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Contact Hours: **5**

Mental Health Crisis 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 to address potential knowledge gaps include:

- Distinguish between a mental health “crisis” and “emergency.”
- Describe the types, phases, and balancing factors of a mental health crisis.
- Recognize signs, symptoms, and contributing factors of a mental health crisis.
- Summarize the goals and methods involved in the mental health crisis intervention process.
- Explain the considerations involved in mental health triage.
- List effective communication techniques for use in crisis intervention.
- Discuss steps involved in mental health emergency management.
- Outline the assessment process of the patient experiencing a mental health emergency.
- Describe the appropriate care for patients experiencing substance use or a mental illness.
- Identify ethical and legal concerns related to the care of patients experiencing a mental health crisis or emergency.

INTRODUCTION

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.

A crisis can be defined as an unstable situation with an uncertain outcome in which an individual's coping capacity is temporarily overwhelmed. Such crises may be generated by external events, intrinsic processes, or a combination of both. 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. Many crises will resolve favorably without intervention. Others, however, may require professional crisis management (Novalis et al., 2020).

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 feel a lack of educational preparation, confidence, and experience to provide appropriate assessment and intervention for the person in crisis. Too often they respond as if a mental health crisis and danger to self or others are one and the same.

This narrow focus on dangerousness, however, is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether the person is a danger or that immediate psychiatric hospitalization is indicated. Because only a portion of real-life crises may actually result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late, or no help at all in addressing the root of the 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**, which can be life-threatening. Most often mental health emergencies involve the threat of suicide or acting on a suicide threat. Other emergencies may involve a threat of harm to another individual (Shiva, 2017).

WHAT IS A MENTAL HEALTH CRISIS?

A **mental health crisis** is defined as any non-life-threatening situation in which people experience an intensive behavioral, emotional, or psychiatric response triggered by a precipitating event and whose behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community (NAMI, 2020).

Types of Crises

Crises can be categorized as maturational, situational, adventitious, or sociocultural. Individuals may simultaneously experience more than one type in a given situation.

MATURATIONAL CRISES

Maturational or developmental crises may occur at any transitional period in the normal process of bio-psychosocial growth and development. The transitional periods into successive stages of life require cognitive and behavioral changes, and a crisis can develop at any stage of transition when the person is unable to envision being in a new role, lacks adequate resources or communication skills, or others in their social system refuse to see the person in a different role. Life stages and related concerns may include:

Childhood

- Beginning school
- Establishing peer relationships
- Peer competition

Adolescence

- Puberty
- Relationships involving sexual attraction
- Exploring independence
- Choosing a career

Young Adulthood

- Leaving home
- Continuing one's education
- Getting started in an occupation
- Getting married
- Managing a home
- Pregnancy
- Childbirth

Middle Adulthood

- Physical changes of aging, menopause
- Maintaining social status and standard of living
- Dealing with changes in adolescent children

Older Adulthood

- Decreased physical abilities and health
- Changes in residence
- Retirement and reduced income
- Death of spouse
- Death of friends
- Facing one's own death
  (Dwivedi, 2018)

SITUATIONAL CRISES

Situational crises often revolve around grief and loss, usually the loss of an established support or role. They arise suddenly and unexpectedly from an external source and are events or circumstances that threaten the physical, social, and psychological integrity of individuals. These events may originate in the physical body as a result of disease or injury or in social or emotional situations. Such events may include:

- Unexpected job loss
- Change in financial status
- Academic failure
- Divorce
- Mental illness
- Birth of a child with a disability
- Diagnosis of chronic or terminal illness
- Serious injury
- Death of a child
- Loss of a spouse
  (Sabu, 2017)

ADVENTITIOUS CRISES

Adventitious 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
- Global pandemics, such as influenza and COVID-19
- 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 Agency (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 Department of Homeland Security website (DHS, 2020). (See "Resources" at the end of this course.)

SOCIOCULTURAL CRISES

Sociocultural crises occur when an individual or members of a community cease to function in conformity with the interests and values embedded in the social structure of that community. This may involve discriminatory practices based on age, race, sex, sexual preference, or class distinction (Shiva, 2017).

MENTAL ILLNESS CRISES

Individuals with diagnosed mental illness are at greater risk of experiencing crisis, but very often a crisis occurs before a mental illness has been diagnosed. 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 be difficult to predict because often there are no warning signs. 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. It is possible the first point of contact may be with law enforcement personnel instead of medical personnel since behavioral disturbances and substance use are frequently part of the difficulties associated with mental illness (NAMI, 2020).

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 that threatens their self-concept, and they respond with increased feelings of anxiety. 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 trial-and-error 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, compromising needs, or redefining the situation. 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 (Halter, 2018).

Balancing Factors

Individuals respond to a crisis in their own unique ways. There are certain factors that determine the manner in which they respond, referred to as *balancing factors*. They include:

- **Perception of the event.** The perception one has of an event determines the reaction to the situation. If the person has a realistic perception and has access to adequate resources, restoration of homeostasis will occur, and there will be no crisis. A realistic perception occurs when a person is able to distinguish the relationship between an event and feelings of stress.

- **Availability of situational supports.** If the person utilizes support from available persons in the environment and receives assistance in solving the problem, a crisis can be averted. These individuals reflect appraisal of the person's values. When this is not available, the person is more likely to define the event as more overwhelming, thus increasing vulnerability to crisis.

- **Availability of adequate coping skills.** Coping skills or mechanisms are those methods usually used by an individual to deal with anxiety or stress in order to reduce tension in difficult situations. People may have positive or negative coping mechanisms, and many people instinctively opt for a maladaptive coping mechanism. These may include denial, rationalization, repression, regression, dissociation, or avoidance. However, if the person is able to successfully use positive strategies from the past, a crisis can be averted. The inability to use strategies from previous experiences or unsuccessful attempts to use

strategies that were successful in the past can lead to continued disequilibrium, tension, and anxiety.

Developmental factors can also impact a person's response to stress and the development of a crisis. For adults, a crisis can be hard to accept and impossible to understand, which can erode feelings of personal and community safety. Adolescents and children may be even more deeply affected. The effects of crisis on a child may interfere with normal growth and development, leading to negative long-term physical and psychological health outcomes (Casale, 2017).

Crisis Resolution

Crises are acute, time-limited situations that can be resolved in one way or another within a one- to three-month time frame. Crises can become growth opportunities when individuals learn new methods of coping that can be preserved and used when similar stressors occur in the future.

However, when new coping mechanisms or balancing factors are not identified and incorporated, the crisis situation can evolve into longer-term problems and sometimes symptoms of emotional or mental illness, including depression, anxiety, and trauma/stressor-related disorders (Townsend & Morgan, 2018).

The goal of crisis intervention is to return the patient to at least the precrisis level of functioning. In order for problem-solving to be successful and for a healthy resolution of a crisis to occur, the person must have a realistic understanding of the precipitating event and their emotional response to it. 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.

At the resolution of a crisis, the patient will emerge at one of three different functional levels:

- A higher level of functioning
- The same level of functioning as before crisis
- A lower level of functioning
  (Halter, 2018)

RESOLUTION AND OCCUPATIONAL THERAPY

When individuals experience a mental health crisis or emergency, they may become involved with acute psychiatric services, whose main goal is to return each person back into the community or to a more appropriate setting. For this to occur, each patient requires an assessment of the ability to function safely and effectively in the environment they will return to. One reason why a patient may not be able to return to the community setting is the persistence of functional problems and deficits resulting from the crisis.

Skills that address these functional deficits are often present in any acute psychiatric multidisciplinary team; however, occupational therapists are uniquely qualified to assess and

remediate functional performance. They have the skills to provide quality and consistency in outcomes. It has been found that occupational therapists contribute specialist skills to the multidisciplinary team, and individual assessments, therapeutic groups, individual treatment, and discharge planning play key roles in the acute psychiatric setting (Fitzgerald, 2016).

The National Alliance on Mental Illness (NAMI) and the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for **Assertive Community Treatment (ACT)** teams include occupational therapists. The team members help patients address every aspect of their lives, whether it be medication, therapy, social support, employment, or housing.

Occupational therapists assist with crisis stabilization and help reduce the need for restraints or seclusion, and there is much evidence supporting occupational therapy interventions as part of psychiatric rehabilitation. These therapists also work with veterans and service members who have experienced other crises, including posttraumatic stress syndrome, traumatic brain injury, or polytrauma. ACT teams provide services to the following:

- People with severe symptoms of mental illness
- People experiencing psychiatric crises
- People with significant thought disorders
- Young adults with early-stage schizophrenia
- People with stigmatized mental illness
- People with high rates of substance abuse
- People with a significant history of trauma
- Those with frequent hospital stays
- People with overlapping physical and mental illness
- People who are homeless due to mental illness
- People unlikely to attend appointments at hospitals or clinics
- People who have not responded well to traditional outpatient care

(NAMI, 2017c)

The occupational therapists included in these community behavioral health teams can:

- Complete assessments and evaluations that are capable of recognizing factors that contribute to mental illness
- Look for strengths that can enhance improved recovery and participation in the recovery process
- Assist in the removal of barriers to recovery through the establishment of an effective and comprehensive patient-centered treatment plan

(AOTA, 2017)

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 was that 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

While it is important to recognize that warning signs are not always present when a mental health crisis is developing, evidence that a person is experiencing a mental health crisis may include:

- Rapid mood swings (being suddenly depressed and withdrawn to being suddenly happy or calm)
- Talking about suicide
- Increased agitation (inability to stay still, pacing, irritability, excessive talking, problems with staying focused or conversing)
- Inability to perform daily hygiene tasks
- Angry outbursts
- Talking about or making verbal threats
- Paranoid thinking
- Abusive behavior to self or others, including substance use or self-harm
- Isolating from school, work, family, and friends
  (NAMI, 2020)

When an individual in crisis is found to be imminently threatening harm to self or others, 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:

- Acting on a suicide threat
- Severe disorientation
- Evidence of psychosis (losing track of reality, inability to recognize family or friends or to understand what others are saying, hallucinating)
- Homicidal or threatening behavior
- Self-injury requiring immediate medical attention
- Severe impairment by drugs or alcohol
- Highly erratic or unusual behavior indicating unpredictability to safely care for self (UH, 2020)

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 and Protective Factors

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

- Family history of mental health problems
- Presence of or history of mental illness
- History of abuse or traumatic event
- Being bullied or bullying others
- Poor academic achievement
- Presence of concurrent illness or injury
- Use of alcohol or drugs
- Poor nutrition, chronic pain, lack of sleep
- Presence of other stressful life events
- Low self-esteem, negative self-perception
- Lack of emotional awareness
- Belief in an outside locus of control
- Recent loss (e.g., death, divorce)
- Lack of social support

- Pessimistic outlook
- Poverty

Factors that can **decrease the risk** for mental health crises include:

- Having access to a reliable support system
- Emotional self-regulation
- Good coping and problem-solving skills
- Subjective sense of self-sufficiency
- Optimistic outlook
- Positive self-regard
- Good peer relationships
- Economic/financial security
  (AMWA, 2020)

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 of Stress in Adults

Signs and symptoms of emotional distress may occur before or after a crisis. Most symptoms are temporary and will resolve on their own. However, for some, these symptoms may last for weeks or even months and may influence their relationships with families and friends.

Physical

- Sleep disturbances
- Generalized aches and pains
- Tension headaches
- Intestinal cramps, diarrhea, heartburn, constipation
- Muscle tension, fatigue, cold hands and feet, sweaty palms
- Shortness of breath, chest pain, tachycardia, hyperventilation

- Loss of libido
- Increased vulnerability to colds, flu, infections

Psychological

- Anxiety, fear, racing thoughts
- Irritability
- Constant worrying
- Feeling hopeless and helpless
- Impatience
- Poor judgment
- Feelings of doom
- Depression

Behavioral

- Eating disturbances
- Increased conflict and arguing
- Isolation from social activities
- Neglecting responsibilities
- Using alcohol and/or drugs to relax
- Job instability related to conflict with coworkers and employer
- Road rage
- Domestic or workplace violence
- Nervous habits (e.g., nail biting, pacing)
  (Segal et al., 2020)

Signs and Symptoms of Stress 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:

Physical

- Decreased appetite, changes in eating habits
- Headache
- Nightmares
- Sleep disturbances

- Upset stomach or vague stomach pain
- Other physical symptoms with no physical illness

Emotional and Behavioral

- Routinely expressing anxiety, worry
- Crying
- New or recurring fear or displaying fearful reactions
- Clinging behavior to parent or teacher
- Emotional lability
- Aggressive or stubborn behavior
- Regression back to younger behaviors (e.g., thumb-sucking, bedwetting)
- Withdrawal from family or school activities

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
- Abandoning long-time friendships for a new set of peers
- Expressing hostility toward family members
- 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
  (Kaneshiro, 2018; APA, 2020)

MENTAL HEALTH CRISIS INTERVENTION PROCESS

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 approximately 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 mental health crisis management are to:

- Ensure the physical safety and emotional stability of the person experiencing a mental health crisis
- Reduce the intensity of emotional, mental, physical, and behavioral reactions to the crisis in order to avoid further deterioration of the person's mental status and development of serious long-term problems
- Assist in recovery from crisis and the return to a precrisis level of functioning
- Assist in the development or enhancement of more effective coping skills and support system
- Ensure that services are clinically appropriate and in the least intense or restrictive setting
- Provide assistance and referral for ongoing care
  (Shiva, 2017)

Triage Considerations

Triage refers to the assessment that takes place when a patient first makes contact with a health service. Triage may occur in many settings, including an emergency department, community mental health clinic, ambulance call-out, primary care setting, telephone hotline, crisis center, or individual's home.

The **aims** of triage are:

- To determine that it is likely the person has a mental health problem, and if so, what the nature of the problem is
- To establish priority for response based on immediate safety issues
- To inquire about concurrent social or health problems that require attention
- To determine what intervention is best suited for the person and to whom the person should be referred

Triage is usually followed by a comprehensive assessment once immediate issues of safety have been addressed (Evans et al., 2019).

In every crisis event, triage must address both safety concerns and immediacy challenges. This is accomplished most often utilizing a triage assessment tool that offers step-by-step guidance.

MENTAL HEALTH TRIAGE ASSESSMENT SCALE	
Acuity Level/Response	**Observed/Reported Behaviors**
Emergency (Requires treatment within 10 minutes)	• Violent, aggressive, or suicidal • Danger to self or others • Requires police escort
Urgent (Requires treatment within 30 minutes)	• Very distressed or acutely psychotic • Likely to be aggressive • May be a danger to self or others
Semi-urgent (Requires treatment within 60 minutes)	• Long-standing or nonacute mental disorder or problem • Patient has supporting agent or escort
Nonurgent (Requires treatment within 2 hours; referral to an appropriate community resource)	• Long-standing or nonacute mental disorder or problem • Patient has no supportive agent or escort
(Zun, 2016)	

TRIAGE FOR CHILDREN AND ADOLESCENTS

The HEADS-ED is a mental health screening tool used with children and adolescents between the ages of 6 and 18 years who are presenting for primary care or for mental health crisis care. HEADS-ED can be completed within a few minutes by a healthcare practitioner or allied health professional (e.g., crisis worker, school counselor). The tool includes seven components of a patient history, giving a concise picture of the main concerns, and a total score that can indicate overall severity of symptoms. On the basis of this score, the clinician can make determinations as to the patient's disposition and follow-up, which may include:

- Immediately providing a meaningful score (a score of 8 or a suicidality score of 2 indicates that a mental health consultation should be obtained)
- Suggesting whether a consultation for inpatient services may be required
- Identifying appropriate local community resources based on the needs identified that will facilitate continuity of care

HEADS-ED SCREENING TOOL			
Component		**Question**	**Responses (Score)** 0=No action needed 1=Needs action but not immediate 2=Needs immediate action
H	Home	How does your family get along with each other?	• Supportive (0) • Conflicts (1) • Chaotic (2) • Dysfunctional (2)
E	Education	How is your school attendance?	• On track (0) • Grades dropping (1) • Absenteeism (1) • Failing (2) • Not attending school (2)
A	Activities	How are you getting along with your friends?	• No change (0) • Reduced activities (1) • Peer conflicts (1) • Fully withdrawn (2) • Significant peer conflicts (2)
D	Drugs and alcohol	How often have you been using alcohol or other drugs?	• None (0) • Infrequently (0) • Occasionally (1) • Frequently (2) • Daily (2)
S	Suicidality	Do you have any thoughts of wanting to kill yourself?	• No thoughts (0) • Ideation (1) • Plan (2) • Apparent attempt made (2)
E	Emotions, behaviors, thought disturbance	How have you been feeling lately?	• Mildly anxious (0) • Mildly sad (0) • Mild acting out (0) • Moderately anxious (1) • Moderately sad (1) • Moderate acting out (1) • Significantly distressed (2)

			• Unable to function (2) • Out of control (2) • Bizarre thoughts (2)
D	Discharge resources	Are you getting any help, or are you waiting to receive help?	• Ongoing (0) • Well connected (0) • Receiving some (1) • Not meeting needs (1) • None (2) • On wait list (2) • Noncompliant (2)
(Cappelli & Cloutier, 2017)			

Crisis Intervention Communication

The **goals** of crisis intervention communication are to:

- Establish rapport
- Identify the most important concern at that moment
- Assess the person's perception of the problem
- Facilitate the person's expression of emotion
- Recognize the person's needs
- Implement interventions designed to address the needs
- Guide the person toward identifying a plan of action to an acceptable resolution (Belleza, 2020)

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** involves listening with all the senses. This means:

- Seeing the person in front of you
- Hearing the person's voice as they speak
- Observing how the person's speaking and presence makes you feel
- Noticing any smells and sometimes even what you taste

It is the ability to completely focus on a speaker, understand the speaker's message, comprehend the meaning of the information, and respond effectively. 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, essentially, a form of feedback.

ATTENDING/ACKNOWLEDGING

It is important to provide **verbal** and **nonverbal** awareness of the speaker and to convey an interest in what the speaker is saying. This provides an invitation to continue to talk.

Examples

- "Uh-huh."
- "Oh?"
- "When?"
- "Really?"
- "I see."
- "Yes."

Nonverbally, the listener can convey interest by facing the speaker, 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 often 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; Belleza, 2020).

CLARIFYING

Clarifying involves seeking information to make clear that which is not meaningful or that which is vague in order to avoid making assumptions that understanding has occurred when it has not. It is 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

- Listener: "I am not quite sure I understand. Can you tell me …?"
- Listener: "Do you mean that …?"
- Listener: "Are you telling me …?"
- Listener: "Are you saying …?"
- Listener: "Have I heard you correctly?"

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

Restating is repeating the main idea expressed in approximately or nearly the same words the patient has used, while **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.

Examples

- Speaker: "I don't sleep. I stay awake all night."
- Listener (restated response): "You don't sleep, you stay awake all night."
  or
- Listener (paraphrased response): "You have difficulty sleeping."

When restating and paraphrasing, it is important to observe for nonverbal and verbal cues that confirm or refute the accuracy (Cournoyer, 2017; Videbeck, 2020).

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 they 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 they are 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 helpful to ask if a label is correct.

Examples

- Listener: "You sound very frustrated. Is that right?"
- Listener: "Am I correct in saying that you feel overwhelmed by everything?"
- Speaker: "I'm stuck out in the middle of the ocean."
- Listener: "You're feeling alone or deserted. Is that true?"

It is important that the speaker's emotions are validated and not minimized. Labeling and acknowledging emotions help to restore equilibrium (Cournoyer, 2017; Videbeck, 2020).

PROBING SKILLS

Probing skills involve questioning, and the most useful forms of questions are open-ended. These types of questions encourage exploration and begin with probing words such as *when*, *what*, *where*, *how*, or *who*. They elicit more and fuller information than closed-ended questions by requiring more than a simple yes or no answer. The use of open-ended questions encourages the individual to continue to talk. 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

- Listener: "What were you thinking/feeling?"
- Listener: "How did you act?"
- Listener: "When did that happen?"
- Listener: "Where did you go afterward?"
- Listener: "Whom did you go with?"
  (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. Silence allows the person to take control of the discussion. 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 can be used to convey feelings, concerns, needs, and expectations without making the other person feel attacked. "You" messages tend to put people in defensive positions, whereas an effective "I" message places the responsibility and focus on the communicator instead of the recipient. "I" messages allow people to know in a nonthreatening way how the other person feels, why they feel that way, and what the patient can do to remedy the situation. Clinicians use this technique to refocus the patient or when the clinician is being verbally attacked.

Examples

- Listener: "I feel uncomfortable when I'm spoken to that way. Please don't yell at me."
- Listener: "I need to better understand what I heard you say. Tell more about that."

Fogging is a related empathic technique used to slow down a potentially explosive situation. It is a way to accept critical remarks by using "I" messages. When a patient is being critical, the listener accepts the criticism, or part of the criticism, even if it is untrue and repeats it back to the speaker.

Example

- Speaker: "You're so stupid!"
- Listener: "Yes, I can see that you don't think I'm that smart."

The word *yes* takes the person by surprise, slows them down, and reduces tension. The listener is not agreeing that they are stupid; rather they are acknowledging that the speaker thinks so (Cournoyer, 2017; Townsend, 2018).

CASE: Triage Communication Techniques

Jeremy is a nurse with three years' experience working in an emergency department 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 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 making assumptions or 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 female caller adequate time to tell her story.

Daniel observes Jeremy completing his screening and risk 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 discussion of options and collaborative planning with the caller for appropriate intervention. Daniel listens while Jeremy ensures the caller understands the instructions and summarizes key information before terminating the call. Jeremy enters the call in the crisis records, and Daniel tells him he is ready to handle the hotline calls.

Crisis Intervention Model

There are many crisis intervention models, one of them being the **ACT Model of Crisis Counseling**. ACT stands for assessment, crisis intervention, and trauma treatment and is a three-stage model emphasizing:

1. Assessment of the presenting problem
2. Connecting patients to support systems
3. Helping those in crisis work through the distress and emotional pain

This three-stage intervention model integrates assessment and triage protocols with **Robert's Seven-Stage Crisis Intervention Model** (R-SSCIM) and 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 R-SSCIM model identifies seven critical stages a clinician goes through to help the individual reach stabilization, resolution, and mastery. The stages are sequential but may overlap in the process:

1. Assessment
2. Rapidly establish rapport
3. Identify major problems
4. Explore feelings and emotions
5. Generate and explore alternatives
6. Develop and formulate an action plan
7. Plan follow-up

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 is conducted 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 conducted 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 Risk of 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 they 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 (Black & Flynn, 2021; Yeager & Roberts, 2015).

Assessing for Risk of Harm to Self or Others

Individuals experiencing a mental health crisis should always be assessed for the risk of harm to self or others. The routine practice of undressing all patients and placing them in a gown serves as a nonconfrontational way to search for weapons. The patient interview setting should be private, but not isolated. The patient and clinician may be seated roughly equidistant from the door, or the clinician may sit between the patient and the door. The patient, however, should not sit between the clinician and the door (Moore & Pfaff, 2020).

ASSESSING RISK FOR SUICIDE

The purpose of a suicide risk assessment is to determine a patient's risk and protective factors with a focus on identification of targets for intervention. There are a number of standardized scales available to evaluate risk of suicide, but none of them is associated with a high predictive value (Schreiber & Culpepper, 2019).

A suicide risk assessment includes:

- Performing a clinical evaluation
- Identifying risk-enhancing factors
- Identifying risk-reduction factors
- Employing clinical judgment

Different kinds of organizations and settings may use different screening tools. The following table lists examples of validated, evidence-based screening tools.

SUICIDE RISK ASSESSMENT TOOLS		
Tool	**Setting**	**Questions/Areas Addressed**
Columbia-Suicide Severity Rating Scale (C-SSRS) Screening Version	For all ages in general healthcare settings; used by individuals trained in its administration	• Suicidal ideation • Intensity of ideation • Suicidal behavior • Actual suicide attempts
Suicide Behavior Questionnaire-Revised (SBQ-R)	Self-report questionnaire for use in ages 13 to 18	• Lifetime suicide ideation and/or suicide attempt • Frequency of suicidal ideation over the past 12 months • Threat of suicide attempt • Self-reported likelihood of suicidal behavior in the future
Ask Suicide-Screening Questions (ASQ)	For patients ages 10 to 24 in emergency departments, inpatient units, and primary care facilities	• "In the past few weeks, have you wished you were dead?" • "In the past few weeks, have you felt that you or your family would be better off if you were dead?" • "In the past week, have you been having thoughts about killing yourself?" • "Have you ever tried to kill yourself? If yes, how?"
(TJC, 2018; NIMH, 2019)		

Once it has been established that an individual is having suicidal thoughts or has attempted suicide, a complete assessment of suicidal thinking and behavior, including the nature and extent of the risk, should be obtained (ZeroSuicide, 2020).

ASSESSING FOR RISK FOR HARM TO OTHERS

The risk for harm to others increases in adolescence, with a peak from late teens to early 20s, then a dramatic reduction in the late 20s and a slow reduction until the 60s, when there is another dramatic reduction. A history of violence or risk to others is vitally important to ascertain. It is also important to remember that some risks are specific with identified potential victims (RCPsych, 2020).

Risk assessment tools provide a standard against which to evaluate individuals for potential harm to others, enabling all healthcare providers to share a common frame of reference and understanding. One such tool is described in the box below.

ASSAULT AND HOMICIDAL DANGER ASSESSMENT TOOL		
Key to Danger	**Immediate Dangerousness to Others**	**Typical Indicators**
1	No predictable risk of assault or homicide	• No assaultive or homicidal ideation, urges, or history of same • Satisfactory support system • Social drinker only
2	Low risk of assault or homicide	• Occasional assault or homicidal ideation (including paranoid ideas) with some urges to kill • No history of impulsive acts or homicidal attempts • Occasional drinking bouts and angry verbal outbursts • Satisfactory support system
3	Moderate risk of assault or homicide	• Frequent homicidal ideation and urges to kill but no specific plan • History of impulsive acting out and verbal outbursts while drinking, on other drugs, or otherwise • Stormy relationship with significant others • Periodic high-tension arguments
4	High risk of homicide	• Has homicidal plan and available means • History of substance abuse • Frequent acting out against others but no homicide attempts • Stormy relationships and much verbal fighting with significant others • Occasional assaults with significant others
5	Very high risk of homicide	• Has current high-lethality plan • Available means • History of homicide attempts or impulsive acting out • Feels a strong urge to control and "get even" with a significant other • History of serious substance abuse • Possible high-level suicide risk
(Hoff, 2009; CDC, 2020)		

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 on his way to the hospital.

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." He reported the gun belonged to his father.

Alan then began an assessment of the risk for harm to others by asking question included in the Assault & Homicidal Danger Assessment Tool. "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. He did, however, respond negatively to questions regarding history of impulsive behaviors and drug or alcohol abuse. Jason reported a positive relationship with his family members, and when asked if he ever felt like "getting even with someone," he replied that he did, but would not disclose who that someone was.

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, based upon his suicidal and homicidal risk assessments.

MENTAL HEALTH EMERGENCY BEHAVIOR MANAGEMENT

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

Such aggressive, violent patients are often psychotic or have substance use issues, but it must never be assumed that the cause of the behavior is a mental disorder or intoxication, including for 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, 2020).

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

- Prevent violent behavior
- Maintain the safety of the patient, healthcare personnel, and others in the area
- Avoid the use of restraints
- Improve patient-personnel connections
- Enable patients to manage their own emotions and to regain personal control (Daum, 2019)

De-escalation

The first step in responding to mental health emergencies is to attempt de-escalation. De-escalation is a combination of strategies, techniques, and methods intended to reduce a patient's agitation and aggression. Nearly all patients who present with agitation or violent behavior should be given the chance to calm down in response to verbal techniques before physical restraints or sedation with medication (*formerly chemical restraint*) are implemented.

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 will not 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 they 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 "Crisis Intervention Communication" earlier in this course.)

- **Agree or agree to disagree.** Use fogging, an empathic technique in which one finds something about the patient's position upon which to agree. (See also "Crisis Intervention Communication" earlier in this course.)

- **Collaborate.** Use a collaborative approach with the goal, of helping the patient calm themself.

- **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 their perspective of the event. Options or alternative strategies should be discussed with the patient and with staff should the situation arise again.
  (Moore & Pfaff, 2020; Daum, 2019)

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 is more humanizing and 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

Initial management should include use of the de-escalation techniques described above. But 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, equipment, or use of medications against the person's will that immobilizes the patient or reduces their ability to move arms, legs, body, or head freely. Restraints may only be used to ensure the immediate physical safety of the patient, a staff member, or others in the vicinity, and they must be removed as soon as the patient and persons in the vicinity are safe.

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 (MHA, 2020; Dugdale, 2019).

SEDATION

Sedation with medication, often referred to as *chemical restraint,* is defined as a drug or medication, or a combination, used as a method for managing a person's behavior, restricting the person's freedom of movement, or impairing the patient's ability to appropriately interact with their surroundings.

Chemical restraint, however, is now considered a historical concept, and **is not standard treatment for the patient's underlying condition**. Today there is an understanding that medications are instead used to treat the condition of agitation and its underlying causes, not for restraint (Zeller, 2017; Moore & Pfaff, 2020).

Sedation with medications may be necessary, with or without physical restraints, and rapid tranquilization may be required in the agitated or violent patient who does not respond to verbal de-escalation techniques. Rapid tranquilization may be required in the severely agitated or violent patient.

Drugs often used for sedation include benzodiazepines, antipsychotics, and dissociative anesthetics. However, currently there are no drugs in the United States that are FDA-approved for use as "chemical restraints."

Because the use of medications for purposes of restraint is not standard treatment for the patient's condition, many hospitals have come to include in their bylaws that they never utilize

"chemical restraints" in their institutions. Instead, they only prescribe appropriate medications indicated in specific clinical conditions.

RESTRAINT REGULATIONS AND REQUIREMENTS

According to the Joint Commission and the Centers for Medicare and Medicaid Services, there are many regulations and requirements that address restraints and restraint use, including:

- The initiation and evaluation of preventive measures that can reduce or prevent the use of restraints
- The use of the least restrictive restraint when a restraint is necessary
- Monitoring the patient during the time that a restraint has been applied
- The provision of care to clients who are restrained

(See also "Resources" at the end of this course.)

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 on 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, while a second nurse assessed the psychiatrist whom Jerry had punched for immediate medical needs.

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.

ASSESSING THE PATIENT EXPERIENCING A MENTAL HEALTH EMERGENCY

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

- Clinical interview and mental status examination
- Assessing for medical causes
- Assessing for substance use causes
- Assessing for mental health disorders

Clinical Interview and Mental Status Examination

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" earlier in this course.)

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, 2018; Moore & Pfaff, 2020).

A mental status examination is a standardized format for the collection of data to evaluate, quantitatively and qualitatively, a range of mental functions and behaviors at a specific point in time. Subjective and observable data obtained is combined with the patient's biographical information, history, and physical for the purpose of making an accurate diagnosis and determining appropriate treatment.

The components of a mental status examination are listed in the table below:

MENTAL STATUS EXAMINATION	
Component	**Assessment Areas**
General appearance	• Body build, posture, dress, grooming, hygiene, prominent physical abnormalities • Level of alertness: somnolent, alert • Emotional facial expression • Cooperative, noncooperative

Psychomotor activity	• Eye contact: intermittent, occasional and fleeting, sustained and intense, no eye contact • Movements: slowed or agitated, tremors, abnormal movements, abnormal gait
Mood	• Prevalent emotional state the patient reports
Affect (emotional state observed)	• Type: euthymic (normal), depressed, irritable, angry, euphoric (elevated, elated), anxious • Range: full (normal), restricted, blunted or flat, labile • Congruent to patient description of mood • Stability: stable, labile
Speech	• Rate: normal, slow, fast, pauses, pressured • Rhythm: speech patterns, dysarthria (e.g., stuttering), monotone, slurred • Organized, disorganized • Volume: loud, soft, muted • Content: fluent, talkative, minimal, impoverished
Perceptions	• Illusions, hallucinations, depersonalization (sensation of unreality concerning the self)
Thought process	• Rate: normal, logical and linear, coherent and goal directed • Abnormal: associations unclear, disorganized, incoherent
Cognitive function	• Level of consciousness • Attention and concentration • Appropriate ability to shift mental attention • Orientation to person, time, and place • Memory: immediate, short and long term • Abstraction: proverb interpretation
Insight/judgment	• Awareness of one's own illness and/or situation • Ability to anticipate consequences of behavior • Ability to make decisions to safeguard one's well-being and that of others
(Townsend, 2018; Alhadi, 2020)	

Assessing for Medical Causes

Medical illness can cause many emotional, cognitive, and behavioral problems, and many times those who have these problems are not aware of them. Therefore, whenever a patient presents

with a psychological problem, there is a real chance there may be a medical condition involved as the cause. **Signs and symptoms** suggesting a medical cause of behavioral abnormalities include:

- Abnormal vital signs
- Cough and fever
- Evidence of head injury or focal neurological findings
- Disorientation with clouded consciousness
- Abnormal mental status exam findings
- Recent memory loss
- Visual hallucinations
- Significant abnormalities on physical examination

"Red flags" that raise the possibility of an underlying medical condition include:

- Absence of mental illness in the family history
- New-onset psychiatric symptoms in patients over 40 years of age
- Patients aged 65 or older
- Rapid onset of symptoms (most mental disorders develop slowly and get worse with time)
- Fluctuation of mental status, which often indicates a dementia, delirium, or metabolic issue
- Unusual sleep patterns, including apnea
- Recent exposure to drugs or toxins
- Polypharmacy in older adults
  (Rodriguez, 2018)

Laboratory tests that should be considered to rule out medical causes of psychiatric signs and symptoms include:

- Pulse oximetry
- Fingerstick glucose testing
- Measurement of therapeutic drugs levels
- Urine drug screen
- Blood alcohol level

- Complete blood count
- Urinalysis

Other tests may include:

- Head CT for patients with new-onset mental symptoms or with delirium, headache, history of recent trauma, or focal neurological findings
- Lumbar puncture for patients with meningeal signs or with normal head CT findings plus fever, headache, or delirium
- Thyroid function tests
- Chest X-ray for patients with low oxygen saturation, fever, productive cough, or hemoptysis
- Blood cultures for seriously ill patients with fever
- Hepatic testing for those with signs or symptoms of liver disease, a history of alcohol or drug use disorder, or with no obtainable history

Less often, findings may suggest the need for testing for:

- Systemic lupus erythematosus
- Syphilis
- Demyelinating disorders
- Lyme disease
- Vitamin B_{12} or thiamine deficiency, especially in those with signs of dementia
- Toxicology screen for recent history of substance abuse
  (First, 2020)

MEDICAL MIMICS

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. Such organic causes may include, but are not limited to:

Endocrine Diseases

- Hypothyroidism (myxedema madness)
- Hypercortisolism (Cushing's disease)
- Pancreatic tumor (insulinoma)

- Adrenal gland tumor (pheochromocytoma)
- Addison's disease (adrenal failure)
- Hypoglycemia

Genetic Disorders

- Huntington's chorea

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)
- Pellegra and other complex vitamin B deficiencies
- Zinc deficiency

Autoimmune Diseases

- Systemic lupus erythematosus
- Hashimoto's encephalopathy
- Multiple sclerosis

Central Nervous System Infections

- Toxoplasmosis
- Cerebral malaria
- HIV
- Neurosyphilis
- Herpes simplex encephalitis
- Meningitis

Seizure Disorders

- Temporal lobe epilepsy

Progressive Neurological Diseases

- Alzheimer's disease
- Pick's disease

Space-Occupying Lesions

- Brain tumors
- Bleeding (subarachnoid hemorrhage, subdural hematoma)
- Brain abscess

Other

- Stevens-Johnson syndrome
- Sepsis
- Urinary tract infections (often missed)
- Medication reactions related to a medical condition
- Delirium tremens
- Hypoxia
- Poisoning
- Sleep apnea/deprivation
  (Diamond, 2019)

MANAGING A PATIENT WITH DELIRIUM

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

- Assess level of anxiety and behaviors that indicate anxiety is increasing; recognize and intervene before violence occurs.
- Monitor for changes in mental status.
- Provide a calm environment with low level of stimuli (increased levels of visual and auditory stimulation can be misinterpreted).
- Orient the patient frequently to time, place, and person, as well as the surroundings, staff, and necessary activities; identify self by name with each contact (increased orientation ensures greater degree of safety).
- Medicate or restrain the patient as prescribed.

- Maintain a calm manner and provide continual reassurance and support.
- Repeat questions if necessary and allow adequate time for response.
- Remove all potentially dangerous objects from the environment.
- Promote safety with one-on-one supervision and have staff available to provide for physical safety of patients and/or caregivers.

(Belleza, 2019a)

Assessing for Substance Use Causes

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, 2017a).

CAUSES OF SUBSTANCE-INDUCED PSYCHOSES

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

- Alcohol
- Stimulants (amphetamines and related substances, crack, cocaine)
- Cannabis (marijuana)
- Hallucinogens (LSD, phencyclidine, ecstasy)
- Inhalants (glue, paint thinner, lighter fluid)
- Phencyclidine (PCP) and related substances
- 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:

- Anesthetics
- Analgesics
- Anticholinergic agents
- Anticonvulsants
- Antidepressants
- Antihistamines
- Antihypertensive and cardiovascular medications
- Antimicrobials
- Anti-Parkinsonian medications
- Chemotherapeutic agents
- Corticosteroids
- Disulfiram
- Gastrointestinal medications
- Muscle relaxants
- NSAIDS
- 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, 2020; Thomas, 2019)

RECOGNIZING SIGNS OF SUBSTANCE-INDUCED PSYCHOSES

Clinicians routinely assess patients for substance use, especially when they exhibit bizarre behaviors typical of mind-altering substances. When people do not know or will not tell caregivers what substances 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.

SIGNS OF INTOXICATION	
Substance	**Typical Signs**
Alcohol	• Disinhibition of sexual or aggressive impulses • Impaired social or occupational functioning • Mood lability • Clumsiness • Difficulty walking • Slurred speech • Sleepiness • Poor judgment • Dilated pupils • Flushed face • Nystagmus (rapid, involuntary movement of the eyes) • Odor of alcohol
Marijuana	• Glassy, red eyes • Loud talking and inappropriate laughter followed by sleepiness • A sweet burnt scent • Loss of interest, motivation • Weight gain or loss

Stimulants (cocaine, crack, methamphetamine, amphetamines, and related substances)	• Hyperactivity • Euphoria or affective blunting (decreased intensity of emotion) • Irritability • Anxiety • Anger • Excessive talking followed by depression or excessive sleeping at odd times • Failure to eat or sleep for long periods • Dilated pupils • Weight loss • Dry mouth and nose
Opiates (heroin, morphine, codeine, methadone, hydromorphone, oxycodone)	• Needle marks • Sleeping at unusual times • Sweating • Vomiting • Coughing and sniffling • Twitching • Loss of appetite • Contracted pupils • No response of pupils to light
Depressants (including barbiturates and tranquilizers)	• Appearing drunk from alcohol but without associated odor of alcohol • Difficulty concentrating • Clumsiness • Poor judgment • Slurred speech • Sleepiness • Contracted pupils
Hallucinogens (mescaline, LSD, psilocybin)	• Dilated pupils • Bizarre and irrational behavior • Paranoia • Aggression • Hallucinations • Mood swings • Detachment from people

	• Absorption with self or other objects • Slurred speech • Confusion
Inhalants (glues, aerosols, vapors)	• Watery eyes • Impaired vision, memory, thought • Secretions from the nose or rashes around the nose and mouth • Headaches and nausea • Appearance of intoxication • Drowsiness • Poor muscle control • Anxiety • Irritability
(Phoenix House, 2020; Erlach, 2017)	

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 every drug is different. Some drugs produce significant physical withdrawal (alcohol, opiates, and tranquilizers). Some drugs produce little physical but more emotional withdrawal (cocaine, marijuana, and ecstasy). Withdrawing from alcohol and tranquilizers can be the most dangerous process, leading to serious complications and even death.

Emotional withdrawal symptoms produced by all drugs may include:

- Anxiety: panic attacks, restlessness, irritability
- Depression: social isolation, lack of enjoyment, fatigue, poor appetite
- Sleep problems: insomnia, difficulty falling asleep, difficulty staying asleep
- Cognitive issues: poor concentration, poor memory

Physical withdrawal symptoms that usually occur with alcohol and tranquilizers may include:

- Head: headaches, dizziness
- Chest: chest tightness, difficulty breathing
- Heart: tachycardia, arrhythmias, palpitations
- Gastrointestinal: nausea, vomiting, diarrhea, stomach pains
- Muscular: muscle tension, twitches, tremors, shakes, myalgia
- Skin: sweating, tingling sensations

Dangerous consequences of withdrawal may include:

- Grand mal seizures
- Heart attacks
- Strokes
- **Delirium tremens (DTs)**, with symptoms including agitation/excitement, irritability, confusion/disorientation/delirium, sudden mood change, fatigue or stupor, restlessness, body tremors, changes in mental function, decreased attention span, sensitivity to light, sound, and/or touch, seizure, hallucinations

Withdrawal from opiates is extremely uncomfortable but not dangerous, unless they are mixed with other drugs. Heroin withdrawal on its own does not produce seizures, heart attacks, strokes, or delirium tremens (Melemis, 2020). Symptoms of withdrawal from opiates include:

- Dysphoric mood
- Nausea or vomiting
- Muscle aches and pains
- Abdominal cramping
- Teary eyes
- Rhinorrhea
- Dilated pupils
- Piloerectors (goose bumps)
- Diaphoresis
- Diarrhea
- Yawning
- Fever
- Insomnia

(Townsend, 2018; Thomas, 2019)

EVALUATION AND MANAGEMENT OF INTOXICATED PATIENTS

Evaluation of intoxicated persons requires obtaining a history of substance use whenever possible, recognition and exclusion of other potential causes of changes in mental status such as medical illness or injury, and identification of the agent or agents involved, including the severity and prediction of toxicity.

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 any diagnostic studies deemed appropriate.

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. Blood alcohol concentrations and toxicology screens may be conducted to confirm a diagnosis.

Management of an intoxicated individual consists of:

- **Supportive care** including airway protection, thermal regulation, maintenance of adequate tissue perfusion and seizure prevention. Supportive care is the most important aspect of treatment and frequently is sufficient to effect complete patient recovery.

- **Prevention of drug absorption** (decontamination) with antitoxin such as activated charcoal.

- **Enhancement of drug elimination** with antidotes such as parenteral naloxone for opiate overdose to treat hypoventilation.

For patients with ethanol intoxication, identification and correction of hypovolemia and hypoglycemia should be done, and intravenous thiamine should be administered in patients at risk of Wernicke's encephalopathy.

Cocaine-intoxicated patients require airway management, benzodiazepine for psychomotor agitation, treatment of severe or symptomatic hypertension (do not use beta blockers), and assessing for and managing cocaine-associated myocardial ischemia. Patients with evidence of end-organ toxicity should be admitted to the hospital (Cowan & Su, 2020; Nelson & Odujebe, 2019; Stolbach & Hoffman, 2019).

Assessing for 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 personality disorder (BPD), characteristically may present in crisis. The core features of a patient with BPD include:

- Impulsive-behavioral dyscontrol

- Unstable and stormy interpersonal relationships

- Unstable self-image and affect

- Cognitive-perceptual symptoms: suspiciousness, ideas of reference, paranoid ideation, illusions, derealization, depersonalization, hallucination-like symptoms

- High rate of self-injury, usually without suicidal intent
- Bouts of intense anger, depression, and anxiety
- Impulsive aggression
- Drug and alcohol abuse

A crisis situation may be triggered by seemingly minor incidents or precipitated by threats of separation, fear of rejection, or expectations that the patient assume responsibility for themselves.

Persons with BPD present complex treatment challenges. They can be exhausting and engage in "black-and-white" thinking, meaning others are either 100% for them or 100% against them (referred to as *splitting*), and they can be dramatic, provocative, and attention-seeking (Slotema et al., 2018; Skodol, 2019).

During a crisis, they may present to a primary care facility in a disinhibited state (i.e., impulsive, angry, raging, verbally and/or physically aggressive) and may display transient psychotic symptoms. Self-harm behaviors and suicidal ideations are the main reasons people with borderline personality disorder present for healthcare services.

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 and begins with the establishment of therapeutic boundaries that provide structure, containment, and direction (WCHM, 2020a).

TIPS FOR WORKING WITH PATIENTS WITH PERSONALITY DISORDERS

- Listen to the person's current experience.
- Acknowledge the patient's feelings and validate the emotional experience.
- 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.

- Maintain a nonjudgmental approach.
- Stay calm.
- Remain respectful.
- Expect a heightened vulnerability to rejection and situational stress.
- Do not take interactions personally or react emotionally to behaviors.
- Avoid power struggles.
- Inquire about effective management strategies used in the past.
- Assist in alleviating anxiety by encouraging the use of coping skills and focusing on the current problem.
- Convey encouragement and hope about the capacity for change.
- Give choices as often as possible, with clear and reasonable limits.
- Do not threaten, give ultimatums, or set excessive restrictions, as they will give the patient reason to escalate.
- Try to accommodate needs if able and explain why if unable.
- Be aware of both verbal and nonverbal communication.
- Explain what is happening and try to decrease anxiety as much as possible.
- Remember that aspects of challenging behaviors have survival value given past experiences.
- Expedite the process of evaluation.

(WCHM, 2020b)

MANIA

Mania, the manic aspect of bipolar disorder (also known as *manic-depressive disorder*), is characterized by cycles of extreme mood swings and behavior. It is important to remember that mania can also be caused by medical disorders such as metabolic abnormalities, neurological disorders, central nervous system tumors, medications, or certain substances of abuse.

Manic moods can rapidly move on to irritability, with unpredictable behavior and impaired judgment. The person may 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. 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 episode, an individual can behave impulsively, recklessly, and take unusual risks. One important feature of manic episodes is the person's failure to be aware of negative

consequences. These people are totally unaware of the magnitude of their impairment and harmful behaviors. Such behaviors can include drug abuse, promiscuity, looting financial resources, and gambling, among others. Persons in a manic state may also be uncharacteristically creative, charismatic, or generous.

During a manic phase, patients may be labile, anxious, or paranoid. They often feel invincible and act impulsively with little regard for their personal safety or painful consequences. There is a high risk of killing themselves either intentionally or accidentally by putting oneself deliberately in a position of high risk. Often, they are confused about why others are concerned about them, as they do not see anything wrong with their behaviors (NAMI, 2017b).

Severe episodes of mania are medical emergencies characterized by suicidal or homicidal ideation or behavior, aggressiveness, psychotic features, and/or poor judgment that places the patient or others at imminent risk of being harmed. Acutely ill patients may require physical restraints or sedation with a benzodiazepine. Severely ill patients generally require hospitalization and stabilization with medications (Stovall, 2019).

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 make safety a priority goal and 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
  (Belleza, 2019b)

PSYCHOTIC DISORDERS

There are several types of psychotic disorders, one of which is schizophrenia, a catastrophic chronic psychotic disorder that 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, for example, "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, for example, breaking a window to "let the bears out."

Patients with schizophrenia are frequently seen in emergency departments. They present with issues such as exacerbation of systems due to medication noncompliance; adverse reactions to medications; or socioeconomic crises that arise from either substance abuse, poverty, homelessness, or a failed support system.

Suicide is the largest contributor to the decreased life expectancy in individuals with schizophrenia. Throughout the first decade of their disorder, patients with schizophrenia are at substantially elevated suicide risk, although they continue to be at elevated risk throughout their lives, with times of worsening or improvement (Sher & Kahn, 2019).

Acute psychosis is a common mental health emergency, and verbal de-escalation should be attempted first. The primary concern in both prehospital care and emergency department care is the providers' and the patient's safety, and this may require physical restraints or sedation (Kohn, 2018). Other **interventions** include:

- Speaking in a low voice and as slowly as possible
- Using clear or simple words and keeping directions simple as well
- Using simple, concrete, and literal explanations
- **Not** pretending to understand what the patient is saying; letting the patient know you are having difficulty understanding
- Keeping the environment calm, quiet, and as free of stimuli as possible
- Recognizing that delusions are the patient's perception of the environment; helping draw focus away by directing attention to concrete things in the environment
- Identifying feelings related to delusions to reduce anxiety and letting the patient know they are being understood

- Looking for themes in what is being said, since often the choice of words is symbolic of feelings
- Explaining procedures before carrying them out
- Redirecting to reality-based activity to help the patient focus attention externally
- Giving the patient a lot of space and **not** touching the patient unless absolutely necessary, since a suspicious patient may misinterpret such gestures as sexual or aggressive
- Avoiding attempts to convince the patient that hallucinations or delusions are not real, as this increases defensiveness
- Empathizing with and reassuring the patient of acceptance
- Offering comforting options such as a meal, a blanket, or a pillow in order to decrease anxiety
- Utilizing standard safety measures

(Martin, 2019)

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 (hypochondria), anxiety, agitation, or physical immobility. They very often present with suicidal ideation or behaviors.

Depression can also present with psychotic features, including delusions, auditory hallucinations, or some other break with reality. Psychotic depression affects roughly 1 out of every 4 people admitted to the hospital for depression. Having one episode of psychotic depression increases the chance of bipolar disorder with reoccurring episodes of psychotic depression, mania, and even suicide. 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).

Delusions are often mood-congruent, 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 their wake and sleep cycle, neglect personal hygiene, and abuse alcohol and drugs. They may worry excessively that they are sick to the point of debilitation. They are also at elevated risk for accidental injury, self-harm, or suicide (Bhandar, 2020).

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

- Anger, irritability, or annoyance even over small matters
- Frequent somatic complaints, such as stomach aches or headaches
- Extreme sensitivity to criticism, rejection, or failure
- 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
- Poor performance in school
- 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 (Mayo Clinic, 2020; Alli, 2018).

Initial management of a patient with major depressive disorder is to ensure safety. These patients must be assessed for suicidal ideation, suicide plans, and psychotic symptoms that place the patient at imminent risk of coming to harm, as well as to rule out medical causes of a major depressive disorder.

Treatment for severe depression may require a hospital stay or an outpatient treatment program until symptoms improve. Usually, treatment for psychotic depression is given in a hospital setting, where the patient can be closely monitored by mental health professionals. Major depression with psychotic features is often treated with an antidepressant and an antipsychotic or with electroconvulsive therapy (Rothschild, 2019; Bhandar, 2020).

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, sobbing, “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 even harder. 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 can result in hysterical or irrational behavior. They may behave automatically, lose touch with reality, and experience false sensory perceptions.

It is common for these patients to present to health professionals repeatedly, with pressing but long-standing concerns that prove to be medically unexplained. Anxiety disorders have one of the longest differential diagnosis lists of all psychiatric disorders and may be related to a wide variety of medical or psychiatric syndromes. Symptoms can also be the result of certain medications (Bhatt, 2019).

People experiencing a panic attack may come to the emergency department because they feel they are experiencing a heart attack, and evaluation must ensure that there is no underlying medical condition to account for the following symptoms and signs:

- Chest pain or discomfort
- Dizziness or feeling faint
- Fear of dying, sense of doom

- Feeling of choking
- Feelings of detachment
- Feelings of unreality
- 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
  (Berger, 2018)

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, 2018).

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. Intravenous anxiolytic medication may be necessary in patients with panic disorder who have poor impulse control and pose a risk to themselves or to those around them.

Patients in crisis with anxiety disorders usually do not require hospitalization. Instituting treatment for panic disorder in the emergency department is appropriate in a very limited subset of patients who are highly motivated and cooperative and who have an understanding of the psychological nature of their disorder. 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, who will determine the need for anxiolytic medications (Memon, 2018).

ETHICAL AND LEGAL ISSUES

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. Ethics is 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 (OU, 2017).

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 and offer 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, 2018). 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. There currently are many state, federal, and case laws that affect the treatment of people with psychiatric disorders. 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
  (Casarella, 2020)

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, 2020)

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 undergoing any form of 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 a **psychiatric advance directive** (PAD), a legal document that puts forth a person's preferences for future mental health treatment if unable to make decisions during a mental health crisis. A psychiatric advance directive may be drafted when a person is well enough to consider preferences for future mental health treatment and allows appointment of a health proxy to interpret those preferences during a crisis (NRCPAD, 2018).

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 them to hurt themself, 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.

The Code of Federal Regulations (2019) states that restraints and seclusion may be used only when absolutely necessary or when patients request seclusion to reduce sensory stimulation. Restraints should be applied only by healthcare professionals who are adequately trained in correct techniques and in protecting patient rights and safety. Orders for restraint or seclusion must be given by a physician or other licensed practitioner permitted by the state and the facility and who is trained in their use. They should be for the least restrictive emergency safety intervention most likely to be effective in resolving the situation.

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. 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.

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 hospitalization for evaluation is a crisis response in which a patient is admitted to a treatment facility for psychiatric evaluation, typically for a short period of fixed time (e.g., 72 hours). This is often referred to as a *psychiatric hold*. In general, emergency hospitalization is permitted when people are a danger to themselves, a danger to others, or severely disabled (unable to provide for their basic human needs such as food, clothing, shelter, health, or safety).

Inpatient civil commitment is a process in which a judge orders hospital treatment for a person who continues to meet the state's civil commitment criteria after the emergency evaluation period. Inpatient commitment is practiced in all states, but the standards that qualify an individual vary from state to state. *Involuntary hospitalization* is another term used to describe the process.

Outpatient civil commitment is a treatment option in which a judge orders a qualifying person with symptoms of mental illness to adhere to a mental health treatment plan while living in the community. Standards and laws vary from state to state. Other terms to describe this process include "*outpatient commitment, involuntary outpatient commitment,* or *mandated outpatient treatment*.

In order to secure treatment during or following a mental health crisis, it is important to know the civil commitment laws and standards that determine eligibility for intervention in the state in which the person resides (Treatment Advocacy Center, 2018).

THE HISTORY AND 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. Involuntary hospitalization has its beginnings in the 12th century, and historical evidence finds that in 17th-century Europe placement in an "asylum" was common among:

- Poor inhabitants up to age 25
- Girls who were involved in socially unacceptable sexual behaviors or were at risk for such behaviors
- Other "miserables" of the community, including those with epilepsy, venereal disease, and chronic diseases of all sorts

(Rosen, 1963)

For example, in the State of Illinois in 1860, the wife of a minister was incarcerated for disagreeing with him on a spiritual matter, declared "morally insane," lost custody of her children, and was placed in a mental hospital, where she remained for 3 years. Illinois statutes of the time declared that married women may be entered or detained in the hospital at the request of the husband or guardian "without the evidence of insanity that would be required in other cases" (Packard, 1868).

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."

Currently there is considerable debate between those who demand liberty and privacy for psychiatric patients and those who advocate for reasonable interventions to better serve

patients, families, and the public. The point of view of those who side with the principles of liberty and privacy states that individuals should be free from societal restraints and that access to personal information, or in this case medical information, should be obtained only if consent is given or in emergency situations.

The other point of view is that judicious and limited use of involuntary and humane psychiatric care should be used, but as a last resort, after every attempt has been made to thoughtfully engage patients in accessible, kind, and comprehensive services on a voluntary basis. The debate, however, hinges upon how "judicious" and "limited" are defined and acted upon (Miller & Hanson, 2017).

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

People can experience mental health crises for many different reasons. Some require a quick crisis intervention, and some require more in-depth interventions. Healthcare professionals are likely to encounter a patient who is experiencing a mental health crisis, and using a systematic approach to helping these patients resolve the 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 disorder, or mental illness diagnosis. 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 for healthcare and with regard for the legal issues and consequences that may be involved.

RESOURCES

Community Emergency Response Team (CERT) (FEMA)
https://www.ready.gov/cert

Crisis text line
https://www.crisistextline.org
Text "HOME" to 741741

Hospital patient's rights law
http://federal.elaws.us/cfr/title42.part482.section482.13

Joint Commission Standards on Restraint and Seclusion
https://www.crisisprevention.com/CPI/media/Media/Resources/alignments/Joint-Commission-Restraint-Seclusion-Alignment-2013.pdf

Mental Health America
https://www.mhanational.org

National Alliance on Mental Illness
https://www.nami.org/Home

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org
988 or 800-273-TALK (8255)
866-833-6546 (teen link)
741741 (crisis text line)

Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline
https://www.samhsa.gov/find-help/national-helpline
800-622-HELP (4357)

Sober Recovery
http://www.soberrecovery.com

Violence prevention (CDC)
https://www.cdc.gov/violenceprevention

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TEST

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1. Which behavior would indicate a mental health **emergency** instead of a mental health crisis?

a. Paranoid thinking
b. Not being able to take care of oneself
c. Acting on a suicide threat
d. Missing some doses of prescribed psychiatric medications

2. A young mother who has feelings of anger toward her newborn may be experiencing which **type** of crisis?

a. Maturational
b. Situational
c. Social
d. Adventitious

3. A person who has become overwhelmed with anxiety and for whom external supports become necessary is in which **phase** of crisis?

a. Escalation phase
b. Personality disorganization phase
c. Crisis phase
d. Initial threat or triggering phase

4. 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 response is an example of using which **balancing factor**?

a. An available situational support
b. An adequate coping skill
c. A crisis equalizer
d. An unrealistic perception

5. Which contributing factor increases the risk for a mental health crisis?

a. Belief in an internal locus of control
b. Emotional awareness
c. Lack of sleep
d. Optimistic outlook

6. A sign or symptom of crisis seen more often in younger children is:

a. Moodiness.
b. Poor concentration.
c. Regression.
d. Anger and frustration.

7. One of the **goals** of crisis intervention is to:

a. Decrease the person's support system.
b. Avoid experiencing future challenges.
c. Increase the number of balancing factors.
d. Return to a precrisis level of functioning.

8. In performing a focused assessment for a patient experiencing a mental health crisis, the emergency department triage nurse's **primary** consideration is:

a. The acuity of patients already receiving treatment in the ED.
b. How quickly and to whom the patient should be referred.
c. The number of other patients in the intake area who have not yet been triaged.
d. How many ambulances are said to be en route to the facility.

9. Asking a patient, "What were you feeling when that happened?" is an example of which communication technique?

a. Encouraging
b. Attending/Acknowledging
c. Probing
d. Using an "I" message

10. Which is a **correct** statement about Roberts' Seven-Stage Crisis Intervention Model?

a. Stages are sequential but may overlap in process.
b. Stage 1 involves identifying major problems.
c. Stages must be completed before moving to the next stage.
d. Stage 2 explores alternatives.

11. When attempting to de-escalate a mental health emergency with a patient who is threatening violent behavior, which action does the clinician take?

a. Immediately moves to physically restrain the patient
b. Stands with hands on hips and makes continuous eye contact with the patient
c. Interrupts the patient whenever they make aggressive statements
d. Gives the patient the chance to calm down in response to verbal techniques

12. Which is a **true** statement concerning the use of seclusion and restraints?

a. Restraints involve using the most restrictive measures possible.
b. Seclusion and restraints are considered treatment interventions.
c. Seclusion and restraints are employed in order to help the patient change behavior.
d. Seclusion and restraints are safety measures of last resort.

13. A mental status examination includes an assessment of the patient's:

a. Allergies.
b. Social habits.
c. Past surgical history.
d. Insight and judgment.

14. Which is a "red flag" that raises the possibility of an underlying medical condition causing a psychological problem?

a. A positive family history of mental illness
b. A new onset of psychiatric symptoms
c. An abnormal mental status exam finding
d. A slow onset of psychiatric symptoms

15. Which are typical behaviors that the clinician may observe in a patient with schizophrenia who is experiencing a mental health crisis?

a. Delusions, hallucinations, and flat affect
b. Extreme elevation of mood and psychomotor agitation
c. Black-and-white thinking and recurrent suicidality
d. Reverse wake and sleep cycle and neglect of personal hygiene

16. Patients with anxiety disorder in mental health crisis may present with:

a. Mania.
b. Hallucinations.
c. Bouts of intense anger and depression.
d. Symptoms similar to those of a heart attack.

17. Which action by the clinician supports the autonomy of a patient experiencing a mental health crisis?

a. Choosing and evaluating medical interventions for the patient

b. Recognizing that beneficence overrides the patient's autonomy

c. Providing factual information on interventions, including the benefits and risks

d. Encouraging the patient to ignore the risks of an intervention

18. A legal document that specifically puts forth a person's preferences for future mental health treatment during a mental health crisis is called a:

a. Psychiatric advance directive.

b. Healthcare proxy.

c. Living will.

d. Durable power of attorney for healthcare.

19. Prior to securing the involuntary admission of a patient for inpatient treatment during or following a mental health crisis, the clinician's priority is to determine:

a. The beneficence of all potential treatment interventions.

b. The civil commitment laws and standards in the state.

c. Whether restraints or seclusion will be required during hospitalization.

d. Whether the patient has mental health insurance coverage.