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Contact Hours: **5**

## Mental Health Crises Intervention and Support for Patients

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**LEARNING OUTCOME AND OBJECTIVES:** Upon completion of this course, you will have increased your knowledge of appropriate responses and care for persons experiencing a mental health crisis, ranging from short-term intervention to emergency management of a life-threatening situation. Specific learning objectives include:

- Distinguish between the definitions of mental health “crisis” and “emergency.”
- Describe the types and phases of mental health crises.
- Explain the considerations that are specific to the triage process for patients experiencing mental health crises.
- Outline the stages of crisis intervention.
- Describe effective communication and de-escalation techniques to use with people in crisis.
- Discuss the steps involved in mental health emergency management.
- Describe the appropriate care for patients experiencing mental health crises related to a mental illness diagnosis.
- Identify ethical and legal issues related to the care of patients experiencing a mental health crisis.

### INTRODUCTION

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Everyone experiences personal crises. Crises are acute, time-limited events experienced as overwhelming emotional reactions to one’s perception of an event. Crises are experienced by people of all ages, cultures, and socioeconomic conditions and may or may not be related to a specific mental disorder.

Crises are self-defined and environmentally based. What is a crisis for one person may not be for another, and what is now a crisis may not have been a crisis before or would not be a crisis in a different setting. Crises can be looked upon as a system out of balance. Crises occur when balance cannot be regained, even though a person is trying very hard to correct the imbalance.

Locations for crisis interventions may range from community to healthcare settings. Most often clinicians encounter an individual in crisis in emergency departments and on crisis hotlines. However, these individuals may also be encountered in the community as well as in inpatient units, rehabilitation facilities, outpatient clinics, nursing homes, assisted living facilities, and home health settings.

Healthcare providers may lack the educational preparation, confidence, and experience to provide appropriate intervention and satisfactory care for the person in crisis, and their approach is often a reactive one. In addition, many clinicians consider a mental health crisis to be only a situation in which an individual is threatening harm to self or others.

This narrow focus on dangerousness, however, is not a valid approach to addressing a mental health crisis. It is important to recognize that addressing problems before physical safety becomes an issue is an important step in the successful management of patients experiencing a mental health crisis before it becomes a mental health emergency.

The goals of mental health crisis management are to:

- Ensure the safety and emotional stability of the person experiencing an emotional crisis or mental illness
- Avoid further deterioration of the person's mental status
- Assist in the development or enhancement of more effective coping skills and support system
- Help in obtaining ongoing care for emotional crisis or mental illness
- Ensure that services are clinically appropriate and in the least intense or restrictive setting

## WHAT IS A MENTAL HEALTH CRISIS?

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A **mental health crisis** is defined as a non-life-threatening situation in which a person experiences an intensive behavioral, emotional, or psychiatric response triggered by a precipitating event. The person may be at risk of harm to self or others, disoriented or out of touch with reality, functionally compromised, or otherwise agitated and unable to be calmed. If this crisis is left untreated, it could result in a mental health emergency.



Evidence that a person is experiencing a mental health crisis may include:

- Talking about suicide
- Talking about threatening behavior
- Self-injury that does not need immediate medical attention
- Alcohol or substance abuse
- Highly erratic or unusual behavior
- Eating disorders
- Not taking prescribed psychiatric medications
- Being emotionally distraught, very depressed, angry, anxious, irritable
- Paranoid thinking

When an individual in crisis is found to be imminently threatening harm to self or others, is severely disoriented or out of touch with reality, is functionally disabled, or is extremely distraught and out of control, the crisis has now become a life-threatening situation, and a **mental health emergency** exists.

Evidence that a person is experiencing a mental health emergency may include:

- Active assault
- Acting on a suicide threat
- Self injury requiring immediate medical attention
- Throwing or breaking things
- Belligerent, hostile, or threatening behavior
- Loud, aggressive speech
- Severe impairment by drugs or alcohol
- Highly erratic or unusual behavior indicating unpredictability to safely care for self

## Types of Crises

Although crises arise from many different sources, most healthcare professionals agree there are at least four causal categories of crises: maturational, situational, adventitious (rare/unexpected/disastrous), and mental illness.

### **MATURATIONAL CRISES**

Maturational crises have to do with the predictable transitions individuals experience as they move from one stage of human development to another. At various times every individual must



make adjustments and adapt to new responsibilities and life patterns. Those transitional periods or events most commonly known to increase the risk for crisis are:

- Adolescence
- Marriage
- Midlife
- Retirement

These transition periods often produce disequilibrium, when persons need to make cognitive and behavioral changes that accompany development. Successful transitions depend upon previous successes, the availability of support, role model influences, and the acceptance by others of the person's new role.

Maturational crises are predictable and can be prepared for and prevented. Proactively identifying actual or possible changes that the event will cause and then taking steps to become more prepared for those changes can minimize the disruption. For example, a young couple can take parenting classes to help prevent pediatric head trauma that could result from shaking their infant out of frustration during a period of uncontrollable crying. Or an older person can make financial plans for upcoming retirement.

### **SITUATIONAL CRISES**

Situational crises arise suddenly and unexpectedly from an external source and are events or circumstances that threaten the physical, social, and psychological integrity of individuals. Situational crises often revolve around grief and loss. These events may originate in the physical body as a result of disease or injury or in social or emotional situations, such as the loss of a job, divorce, mental illness, death of a child, move to another locale, or failure in school. Sometimes maturational and situational crises occur at the same time, and occasionally, one crisis triggers another, compounding the problem.

For example, a teenage boy and girl are attracted to one another and experiment with sexual intimacy. When the menstrual period of the girl is late, both adolescents are thrust into a state of emotional disequilibrium as they experience both the maturational crisis of adolescence and the situational crisis of a potential pregnancy. The actions they take to resolve the crisis may thrust them into even greater confusion and tumult.

### **ADVENTITIOUS OR SOCIAL CRISES**

Adventitious or social crises have been called events of disaster. They are rare, unexpected happenings that are not part of everyday life and may result from:

- Natural disasters, such as floods, fires, and earthquakes
- National disasters, such as airplane crashes, riots, and wars



- Interpersonal disasters, such as assault and rape
- Acts of terrorism

Because of the severity of the effects of such events, normal coping strategies may not be effective, and support systems may not be available because mental health professionals must respond quickly and to large numbers of people, at times including an entire community.

The Federal Emergency Management Association (FEMA) provides a systematic approach to the work necessary during such disaster situations. Training material for Community Emergency Response Teams (CERT) can be found on the FEMA website.

## MENTAL ILLNESS CRISES

Individuals living with mental illness face the same stressors as persons who do not have a mental illness, but these stressors can be especially difficult to deal with for someone living with a mental illness. Crises can occur even if the person has been complying with treatment or a crisis prevention plan, using techniques learned from mental health professionals. At times the person may present with behaviors that indicate an impending crisis, but other times a crisis can occur suddenly and without warning (NAMI, 2016a).

## Phases of Crisis

Gerald Caplan (1964), a pioneer in the field of crisis intervention, identified four predictable phases of crisis:

1. **Initial threat or triggering event.** People are faced with a problem or conflict. In an effort to lower the level of anxiety (fear), they employ various defense mechanisms, such as compensation (using extra effort), rationalization (reasoning), and denial. For some people with strong coping skills, the problem may be resolved, the threat disappears, and there is no crisis.
2. **Escalation.** If the problem persists and the usual defensive response fails, anxiety continues to rise to serious levels, causing extreme discomfort. Problem-solving ability is arrested or becomes unsuccessful. The person becomes disorganized and has difficulty thinking, sleeping, and functioning. Trial-and-error efforts are initiated to solve the problem and restore emotional equilibrium. Lack of success in finding an appropriate coping strategy leads to a sense of helplessness.
3. **Crisis.** The individual expands the search for helpful resources in an effort to relieve the psychological discomfort, drawing on all available resources. When all attempts fail, anxiety intensifies to a severe level and then to panic, and the person mobilizes automatic relief behaviors (flight or fight). At this point, some people may seek assistance from professionals for possible answers and resolution. Some form of resolution may be made, such as redefining the problem, attacking it from a new angle, and trying again to find a



solution. If new methods are successful, the crisis will resolve and the person will return to a functional level that may be the same, higher, or lower than previously.

4. **Personality disorganization.** If the problem is not resolved in the second or third phase and new coping skills are ineffective, anxiety may overwhelm the individual and lead to panic or despair, a hallmark of this phase. Serious disorganization, confusion, depression, possible psychotic thinking, or violence against oneself or others may be present, and it is at this point that external supports become necessary (Casale, 2016).

## Balancing Factors

In her seminal work on crisis, Donna Aguilera (1998) noted that the equilibrium of people in crisis is significantly affected by three balancing factors: their perception of an event, their support system, and their coping mechanisms.

- **Perception** of an event refers to the importance of a problem to the individual in crisis and includes such things as health, career, financial status, and reputation.
- **Support system** refers to the resources possessed by the person in crisis, such as other people the individual trusts who can provide support and assistance during a time of need.
- **Coping mechanisms** are skills or methods people use to reduce anxiety and solve problems, such as reasoning, meditation, physical exercise, sleep, and denial.

## Resolution

For a healthy resolution of a crisis to occur, the person must have a realistic understanding of the precipitating event and the emotional response to it in order for problem-solving to be successful. There must be systems of support available and there must be a supply of effective coping measures developed over a lifetime available for application to stressful situations.

There are three possible ways for a crisis to be resolved:

- **Pseudo resolution.** When the person in crisis represses or pushes the event and emotions associated with it out of consciousness, those repressed feelings may resurface and influence the response to a new crisis. When this occurs, the new crisis will be more difficult to resolve.
- **Unsuccessful resolution.** In this instance, the person avoids emotions, or minimizes feelings and fails to accept the real or perceived loss. This pathological adaptation can give rise to symptoms of depression, leading to major depression requiring treatment to resolve.
- **Successful resolution.** The person has worked through the various phases of the crisis and begins to utilize effective coping measures to resolve the crisis.



When a crisis is resolved and emotional equilibrium is restored, individuals again face the everyday issues of life. Ideally, as a result of a crisis, they learn new coping skills, gain greater self-confidence, enlarge their support system, and raise their level of functioning (Casale, 2016; Goldberg, 2016a).

### CASE: Elements of a Crisis

Peter, a teenager, failed to make the football team. His world crumbled as he tried to cope with both a maturational and situational crisis. To make himself feel better, Peter took a bottle of whiskey from the kitchen cabinet, climbed into the family car, drove to an isolated park, and drank several ounces of the whiskey. After an hour or so, he felt groggy and nauseous, decided to drive home, and crashed the car, suffering serious injury.

Peter's perception of the event (making the football team) was the most important thing in his life. He was devastated when he did not get on the team. Instead of calling on a support system (family or friends who could bolster his feeling of worth), he self-medicated with alcohol, eventually leading to an accident and injury. Now he feels even worse than before.

During his recovery, Peter worked with a counselor on a weekly basis to gain an understanding of his response to his maturational and situational crises and learned new coping mechanisms to utilize in the future. He recognized that more effective coping mechanisms could have been to take a long walk (physical exercise), talk about his disappointment with a friend (counseling), or think about other ways to gain recognition (reasoning).

## RECOGNIZING A MENTAL HEALTH CRISIS

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Being aware of various risk factors may alert clinicians to patients facing a potential mental health crisis. Likewise, an individual experiencing a crisis may have physical and psychological as well as interpersonal signs and symptoms.

### Contributing Risk Factors

Factors that can increase the risk for mental health crisis include:

- Presence of concurrent illness, injury, poor nutrition, chronic pain, lack of sleep
- Presence of other stressful life events
- Negative attitude about ability to cope
- Lack of emotional awareness
- Belief in an outside locus of control
- Lack of social support
- Pessimistic outlook
- History of poor coping skills



- Developmental or physical challenges
- History of substance abuse  
(NAMI, 2016b)

It is important to remember that mental health crises can arise due to **mental illness or medical conditions** such as:

- Diabetes (low blood sugar)
- Hypoxia
- Traumatic brain injury
- Decreased cerebral blood flow
- Central nervous system infections (meningitis)

## Signs and Symptoms in Adults

### Physical

- Sleep disturbances
- Jaw, shoulder, back, neck pain
- Tension headaches
- Intestinal cramps, heartburn, constipation, eating disturbances
- Muscle tension, fatigue, cold hands and feet, sweaty palms
- Shortness of breath, chest pain
- Skin problems
- Increased vulnerability to cold, flu, infections

### Psychological

- Anxiety, fear
- Irritability
- Hopelessness
- Helplessness
- Impatience
- Feelings of doom
- Nervousness

### Interpersonal

- Increased conflict and arguing
- Isolation from social activities
- Job instability related to conflict with coworkers and employer





- Road rage
- Domestic or workplace violence

(Suthar, 2015)

## Signs and Symptoms in Children and Adolescents

At each stage of development there are unique responses. In children and adolescents, the responses may differ from those of an adult. In **younger children**, the following may occur:

- Regression: thumb-sucking, bed-wetting, fear of the dark and other specific fears
- Separation anxiety: clinging behaviors
- Self-destructive behavior
- Behavioral and academic problems

**Adolescents** in crisis may experience or exhibit the following:

- Generalized anxiety rather than specific fears
- Decrease in academic performance
- Poor concentration
- Increased aggression and oppositional behaviors
- Out-of-control anger and frustration
- Increased risk-taking behaviors
- Substance abuse and alcohol use
- Moodiness and social withdrawal
- Use of denial as a coping mechanism

(Suthar, 2015)

## MENTAL HEALTH CRISIS INTERVENTION PROCESS

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Mental health crisis intervention refers to methods that offer immediate, short-term help to individuals who are experiencing an event that is producing emotional, mental, physical, and behavioral distress or problems. Mental health crises are usually temporary, short-lived, and last no longer than one month. The length of crisis intervention may range from one session to an average of four weeks, and session lengths may range from 20 minutes to more than two hours. Crisis intervention is appropriate for all ages and can take place in a range of settings.

The **goals** of crisis intervention are patient safety, reduction of anxiety, the return to pre-crisis functioning, and when possible, raising functioning to a higher level than before the crisis.



## Triage Considerations

When an individual in distress calls a telephone hotline or goes to an emergency department or other crisis intervention facility, healthcare professionals must first determine the priority for treatment based on the severity of the person's condition. This process is referred to as triage. During triage the professional identifies the problem and precipitating event, considers influencing factors, and plans appropriate intervention. Triage is an integral part of the clinical process and key to ensuring that individuals are linked to the right care and support.

In every crisis event, triage must address both safety concerns and immediacy challenges.

### SAFETY CONCERNS

The most urgent concern of healthcare professionals is the safety of people in crisis as well as others who may be in danger. Clinicians gather information about:

- The presence of guns, knives, explosives, or other harmful devices
- Threats of violence by the person in crisis to self or others
- History of harm by the person in crisis to self or others
- Intoxication of the person in crisis or others through various substances
- Environmental hazards that might complicate interventions (e.g., fire, wind, water, trauma, toxic fumes, random gunfire)

### IMMEDIACY CHALLENGES

Mental health triage may occur in emergency departments, call centers, community health centers, and many other crisis assessment settings. Central to triage is a risk assessment that identifies the nature and severity of a mental health problem in order to determine how urgently a response is required and the type of service response that would best meet the patient's needs.

In an emergency department, a designated triage nurse performs a brief, focused medical or mental health assessment and assigns the patient a triage acuity level that indicates how quickly and by whom a patient should be seen for assessment and treatment. In many facilities, a triage assessment tool may be utilized to assist in the prioritizing process.



<b>MENTAL HEALTH TRIAGE ASSESSMENT TOOL</b>		
<b>Acuity Level</b>	<b>Assessment</b>	<b>Observed/Reported Behaviors</b>
Immediate intervention	<ul style="list-style-type: none"> <li>• Definite danger to life (self or others)</li> </ul>	<ul style="list-style-type: none"> <li>• Violent behavior</li> <li>• Possession of a weapon</li> <li>• Self-destructive behavior</li> <li>• Extreme agitation/restlessness</li> <li>• Bizarre/disoriented behavior</li> <li>• Verbal commands to do harm to self or others that the person is unable to resist</li> <li>• Recent violent behavior</li> </ul>
Intervention within 10 minutes	<ul style="list-style-type: none"> <li>• Probable risk of danger to self or others</li> <li>• Severe behavioral disturbance</li> <li>• Patient physically restrained in the department</li> </ul>	<ul style="list-style-type: none"> <li>• Extreme agitation/restlessness</li> <li>• Physically/verbally aggressive</li> <li>• Confused/unable to cooperate</li> <li>• Hallucinations/delusions/paranoia</li> <li>• Requires restraint/containment</li> <li>• High risk of absconding and not waiting for treatment</li> <li>• Attempt at self harm/threat of self harm</li> <li>• Threat of harm to others</li> <li>• Unable to wait safely</li> </ul>
Urgent intervention, within 30 minutes	<ul style="list-style-type: none"> <li>• Possible danger to self or others</li> <li>• Moderate behavioral disturbance</li> <li>• Severe distress</li> </ul>	<ul style="list-style-type: none"> <li>• Agitation/restlessness</li> <li>• Intrusive behavior</li> <li>• Confused</li> <li>• Ambivalence about treatment</li> <li>• Not likely to wait for treatment</li> <li>• Suicidal ideation</li> <li>• Situational crisis</li> <li>• Unable to wait safely</li> <li>• Presence of psychotic symptoms</li> <li>• Presence of mood disturbance</li> </ul>
Semi-urgent intervention, within 60 minutes	<ul style="list-style-type: none"> <li>• Moderate distress</li> </ul>	<ul style="list-style-type: none"> <li>• No agitation/restlessness</li> <li>• Irritable without aggression</li> <li>• Cooperative</li> <li>• Gives coherent history</li> <li>• Preexisting mental health disorder</li> </ul>



		<ul style="list-style-type: none"> <li>• Symptoms of anxiety or depression without suicidal ideation</li> <li>• Willing to wait</li> </ul>
Nonurgent intervention, within 120 minutes	<ul style="list-style-type: none"> <li>• No danger to self or others</li> <li>• No acute distress</li> <li>• No behavioral disturbance</li> </ul>	<ul style="list-style-type: none"> <li>• Cooperative</li> <li>• Communicative and able to engage in developing management plan</li> <li>• Able to discuss concerns</li> <li>• Compliant with instructions</li> <li>• Known patient with chronic psychotic symptoms</li> <li>• Preexisting nonacute mental health disorder</li> <li>• Known patient with chronic unexplained somatic symptoms</li> <li>• Requests for medication</li> <li>• Minor adverse effect of medication</li> <li>• Financial, social, accommodation or relationship problems</li> </ul>
Source: Adapted from AGDOH, 2013		

## Crisis Intervention Communication

In order to be effective in the process of intervention with an individual in crisis, it is essential that the clinician use effective communication techniques. The most essential of these are active listening skills. **Active listening skills** involve hearing and observing, encouraging, and remembering. The practice of active listening is complex, as each skill involved is used concurrently with the others while also trying to remain empathetic and objective. Active listening is listening with all the senses and is, essentially, a form of feedback.

### ENCOURAGING

It is important to convey an interest in what the speaker is saying and to encourage the speaker to keep talking. Encouraging can involve both verbal and nonverbal communication that invites individuals to express themselves.

#### Examples:

- “Uh-huh.”
- “Oh?”
- “When?”
- “Really?”



- “I see.”
- “Yes.”

Nonverbally, the listener can convey interest by maintaining eye contact, nodding, and smiling. Small smiles combined with nods can be powerful in affirming that messages are being heard and understood. Because eye contact can be intimidating and culturally specific, it is essential to gauge how much is appropriate. It is best to use eye contact along with smiles and other nonverbal messages.

The listener’s posture can indicate attentive listening. These may include leaning slightly forward or sideways while sitting, slanting the head slightly, or resting the head on one hand.

Another nonverbal technique is referred to as “mirroring.” This may involve the automatic reflection of the facial expressions of the speaker and can indicate empathy. The slight mirroring of posture or gestures also can build rapport. Mirroring may also include speech pacing, vocabulary choices, volume and tone of voice, as well as speech patterns. Mirroring, however, must be genuine to be effective (Cournoyer, 2017).

## **CLARIFYING**

Clarifying involves the ability to reflect back to the speaker the words and feelings expressed in order to ensure that they have been understood correctly and that both the speaker and listener agree upon a true representation of what has been said.

### **Examples:**

- “I am not quite sure I understand. Can you ...?”
- “Do you mean that ...?”
- “Are you telling me ...?”
- “Are you saying ...?”

Clarifying uses paraphrasing and restating to show an understanding of what the speaker has said and to help the speaker evaluate feelings by hearing them expressed by someone else.

Paraphrasing involves the use of other words to reflect back to the speaker what has been said. When paraphrasing, it is essential that the listener does not ask questions, is nondirective, and is nonjudgmental. It shows the speaker that the listener is attempting to understand what has been said.

It can be quite difficult to avoid asking questions when first learning this skill, as it may not feel natural. To become comfortable, this skill requires practice.

### **Examples:**

- “You are telling me ...”
- “What you are saying is ...”



When restating and paraphrasing, it is important that it be done using simple terms, while observing for nonverbal and verbal cues that confirm or refute the accuracy (Cournoyer, 2017).

## **EMOTIONAL LABELING**

During a mental health crisis, feelings may often be confusing and hard to define. Some people experience greater difficulty labeling their emotions than others do. This inability has been found to be associated with deficits in the ability to regulate those emotions. The less aware a person is of their emotions, the less likely he or she may be able to regulate them.

Emotional labeling allows a clinician to apply a tentative label to the feelings the person is expressing or implying by words and actions. Labeling emotions lets the person know he or she is being heard and helps the person make sense of them and gain some control. The simple act of thinking about and then labeling an emotion can distract from and disrupt the intensity. It is important not to assume one knows how another person feels. It is best to ask if a label is correct.

### **Examples:**

- “You sound very frustrated. Is that right?”
- “Am I correct in saying that you feel overwhelmed by everything?”

It is important that the person’s emotions are validated and not minimized. Labeling and acknowledging emotions help to restore equilibrium (Cournoyer, 2017; Valeo, 2013; Thompson, 2013).

## **OPEN-ENDED QUESTIONS**

The use of open-ended questions encourages the individual to continue to talk. They usually begin with how, what, when, and where and encourage exploration. It is important to avoid yes and no questions, which limit answers. It is also important to avoid why questions, as they may be interpreted as accusations, resulting in the person feeling defensive. Why questions may also imply that the person should know something that they may not know.

### **Examples:**

- “What were you thinking/feeling?”
  - “How did you act?”
  - “When did that happen?”
  - “Where did you go afterward?”
- (Cournoyer, 2017)



## EFFECTIVE PAUSES/SILENCE

Part of effective communication includes the use of silence and waiting or pausing before speaking. Silence and pauses can be used effectively for several purposes. Most people are not comfortable with silence and will talk in order to fill it. Therefore, a period of silence may encourage a person to continue speaking. Silence can also be used to emphasize a point just before or just after saying something important (Cournoyer, 2017).

## “I” MESSAGES

“I” messages allow a listener to let the speaker know how he or she feels, why the listener feels that way, and what the speaker can do to remedy the situation in a nonthreatening way. Listeners use this technique to refocus the speaker or when the listener is being verbally attacked.

### Examples:

- “I feel uncomfortable when I’m spoken to that way. Please don’t yell at me.”
  - “I need to better understand what I heard you say. Tell more about that.”
- (Cournoyer, 2017; Townsend, 2014)

### CASE: Communication Techniques

Jeremy is a nurse with three years’ experience working in an emergency room and two years on an acute psychiatric unit. He has volunteered to answer the crisis hotline one night a week at the Northside Healthcare and Crisis Center. Jeremy arrives for his initial orientation and training with the crisis center manager, Daniel, who proceeds to instruct him, offering tips and suggestions along the way.

Jeremy’s training includes the following:

- An introduction to the triage algorithm utilized by the center
- Recognizing the difficulty of developing a rapport with a caller when you are unable to see the person
- Maintaining an even, unhurried tone of voice
- Identifying oneself at the beginning of the call and explaining what the triage process is
- Remembering the caller’s name by writing it down immediately
- Ensuring that the caller has enough time to explain what the situation is
- Completing the assessment following the triage algorithm
- Determining the urgency and type of response required
- Requesting callers to repeat instructions and asking them to write them down



- Encouraging a call back if the situation changes or if more assistance is needed
- Documenting the call in the crisis records
- Using active listening skills
- Using open-ended questions and offering suggestions to help callers remember details
- Learning about barriers to effective telephone communication such as inappropriately using language, making assumptions, being judgmental

Jeremy listens in on two hotline calls and then answers a third call while Daniel listens in. Using all the skills he has honed working with people in the emergency department and the acute psychiatric unit, Jeremy establishes rapport quickly by actively listening, speaking calmly, and giving the caller adequate time to tell her story.

Daniel observes Jeremy completing his assessment following the triage algorithm, his correct determination of the urgency and need of the caller who was distraught and having thoughts of harming herself, as well as Jeremy's appropriate intervention. Jeremy enters the call in the crisis records, and Daniel tells him he is ready to work on his own.

## Crisis Intervention Model

There are several approaches to crisis intervention, but the one most commonly used is **Roberts' 7-Stage Crisis Intervention Model** (Yeager & Roberts, 2015). This systematic and structured model for crisis assessment and intervention is useful with persons calling or walking into an outpatient psychiatric clinic, psychiatric screening center, community mental health center, counseling center, or crisis intervention setting. The model identifies seven critical stages an individual goes through to reach stabilization, resolution, and mastery. The stages are sequential but may overlap in the process.

### STAGE 1: ASSESSMENT

The first step in the assessment of an individual experiencing a mental health crisis is to begin a fast but thorough biopsychosocial assessment, which includes inquiring about the major physical, psychological, and social issues of the person. This assessment should provide a brief medical history, medications being taken, current and past history of alcohol or drug use, environmental resources and supports available to the person, mental health problems and symptoms, as well as cultural considerations.

Assessment should inquire about the **support system** and resources available to the person in crisis. Family and friends, social clubs, church groups, and networks of professional associates are all sources of support. When these resources are not available, caregivers act as a temporary support system for the patient. Some questions a clinician might ask about a support system are:

- "With whom do you live?"





- “When you feel lonely and overwhelmed by life, whom do you talk to?”
- “Is there someone in your life whom you trust?”
- “In the past, during difficult times, whom did you want to help you?”
- “Where do you go to school (to worship, to have fun)?”

Assessment of the level of anxiety the person is experiencing should be done as well as the person’s usual **coping methods**. Some people drink, some eat, some sleep, and some gamble. Others engage in physical activity, work harder, pick fights, or talk to friends. Some questions clinicians may ask about coping methods are:

- “What do you do to make yourself feel better?”
- “Did you try doing that this time?”
- “If you did, what was different this time?”

Assessment of the person’s **strengths and needs** also begins in this stage and continues throughout the crisis intervention. It is also important to determine whether the patient is unable to take care of personal needs such as eating, sleeping, and tending to personal hygiene and safety.

Assessment of **lethality** is done to determine whether the person is suicidal or homicidal by asking:

- “Have you thought of killing yourself or someone else?”
- “How would you go about doing this?”

If there is any concern about suicidality, it is essential to find out what the person’s thoughts are, if there is intent and the strength of the intent, whether there is a plan and the lethality of the plan, any past history of suicide attempts, and other specific risk factors for suicide such as substance abuse, social isolation, or recent losses. In cases of imminent danger, emergency medical or police intervention is often necessary. (See also “Assessing for Harm to Self or Others” below.)

## STAGE 2: RAPIDLY ESTABLISH RAPPORT

Stage 1 and stage 2 most often occur simultaneously. Establishing rapport and a collaborative therapeutic relationship begins with the initial contact between the crisis clinician and the person. The main task for the clinician at this point is to establish rapport by conveying genuine respect for and acceptance of the person’s feeling and circumstances. The person may need reassurance that he or she can be helped and that this is the appropriate place to receive such help.

The clinician demonstrates an understanding of the person’s situation and feelings by showing patience and empathy, engaging in active listening, and concentrating on what the person is



communicating verbally and nonverbally. It is also important to reinforce any evidence of the person's resiliency.

Other ways in which rapport can be made is through eye contact, being nonjudgmental, mirroring physical posture and movement to indicate listening intently, and the cautious use of touch to convey understanding.

### **STAGE 3: IDENTIFY MAJOR PROBLEMS**

This stage involves identifying the major problem(s) the person is having, including the chain of events leading up to the crisis and the "last straw" that brought things to a head. The clinician encourages the person to examine when and how the crisis occurred, the contributing circumstances, and how the person attempted to deal with it. Questions clinicians might ask about a precipitating event are:

- "What happened to make you so upset?"
- "How are you feeling right now?"
- "How does this event affect your life?"
- "How will this event affect your future?"
- "What needs to be done to fix the problem?"

Exploration of other problems the patient is concerned about is also accomplished during this stage. It can be useful to prioritize the problems in terms of which problems the person wants to work on first, recognizing that the focus of crisis intervention is the current problem rather than issues from the past.

### **STAGE 4: EXPLORE FEELINGS AND EMOTIONS**

It is extremely important to allow the person to vent feelings and emotions and to validate them by accepting them and recognizing them as understandable. This is best accomplished by using active listening skills, such as paraphrasing, reflective listening, and probing questions.

With caution, the clinician may also challenge maladaptive thinking and behavior. Challenging responses can include giving the person information, reframing and interpreting thoughts and behaviors, and playing "devil's advocate."

- "How many times in the past have you had this kind of thought? Have you ever been wrong?"
- "What could you do to determine if this thought is true?"
- "Even if that's true, tell me if you can think of more positive behaviors you might engage in?"



When used appropriately, these challenging responses help the person take a second look at thoughts and behaviors and to consider other options.

### **STAGE 5: GENERATE AND EXPLORE ALTERNATIVES**

This process may be the most difficult to accomplish in crisis intervention, People in crisis often lack the ability to see the big picture and hold on to familiar ways of coping even when they are not working.

The clinician draws conclusions about the patient's strengths and needs related to the current crisis and evaluates the potential for recovery. The person's strengths are tapped to improve self-esteem, which also provides the energy and skills for problem-solving.

During this stage of intervention, the clinician and the individual collaborate and negotiate to come up with options that will improve the current situation. It is important that such collaboration occur in order to ensure that the options selected are "owned" by the person. Brainstorming about possibilities or asking about what has been helpful in the past can elicit the person's input.

### **STAGE 6: DEVELOP AND FORMULATE AN ACTION PLAN**

At this point there is a shift from crisis to resolution. The person and the clinician begin to take the steps negotiated in stage 5, and the person begins to make meaning of the crisis event by exploring why it happened. It is important for the person to obtain a realistic picture and understanding of what happened and what led to the crisis. It is also important for the person to understand the specific meaning of the event and how it conflicts with expectations, life goals, and belief system. Working through the meaning of an event is important in order to gain mastery over the situation and for being able to cope with similar situations in the future.

During this stage, the person begins to restructure, rebuild, or replace irrational beliefs and erroneous thinking with rational beliefs and new thinking. Action plans may also involve options such as entering a 12-step treatment program, joining a support group, or entering a women's shelter. These are often critical options for restoration of the person's equilibrium and psychological balance.

### **STAGE 7: PLAN FOLLOW-UP**

A plan for follow-up with the person after initial intervention should be done to make certain the crisis is being resolved and to evaluate the postcrisis status of the person. Such an evaluation may include current functioning and assessment of progress as well as satisfaction with treatment. It is recommended for those individuals who are grieving that a follow-up session be scheduled around the one-month and one-year anniversary of a death. This is also recommended for individuals who are victims of violent crimes.



**CASE: 7-Stage Crisis Intervention Model and Communication Techniques**

Jessie is a 78-year-old woman living with her 82-year-old husband, George, in an older adult housing complex. Jessie recently fell and now has a compressed nerve in her hip. She has been unable to leave her apartment due to her inability to get into a car, and she is receiving physical therapy at home. Jessie's husband has Alzheimer's disease and spends part of his day in senior daycare at the complex.

Randy, the physical therapist, has been working with Jessie twice a week for two weeks, and she has been making slow progress. He is familiar with her medical and psychosocial history. (Stage 1: Assessment)

Today, when Randy arrives to the apartment, Jessie immediately begins crying, saying, "I can't keep doing this anymore, I just simply can't!"

Randy sits down in the chair next to Jessie and leans slightly toward her. (Stage 2: Establish rapport; active listening posture) "Oh, dear," he says. (Encouraging) "You sound very discouraged. Is that right?" (Emotional labeling) "What has happened to make you so upset?" (Stage 3: Identifying major problem)

"It's George!" Jessie replies. "He's driving me crazy!"

"Oh?" says Randy, raising his eyebrows. (Encouraging) "Can you tell me what's been happening with George?" (Open-ended questioning)

"I have to follow him around all day and night picking up after him and watching him," says Jessie, still in tears.

"Tell me what he does that makes you have to watch him," asks Randy. (Open-ended questioning)

"Oh, he gets up at all hours and wanders around. One time he went out in the hall and I had to run out after him. He turns on the stove to make coffee and forgets about it. And with this hip pain, I just can't keep doing this. I'm exhausted!" cries Jessie.

"I see," says Randy, nodding, with a concerned expression. (Mirroring) "That must be very frustrating for you, and I can see how that would be very difficult, especially when you're not feeling very well." (Empathizing) "You're telling me that your hip pain is making it hard to care for George. Is that right?" (Stage 4: Exploring feelings and emotions; clarifying.)

"I think he's doing these things on purpose!" Jessie says.

"You sound quite angry with George. Are you telling me he's trying to be mean?" asks Randy. (Clarifying)

"Well, I wouldn't put it past him!" say Jessie, with less frustration and a bit of a smile on her face.



Randy asks with slight smile (Mirroring), “Could you be wrong about that?” (Playing devil’s advocate)

“Oh, I know it’s his dementia. He’s never, ever been mean to me,” says Jessie, calmer now.

“Well, then, what do you think we can do about making things easier for you to take care of George?” (Stage 5: Generating and exploring alternatives; collaborating)

“Well, I would like to be able to get a good night’s sleep!” says Jessie. “That’s really all I’m asking for. Between the pain and George being busy all night, I don’t know what to do. I’m so darn tired!”

Randy asks, “Is there a family member or a friend who might help you out?”

“Well, my children live out of town, and my grandchildren are all over the country. I do have one friend, but she’s as old as I am and probably needs her sleep, too.”

“Would you like to give her a call and see if she or someone she knows could help you out just until we’ve gotten you over the problem with the hip pain? Would that be a possibility?” asks Randy.

“Well, she’s does have a lot of grandchildren. Maybe one of her granddaughters could come to spend a couple of nights a week for a few dollars until I get back on my feet. I think I’ll call her after you leave and see if she can help me out.” (Stage 6: Developing and formulating an action plan)

Randy replies, “I think that’s a great idea. And if you don’t have success, call me right away and let me know. If it doesn’t work out, I’ll see what other options are available. Would that work for you?”

“Yes,” replies Jessie. “Just thinking about it makes me feel better already.”

Three days later Randy arrives for a therapy session and finds Jessie up and moving about. She smiles when he enters. He asks her how she is doing, and Jessie tells Randy that her friend’s 15-year-old granddaughter came and spent two nights on the sofa keeping an eye on George. Jessie was able to get six good hours of sleep each night and says she is feeling so much better. Even the pain in her hip is better. She thanks Randy for listening to her and helping her solve her problem. (Stage 7: Follow-up)

## Assessing for Risk of Harm to Self or Others

Individuals experiencing a mental health crisis should always be assessed for the potential risk of harm to self or others.



## SUICIDE ASSESSMENT

A suicide risk assessment includes:

- Clinical evaluation
- Identifying risk enhancing factors
- Identifying risk reduction factors
- Employing clinical judgment

The **Ask Suicide-Screening Questions (ASQ)**, a tool that is available to be used with all patient populations, takes two minutes to administer and asks four basic questions:

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? If yes, how?

A yes answer to any of the four questions constitutes a positive screen, and once the patient is suspected of thinking about dying by suicide, additional specific and direct questions should be asked:

- Have you ever felt that life is not worth living?
- Have you been thinking about death recently?
- Did you ever think about suicide?
- Have you ever attempted suicide?
- Do you have a plan for suicide?
- What is your plan for suicide?

For **children and adolescents** evaluated in the emergency department, the ASQ screening tool has value in identifying risk for suicidal behavior, just as it does in adults. The child or adolescent should be asked about risk factors, suicidal thoughts, and intent. Clinicians should interview adolescents with their parents as well as separate from parents, as interviewing the patient alone may enable a more open discussion about suicidal ideation and behavior. Confidentiality should not be promised, since it cannot be maintained under these circumstances.



Once a child or adolescent has disclosed suicidal ideation, an assessment of risk should be done, which includes:

- Content and chronicity of the suicidal thoughts
- Existence and details of a suicide plan
- Access to the means described in the plan
- Level of intent
- Stressors, emotional pain, behavior regulation, and social support
- Substance abuse
- Functional impairment
- Lack of developmental progress

When children or adolescents are in an acute suicidal crisis, the focus of intervention is safety until the suicidal state abates. In the emergency room they should have one-to-one attention until the seriousness of the intent is evaluated by the appropriate clinician.

Disposition of suicidal children or adolescents from the emergency department will depend on the immediate risk of suicide. In almost all instances, psychiatric hospitalization for evaluation and therapy is indicated (Kennebeck & Bonin, 2017).

### **ASSESSING FOR RISK OF HARM TO OTHERS**

The clinician should note whether the patient expresses feelings of being threatened or indicates having violent thoughts, or if the person expresses hostile or violent intent toward a specific person or person(s). It should be remembered that the more intimate the relationship between the patient and intended victim, the more likely the threat will be carried out (Gemma, 2013).

Because of the danger to themselves and others in aggressive patients, it is important for clinicians to recognize **common predictors of violence**. These include:

- A history of recent acts of violence
- Intoxication with alcohol or drugs
- Possession of a potential weapon
- Situations that lead to violence (overcrowding, arbitrary rules, apparent favoritism)
- Signs and symptoms of violence (hyperactivity, restlessness, clenched jaw, fierce facial expression, increasing tension, mumbling to self, clenched fist, profanity, loud voice, soft voice, argumentative, avoidance of eye contact, intense eye contact)



Guidelines caregivers can use to assess anger and violence in patients include:

- Hyperactive, irritable, impulsive behavior
- Risk factors: wish or intent, plan to harm, means to carry out plan
- Demographic factors: male aged 14 to 24 years, low socioeconomic status, lack of support system, limited coping skills, frequent use of intimidation to meet needs
- Intolerance of limit-setting by authorities

When a patient presents with a threat of harm to self or others, or when such a threat is thought to exist, an emergency psychiatric evaluation is requested (Gemma, 2013). If there is a violence risk and for some reason the patient must be released, steps must be taken to protect any identifiable victims. Most states have “duty to warn” laws that either require or permit specified healthcare professionals (psychiatrists, physicians, social workers, psychologists, mental health nurses, and others) to disclose information about patients who might be violent in order for intended victim(s) to be warned. The intended victim(s) will be notified as well as law enforcement (NCSL, 2015).

#### **CASE: Assessing for Risk of Suicide and Harm to Others**

Jason, a 15-year-old adolescent, was brought by police from the local high school to the hospital emergency department after a classmate informed a teacher that Jason had a gun and was threatening to use it “on myself or somebody else.” Police were called, the gun in his locker was confiscated, and he was brought to the ED for evaluation. Jason’s father was notified and was on his way.

When Jason arrived at the ED, he initially refused to speak to anyone or answer any questions. He was taken by Alan, an RN, to an examination room, where he was asked to undress and put on a hospital gown. His clothing and other belongings were bagged, labeled, and removed from the room. During this time, Alan remained in the room, talked quietly to Jason, and asked him if he wanted something to drink. Jason shook his head no. Alan then said, “You haven’t been having a good day so far. Is that right?”

Jason looked at Alan and became tearful. Alan then stated, “I understand you’ve been thinking about hurting yourself or someone else.” Jason nodded yes and began to sob quietly.

Utilizing the ASQ suicide risk screening tool, Alan asked Jason, “Over the past few weeks have you wished you were dead?” Jason nodded his head to indicate a yes.

“In the past few weeks, have you felt that you or your family would be better off if you were dead?” Jason said, “I know I would be better off!”

“I see,” said, Alan. “And over the past week have you been having thoughts about killing yourself?” Jason replied simply, “Yes.”





“So, Jason, have you ever tried to kill yourself in the past?” “No,” said Jason, “I’ve never felt this way before.”

“I understand you had a gun in your possession, Jason. Was that part of a plan for suicide?” Jason replied that it was.

Alan tried to assess the level of Jason’s intent, but he was only able to determine that there was no substance abuse involved and that Jason really had no definite plan other than to “shoot myself.” Jason would not talk about any stressors or emotional issues and said everything was “good at home and school.”

Alan then began an assessment of the risk for harm to others by asking, “It is also my understanding that you said you might want to kill someone else with the gun. Is that correct?” Jason refused to answer.

Alan determined that Jason demonstrated no common predictors of violence other than that he was a male between the ages of 14 to 24 and had possession of a weapon, which he said he took from his father’s gun cabinet.

Because of the positive ASQ screening and the potential for harm to others, an immediate psychiatric consult was ordered. While awaiting the arrival of the psychiatrist, Jason continued to cry. Alan asked him, “Tell me how you’re feeling right now,” and Jason replied, “Angry! Angry!”

“What has been happening to make you feel that way?” Alan then asked. Jason shook his head and said, “I can’t tell anyone.”

During the psychiatric evaluation Jason divulged that a neighbor had been sexually molesting him for the past month, threatening him, and swearing him to secrecy. He admitted to the psychiatrist that he was feeling ashamed and angry with himself for not telling anyone and angry enough at the neighbor to want to kill him. He said he did not want his parents to know what has been going on and asked the psychiatrist not to tell them. The psychiatrist told him he could not promise to keep that confidential.

When Jason’s father arrived, the psychiatrist interviewed both Jason and his father together, during which time Jason did not reveal the neighbor’s behavior. Jason’s father said he had noticed that Jason was not his usual cheerful self lately, but that Jason always denied there was anything wrong whenever he was asked.

The psychiatrist then met separately with the father and informed him of the situation, telling him that the police would be involved, and discussed the recommendation that Jason be admitted to the hospital for evaluation, both medically and psychiatrically.



## MENTAL HEALTH CRISIS EMERGENCY MANAGEMENT

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A mental health emergency is considered a life-threatening situation. The person is imminently threatening harm to self or others, severely disoriented or out of touch with reality, functionally disabled, or extremely distraught and out of control.

Very often such aggressive, violent patients are psychotic or have substance abuse issues, but it must never be assumed that the cause of the behavior is a mental disorder or intoxication, including those patients known to have a psychiatric disorder or an odor of alcohol on their breath.

During such emergency crises, management and evaluation must occur simultaneously. Often these patients are unable or even unwilling to provide a clear history, and other sources must be found and consulted as rapidly as possible. This might include family members, friends, therapists or caseworkers, and medical records. Confidentiality is waived during psychiatric or medical emergencies, allowing for collection of such collateral data (USDHHS, 2014).

When working with an agitated and/or aggressive person there are four main goals:

- Ensure the safety of the patient, staff, and others in the area
- Help the patient to manage emotions and distress and to regain and maintain control of behavior
- Avoid the use of restraints whenever possible
- Avoid coercive interventions that can escalate agitation

(Moore & Pfaff, 2017)

### De-escalation

The first step in responding to mental health emergencies is to attempt de-escalation. This is key to helping the patient become an active partner in evaluation and treatment. When a patient is unable to control emotions or behaviors, the following de-escalation techniques have been found to be frequently successful in less than five minutes.

- **Remove from stimuli.** The physical environment can make a patient feel threatened and/or vulnerable. Removal from a noisy environment to a quieter space helps reduce a patient's stress and frustration.
- **Respect personal space.** Remain two arms'-length distance from the patient and maintain an unobstructed path out of the room for both the patient and staff.
- **Set clear limits and expectations.** Tell the patient that injury to self or others is unacceptable and that violence or abuse cannot be tolerated.



- **Minimize provocative behavior.** It is important to remain calm and to speak in a calm voice. Movements should be slow and actions should be announced prior to initiating them. Avoid touching the person unless asking permission first.

Posture and behaviors can make a patient feel threatened and/or vulnerable so a calm demeanor and facial expression should be maintained. Keep hands visible and unclenched, as concealed hands might imply a hidden weapon. Avoid confrontational body language such as hands on hips, arms crossed, directly facing the patient, and continuous eye contact.

- **Establish verbal contact.** If possible, the first person to contact the patient should be the staff leader. Otherwise designate one or limited staff members to interact with the patient. Introduce self and staff and orient the patient to the emergency department or facility and what is to be expected. Reassure the patient that he or she will be helped. Recognize that the person in the midst of a mental health crisis emergency may be unable to clearly communicate thoughts, feelings, or emotions.
- **Use concise and simple language.** Agitated patients may be impaired in their ability to process information. Repeating the message and allowing adequate time for the patient to respond can be helpful.
- **Use active listening skills.** Identify feelings and desires. Listen attentively and empathize with the person's feelings. (See also "Communication Techniques" earlier in this course.)
- **Agree or agree to disagree.** Use fogging, an empathic behavior in which one finds something about the patient's position upon which to agree. "Yes, I agree with what you said."
- **Collaborate.** Use a collaborative approach with the goal of helping the patient calm him/herself.
- **Offer choices and optimism.** Realistic choices aid in empowering the patient to regain control and feel like a partner in the process.
- **Do not:**
  - Criticize the patient
  - Argue with the patient
  - Interrupt the patient
  - Respond defensively
  - Take the patient's anger personally
  - Lie to the patient
  - Make promises about something that may not happen
- **Debrief the patient and the staff.** If an involuntary intervention is indicated, debriefing may help restore the working relationship with the patient and help staff plan for possible



future interventions. Debriefing should involve an explanation as to why the intervention was necessary, and the patient should be asked to explain his or her perspective of the event. Options or alternative strategies should be discussed with the patient and with staff should the situation arise again.

(Moore & Pfaff, 2017; Chun et al., 2016)

De-escalation, when effective, can avoid the need to use restraints. It is important to remember that taking the time to de-escalate the patient and working collaboratively as the patient settles down can be much less time-consuming than placing the person in restraints, which requires additional resources during the application and during the period following application.

## **Restraints and Seclusion**

When people in crisis become so distressed that they are a danger to themselves or others, it may be necessary to place them in restraints or to isolate them. Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is prevented physically from leaving. It may be used only for the management of violent or self-destructive behavior. A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes the patient or reduces the ability to move arms, legs, body, or head freely. Such a restraint may only be used to ensure the immediate physical safety of the patient, a staff member, or others.

Seclusion and restraints are safety measures of last resort and not treatment interventions. Restraints and seclusion do nothing to relieve the patient's emotional suffering, they do not change behavior, and they do not help people with serious mental illness to better manage the thoughts and emotions that trigger behaviors that can injure themselves or others.

### **WHEN THEY MAY BE USED**

Restraints and seclusion may be used only when absolutely necessary or when patients request seclusion to reduce sensory stimulation. If restraints or seclusion are deemed essential, a physician may prescribe them but must specify the length of time they may be used, for example, "for 2 hours within a 12-hour period of time."

Physical restraints should be applied only by healthcare professionals who are adequately trained in correct techniques and in protecting patient rights and safety.

Currently there remains a lack of consensus about the use of seclusion and restraints. There are as yet no uniform national standards over how and when to use restrictive measures. Few states even require the reporting and investigation of deaths in private or state psychiatric facilities, and the federal government does not collect data on how many patients are injured or killed by these techniques (MHA, 2015).

Because history is replete with accounts of the excessive use of restraints and seclusion, current state laws and recent court decisions affirm that least restrictive measures must be used. (See also



“Ethical and Legal Issues: Restraint/Seclusion” later in this course.) A stated principle of mental health law, the doctrine of “least restrictive alternative” is an important concept that applies to the care of patients. This doctrine affirms that caregivers must use the least restrictive means to achieve a specific end. For example, if four-point restraint of both arms and both legs is enough to protect disturbed patients from harming themselves or others, they may not be placed in five-point restraint of the waist, both arms, and both legs.

## CHEMICAL RESTRAINTS

A drug is considered a chemical restraint when it is used to manage a patient’s behavior or to restrict a patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

Chemical restraints are medications such as typical and atypical antipsychotics and benzodiazepines used to restrain agitated or out-of-control persons in mental health emergencies. Medications have been considered less invasive than physical restraint and seclusion. Currently, however, no drugs have been approved by the U.S. Food and Drug Administration for use as chemical restraints, and Black Box warnings for the off-label use of medications have been issued (Kincaid & Tomasso, 2013).

There remain unresolved issues concerning the use of chemical restraints:

- Are chemical restraints ever appropriate?
- If appropriate, what are the reasonable thresholds for their appropriate use?

Most experts agree that verbal de-escalation is the first choice, considering physical restraints as the last resort. Concerning chemical restraints, the agreement is that the “ideal” medication should calm without over-sedating, and oral or inhaled formulations should be preferred over parenteral routes. Intravenous treatments should be avoided (Garriga et al., 2016; Mattingly, 2016).

### CASE: Use of Restraints

Jerry, a known mental health patient with bipolar disorder, was admitted at 8:30 p.m. to the secure unit of the Mental Health Care Center under a 72-hour hold for evaluation. He had been brought in by the police because of his bizarre behavior in the local mall, grabbing and shoving people toward an exit and shouting at them to “get out of here, right now! We’re under attack!” During the night, he was cooperative, but he remained agitated and argumentative.

In the morning, Jerry was taken by a psychiatric technician to the interview room for evaluation by the psychiatrist, the psychiatric nurse, and the social worker. Initially he was euphoric, grandiose, and very friendly. As the evaluation proceeded, he suddenly became more agitated. Attempts were made to help him gain control, but at one point, he jumped out of his chair, ran to the psychiatrist, and punched him in the face. The psychiatrist fell backward in his chair and hit his head against the wall. The psych tech picked up the phone and dialed for a “Doctor Green.”



Using de-escalation techniques, the nurse and the social worker attempted to calm Jerry down, but he became more belligerent and threatening and took several swings with his fists at the staff. In less than a minute, the five-member “Doctor Green” team arrived and took Jerry down to the floor. The team then made the decision to apply restraints based upon the fact that Jerry was physically combative and a danger to others, unable to be subdued using de-escalation methods, and further delay in the use of restraints might subject other staff persons to the risk of harm.

The restraint gurney was brought in, and Jerry was placed on his back in four-point leather restraints. The head of the gurney was raised 30 degrees to avoid aspiration. While restraints were being applied, the team leader explained to Jerry what they were doing and why. The other four members of the team each applied a restraint to an extremity and made certain the devices were secured to the gurney frame and that circulation to the extremities was not compromised.

While Jerry was being restrained, the nurse assessed the patient for immediate first aid needs and called the medical staff to evaluate his status.

Jerry was taken to an isolation room, and within an hour a member of the medical staff came to conduct a face-to-face evaluation of the need for restraints. Jerry continued to threaten harm to staff persons. Following the assessment, an order was written for restraints to be used for the maximum of four hours per Joint Commission standards.

A psychiatric nurse was assigned to remain in the room with Jerry to continually assess, monitor, and reevaluate him for the continued need for restraints.

## Assessment

Once the patient’s behaviors are under control and safety is secured, assessment continues in order to determine the underlying cause of the patient’s presentation. An assessment involves obtaining medical and psychosocial histories; conducting physical, neurological, and mental status examination; and assessing for risk of suicide and harm to others.

### RULING OUT MEDICAL CONDITIONS

The priority in assessment is to rule out medical conditions as the cause of the patient’s psychiatric symptoms. All patients should have a detailed history, a complete physical examination, including neurological, and mental status examinations before medical stability can be concluded.

Criteria that can be used to aid in identifying a medical cause of psychiatric symptoms include:

#### Organic Clues

- Age less than 12 or older than 40
- Sudden onset (within hours to days)



- Fluctuating course
- Disorientation
- Decreased consciousness
- Visual hallucinations
- No psychiatric history
- Emotional lability
- Abnormal vital signs
- Abnormal physical exam findings
- History of substance abuse

### **Psychogenic Clues**

- Age 13 to 40 years
- Gradual onset (weeks to months)
- Continuous course
- Scattered thoughts
- Awake and alert
- Auditory hallucinations
- Psychiatric history
- Flat affect
- Normal physical exam findings

(Emembolu & Zun, 2010)

A rapid blood glucose determination and pulse oximetry should be obtained on all acute psychiatric patients. A consensus exists among emergency physicians, however, that other laboratory and other diagnostic testing needs to be individually determined, based upon history and clinical presentation rather than blanket profiles.

Additional studies that may be useful in selected patients include serum electrolytes, blood and urine toxicology screening, serum ethanol, thyroid screening, and cranial imaging. An ECG may be useful in assessing an older adult (ACEP, 2014; Moore & Pfaff, 2017).

### **MENTAL STATUS EXAMINATION**

After the physical and neurological examination is completed, a mental status examination (MSE) should be done to evaluate critical areas of cognition and emotion. A systematic approach to assessing mental status is a key element in the identification of alterations in mental status and for directing diagnostic testing and management.

Although there are standardized tools to accomplish this, the exam remains primarily subjective beginning when the patient enters the healthcare setting. In an emergency, clinicians may need to



modify the examination; however a complete mental status examination includes the following (see table below):

<b>BASIC ELEMENTS OF A MENTAL STATUS EXAM</b>	
<b>Head</b>	<b>Head</b>
Personal Information	<ul style="list-style-type: none"> <li>• Age</li> <li>• Sex</li> <li>• Marital status</li> <li>• Religious preference</li> <li>• Ethnic background</li> <li>• Employment</li> <li>• Living arrangements</li> </ul>
Appearance	<ul style="list-style-type: none"> <li>• Grooming and dress</li> <li>• Hygiene</li> <li>• Motor activity</li> <li>• Facial expression, eye contact</li> <li>• Height, weight, nutritional status</li> <li>• Posture</li> <li>• Unique body markings, scars</li> <li>• Appearance related to stated age</li> </ul>
Behavior	<ul style="list-style-type: none"> <li>• Body movement: excessive or reduced</li> <li>• Peculiar movement: scanning, gesturing, balance, gait</li> <li>• Abnormal movement: tremors, teeth chattering</li> <li>• Eye contact</li> <li>• Attitude toward examiner: hostile, friendly, defensive, cooperative</li> </ul>
Speech	<ul style="list-style-type: none"> <li>• Rate: slow, rapid, normal</li> <li>• Volume: loud, soft, normal</li> <li>• Disorganized, rapid</li> <li>• Quantity</li> </ul>
Affect and Mood	<ul style="list-style-type: none"> <li>• Affect: flat, bland, animated, angry, withdrawn, appropriate to context, expansive, constricted</li> <li>• Mood: sad, labile, euphoric</li> </ul>
Thought	<ul style="list-style-type: none"> <li>• Process: coherent, flight of ideas, neologism, thought blocking, circumstantiality, tangential, loose associations, word clanging, punning</li> <li>• Content: delusions, obsessions, suicidal ideations, homicidal ideations, poverty</li> </ul>





Perceptual Disturbances	<ul style="list-style-type: none"> <li>• Hallucinations: auditory, visual</li> <li>• Illusions: perceptual misinterpretations</li> </ul>
Cognition	<ul style="list-style-type: none"> <li>• Orientation as to time, place, person</li> <li>• Level of consciousness: alert, confused, clouded, stuporous, unconscious, comatose</li> <li>• Memory: remote, recent, immediate</li> <li>• Fund of knowledge (historically accumulated and culturally developed knowledge essential for functioning and well-being)</li> <li>• Abstractions: performance on tests involving similarities, proverbs</li> <li>• Insight into problems</li> <li>• Judgment</li> <li>• Impulsivity</li> </ul>
Source: Brannon, 2016.	

Legally, obtaining consent is a must for anything other than a routine physical examination. If a mental status examination is conducted against the patient’s will, it is considered assault with battery. Therefore, it is important to secure the patient’s permission or to document that a mental status examination is being done without the patient’s approval in an emergency situation (Brannon, 2016).

### CLINICAL INTERVIEW

An emergency psychiatric evaluation is often requested when a patient presents with an immediate harm to self or others, when such a threat is thought to exist, or when there is a need to identify a psychiatric diagnosis. A clinical interview is conducted face-to-face to gather pertinent data and explore the presenting problem. The interview method is modified to match the circumstances, age, and cognitive ability of the person in crisis. Data collection is enhanced by information gathered from family members, other healthcare providers, and authorities such as police officers. Assessment includes the person’s perception of the event, situational supports, and coping skills. (See also “Crisis Intervention Model: Stage 1” earlier in this course.)

Having a psychiatrist available to see patients either in person or via telemedicine has been shown to decrease the need for inpatient admission. Telemedicine can be an effective tool for patient evaluation, allowing for access to care in an emergency setting (Wiler et al., 2014).

The face-to-face clinical interview should take place in a quiet, safe environment, and the maintenance of such an environment should be emphasized to the patient at the beginning. Patients may require medication prior to being interviewed, and if a patient is potentially assaultive, it is best that the interview be conducted with multiple staff members present.



If the patient is in restraints, the initial step should be to let the patient know what is required in order to have the restraints removed. If the patient is not restrained, the clinician should not block exit from the interview area or be situated in such a way that there is no escape.

The clinical interview begins with identification of the **chief complaint** followed by the **history of present illness**. If the patient is capable, a longitudinal history of the course of the illness can be explored; but if the patient is too impaired to completely participate, the emphasis should be on the current episode. The history of present illness should include information about how the patient was functioning prior to the episode, the current symptoms, whether there is a **past history** of prior episodes, and what the precipitating factors were. It is also important to examine recent or chronic stressors and their severity and to assist the patient to connect the stressors to the symptoms of the current crisis.

The patient should be asked about any psychiatric history, past treatment, and illness episodes. It is important to remember that a denial of a history of mental illness in the past should not be accepted without further inquiry, as stigma may play a significant role in unwillingness to disclose such a history.

A **review of systems** should be done to attempt to discover other issues not brought up during the history of present illness (Scher, 2016; Moore & Pfaff, 2017).

## **Mental Health Crisis Emergency Etiologies**

Mental health crisis emergencies can arise due to a medical condition, substance use or abuse, or a psychiatric disorder.

### **MEDICAL CONDITIONS**

The most common causes for severe mental status changes in patients admitted to the emergency department are organic (e.g., delirium as a result of a general medical illness) and not psychiatric.

Numerous acute and chronic medical conditions frequently encountered in a mental health crisis emergency can mimic psychiatric disorders. The first priority in a mental health crisis emergency is to determine whether the symptoms are caused by a psychiatric disorder or whether the changes reflect manifestations of an acute or chronic medical condition. Such medical conditions may include but are not limited to:

#### **Endocrine diseases**

- Myxedema madness
- Cushing's disease
- Insulinoma
- Pheochromocytoma
- Hypoglycemia



### **Metabolic diseases**

- Acute intermittent porphyria
- Tay-Sachs disease
- Accumulation of toxins from severe liver or kidney disease
- Electrolyte disturbance

### **Deficiency states**

- Thiamine deficiency (Wernicke-Korsakoff syndrome)
- Pellagra and other complex vitamin B deficiencies
- Zinc deficiency

### **Autoimmune diseases**

- Systemic lupus erythematosus
- Hashimoto's encephalopathy

### **Central nervous system infections**

- Toxoplasmosis
- Cerebral malaria
- HIV
- Neurosyphilis
- Herpes simplex cephalitis

### **Seizure disorders**

- Temporal lobe epilepsy

### **Progressive neurological diseases**

- Multiple sclerosis
- Alzheimer's disease
- Pick's disease

### **Space-occupying lesions**

- Brain tumors
- Bleeding
- Brain abscess

### **Other**

- Stevens-Johnson syndrome
- Sepsis
- Urinary tract infections (often missed)



- Medication reactions related to a medical condition

(McKee & Brahm, 2016)

### **MANAGING A PATIENT WITH DELIRIUM**

The ultimate goal for management is identification and treatment of the underlying medical condition. While evaluation is being done, the following measures are helpful in managing a patient with delirium:

- Provide a calm environment. Increased levels of visual and auditory stimulation can be misinterpreted.
- Orient the patient to the surroundings, staff, and necessary activities. Identify self by name with each contact. Increased orientation ensures greater degree of safety.
- Ask a family member or significant other to remain with the patient to enhance the patient's level of comfort.
- Orient the patient frequently to time, place, and person.
- Repeat questions if necessary and allow adequate time for response.
- Observe the patient's behavior and attempt to identify the message, emotion, or need being expressed.
- Provide safety needs with one-on-one supervision.
- Monitor the patient for further decline in mental status

Source: Wayne, 2017.

### **SUBSTANCE USE**

Mental health emergencies can result from the use of illicit intoxicants, any use of a prescription medication outside the direction of the prescriber, or excessive use of legal substances such as alcohol. Other emergencies can arise from prescription medication interactions, and in rare instances, very sensitive individuals can experience psychosis as a side effect of a medication even when taking it as prescribed.

People in crisis often resort to mind-altering substances to dull their senses, lift their spirits, or in some way relieve their discomfort. Usually, they appear in emergency departments because they have been brought there by someone else for some other reason than abuse of a substance.

Studies have shown that almost one third of persons with a mental illness and almost one half of persons with severe mental illness also experience substance abuse. Likewise, more than one third of all alcohol abusers and one half of all drug abusers have mental illness (NAMI, 2017).



### ***Causes of Substance-Induced Psychoses***

Drug-induced psychotic symptoms can result from **intoxication** due to:

- Alcohol
- Stimulants (amphetamines and related substances, crack, cocaine)
- Marijuana
- Hallucinogens (LSD, phencyclidine, ecstasy)
- Inhalants (glue, paint thinner, lighter fluid)
- Opioids
- Sedatives
- Hypnotics
- Anxiolytics
- Unknown substances

Psychotic symptoms can also be due to **withdrawal** from:

- Alcohol
- Sedatives
- Hypnotics
- Anxiolytics
- Unknown substances

Other causes of psychotic symptoms may result from taking too much of a certain drug or having an adverse reaction from mixing substances. In some people, **over-the-counter or prescription medications** may induce psychotic symptoms. These may include, but are not limited, to:

- Analgesics
- Anticonvulsants
- Antihistamines
- Antimicrobials
- Anti-Parkinsonian medications
- Chemotherapeutic agents
- Corticosteroids
- Gastrointestinal medications
- NSAIDS



- Antidepressants
- Antihypertensive and cardiovascular medications

**Additional toxins** to rule out which may induce psychotic symptoms include:

- Organophosphate insecticides
- Carbon monoxide
- Carbon dioxide
- Volatile substances such as fuel or paint

(EMD, 2017; AAC, 2017)

### ***Recognizing Signs of Substance-Induced Psychoses***

Clinicians routinely assess patients for substance use, especially when they exhibit bizarre behavior typical of mind-altering substances. When people do not know or will not tell caregivers what substance they have taken, clinicians look for typical signs of stimulants, depressants, inhalants, hallucinogens, intoxicants, opiates, and other drugs. Signs of intoxication by the most common types of drugs are described in the following table.

<b>SIGNS OF INTOXICATION</b>	
<b>Substance</b>	<b>Typical Signs</b>
<b>Alcohol</b>	<ul style="list-style-type: none"> <li>• Clumsiness</li> <li>• Difficulty walking</li> <li>• Slurred speech</li> <li>• Sleepiness</li> <li>• Poor judgment</li> <li>• Dilated pupils</li> <li>• Odor of alcohol</li> </ul>
<b>Marijuana</b>	<ul style="list-style-type: none"> <li>• Glassy, red eyes</li> <li>• Loud talking and inappropriate laughter followed by sleepiness</li> <li>• A sweet burnt scent</li> </ul>
<b>Stimulants</b> (cocaine, crack, methamphetamine, amphetamines, and related substances)	<ul style="list-style-type: none"> <li>• Hyperactivity</li> <li>• Euphoria</li> <li>• Irritability</li> <li>• Anxiety</li> <li>• Excessive talking followed by depression or excessive</li> </ul>



	<p>sleeping at odd times</p> <ul style="list-style-type: none"> <li>• Failure to eat or sleep</li> <li>• Dilated pupils</li> <li>• Dry mouth and nose</li> </ul>
<p><b>Opiates</b> (heroin, morphine, codeine, methadone, hydromorphone)</p>	<ul style="list-style-type: none"> <li>• Needle marks</li> <li>• Sweating</li> <li>• Vomiting</li> <li>• Coughing and sniffing</li> <li>• Twitching</li> <li>• Contracted pupils</li> <li>• No response of pupils to light</li> </ul>
<p><b>Depressants</b> (including barbiturates and tranquilizers)</p>	<ul style="list-style-type: none"> <li>• Appearing drunk from alcohol but without associated odor of alcohol</li> <li>• Difficulty concentrating</li> <li>• Clumsiness</li> <li>• Poor judgment</li> <li>• Slurred speech</li> <li>• Sleepiness</li> <li>• Contracted pupils</li> </ul>
<p><b>Hallucinogens</b> (mescaline, LSD, psilocybin)</p>	<ul style="list-style-type: none"> <li>• Dilated pupils</li> <li>• Bizarre and irrational behavior</li> <li>• Paranoia</li> <li>• Aggression</li> <li>• Hallucinations</li> <li>• Slurred speech</li> <li>• Confusion</li> </ul>
<p><b>Inhalants</b> (glues, aerosols, vapors)</p>	<ul style="list-style-type: none"> <li>• Watery eyes</li> <li>• Impaired vision, memory, thought</li> <li>• Secretions from the nose or rashes around the nose and mouth</li> <li>• Appearance of intoxication</li> <li>• Drowsiness</li> <li>• Poor muscle control</li> <li>• Anxiety</li> <li>• Irritability</li> </ul>
<p>Source: ACDE, 2017.</p>	



When a person uses drugs or alcohol, the body can develop homeostasis with the substance, and as soon as the substance is taken away, the balance is upset. This causes withdrawal symptoms. Each person withdraws from these substances differently, and withdrawing from alcohol and tranquilizers can be the most dangerous process leading to serious complications and even death. Signs and symptoms that are present when an individual is experiencing an emergency mental crisis due to **withdrawal** may include:

- Sweating
- Tachycardia
- Heart arrhythmias, palpitations
- Muscle tension
- Tightness in the chest
- Difficulty breathing
- Tremor
- Nausea, vomiting, diarrhea

Additional dangerous consequences of withdrawal may include:

- Grand mal seizures
- Heart attacks
- Strokes
- Delirium tremens (DTs) characterized by hallucinations, mental confusion, and disorientation

Withdrawal from opiates is uncomfortable but not dangerous unless they are combined with other drugs (Melemis, 2017).

### ***Evaluation and Management of Patients***

Evaluation should be done to ensure no medical illness or injury is the cause of the patient's presentation. All intoxicated patients should be undressed so that all body surface areas can be assessed. A physical examination, vital signs, and neurological exam are performed, as well as diagnostic studies deemed appropriate. Whenever possible, a history of substance use should be obtained.

Management of an intoxicated individual is largely supportive, which includes airway protection, thermal regulation, maintenance of adequate tissue perfusion, and seizure prevention.

In cases of a drug overdose, the time of ingestion should be obtained and whether the ingested substance was a sustained or immediate-release drug. A toxicology screen is





often done to rule out coingestants (such as acetaminophen or aspirin) that could complicate treatment.

Medications may be administered, such as anti-toxin (e.g., activated charcoal) for drug overdose, thiamine for chronic alcohol use, or naloxone for opiate overdose.

Depending on the circumstances and intent behind the crisis, the patient may require hospitalization. In other situations, a period of observation is often the recommended choice to monitor mental status and to identify hidden or subtle problems. When planning discharge following resolution, the patient's clinical condition and support network resources for follow-up care are considered (Black, 2015).

## **MENTAL HEALTH DISORDERS**

Certain psychiatric disorders make the person more prone to crisis than others. When precipitating events occur in the lives of people with major mental illnesses, they may become so distressed that they seek help in an emergency department or by means of a crisis hotline. This is not surprising, since the coping skills and support systems of these individuals often are limited.

### ***Personality Disorders***

People with personality disorders, especially borderline and antisocial, characteristically may present in crisis. Such patients can present with a wide range of symptoms and behaviors including:

- Behavioral disturbance
- Cutting and other self-injurious behavior
- Impulsive aggression
- Short-lived psychotic symptoms
- Intense anxiety, depression, or anger

These individuals can be dramatic, provocative, and attention-seeking. They can also be involved in power struggles and use passive-aggressive communication. They also have a poor understanding of the norms of interpersonal relationships.

Persons with borderline personality disorder see everything in “black or white,” “all or nothing,” or “good or bad” terms. This thinking makes them vulnerable to emotional storms and impulsive behaviors. They are often fearful of and make frantic attempts to avoid real or imagined abandonment. Recurrent suicidality is a central feature of this disorder and is often the focal point for treatment.

People with borderline personality disorders can become overwhelmed, needy, easily frustrated, and agitated. They are often hypersensitive to criticism, and anxiety resulting



from the perception that they are being poorly treated or ignored is a common trigger for acting out (NIMH, 2016a; Pozesny, 2015).

Crisis intervention with patients who have borderline personality disorders requires that every attempt be made to ensure treatment provided is in conjunction with the patient's attending physician or primary therapist.

Dealing with the immediate problem is usually the key component to effective crisis management when a person with this disorder presents in a hospital emergency department, followed by discharge to the patient's usual care provider when emotions, impulses, and behaviors have been reduced to a manageable level.

The overall aim during the management of a crisis is to help the person return to a more stable level of mental functioning as quickly as possible without inducing any harmful effects that might prolong the problems. The person's autonomy should be maintained as far as possible, and the person's safety and that of others assured. Emotions, impulses, and behaviors should be reduced to a manageable level. Supportive and empathic comments are necessary in the first instance, and these may be particularly beneficial if the initial contact in the crisis is by telephone. Medication use should be limited and for only short-term use. Specific goals of treatment should be set (Bressert, 2017).

#### **TIPS FOR WORKING WITH PATIENTS WITH PERSONALITY DISORDERS**

- Try to understand the crisis from the patient's point of view.
- Explore the patient's reasons for distress.
- Use emphatic, open-ended questioning, including validating statements, to identify the onset and course of the current problems.
- Avoid minimizing the patient's stated reasons for the crisis.
- Refrain from offering solutions before receiving full clarification of the problems.
- Explore other options before considering admission to a crisis unit or inpatient unit.
- Avoid judgment and labeling as manipulative or attention-seeking.
- Expect a heightened vulnerability to rejection and situational stress.
- Do not take interactions personally.
- Avoid power struggles.
- Give choices as often as possible, with clear and reasonable limits.
- Do not react emotionally to behaviors.



- Do not threaten, give ultimatums, or set excessive restrictions, as they will give the patient reason to escalate.
- Spend time, if possible, talking with the patient to find out what he/she needs and wants.
- Try to accommodate needs if able and explain why if unable.
- Be aware of nonverbal communication.
- Explain what is happening and try to decrease anxiety as much as possible.
- Check back often with the patient.
- Expedite the process of evaluation.

### ***Mania***

Mania, the manic aspect of bipolar disorder (also known as manic-depressive disorder), is characterized by cycles of extreme mood swings and behavior. Manic individuals may be labile, anxious, or paranoid. They experience periods of unusually intense emotion; changes in eating, sleeping patterns, and activity levels; and unusual behaviors. Sometimes, a person with mania may experience psychotic symptoms such as hallucinations or delusions.

Manic episodes are periods of extreme elevation of mood when people feel expansive, energetic, grandiose, and sometimes irritable and short-tempered. They have a decreased need for sleep, are pressured to keep talking, may experience psychomotor agitation, and have an increase in goal-directed activity (either socially, at work or school, or sexually).

Patients experiencing a manic episode may harm themselves or others because of their poor impulse control. Because they may not eat or be able to sleep for several days, they may become exhausted to the point of death.

During a manic phase, patients often feel invincible and act impulsively with little regard for their personal safety or painful consequences. There is a high risk for intentionally or “accidentally” killing themselves. Often they are confused about why others are concerned about them, as they do not see anything wrong with their behaviors (NIMH, 2016b).

Patients experiencing a mental health emergency related to mania often require hospitalization to become stabilized on medications prior to returning home (Wayne, 2017). If patients are not cooperative and are a danger to themselves or others, emergency involuntary commitment may be necessary (see “Hospital Confinement” later in this course). To gain patients’ cooperation and communicate more effectively, clinicians:

- Decrease environmental stimuli to help reduce anxiety and manic symptoms.



- Use short and concise statements and explanations, as their short attention span limits understanding to small pieces of information.
- Use a calm but firm approach to provide structure and control.
- Frequently assess behavior for increased agitation to avoid the need for restraint.
- Remain neutral, and do not argue with the patient, as this can justify escalation.
- Maintain a consistent approach, expectations, and structured environment to minimize potential for manipulation of staff by the patient.
- Coordinate care with other staff members to avoid manipulation.

### ***Schizophrenia/Psychosis***

Schizophrenia, a catastrophic chronic psychotic disorder, can be either persistent or episodic. The hallmark features of this disorder include delusions, hallucinations, disturbed thought processes, flattened affect, and abnormal behaviors.

Delusions are fixed false beliefs that are not based in reality. Hallucinations involve seeing or hearing things that do not exist. In the person with schizophrenia these hallucinations have the full impact of a normal experience. Hearing voices is the most common hallucination.

Disorganized thinking, which impairs effective communication and can become meaningless, is evident by the person's speech. The person may make irrational statements or laugh inappropriately, and conversation may be illogical or incoherent. Paranoia may become apparent in statements such as, "My boss is poisoning me."

The person may have extremely disordered or abnormal motor behavior. Such behaviors may include resistance to instructions, inappropriate or bizarre posturing, a complete lack of response, and useless or excessive movements. During acute psychotic episodes, the person may act out hallucinations, such as breaking a window to "let the bears out."

Suicide is always a risk for persons with schizophrenia and is more likely to occur during an upswing of the illness, when symptoms have begun to abate (Gerstein, 2015).

Acute psychosis is a common mental health emergency, and verbal de-escalation should be attempted first. Other interventions include:

- Recognize that delusions are the patient's perception of the environment.
- Identify feelings related to delusions to reduce anxiety and let the patient know they are being understood.
- Explain procedures before carrying them out.
- Redirect to reality-based activity to help the patient focus attention externally.



- Give the patient a lot of space and do not touch the patient unless absolutely necessary, as a suspicious patient may misinterpret such gestures as sexual or aggressive.
- Avoid attempts to convince the patient that hallucinations or delusions are not real, as this increases defensiveness.
- Empathize with and reassure the patient of acceptance.
- Offer comforting options such as a meal, a blanket, or a pillow in order to decrease anxiety.
- Utilize standard safety measures.

If the patient continues to be agitated and display aggressive behaviors that pose a risk of harm to themselves or others, physical restraints should be considered. If physical restraints are used, medications may also be considered (Wayne, 2017).

### ***Major Depression***

Major depression is a mood disorder that interferes with activities of daily living and can distort how one perceives self, life, and the people around oneself. To the person with depression, everything is viewed negatively and problem-solving can be impaired. Depression may occur spontaneously without being associated with a life crisis, physical illness, or other risk. People with depression may come to an emergency department with somatic complaints such as unexplained abdominal pain or chest pain.

Depression can also present with psychotic features, including delusions, auditory hallucinations, or some other break with reality. Delusions are often mood-congruent and consistent with a depressed mood, and the auditory hallucinations (voices) may emphasize the patient's worthlessness. These delusions and/or hallucinations may cause the patient to feel humiliated or ashamed, and they may try to hide these feelings. People with psychotic depression may get angry for no apparent reason, reverse wake and sleep cycle, and neglect personal hygiene. They may worry excessively that they are sick to the point of debilitation.

Persons with depression frequently abuse alcohol and drugs to numb painful thoughts. These substances, however, trigger depressive symptoms. As a result, depression and substance abuse feed into each other, and one condition makes the other worse. A very serious concern for those with depression is the risk of accidental injury, self-harm, or suicide (Khav et al., 2013; Goldberg, 2017).

**Adolescents** with depression have most of those same symptoms, with the addition of the following:

- Anger or irritability, rather than sadness, as the predominant mood
- Frequent unexplained aches and pains, such as stomachaches or headaches



- Extreme sensitivity to criticism
- Unlike adults who isolate from everyone, withdrawal from some, but not all, people
- Symptoms of other disorders such as anxiety, eating disorders, or substance abuse
- Self-harming activities such as hitting or cutting

Younger **children** with depression may pretend to be sick, refuse to go to school, cling to a parent, or express fear that a parent may die. Older children may get into trouble in school, sulk, and be irritable (Smith et al., 2014; NIMH, 2016c).

The risk for suicide in people with major depressive disorder is higher than that of the general public. It is the tenth leading reported cause of death in the United States (Andrew, 2016). When depressed persons are judged to be a danger to themselves or others, clinicians must consider the need for emergency hospitalization (see also “Hospital Confinement” later in this course).

#### CASE: Depression

Juana came to the community counseling center for help. She told Mary, the counselor, that the man she had been dating left her and returned to Mexico to marry a girl from his home village. Juana burst into tears: “I don’t think I can live without him.”

Mary listened attentively and asked, “Have you been thinking about **not** living? Juana nodded and whispered, “Yes,” and began to sob. The counselor said, “And what have you thought about doing?” After a long pause, Juana said, “I just want to go to sleep and never wake up.”

With further interaction, Mary determined that Juana did not have a specific plan to end her life but was at risk of overdosing on alcohol or drugs, the most common means women use to commit suicide. She told Juana to refrain from taking alcohol in any form until she felt better; asked if Juana had a friend or relative who could stay with her for a few days, just to be there for her; gave Juana her card and the crisis hotline number to call if she felt like harming herself; and referred Juana to a support group of others who had suffered loss.

Eight days later, Juana was taken to the emergency department by a coworker, Liz, who stopped by to see why Juana had been absent from work for the past week. Liz said that she found Juana lying on the sofa, tearful, and saying she wanted to die.

When Juana arrived at the hospital emergency department, she was interviewed by a nurse, who obtained her history. Juana indicated she had not attended the recommended support group and had forgotten about the hotline number the counselor had given her. The nurse noted that Juana had a very flat affect, her speech and movements were slow, and she had problems understanding some of the questions asked. She was unkempt and admitted that she had not been eating or drinking much over the past week. She denied



using any medications or alcohol during this time. Juana told the nurse, “I don’t want to live anymore. I’m so tired.”

The nurse asked Juana if she was thinking of harming herself, and Juana replied that she was. She admitted that she was planning to lie in a tub of hot water and slit her wrists, but “I haven’t gotten the energy to do it so far.” The nurse assigned an ED tech to stay with Juana until the emergency department physician could see her.

The ED physician interviewed Juana, performed physical and neurological examinations to rule out medical conditions, and recommended she be hospitalized for treatment of major depression with the need for suicide precautions. Juana agreed to voluntarily enter the hospital.

### ***Anxiety Disorders***

People with anxiety disorders often seek treatment in the emergency department. Anxiety is a sudden intense feeling of fear caused by an imminent threat to one’s sense of security. Symptoms can range from mild anxiety to panic. A panic attack is the most extreme level of anxiety. Persons experiencing panic have a sudden, overwhelming fear, with or without cause, which produces hysterical or irrational behavior. They may behave automatically, lose touch with reality, and experience false sensory perceptions.

People experiencing a panic attack may come to the emergency department because they feel they are experiencing a heart attack, presenting with the following symptoms and signs:

- Chest pain or discomfort
- Dizziness or feeling faint
- Fear of dying, sense of doom
- Nausea
- Numbness or tingling in hands, feet, or face
- Irregular heartbeat, tachycardia, or pounding heart
- Sensation of shortness of breath or smothering
- Sweating, chills, or hot flashes
- Trembling or shaking

Evaluation must ensure that there is no underlying medical condition to explain these signs and symptoms.

Anxiety can cause symptoms that are similar to psychosis, but while the onset of psychosis is gradual and the person is unaware of a break with reality, in the individual experiencing anxiety, symptoms come on rapidly and fade rapidly. A common similarity



is the feeling of losing control. During an anxiety attack, the person may have an absence of emotions, have problems concentrating, and experience depersonalization (watching oneself out of one's body) (Berger, 2016; NIMH, 2016d).

The patient experiencing a panic attack should be told that the symptoms are not from a serious medical condition or from a psychotic disorder but from a chemical imbalance in the fight-or-flight response. It is important to listen, remain empathic, and avoid belittling the patient's concerns (Memon, 2016).

Self-harm is the most severe complication of acute anxiety and panic. The majority of persons experiencing acute anxiety or panic do not really want to die, but they genuinely want to break free from suffering. They may see suicide as a way to escape from oneself rather than from daily life.

Patients in crisis with anxiety disorders usually do not require hospitalization. Healthcare professionals encourage people with symptoms of anxiety to participate in planning their treatment. Social service intervention may be of benefit to explore resources for outpatient care. Patients with panic disorder are best served by referral to a psychiatrist.

## ETHICAL AND LEGAL ISSUES

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### Ethical Principles and Mental Crises

Ethical principles are fundamental concepts by which people make decisions. Healthcare professionals follow ethical standards of care at all times, whether or not a patient is in crisis. These standards are based on ethics, the branch of philosophy concerned with the rightness or wrongness of human behavior and the goodness or badness of its effects. However, in emergency circumstances where there is a need to intervene rapidly, caregivers may sometimes be challenged to remember the importance of such principles.

Ethical principles serve as general guides for behavior. There are four commonly accepted principles of healthcare ethics:

- Respect for autonomy
- Nonmaleficence
- Beneficence
- Justice

**Respect for autonomy** means respecting the right of self-determination, independence, and freedom. This principle implies that the patient has the capacity to act intentionally, with understanding, and without controlling influences that would negatively impact a free and voluntary act. This is the principle underlying the practice of "informed consent," wherein the provider gives factual, scientific, and relevant information about treatment, including benefits and risks. The issue of veracity or truth-telling is closely related to that of informed consent, as it





involves weighing paternalistic concerns against the autonomy interests of the patient (BRL at GU, 2016; McCormick, 2013).

When applied to mental health crises, autonomy means caregivers:

- Inform patients about treatment options and risks, making sure they understand
- Respect and accept decisions made by patients about their personal care
- Implement and evaluate interventions chosen by patients
- Hold in confidence all personal information, divulging it only when patients or their legal guardians give permission

**Nonmaleficence** means to do no harm, or to inflict the least harm possible, to reach a beneficial outcome. The pertinent ethical issue is whether the benefits of treatment or intervention outweigh the risks or burdens. The potential benefits of any treatment or intervention must outweigh the risks in order for the action to be ethical.

**Beneficence** means that healthcare providers have a duty to be of benefit to the patient. The principle implies that a patient can enter into a relationship with a person that society has licensed or certified as competent to provide healthcare, and that actions taken by such a person will help prevent or remove harm or simply improve that patient's situation.

When applied to mental health crises, beneficence means caregivers:

- Relate to patients professionally and objectively
- In consultation with other clinicians, follow treatment plans
- Choose the option that will do good and avoid harm
- Recognize that under certain conditions beneficence overrides autonomy and that compulsory treatment may be justified

**Justice** implies fairness and equality, requiring impartial treatment of patients. Like other ethical principles, justice is based on respect for human life and dignity (McCormick, 2013). The historic image of justice is a blindfolded woman with a scale, weighing an issue on the basis of objective evidence and judicial precepts. Justice means that scarce resources will be distributed equally, using the same criteria for everyone.

## Laws and Mental Health Crises

Laws flow from ethical principles and consist of rules about specific situations. These rules are enforced by an authority with the power to see that they are obeyed. In recent years, the number and scope of state, federal, and case laws that affect the treatment of people with psychiatric disorders has increased dramatically. Of special interest to those who care for people in crisis are



laws concerning civil rights, confidentiality, patient rights, treatment decisions, restraints, seclusion, and hospital confinement.

## **CIVIL RIGHTS**

Under federal and state laws, people with mental illness are guaranteed the same civil rights as every other citizen in the land. These laws guarantee the rights of all people to humane care, to interact socially, to press charges against others, to vote, to speak, to enter into contractual relationships, to make purchases, to obtain a license to drive an automobile, to follow religious practices, to participate in legal activities, and to travel within the United States. Some laws that address these rights include:

- Americans with Disabilities Act
- Fair Housing Amendments Act
- Civil Rights of Institutionalized Persons Act
- Individuals with Disabilities Education Act  
(Goldberg, 2016b)

## **CONFIDENTIALITY**

In 1996, to protect the privacy of individuals and the confidentiality of patient records at the dawn of the age of electronic data collection, the U.S. Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Phased in between 2000 and 2003, HIPAA provides that without the prior consent of patients or their legal guardian, medical records may not be read or copied. The act affirms the right to privacy and supports the concept of respect for all human beings.

## **PATIENT RIGHTS**

“Patient rights” refers to a general statement adopted by most healthcare professionals that covers matters including access to care, patient dignity, confidentiality, and consent to treatment. These basic rights include:

- The right to open and honest communication between the patient and the healthcare provider
- The right to informed consent based on the moral and legal premise of patient autonomy
- The right to confidentiality, subject to certain exceptions because of legal, ethical, and social considerations (i.e., risk of harm to self or others)
- The right to healthcare (although the right to healthcare in the United States is open to debate, the Consolidated Omnibus Budget Reconciliation Act [COBRA] and the



Emergency Medical Treatment and Active Labor Act [EMTALA] mandate an evaluation for patients seeking attention at emergency facilities regardless of ability to pay)

- The right to not be abandoned by a healthcare provider unless the patient is referred, transferred, or no longer requires treatment and is discharged
- The right to refuse care (exceptions occur for those without the ability to make a competent decision)

(Davis, 2016)

## TREATMENT DECISIONS

The Hospitalization of the Mentally Ill Act of 1964 requires that all patients in public hospitals have a right to treatment. Prior to that time, patients could be hospitalized for indefinite periods of time without treatment. Since then, the courts have ruled that patients must be cared for in a humane environment by sufficient numbers of qualified clinicians according to individualized care plans.

In other rulings, both federal and state courts have ruled that patients have the right to refuse electroconvulsive therapy and antipsychotic medications. Furthermore, according to the Federal Patient Self-Determination Act of 1990, patients have the right to prepare an “advance care directive” that will be respected in case they become incapacitated (NRCPAD, 2015).

## Restraint/Seclusion

To prevent injury in mental health crises, clinicians may need to restrain patients, administer tranquilizing drugs, or place patients in seclusion against their will. Similarly, when a patient is a danger to self or others, as with the patient who hears voices telling him to hurt himself, it may be necessary to call the authorities for emergency involuntary commitment. The individual is then restrained and taken to a locked facility for evaluation and treatment. These situations raise both legal and ethical issues, including the ethical dilemma created by the conflict of the ethical principles of autonomy and beneficence.

## HOSPITAL CONFINEMENT

Admission to the hospital related to a mental health crisis emergency may be either voluntary or involuntary.

- **Voluntary** means the patient is in control and decides when to enter the facility and when to leave.
- **Involuntary** means the patient does not have to agree to admission.

Discharge from the hospital depends on the status of patients at the time they were admitted. In general, those who entered voluntarily have the right to be released voluntarily unless their



condition changes significantly during their hospitalization. Some states provide a conditional release of people who were admitted voluntarily. Such a provision allows physicians or administrators to arrange for ongoing treatment on an outpatient basis.

**Emergency involuntary commitment** of people in crisis, also called **civil commitment**, is controlled by state statutes specifying the conditions under which people can be held against their will. In general, involuntary admission is permitted when people are a danger to themselves, a danger to others, or gravely disabled (unable to provide for their basic human needs such as food, clothing, shelter, health, or safety).

Many states give police officers, physicians, and certain mental health professionals authority to judge the mental status of individuals and to indicate the length of time they are to be held against their will. Often, that time is 72 hours, during which the person is evaluated and a plan of care is devised.

**Civil commitment for observation**, also called **temporary involuntary hospitalization**, is for a longer period of time than emergency hospitalization. Its primary purpose is observation, diagnosis, and treatment of people who have a mental illness or pose a danger to themselves or others. The length of time is specified by statute and varies from state to state. Application for this type of commitment can be made by a guardian, family member, physician, or other public health officer and may require a certificate affirming mental illness.

**Long-term commitment for involuntary hospitalization** is intended to give patients extended care and treatment. As with patients who undergo temporary involuntary hospitalization for observation, extended involuntary hospitalization can occur only with judicial or administrative action and medical certification. This type of involuntary hospitalization may be for 60 to 180 days or, under some circumstances, for an indeterminate period of time.

**Involuntary outpatient commitment** is a legal category of care that was initiated in 1990 following the doctrine of the least restrictive alternative. Involuntary outpatient treatment is court-ordered, community-based treatment for people with untreated severe mental illness. These individuals are often too ill to know they need medical care and have a history of medication and treatment noncompliance. The goal is to provide treatment before they require inpatient treatment by reducing homelessness, violence, and noncompliance. Opponents to this form of treatment feel it removes a patient's civil right to choose where and how to receive care.

Although every state and the District of Columbia have emergency involuntary commitment laws, state law varies on the length of such holds, who can initiate an emergency hold, extent of judicial oversight, and the rights of patients during the commitment. The main criterion that justifies an involuntary commitment is mental illness that results in danger to self or others, but many states have added further specifications. Only 22 states require some form of judicial review of the emergency commitment process, and only nine require a judge to certify the commitment before a person is hospitalized. Five states do not guarantee assessment by a qualified mental health professional during an emergency commitment (Hedman et al., 2016).



## THE DEBATE OVER INVOLUNTARY COMMITMENT

In the past, people could be hospitalized under the flimsiest of pretexts, by almost anyone, for nearly any length of time. It took nearly 200 years for the Fifth Amendment to the U.S. Constitution to be applied to mentally ill individuals. In *Humphrey v. Cady*, the U.S. Supreme Court (1972) recognized that involuntary civil commitment to a mental hospital was a “massive curtailment of liberty” and required “due process protections.”

Current debate between those who wish to preserve the status quo and those who want to change involuntary treatment and/or involuntary commitment laws to make it easier to treat the mentally ill has been going on for the past few years. There are several reasons for this trend:

- Media stories about mentally ill killers on the rampage are creating fear in the public.
- The public is becoming angry and feeling helpless at seeing so many homeless mentally ill people on the streets.
- Families are distressed over having to wait until an ill family member becomes a danger to self or others to get care. They believe laws should prevent dangerousness, not require it.

From a civil rights perspective, however, involuntary commitment creates a class of people who can be taken, however briefly, into police custody and then placed in “preventive” detention (incarceration). No other members of the public can be confined somewhere for something people believe they will do but have not yet done (danger to self or others).

“At its core, involuntary psychiatric commitment is a conflict among the desire of a family to care for a loved one, the need to feel safe from real or perceived danger, an individual’s civil liberties, and the imperative of psychiatry to respect patient autonomy while abiding by professional ethics” (Miller & Janson, 2016).

Both points of view have validity and remain in contention (Jaffe, 2011).

### CASE: Involuntary Commitment

Victoria, a 48-year-old woman with a long-standing manic disorder, built a fire on her living room floor, and when her husband tried to extinguish the fire, she attempted to stab him with a knife. She was taken by police to the emergency department and admitted involuntarily for treatment, where she accepted medications to help her sleep but declined to take any mood-stabilizing drugs. She said, “They make me feel like I’m moving in slow motion, going through Jell-O. I can’t stand them.”

The healthcare team recognized the dilemma among the three ethical principles of beneficence (providing treatment), autonomy (right of self-determination), and justice (fairness and equality).



In Victoria's case, a crisis situation, it was readily accepted that treatment with medications was clinically indicated and likely to be of benefit (beneficence). They also recognized that Victoria has significant mental illness and her ability to make informed decisions was seriously impaired (autonomy). The decision to involuntarily commit her was based on dangerousness evidenced by the attempt to stab her husband. Equal treatment would require Victoria to be charged with a criminal act (justice). Instead, Victoria was court-ordered to be detained and started on lithium 600 mg per day in three divided doses, recognizing that the potential benefits of the treatment outweighed the risks (nonmaleficence).

## CONCLUSION

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People can experience mental health crises for many different reasons. Some require a quick crisis intervention, and some require more in-depth interventions. All healthcare professionals have at least one time dealt with a crisis experienced by a patient, and using a systematic approach to helping these patients resolve a crisis is a skill that all healthcare providers should acquire.

Individuals experiencing an emergency-producing mental health crisis need immediate, appropriate, and sensitive care, whether the crisis is caused by a medical condition, substance use, or mental illness. Although clinicians who work in emergency departments and on crisis hotlines encounter these individuals every day, all healthcare professionals should be educated to rapidly assess, plan, and intervene in such emergency situations.

Mental health crises have a high risk for poor outcomes, and it is imperative that healthcare professionals respond appropriately following ethical principles and with regard for the legal issues that may be involved.



## RESOURCES

CERT training materials (FEMA)

<https://www.fema.gov/community-emergency-response-teams>

Core Elements for Responding to Mental Health Crises (SAMHSA)

<http://www.samhsa.gov>

National Suicide Prevention Lifeline

<https://suicidepreventionlifeline.org>

800-273-8255

Sober Recovery

<http://www.soberrecovery.com>

Violence prevention (CDC)

<https://www.cdc.gov/violenceprevention>



## REFERENCES

- Aguilera D. (1998). *Crisis intervention: theory and methodology* (8th ed.). St. Louis: Mosby.
- American Addiction Centers (AAC). (2017). How to identify substance abuse psychosis. Retrieved from <http://americanaddictioncenters.org/rehab-guide/drug-psychosis/>
- American College of Emergency Physicians (ACEP). (2014). Care of the psychiatric patient in the emergency department—a review of the literature. Retrieved from [https://www.acep.org/uploadedFiles/ACEP/Clinical\\_and\\_Practice\\_Management/Resources/Mental\\_Health\\_and\\_Substance\\_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf](https://www.acep.org/uploadedFiles/ACEP/Clinical_and_Practice_Management/Resources/Mental_Health_and_Substance_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf)
- American Council for Drug Education (ACDE). (2017). Signs and symptoms of substance abuse. Retrieved from [http://www.phoenixhouse.org/prevention/signs-and-symptoms-of-substance-abuse/#section\\_two](http://www.phoenixhouse.org/prevention/signs-and-symptoms-of-substance-abuse/#section_two)
- Andrew L. (2016). Depression and suicide. Medscape. Retrieved from <http://emedicine.medscape.com/article/805459-overview>
- Australian Government Department of Health (AGDOH). (2013). Mental health triage tool. Retrieved from <http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~trriageqrg-mh>
- Berger F. (2016). Panic disorder. Retrieved from <https://medlineplus.gov/ency/article/000924.htm>
- Bioethics Research Library at Georgetown University (BRL at GU). (2016). Truth telling. Retrieved from <https://bioethicsarchive.georgetown.edu/phil105/classical-biomedical-ethics-physician-patient-encounter/truth-telling/index.html>
- Black M. (2015). Management of acute overdose. Retrieved from [http://www.bc.edu/content/dam/files/schools/son\\_sites/npconference/pdf](http://www.bc.edu/content/dam/files/schools/son_sites/npconference/pdf)
- Brannon G. (2016). History and mental status exam. Medscape. Retrieved from <http://emedicine.medscape.com/article/293402-overview>
- Bressert S. (2017). Borderline personality disorder treatment. Psych Central. Retrieved from <https://psychcentral.com/disorders/borderline-personality-disorder-treatment/>
- Caplan G. (1964). *Symptoms of preventive psychiatry*. New York: Basic Books.
- Casale K. (2016). Crisis and crisis intervention. In Jones J, Fitzpatrick J, & Rogers V. (Eds.), *Psychiatric mental health nursing* (2nd ed.), pp. 79–95. New York: Springer Publishing.
- Chun T, Mace S, & Katz E. (2016). Evaluation and management of children and adolescents with acute mental health or behavioral problems. Part I: common clinical challenges of patients with mental health and/or behavioral emergencies. Retrieved from [http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1570?trendmd-shared=0&utm\\_source=TrendMD&utm\\_medium=TrendMD&utm\\_campaign=Pediatrics\\_TrendMD\\_0#xref-ref-39-1](http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1570?trendmd-shared=0&utm_source=TrendMD&utm_medium=TrendMD&utm_campaign=Pediatrics_TrendMD_0#xref-ref-39-1)
- Cournoyer B. (2017). *The social work skills workbook*. Boston: Cengage Learning.
- Davis C. (2016). Patient rights. Retrieved from [http://www.emedicinehealth.com/patient\\_rights/article\\_em.htm#what\\_are\\_patient\\_rights](http://www.emedicinehealth.com/patient_rights/article_em.htm#what_are_patient_rights)



- Emembolu F & Zun L. (2010). Medical clearance in the emergency department: is testing indicated? *Primary Psychiatry*, 17(6), 29–34.
- Encyclopedia of Mental Disorders (EMD). (2017). Substance-induced psychotic disorder. Retrieved from <http://www.minddisorders.com/Py-Z/Substance-induced-psychotic-disorder.html#ixzz4epYYTfea>
- Federal Emergency Management Agency (FEMA). (2016). National incident management system. Retrieved from <http://www.fema.gov/national-incident-management-system>
- Garriga M, Pacchiarotti I, Kasper S, Zeller S, Allen M, Vasquez G, et al. (2016). Assessment and management of agitation in psychiatry: expert consensus. *World Journal of Biological Psychiatry*, 17(2), 86–128. doi:10.3109/15622975.2015.1132008
- Gemma R. (2013). Duty of care: assessing risk to others. Retrieved from <https://www.slideshare.net/DrGemmaRussell/professional-risk-assessment>
- Gerstein P. (2015). Emergent treatment of schizophrenia. *Medscape*. Retrieved from <http://emedicine.medscape.com/article/805988-overview>
- Goldberg J. (2017). Psychotic depression. *WebMD*. Retrieved from <http://www.webmd.com/depression/guide/psychotic-depression#2>
- Goldberg J. (2016a). Grief and depression. *WebMD*. Retrieved from <http://www.webmd.com/depression/guide/depression-grief#2>
- Goldberg J. (2016b). Rights for people with mental illness. *WebMD*. Retrieved from <http://www.webmd.com/mental-health/rights-mental-illness>
- Hedman L, Petrila J, Fisher W, Swanson J, Dingman D, & Burris S. (2016). State laws on emergency holds for mental health stabilization. *Psychiatric Services*, 67(5), 529–35. Retrieved from <http://dx.doi.org/10.1176/appi.ps.201500205>
- Jaffe D. (2011). How and why to change involuntary treatment and/or involuntary commitment laws in your state for persons with mental illness. Retrieved from <http://mentalillnesspolicy.org/ivc/involuntary-treatment-workshop.html>
- Kennebeck S & Bonin L. (2017). Suicidal ideation and behavior in children and adolescents: evaluation and management. *UpToDate*. Retrieved from <http://www.uptodate.com/contents/suicidal-ideation-and-behavior-in-children-and-adolescents-evaluation-and-management>
- Khav N, Weiland T, Jelinek G, Knott J, & Salzberg M. (2013). Depression symptoms and risk factors in adult emergency department patients: a multisite cross-sectional prevalence survey. *ISN Emergency Medicine*, article ID 965103, 8 pages. Retrieved from <http://dx.doi.org/10.1155/2013/965103>
- Kincaid L & Tomasso V. (2013). Elder abuse in long-term care. Retrieved from <http://www.napsa-now.org/wp-content/uploads/2013/10/NAPSA-Chemical-Restraint.pdf>
- Mattingly B. (2016). Chemical restraint. *Medscape*. Retrieved from <http://emedicine.medscape.com/article/109717-overview#a5>
- McCormick T. (2013). Ethics in medicine. Retrieved from <https://depts.washington.edu/bioethx/tools/princpl.html>





McKee J & Brahm N. (2016). Medical mimics: differential diagnostic considerations for psychiatric symptoms. *Mental Health Clinician*, 6(9), 289–96.

Melemis S. (2017). Withdrawal. Retrieved from <https://www.addictionsandrecovery.org/withdrawal.htm>

Memon M. (2016). Panic disorder management. *Medscape*. Retrieved from <http://emedicine.medscape.com/article/287913-treatment#d8>

Mental Health America (MHA). (2015). Position statement 24: seclusion and restraints. Retrieved from <http://www.mentalhealthamerica.net/positions/seclusion-restraints>

Miller D & Janson A. (2016). *Committed: the battle over involuntary psychiatric care* (1st ed.). Baltimore: Johns Hopkins University Press.

Moore G & Pfaff J. (2017). Assessment and emergency management of the acutely agitated or violent adult. *UpToDate*. Retrieved from [https://www.uptodate.com/contents/assessment-and-emergency-management-of-the-acutely-agitated-or-violent-adult?source=see\\_link](https://www.uptodate.com/contents/assessment-and-emergency-management-of-the-acutely-agitated-or-violent-adult?source=see_link)

National Alliance on Mental Illness (NAMI). (2017). Dual diagnosis. Retrieved from <https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Dual-Diagnosis>

National Alliance on Mental Illness (NAMI). (2016a). Reducing relapse. Retrieved from <http://namila.org/resources/mental-health-resources/illness-management/reducing-relapse/>

National Alliance on Mental Illness (NAMI). (2016b). Mental health crisis overview. Retrieved from [https://static1.squarespace.com/static/52d2fc5ce4b0ed895b7f3e99/t/56e71a6e9f72666c1e78df0e/1457986164986/Mental+health+crisis\\_full+section.pdf](https://static1.squarespace.com/static/52d2fc5ce4b0ed895b7f3e99/t/56e71a6e9f72666c1e78df0e/1457986164986/Mental+health+crisis_full+section.pdf)

National Conference of State Legislatures (NCSL). (2015). Mental health professional’s duty to warn. Retrieved from <http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>

National Institute of Mental Health (NIMH). (2016a). Borderline personality disorder. Retrieved from <https://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml>

National Institute of Mental Health (NIMH). (2016b). Bipolar disorder. Retrieved from <https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml>

National Institute of Mental Health (NIMH). (2016c). Depression basics. Retrieved from <https://www.nimh.nih.gov/health/publications/depression/index.shtml>

National Institute of Mental Health (NIMH). (2016d). Anxiety disorders. Retrieved from <https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>

National Resource Center on Psychiatric Advance Directives (NRCPAD). (2015). PAD: psychiatric advance directive. Retrieved from <http://webcasts.nrc-pad.org/CKPresentation/081506duke.html>

Pozesny M. (2015). Crisis intervention: borderline personality. Retrieved from <https://archive.org/details/Podcast0252CrisisInterventionBorderlinePersonality>

Scher L. (2016). Psychiatric interview. *Medscape*. Retrieved from <http://emedicine.medscape.com/article/1941476-overview#a14>



Smith S, Barston S, & Seagal J. (2014). Teen depression: a guide for parents. Retrieved from [http://www.helpguide.org/mental/depression\\_teen.htm](http://www.helpguide.org/mental/depression_teen.htm)

Suthar S. (2015). Crisis intervention in psychiatry. Retrieved from [https://www.slideshare.net/drsunilsuthar/crisis-intervention-in-psychiatry?qid=dc4fdf2c-db44-40fc-a438-440e8120aa9a&v=&b=&from\\_search=4](https://www.slideshare.net/drsunilsuthar/crisis-intervention-in-psychiatry?qid=dc4fdf2c-db44-40fc-a438-440e8120aa9a&v=&b=&from_search=4)

Thompson J. (2013). Active listening techniques of hostage & crisis negotiators. Retrieved from <https://www.psychologytoday.com/blog/beyond-words/201311/active-listening-techniques-hostage-crisis-negotiators>

Townsend M. (2014). Psychiatric mental health nursing: concepts of care in evidence-based practice (8th ed.). Philadelphia: F.A. Davis Company.

United States Department of Health and Human Services (USDHHS), Office for Civil Rights. (2014). Bulletin: HIPAA privacy in emergency situations. Retrieved from <https://www.hhs.gov/sites/default/files/emergencysituations.pdf>

United States Supreme Court. (1972). *Humphrey v. Cady*, 405 U.S. 504. Retrieved from <https://supreme.justia.com/cases/federal/us/405/504/>

Valeo T. (2013). When labeling an emotion quiets it. Retrieved from [http://www.dana.org/BrainWork/2013/When\\_Labeling\\_an\\_Emotion\\_Quiets\\_It/](http://www.dana.org/BrainWork/2013/When_Labeling_an_Emotion_Quiets_It/)

Wayne G. (2017). Nursing care plans. Retrieved from <https://nurseslabs.com/category/nursing-care-plans>

Wiler J, Brown N, Canmugam A, Enguidanos E, Farley H, et al. (2014). Care of the psychiatric patient in the emergency department—a review of the literature. Retrieved from [https://www.acep.org/uploadedFiles/ACEP/Clinical\\_and\\_Practice\\_Management/Resources/Mental\\_Health\\_and\\_Substance\\_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf](https://www.acep.org/uploadedFiles/ACEP/Clinical_and_Practice_Management/Resources/Mental_Health_and_Substance_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf)

Yeager K & Roberts A (Eds.). (2015). *Crisis intervention handbook: assessment, treatment and research* (4th ed.). New York: Oxford University Press.





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## TEST

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1. Which behavior would indicate a person is experiencing a mental health **emergency**?
  - a. Alcohol abuse
  - b. Talking about suicide
  - c. Acting on a suicide threat
  - d. Not taking prescribed psychiatric medications
  
2. A mother who is feeling lost and abandoned after her only son leaves for college suggests which type of crisis?
  - a. Maturational
  - b. Situational
  - c. Social
  - d. Adventitious
  
3. Which describes an example of an adventitious crisis?
  - a. Failure to adjust to retirement
  - b. Threat to physical integrity
  - c. Combined maturational and situational crisis
  - d. Earthquake
  
4. According to the phases in which a mental health crisis typically unfolds, which action occurs **first**?
  - a. External supports are required to address personality disorganization.
  - b. In an effort to lower anxiety, various defense mechanisms are employed.
  - c. Automatic relief behaviors (flight or fight) are mobilized.
  - d. Lack of success in finding an appropriate coping strategy leads to a sense of helplessness.
  
5. To deal with her chronic fatigue due to caring for her two-month-old, a new stay-at-home mother uses the “you should sleep when your baby is sleeping” advice given to her by the nursing staff at the birth center. This is an example of using a:
  - a. Coping mechanism.
  - b. Support system.
  - c. Crisis equalizer.
  - d. Perception alteration.



6. Which term is used to describe a type of crisis resolution in which a person in crisis represses or pushes the event and associated emotions out of consciousness?
- Pseudo resolution
  - Repressed resolution
  - Unsuccessful resolution
  - Successful resolution
7. Factors that increase the risk for a mental health crisis include:
- Belief in an internal locus of control.
  - Emotional awareness.
  - Lack of sleep.
  - Optimistic outlook.
8. A sign or symptom of crisis in younger children is:
- Generalized anxiety.
  - Poor concentration.
  - Regression.
  - Anger and frustration.
9. One of the goals of crisis intervention is to:
- Enlarge the person's support system.
  - Avoid experiencing future challenges.
  - Increase the number of balancing factors.
  - Restore the pre-crisis level of functioning.
10. In performing a focused assessment for a patient experiencing a mental health crisis, the emergency department triage nurse's **primary** consideration is:
- The acuity of patients already receiving treatment in the ED.
  - How quickly and by whom the patient should be seen.
  - The number of other patients in the intake area who have not yet been triaged.
  - How many ambulances are said to be en route to the facility.
11. Asking a patient, "Am I correct in saying that you are feeling overwhelmed?" is an example of which communication technique?
- Encouraging
  - Open-ended questioning
  - Emotional labeling
  - Using an "I" message



- 12.** Which is a correct statement about Roberts' 7-Stage Crisis Intervention Model?
- Stages are sequential but may overlap in process.
  - Stage 1 involves identifying major problems.
  - Stages must be completed before moving to the next stage.
  - Stage 2 explores alternatives.
- 13.** During which stage of Roberts' 7-Stage Crisis Intervention Model does prioritizing current problems occur?
- Stage 1
  - Stage 3
  - Stage 5
  - Stage 7
- 14.** When conducting an assessment for risk of harm to others, it is important to remember that:
- There are no known common predictors of violence.
  - The more intimate the relationship between patient and intended victim, the higher the risk for harm.
  - Only law enforcement professionals have the duty to warn third parties of a threat of harm.
  - Males over the age of 30 are the demographic group most highly prone to violent behavior.
- 15.** When attempting to establish verbal contact with a patient who is emotionally or behaviorally out of control, which action is most appropriate?
- Move quickly to physically restrain the patient
  - Stand with hands on hips and make continuous eye contact
  - Use "fogging" to show empathy
  - Designate one staff member to interact with the patient
- 16.** Which is a **true** statement concerning the use of seclusion and restraints?
- Uniform national standards govern the legal use of seclusion and restraints.
  - Seclusion and restraints are considered treatment interventions.
  - Seclusion and restraints are employed in order to help the patient change behavior.
  - Seclusion and restraints are safety measures of last resort.



- 17.** Two criteria that can be used to identify an **organic** cause for psychiatric symptoms are:
- Age 13 to 40 years and psychiatric history.
  - Auditory hallucinations and scattered thoughts.
  - Sudden onset and fluctuating course.
  - Awake and alert and flat affect.
- 18.** Which is a **correct** statement concerning the mental status examination (MSE)?
- MSE evaluates only cognition.
  - MSE does not include the patient's attitude toward the examiner.
  - MSE assesses thought content as well as thought process.
  - MSE is normally conducted without patient consent.
- 19.** A common sign of cocaine or crack use is:
- Slurred speech.
  - Glassy, red eyes.
  - Euphoria.
  - Twitching.
- 20.** A dangerous consequence of withdrawal for individuals experiencing an emergency substance use crisis is:
- Grand mal seizure.
  - Hallucinations.
  - No response of pupils to light.
  - Bizarre behavior.
- 21.** The hallmark features of schizophrenia are:
- Delusions, hallucinations, and flat affect.
  - Extreme elevation of mood and psychomotor agitation.
  - Black-and-white thinking and recurrent suicidality.
  - Reverse wake and sleep cycle and neglect of personal hygiene.
- 22.** Patients with anxiety disorder may present with:
- Mania.
  - Heightened emotions.
  - Acute psychosis.
  - Cardiac signs and symptoms.

**23.** The government mandate that says an evaluation for patients seeking attention at emergency facilities must be done regardless of ability to pay is the:

- a. Health Insurance Portability and Accountability Act (HIPAA).
- b. Hospitalization of the Mentally Ill Act.
- c. Emergency Medical Treatment and Active Labor Act (EMTALA).
- d. Federal Self-Determination Act.

**24.** “Involuntary commitment” poses a dilemma between the ethical principles of beneficence and:

- a. Autonomy.
- b. Nonmaleficence.
- c. Justice.
- d. Respect for human life.

**25.** When a family member, guardian, physician, or other public health officer applies for commitment with a certificate affirming mental illness, it is known as:

- a. Civil commitment for observation.
- b. Emergency voluntary commitment.
- c. Voluntary commitment.
- d. Long-term commitment.

