- Assisting the client to examine his or her thinking patterns and if possible, find ways to reframe his or her situation in order to alter his or her view of the problem which can decrease his or her anxiety level

Step 5: Making a plan led by the client which is very detailed and outlines the persons, groups and other referral resources that can be contacted for immediate support. Provide coping mechanisms and action steps that are concrete and positive for the client to do in the present. It is important that planning is done in collaboration with the client as much as possible, to ensure she feels a sense of ownership of the plan. It is important that she does not feel robbed of her power, independence or self-respect. The most important issues in planning are the client's sense of control and autonomy. Planning is about getting through the short-term in order to achieve some sense of equilibrium and stability.

Step 6: Obtaining commitment. Control and autonomy are important to the final step of the process which involves asking the client to verbally summarize the plan. In some incidents where lethality is involved, the commitment may be written down and signed by both individuals. The goal is to enable the client to commit to the plan and to take definite positive steps toward re-establishing a pre-crisis state of functioning. The commitments made by the client need to be voluntary and realistic. A plan that has been developed only by staff will be ineffective.

A six-step model for crisis intervention is one framework that counsellor may implement to respond to crisis. The model focuses on listening, interpreting and responding in a systematic manner to assist client or survivor return to his or her pre-crisis psychological state to the extent possible. Emphasis is placed on the importance of listening and assessment throughout each step with the first three steps focusing specifically on these activities rather than on taking action. At any point, emerging safety considerations that present risk of the client being hurt or killed should be addressed immediately.

The triage assessment system: The triage assessment model (Myer, 2001; Myer *et al.*, 1991) assumes individual reactions are unique and situational. Crisis workers assess crisis reactions in three domains: affective (feeling), behavioral (doing), and cognitive (thinking). Assessment of the affective domain determines the primary reaction which may be anger, fear or melancholy. Behavioral reactions include approach, avoidance or immobility (fight, flight or freeze). Cognitive reactions refer to the client's perception of the event. Individuals may perceive transgressions of their rights being violated, threats of potential for harm or an experience of irretrievable loss. These perceptions may occur in any domain of life: physical, psychological, social, environmental, values and beliefs.

To accomplish a triage rating, the affective, behavioral and cognitive domain responses are each rated on a scale of 1-10 using criteria to mark escalating severity of impairment. A total TAS score, therefore, may be between 3 and 30 with 3 being no impairment and 30 being the most severe score possible. Affective rating criteria include stability or lability of mood, congruence of affect to situation and degree of effort required to maintain volitional control of affect. Behavioral ratings consider the level of impairment in performance of activities of daily living, effectiveness and adaptability of coping behaviors and potential for harm to self and others. Ratings of cognitive impairment consider the individual's ability to focus and concentrate, problem-solve and make decisions. The presence of confusion, perceptions not matched by reality and limited control over intrusive thoughts rate higher severity scores on the cognitive scale.

Counsellor's narrative

Crisis case scenario: The client is a 23 year old student of education. Next year will be her final year for completing her bachelor degree in education. All this while the client was very happy with her studies and life especially with someone she loved beside her most of the time. She has been going steady with her boyfriend since high school. Both have planned to get married as soon as she graduates from university. Both families agreed with their relationship and prayed for their happiness. Unfortunately, things did not turn out the way she wanted. Last two weeks were very miserable for the client as she cried uncontrollably and shut herself out from other people including her family. She heard from someone that her boyfriend had an affair with his office-mate and both had already engaged and planned to get married very soon. She was so shocked and almost fainted upon hearing that news. She tried to contact her boyfriend many times to confirm the news but he refused to meet her and disappeared from his house. She contacted his boyfriend's family and they said it was true. She felt like the whole world had collapsed as she heard the confirmation from his family. Her dreams shattered and life had no meaning to her anymore. The client stayed in bed crying and grieving for several days. With the help of her friends, arrangement was made to send her to a counselling session.

Part 1: narrative of case scenario

Initial presentation: Question 1: Is this person in crisis? This person was in crisis because she displayed some signs of disequilibrium and immobility in affective, behavioural and cognitive aspects. The signs and the

severity level are shown below in the Triage Assessment System (TAS) taken in the beginning of the interaction.

TRIAGE ASSESSMENT SYSTEM (TAS)

Traumatic Event: The client is a 24 year old student majoring in education. The client is in great trauma because someone she loves and trusts most in her life has betrayed her. Her husband-to-be has engaged and planned to get married with his office-mate this month. She was very shocked and did not believe what had happened. She has been skipping from classes, avoiding meeting people and crying for the last two weeks. She has lost her sense of direction and life seems to be meaningless (Appendix A).

From my observation, the client is immobile and unstable because she is suffering from severe shock or depression due to betrayal by someone she loves and trusts most. The relationship was very important and meaningful to her as it gave her the strength to lead her life. She lost her direction when her relationship broke up and felt embarrassed with her family and other people. Based on the observation and assessment above, the client requires crisis intervention because she is in the state of shock, disbelief, denial, anger, withdrawal, guilt and depression. Thus, she needs assistance to get into self-control before she becomes rational enough to tackle the larger issues brought by the event.

Step 1: Define the problem. Question 2: Why is this person in crisis? The triggering events are:

- Being betrayed by her boyfriend/'husband to be'
- An embarrassment to her family/significant others as both plan to get married very soon
- Loss of an important and meaningful relationship

Meaning attributed to the traumatic event:

- Self 'I'm stupid,'; 'I hate myself,'; 'I'm no good,'; 'I am an embarrassment to my family,'; 'I can't take it anymore,'; 'This is so embarrassing,'; 'I can't live like this'
- Others 'How can I face other people'; 'What would they think of me'; 'How can I trust other people'

Problems the event has created for the client:

- Loss of self-control, loss of sense of direction in life, feeling hopelessness and helplessness being apathetic, lack of interest in life, poor concentration on studies, frequent absence from classes, social avoidance, loss of appetite, sleep disturbance

Dialogue: The client looked very depressed when she first entered the room. Most of the time she just sat quietly without making eye contact and cried whenever I asked her of what had happened. CN: Counsellor, CL: Client. CN: Thank you for coming. I'm glad that you can come today. Well, what brought you here today? CL: (Silence for a while and started to cry). I don't know what to do (and the crying became more intense), I can't believe that he could do this to me, I hate him, I really hate him. CN: I know this is very hard for you. It's OK, try to calm down, take your time. Don't worry; I'll be there for you. You can tell everything to me, I will listen and do my best to help you. CL: How could he do this to me? I didn't do anything wrong. He's the one who betrayed our relationship. I can't believe that all this while he has been lying to me and our relationship is a fake. I can't believe that I've been in love with a big liar! CN: Emm...your facial expression is telling me that you are very angry with him. What has he done that makes you so angry and hate him? CL: He has destroyed everything...our relationship, our dream to get married; my whole life has been destroyed. He has promised to marry me, all of them know about this, but recently I heard that he had already engaged with his office-mate and they planned to get married. I'm so embarrassed...how can I face my family, my friends and people around me? How can I live like this? CN: I can see that you're angry with him because he has betrayed the relationship and destroyed everything that both of you have planned. And this, really puts you down and embarrassed you. CL: Yes... (cried and nodding her head). (Silence) Maybe I'm not too good for him; I'm not the kind of woman he wants.

Step 2: Ensuring client safety. Check on safety is suicide or other lethal behaviour a possibility? Safety is an issue here because the client is in the high-risk group as revealed by the indicators of possible suicide risk. The client is experiencing major loss or separation from a loved one and this has put the client in the high risk group of suicide potential. This exerts a great impact on the client as she has lost a sense of direction and meaning in life. Moreover, the client's level of severity is quite high and she is too immobile to cope with the trauma. In this case, when the client was stabilized, I raised the issue of lethality and discussed the risk of harming herself and others directly concerned with the client. Several approaches have been adopted to assess the presence of clues and risk factors for lethal behaviour such as TAS, 4 specific close-ended questions, risk-assessment checklist and suicide assessment chart (James and Gilliland, 2005).

As indicated in the risk-assessment checklist, the client should be treated as a high-risk person in terms of suicide potential because she has manifested the following 5 out of 26 risk factors:

- Has experienced recent loss of a loved one through separation or relationship break-up
- Displays radical shifts in characteristic behaviors or moods such as apathy, withdrawal, isolation, irritability, panic or anxiety or change in social, sleeping, eating, study, dress, grooming or work habits
- Is experiencing a pervasive feeling of hopelessness/helplessness
- Exhibits a profound degree of one or more emotions such as anger, loneliness, guilt, hostility, grief or disappointment
- Manifests ideas and themes of depression and suicide in conversation

Another assessment I used to assess suicide potential for this client is the suicide assessment chart as indicated in Appendix B.

Based on the chart, the intervention strategies required for this client would fall within the category of "more intrusive/medium risk":

- Communicating empathy
- Expand options (other ways to look at the situation) breadth and urgency
- Discuss the use of additional support systems with the client including seeking permission to tell a helping person/carer of danger (e.g., her close friends and family members that she trusts most)
- Discuss with the client the need to refer to other professional help (e.g., professional agencies, expertise or psychiatrist)
- Monitor the client's action when the client is feeling suicidal (refer to step 5 and 6)
- Discuss case with supervisor

Dialogue: CL: I can't go on like this. I can't take it anymore. He has destroyed everything. One day he will deserve the consequence for what he has done. CN: Sounds like you're feeling pretty hopeless about your life and you hope that something would happen that he would pay for what he has done to you. May I know whether you have any plan to harm yourself, your ex-boyfriend or anybody? CL: I don't know... I can't think of it at this time... but life is meaningless to me. I think it's better that I'm gone. CN: Do you want your ex-boyfriend to 'go' too? CL: I don't know... I just want to

get rid of all the memories with him. CN: Do you have any plan to make you 'gone'? CL: (Cried a bit) I haven't thought about that. It's just that I don't want to live anymore. I don't have the courage to face him, my family and everyone. CN: If it so happens that you have a specific plan to harm yourself or your ex-boyfriend, whom do you think you would approach to tell about your plan. Will you let them know about your plan? CL: (Silence for few minutes...) I don't know... I just can't think about it at this time. This is so painful and I just want to get it over.

The dialogue about safety issue ended here as the client seemed not very sure about her plan of harming herself or other people. My assumption was that the client was so depressed that she just wanted to get rid of the trauma but not to the extent of hurting herself and other people. However, the client's case should be monitored closely to minimize any possible risk.

Step 3: Providing support. Question 3: What does this person need from me right now? Support and safe environment are two key elements the client needs from me right now. I will ensure the safety and support required will be provided. Such support would come from me as a primary support and other supports would come from significant others, other professionals and private or government agencies.

Style of intervention: In terms of level of involvement; initially, I would adopt a directive approach because the client seems to be too immobile to cope with the current crisis and the triage score is in high twenties. Thus, the client needs someone or counsellors to direct and support her through this crisis. When the client is getting more stabilized, I will adopt a more collaborative style with the client.

Breadth and urgency:

- Support the presence or absence of support and who could provide it
- Coping skills what ways in the past did she normally use to handle stress and what could be thought of immediately
- Perceptions what she is saying to herself, what are others saying about her, and how fixed are these and can they be altered?
- Past trauma and information needed has this happened before and what information distortion is there and how can it be rectified?

Dialogue: CN: Does anybody on your side know about this? CL: I don't know, but I don't trust anybody. I don't

want to tell anybody about this, but I know this has spread and that is what makes me embarrassed most. CN: It's OK; you don't have to be embarrassed. I'm sure they know because you are not the one who started this. You are not the one who betrayed. I'm sure those who understand and know you well will be at your side. I want you to know that I'll be here to support you all the way through. This conversation is between you and me, no one will know. You can trust me and I'll do my best to help you. CL: (Silence) I know my family is always there for me and some of my friends are with me but I don't have the courage to face them. I feel bad because I have embarrassed my family. CN: If your family is always there for you, I'm sure they will always be there for you to go through this hard time. Have you ever talked to them or maybe they have asked you about this? CL: I know they know about this but they don't want to start it because they are afraid that this might hurt me. I feel so guilty for them to face such a problem. CN: It's OK. If you allow me to talk with them, I would be very happy to do that for you. You don't have to worry because I will be at your side and support you all the time. I will help you to face your family and other people.

Step 4: Examining alternatives: Question 4: What is the immediate pressing problem that needs addressing? The most immediate pressing problem that the client finds so overwhelming is the feeling of hopelessness in the sense that life is meaningless for her and this is the end of the world. Thus, the aim of this session is to help the client get into control of herself or regain mobility and equilibrium which is also the goal of crisis intervention.

Initially, I used a directive style at the beginning of the conversation as the client was immobile and unstable. However as the conversation went on to step 3 and beyond, I slowly moved to collaborative style and tried to engage the client as much as she could to generate alternative ways of responding to her immediate problem. However, the client was not very responsive as she was still in a depressed mood. Thus, I helped the client to decide on the most reasonable things that I thought she was able to do and I wanted her to think over for the next 24 hours.

Actions: Get herself to talk with her family, read some books, watching TV, start going to class and grooming herself.

Dialogue: CL: Right now I can't think of anything. I don't know what to do. I don't have the mood to think or do anything about the situation. I came here because they asked me to. CN: So, you think that you are here because

they asked you to come here and you did it. I think you did come here partly because you yourself decided to come and I'm sure you want to do something about your problem and I'm sure you can do it. I am here to help you to decide on what to do after this. CL: (Silence) Well...I don't know and not sure about so many things right now. My mind is blank...I can't think of anything right now. CN: It's OK. I will help you all the way through. All you need to do is to struggle to put aside your problems and I want you to do and think about some important tasks for the next 24 h. I want you to think of this task (writing the task on a piece of paper and give it to the client).

Step 5: Making plans

Step 6: Obtaining commitment (more like counselling session as the client is expected to relieve from trauma). In the few days/weeks my plan with the client would be: Study arrangement, meeting more people and doing everyday basic task.

Finally, I hope we can work out a long-term plan and get the client's commitment to implement the plan on: Making sense of what has happened and finding a new meaning in life, evaluating her attitudes, her study commitment and progress and making more social contacts.

Dialogue: CL: I don't want to dismay my family's expectation. I've put my study into jeopardy and he (ex-boyfriend) is happy with his life. I hate him. I won't forgive him. I'll prove to everybody that I'm right. Next year will be my graduation and I will show to everybody that I am a good person. I want to make my family happy and proud of me. CN: You look determined with what you plan to do. Let's work together on what you can plan for the next few days or weeks. I think the priority right now would be to make your study arrangement. CL: Definitely yes. I've been skipping classes, assignments and projects for the last few weeks. I wonder how I am going to catch up with all these. CN: Can you think of the best ways of dealing with this? CL: Actually, one of my roommates is in the same program with me. She is the one who always informs me about what is happening concerning class matters. I think she can help me. At the same time, I have to make an appointment with lecturers involved and other arrangements. CN: Sounds like you have planned pretty well. I'm sure you will slowly get through all these smoothly. If you have anything that blocks you from leading your normal daily life, you can always contact me. I want us to keep in touch and do remember I am always out there for you.

Referral and resource list: Keeping a referral and resource list is an important aspect of crisis work. The effective crisis counsellor researches and maintains information regarding agencies and programs in a client's community that can be sources of future help. Information about potential resources should be clearly printed on a card and carefully reviewed with clients. Clients are better informed if they have some knowledge about the process involved before services are sought. Following are some of the resources from our local community upon which we could draw assistance in getting the client through his or her crisis as well as assist him or her with long term counselling issues.

Women's Aid Organization (WAO): The Women's Aid Organization (WAO) is an independent, non-religious, non-governmental organization based in Malaysia, committed to confronting violence against women.

Sisters In Islam: Sister in Islam (SIS) is a group of Muslim professional women committed to promoting the rights of women within the framework of Islam. Our efforts to promote the rights of Muslim women are based on the principles of equality, justice and freedom enjoined by Qur'an as made evident during our study of the holy text.

All Women's Action society (AWAM): Awam is an independent feminist organization committed to improving the lives of women in Malaysia. Our vision is to create a just, democratic and equitable society where women are treated with respect and free from all forms of violence and discrimination. Toward this, we inform, connect and mobilise those interested in securing women's rights, bringing about equality between men and women and supporting women in crisis.

Women's Center For Change (WCC): WCC is a registered, tax-exempt, non-profit organization set up in 1985 to help women and children facing crisis, irrespective of race, religion or social background. Our work is to provide immediate service for women needing crisis intervention as well as to undertake programmes to promote gender equality in our society.

The BEFRIENDERS Kuala Lumpur: The BEFRIENDERS are friends to those who are suicidal, depressed or in despair. They provide emotional support to people when they are suicidal, alleviate misery, loneliness, despair and depression by listening to those who feel they cannot turn to anyone else who would understand and accept them. It is a non-political, non-sectarian and non-religious organization that is available to everyone, from all walks of life, creed, race, religion, age or sex.

All these resources and other private and government organization (such as counselling clinic or counselling unit in higher institutions, health institutions and Ministry of Women's Development and Family Planning) can help client through his or her crisis as well as assist client with her long term issues.

Behavioral severity scale: 8; Marked impairment

Domain severity scale summary: 1st rating occasion:			
Affective	<u>8</u>	Behavioral	<u>8</u>
Cognitive	<u>8</u>	Total	<u>24</u>
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CONCLUSION

The high frequency and indiscriminateness of violent acts make many individuals vulnerable to crises. During a crisis, normal ways of dealing with the world are suddenly interrupted. Although, reactions and responses to crises are time-limited, they may persist as symptoms of post-traumatic stress. Thus, making an accurate assessment is the most critical aspect of a crisis response because it guides the intervention. A wrong decision in response to a crisis can be potentially lethal. Although, situations may be similar each person is unique therefore, care must be exercised to avoid overgeneralizing. The ability to think quickly and creatively is crucial. People under crisis sometimes develop tunnel vision or are unable to see options and possibilities. The crisis responder must maintain an open mind in order to help explore options and solve problems in an empowering manner with those affected. People in crisis already feel out of control when opportunities to restore control present themselves, they should be grasped quickly.

APPENDIX A

Affective domain: Sad/melancholy (primary); the client had trouble controlling her crying; looked down often; depressed and very sad. Anger/hostility (secondary); the client hated herself for being very 'stupid' and trusting her boyfriend too much; very angry with the betrayal and blamed her boyfriend for what had happened; angry for causing embarrassment to the family. Anger/fear (tertiary); the client was filled with outrage and unduly worried with what other people would say especially with family and people in her hometown and friends who knew about her relationship. Affective severity scale: 8; Marked impairment

Cognitive domain: Fault or Blame (primary); kept blaming herself for what had happened and felt that she was stupid, no good, useless and unlucky. Threat (tertiary); afraid of what other people would say about her and how she was going to face her family and people around her. Loss (primary); loss of an important and meaningful relationship; loss of trust in people especially men.

Client's cognition mainly focused on: Physical concerns (loss of appetite, sleep disturbance, did not care about her physical appearance8..... Psychological concerns (poor concentration, lack of interest in everything, obsessive thinking)8..... Social relationships concerns (socially withdrawn and loss of interest in others; avoided meeting family and friends)8..... Moral / spiritual concerns (personal integrity, values, dignity are seriously affected by the traumatic event)7..... Cognitive severity scale: 8; Marked impairment

Behavioral domain: Approach (tertiary); given up in life; no initiative to change or improve her current situation. Avoidance (secondary); withdrew from others, skipped classes; very reserved and quiet. Immobility (primary); in a state of being very depressed and shocked; most of the time she did not know what to do; felt hopeless and helpless.

APPENDIX B

Suicide assessment chart

1. Suicide plan
 - (a) Details; Some specifics (medium risk).
 - (b) Availability of means; not available. Means yet to be obtained (lower risk).
 - (c) Time; no specific answers as the client said 'do not know' (lower risk).
 - (d) Lethality of methods; no specific answers as the client said 'do not know' (lower risk).
 - (e) Chance of intervention; other means available nearby or if called upon (medium risk).
 - (f) Message; No message prepared (lower risk).
2. Sources of stress
 - (a) Severe reaction to significant loss or change both internal and/or external, unmet needs (high risk).
3. Internal coping mechanisms
 - (a) Coping behaviors; some disturbance to daily routines, e.g. sleep, eating, school/work, leisure. Reluctance to seek help and use support systems (medium risk).
 - (b) Avoidance behaviour; running away, withdrawing, reduced communication (medium risk).
 - (c) Self-directed behaviour; self harm, self-abuse. Risk taking behaviour (medium risk).
 - (d) Previous suicide attempt; none (lower risk).
 - (e) Depression; overwhelmed with feelings of sadness, helplessness, hopelessness and worthlessness (high risk).
 - (f) Perception; absence of future consideration. Irrational and fixed (high risk).
 - (g) Communication; (medium to high risk).
 - (h) Lifestyle; (lower risk).
 - (i) Health status; no significant health problem (lower risk).
 - (j) Substance abuse; (lower risk).
4. External coping mechanisms
 - (a) Support systems; family intact; friends and colleagues are very supportive (lower risk).

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