Understanding Crisis Services: What They Are and When to Access Them

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PSYCHIATRIC EMERGENCIES

Many experts predict a sharp rise in psychiatric emergencies as the nation emerges from sheltering-in-place, especially since individuals are dealing with unprecedented stressors and have been unable to access traditional treatment settings. Mental health crises may be one area in which therapeutic professionals might be a logical substitute for traditional police interventions. But what services comprise the crisis spectrum of care? And, if you treat patients in a private office or clinic, how might you best access these services when you encounter a psychiatric emergency?

Crisis services for behavioral health emergencies may include a wide variety of approaches, and they tend to vary depending on your state, county, or community. Yet, there are general overall concepts applicable to most crisis programs and their target patient populations.

What is a mental health crisis?

A mental health crisis is a situation in which a person's thoughts, emotions, and behaviors can put them in jeopardy of harming themselves or others and/or put them at risk of being unable to care for themselves or access food, clothing, and shelter. Crises also include acute conditions that could quickly deteriorate into dangerousness or inability to care for self, even if those issues do not currently pose a problem.

A mental health crisis can surface anywhere—in public, in the home or work environment, or in any number of clinical settings. This discussion will focus on the considerations when an apparent crisis arises in patients under a clinician's direct care.

Key yes/no questions

The following questions will help determine if a mental health crisis exists and if crisis services should be accessed (Figure).

1. Due to their behavioral health conditions, is this individual acutely dangerous to self or others, or unable to care for self?
2. If the answer to question 1 is not clear, are there concerns that, without prompt intervention, the behavioral health situation could evolve into dangerousness or inability to care for self?

If the answer to question (1) or (2) is "yes," then answer (A) and (B) below.

A. Is this condition unlikely to be resolved by interventions without the need for a higher level of care?
B. Even if our interventions can temporarily stabilize the situation, is there a high degree of concern that dangerousness or inability to care for self will return shortly after our contact has ended?

If the answer to (A) or (B) is "yes," then there is a crisis situation requiring acute external interventions.

Determining dangerousness and/or inability to care for self

The clinician should consider several factors when assessing a patient for dangerousness and ability to care for self.

***Familiarity*.** Is this the first time you have met with this individual, or are they well known to you?

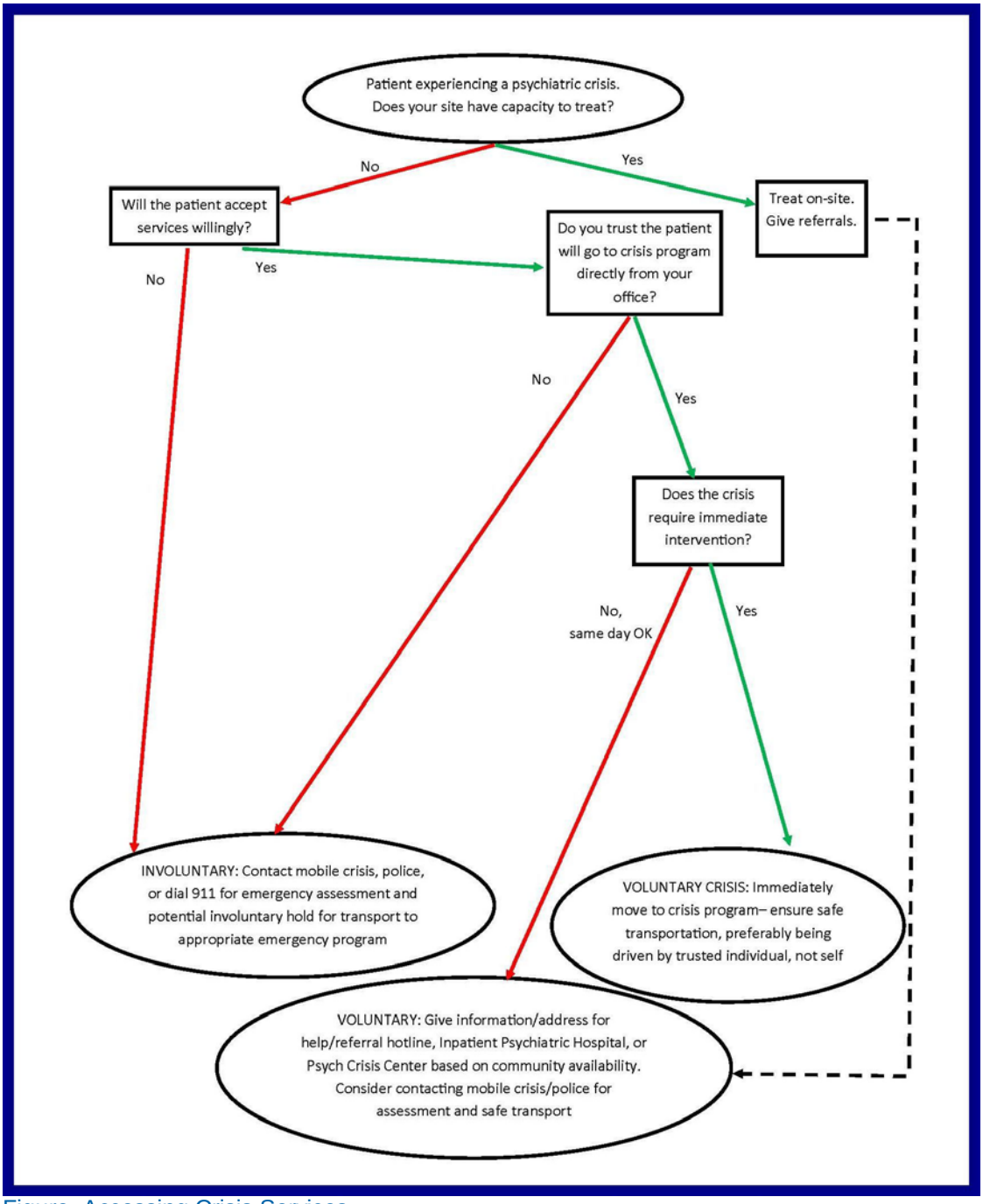

Figure. Accessing Crisis Services

***Trust*.** How certain are you about the veracity of their statements? Do you believe them when they say they will follow through with a plan?

***Knowledge of Past Behaviors*.** What is your understanding of how they have acted when experiencing similar behavioral issues in the past?

***History of Dangerousness*.** Has this person made suicide attempts or become aggressive in the past?

***Collateral Opinions*.** What do family, significant others, co-workers, and caregivers say about the patient's current behavior and their concerns about these behaviors?

The pearls

There are a number of things to keep in mind when a patient appears to be in a psychiatric crisis.

When possible, voluntary engagement is best. A willing, cooperative patient who understands their treatment goals and plan almost invariably has better outcomes than someone forcibly detained and transported involuntarily. If safe to do so, collaborate with patients on an appropriate plan that they find agreeable. The least restrictive, voluntary setting for crisis care should also be targeted in this way.

Err on the side of safety*.* Always choose the option that ensures your patient will safely reach the intended destination. It is far better to have temporarily involved police than to have an individual go missing, fail to arrive for treatment at the emergency program, or jump from a moving vehicle en route to help.

Do not overreact/use knee-jerk responses. Patients may talk about past thoughts or fantasies of dangerous behaviors. Do not immediately call 911 just because a patient says the word *suicide* or offhandedly mentions a thought of killing another out of frustration. Carefully explore what the person is saying before determining the need for referral to a higher level of care. Of course, always err on the side of safety.

Do not fear potential backlash. Therapists might be reluctant to engage emergency services or obtain an involuntary hold because they are concerned their patient will feel betrayed. Although an individual might initially be angry, in most cases, they will later be very thankful that you cared, intervened, and saved their life.

Upon initiation of treatment relationship, obtain signed consents from all your outpatients so you can stay involved during and after any crisis. It is a good idea to have all your patients sign a general consent allowing you to be informed of their assessment, treatment, and disposition within crisis services. A signed consent transmitted to a crisis program will allow that program to involve you in the care of your patient while respecting HIPAA privacy laws. However, it is important to note that the patient can always choose to rescind any previously signed consent.

Be familiar with your community/county resources before you encounter a crisis**.** Trying to determine resources in the heat of the moment is already far too late. Be aware of the voluntary and involuntary crisis services available in your community before you are faced with a crisis.

These considerations and questions help to determine the acuity and level of intervention needed. For example, an initial meeting with reported symptoms requires a different level of evaluation than if the patient and their symptom history are well-known to you. Similarly, a patient that is well-known who reports a sudden change or demonstrates a marked difference from their usual behavior should raise the level of acuity. Based on familiarity, you must evaluate your level of trust with the patient. If trust is nebulous, then it is paramount to delve into collateral opinions of family and significant others. Concerns may first arise from a patient's report, their significant others' report, or your personal assessment. Regardless of the source of the initial warning, the response should be comparable.

Suicidality

Although an individual's mention of the word *suicide* in discussing previous thoughts or incidents may not be considered a reason for accessing crisis services, **any concern that patients may be at risk to harm themselves should be considered a reason for action**. It is most important to learn about an individual's thoughts around suicide, especially if there is any suicidal plan or intent. To determine if a patient needs a higher level of care, clinicians should consider the following issues.

Ideation*.* Is the person thinking/talking about suicide, or saying that death seems to be an option, or expressing that the world would not miss them/would be a better without them?

Plan*.* Does the person have a specific idea about how they would kill themselves? How lethal is this method?

Intent. How much does the person want to use a particular method to kill themselves? How serious are they about it?

Ability*.* Does this individual have access to the means they have described to kill themselves?

Mitigating factors. Does the person have strong religious or cultural beliefs that forbid suicide? Do they have others who rely on them that they feel they cannot leave?

Acute Psychosis

Chronic symptoms of psychosis may be a well-controlled part of an individual's life and not necessitate an emergency referral. **Acute psychosis, however, may lead the patient to harm themselves or others or may cause an inability for them to care for themselves.** For example, if the patient is currently

stable and the hallucinations are tolerable and not placing the patient at risk, then long-standing auditory hallucinations (e.g,, a running commentary of what the patient sees) may be fine. On the other hand, a new delusion may necessitate intervention, especially if the hallucinations have negative consequences for the patient (eg, hallucinations dictating all food is poisonous and must be avoided, which results in the patient starving themselves). Similarly, command auditory hallucinations to attack family members or delusions that one has the ability to fly and should jump off a tall building are clearly psychiatric emergencies. Thus, there are many issues that must be considered.

Auditory Hallucinations. Is the person newly experiencing auditory hallucinations or experiencing a substantial increase in chronic hallucinations? Are the hallucinations commanding them to do things, especially to harm themselves, others, or objects? Are the hallucinations derogatory or highly critical of the patient? Does the patient feel they are unable to resist doing what the hallucinations are telling them?

Delusions/Paranoia. Does the person feel others wish to harm them and they might have to defend themselves or preemptively attack others? Does the person believe other people want to kill them? Is the person obsessively fixated on another person who may not share their feelings? Is the patient paranoid or delusional about anything that would prevent them from accessing food, clothing, or shelter (eg, if they go inside they will die, all foods are poisonous, they are impervious to cold and do not require a coat in subzero weather)?

Disorganization. Has the individual become so confused or withdrawn that they are unable to appropriately interact with others and their environment and, thus, unable to access food, clothing and/or shelter?

Mania/hypomania

When symptoms of mania are uncontrolled, there is risk for harm to self or others as a result of rash judgements, impulsivity, inability to rest, grandiosity, and impaired decision-making. Evaluating the severity of a manic or hypomanic episode may be determined with the following considerations.

Judgment. Is the person displaying poor judgment, unable to differentiate between right and wrong, spending money they do not have, placing themselves into dangerous situations unwittingly?

Energy. Is the patient going without sleep or doing specific activities nonstop for long hours?

Mood. Is the person easily angered, lashing out, or easily moved to anguish and sobbing?

Substance use

Substance use, unlike uncontrolled mania, is often more objectively apparent in terms of current intoxication or effects of drug misuse. The severity of substance abuse may be apparent in terms of mood, judgement, or disorganization.

Mood. Is the person despondent about their substance abuse or inability to quit? Have they mentioned suicide?

Judgment. Is their current intoxication or level of withdrawal clouding their judgment and putting them at risk?

Disorganization. Can the person safely leave the facility and get home on their own?

Types of crisis programs

Fortunately, there are a variety of crisis programs that can assist the clinician in providing help for their patient. Programs vary in their level of care and support as well as cost. By becoming familiar with the options in your area, you will be better able to offer information to patients before a crisis occurs as well as when the need arises.

Hotlines. The national suicide hotline number is available in most areas; it can be reached via 800-273-TALK. The FCC has approved a 3-digit hotline number—988—to make it easier for people to access mental health resources, which should be available by summer 2022. If you are in direct contact with a patient, you likely will not need to refer them to a hotline; however, you will want to ensure patients are informed about such resources and should add the information to your voicemail message.

ACCESS programs. Although technically not crisis programs, many county and municipal programs have a 24-hour mental health line, sometimes called an ACCESS line, to arrange for prompt mental health appointments, referrals, and links to services. These programs can also direct individuals to appropriate crisis services.

Mobile Crisis Teams. These are crisis professionals, typically therapists or social workers, who will go to an individual in crisis for an onsite assessment. When possible, they will attempt to de-escalate and stabilize the patient at the site, so the patient does not need to be moved offsite to access a higher level of care. Based on the assessment, mobile crisis teams will often transport patients to an appropriate destination, which could be a community crisis center, a psychiatry emergency department (ED), a psychiatric inpatient unit, or a general hospital ED. Mobile crisis models can operate independently or may partner with the police; frequently the mobile crisis team can be accessed via police dispatch.

Community crisis programs/centers/mental health urgent care. In recent years, many locations around the country have created drop-in crisis facilities. These can range from a simple set-up, like a section of the community mental health clinic staffed with crisis therapists, to a comprehensive crisis center with crisis intervention, 23-hour crisis stabilization units (intensive outpatient stabilization services which typically have a limit of 23 hours 59 minutes—anyone requiring a longer stay is moved to an inpatient unit), and substance abuse and/or detox programs. Patients typically need to arrive voluntarily, but mobile crisis teams, case managers, and police officers can also bring them to these centers. Although they may be able to accommodate involuntary detention patients, including initiation of involuntary holds, these patients are typically transferred to a medical ED or hospital rather than remaining onsite involuntarily.

Psychiatric Emergency Programs. Although not available in every region,, a substantial number of locations have Psychiatric Emergency Programs that are designated as the main receiving site for involuntary and high-acuity psychiatric detentions. These programs typically accept voluntary patients and self-presenting individuals, but most patients tend to be involuntary cases that arrive via police or ambulance. These programs offer immediate assessment and treatment (including medication) with 23-hour crisis stabilization capacity. These units are invariably locked, so anyone entering will have to be discharged by a clinician before they can leave. For this reason, it may be the preferred option for individuals who refuse emergency care or who are flight risks.

Psychiatric Hospitals. Most inpatient psychiatric hospitals accept the majority of their patients via direct referrals from psychiatrists with hospital admitting privileges or via referrals from regional medical and psychiatric EDs. However, many programs have intake hours in which an individual can self-present on recommendation from their outpatient therapist. In such situations, a member of the psychiatric hospital staff will assess for a possible admission to the inpatient unit.

Hospital Medical EDs. In the United States, the default location to send a crisis patient is the nearest general hospital medical ED, which is open 24 hours a day and obliged to evaluate any individual who requests services. The numbers of behavioral emergency patients presenting at medical EDs around the country has climbed in recent years, and it is currently estimated that 1 in every 8 patients in EDs present with a behavioral emergency as the chief complaint.[1] Most EDs, however, have little more to offer than a medical clearance, (perhaps) sedating medications, or a referral to an inpatient hospital bed.

A promising trend has been to offer higher levels of psychiatric care in medical EDs, including psychiatric assessment and treatment recommendations via on-demand telepsychiatry. Another new and useful trend is the availability of EmPATH (Emergency Psychiatry Assessment Treatment and Healing) units, which are specialized psychiatric emergency programs affiliated with the ED, analogous to an ICU dedicated for emergency behavioral health patients.

911. When there are no other alternatives, calling 911 remains a legitimate best option for activating emergency services. It allows for a patient assessment and transport to a crisis facility or ED. Depending on your community or state as well as the acuity of the emergency, response may be from a crisis team, emergency medical services, and/or police.

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Reference

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