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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

- Review types of crises, mental health emergencies, and how to recognize them.
- Describe the crisis intervention process and models of intervention.
- Summarize the assessment and management of a patient experiencing a mental health crisis.
- Discuss the appropriate care for patients experiencing a crisis related to substance use or a mental illness.
- Identify ethical and legal matters regarding mental health issues.

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.

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).

Mental health issues are widespread, affecting 20% of U.S. adults every year. Many nurses and other healthcare professionals are often the frontline providers when an individual is facing a mental health crisis. However, many of these professionals may feel a lack of educational preparation, confidence, and experience to intervene appropriately. Without knowledge and skills, front-line healthcare workers may experience frustration, unhappiness, fear, and a perception of danger when interacting with patients facing a mental crisis or mental health issues (Peralta et al., 2021).

WHAT IS A MENTAL HEALTH CRISIS?

A crisis in general 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 **mental health crisis** is defined as an acute disruption of psychological homeostasis in which one's usual coping mechanisms fail, with evidence of distress and functional impairment. It is a person's subjective reaction to a stressful life experience that compromises their ability to cope or function (Ernstmeyer & Christman, 2022).

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

Development is a continuous process from infancy to adulthood. Each stage of development brings with it a new set of challenges and opportunities. Maturational (also known as *developmental* or *normative*) crises may occur at any transitional period in the normal process of 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 a person arrives at a new stage, formerly used coping styles are no longer appropriate, and new coping mechanisms have yet to be developed. For a time, the person is without adequate or effective defenses, which leads to increased anxiety and may manifest as variation in the person's normal behavior. Life stages and related concerns may include:

Infancy

- Forming secure healthy attachments

- Stranger wariness and separation anxiety
- Emotional regulation

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
- Marriage
- 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
(Newton, 2022)

SITUATIONAL CRISES

A situational crisis (also referred to as an *accidental* or *external* crisis) results from unanticipated, sudden, and unavoidable events that largely affect a person's identity and roles, and revolves around grief, usually from a loss of an established situation that threatens a person physically, socially, or psychologically. Such events may include:

- Unexpected job loss
- Change in financial status
- Academic failure
- Divorce
- Mental illness
- Birth of a child with a disability or other healthcare issues
- Diagnosis of chronic or terminal illness
- Serious injury
- Death of a child
- Loss of a spouse
(Behera, 2021)

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
- Crimes of violence (e.g., rape, assault, murder in workplace or school, bombing in crowded areas, spousal or child abuse)

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.

COMMUNITY EMERGENCY RESPONSE TEAMS (CERT)

The Federal Emergency Management Agency (FEMA) provides a systematic approach to the work necessary during 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 can take many different forms, but they often involve a fundamental challenge to the values, beliefs, and practices that define a particular culture or society. A sociocultural crisis refers to a situation in which a culture or society experiences significant upheaval or disruption. This can be caused by various factors such as political changes, economic instability, natural disasters, discrimination, or other events that disrupt the way of life for a group of people. A recent example would be the COVID-19 pandemic (Forsyth, 2022).

MENTAL ILLNESS CRISES

Individuals with diagnosed mental illness are at greater risk of experiencing a 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.

Such 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 that 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).

PSYCHIATRIC EMERGENCIES

A psychiatric emergency (also called a *behavioral crisis*) occurs when a person's behavior is so out of control that the person becomes a danger to self and others. The situation is so extreme that the person must be treated immediately. Psychiatric emergencies involve crisis situations in which general functioning has been severely impaired and the individual rendered incompetent or unable to assume personal responsibility. Such emergencies can arise due to mental illness, substance use, or medical conditions that can result in mental changes. The signs of a behavioral emergency include:

- Extreme agitation

- Threats to harm self or others
- Yelling or screaming
- Lashing out, throwing objects
(PsychGuides, 2023)

Phases of Crisis

The CDC describes four phases of crisis:

- **Phase 1: Normal stress and anxiety.** Exposure to a precipitating stressor is considered a minor annoyance and inconvenience of everyday life. Anxiety levels or stress response begin to elevate. The person tries using previously successful problem-solving techniques to attempt resolution of the stressor. At this point, the individual is rational and in control of behavior and emotions.
- **Phase 2: Rising anxiety level.** Problem-solving techniques do not relieve the stressor. Use of past coping strategies are not successful. Anxiety levels increase and the person experiences increased discomfort. Feelings of helplessness, confusion, and disorganized thinking may occur. The person may experience tachycardia and tachypnea. Voice pitch may be high, with a more rapid speech pattern. Nervous habits such as finger or foot tapping may be evident.
- **Phase 3: Severe level of stress and anxiety.** The person uses all possible internal and external resources available. Problems are explored from different perspectives, and new problem-solving techniques are attempted. The person's capacity to reason becomes significantly diminished, and behaviors become more disruptive. The person may begin to pace or clench fists, communication may include yelling and swearing, and the person may become argumentative or use threats.
- **Phase 4: Crisis.** If resolution is not achieved, tension escalates to a critical breaking point. The person may experience unbearable anxiety, increased feelings of panic, and disordered thinking process. Many cognitive functions are impaired, and emotions are labile. Some may experience psychotic thinking. At this point, people may be a danger to themselves or others.
(CDC, 2020a; Ernstmeyer & Christman, 2022)

Balancing Factors

Individuals respond to a crisis in their own unique ways. There are certain factors that determine the way they respond, referred to as *balancing factors*. These 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 access to adequate resources, restoration of homeostasis will occur, and there will be no crisis. A realistic perception occurs when a person can 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 mechanism. These may include denial, rationalization, repression, regression, dissociation, or avoidance. However, if the person can 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 (Shastri, 2020).

Crisis Resolution

Crises are acute, time-limited situations usually lasting several days but no longer than four to six weeks, which can be resolved in some way. Possible crisis outcomes include:

- The situation will change and the person will return to a precrisis state.
- The person will develop new coping skills and resources.
- The person will avoid crisis by substance abuse, suicide attempt, or other destructive behaviors.

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. It is important to note, however, that some precipitating events can never be undone, such as being raped or having a spouse die, and so the option of returning to a precrisis emotional state may not be possible. Even in situations where the crisis may be resolved, the person's range of possible experiences and feelings has been altered and denial may play a role in a resolution that does not include growth and development of new coping skills.

Depending on the stage of the crisis, various intervention strategies and resources can be utilized. Crisis resolution goals are to return the individual to a prior level of functioning as quickly as possible and to lessen any negative impact it can have on future mental health, including anxiety and depression as well as trauma or stressor disorders such as posttraumatic stress disorder (PTSD), acute stress disorder or adjustment disorder (Ernstmeyer & Christman, 2022).

CRISIS 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. Occupational therapy can help patients, groups, and communities manage physical and mental health needs, develop healthy and effective daily routines to promote well-being, and learn and utilize strategies in order to better navigate stressful life situations (AOTA, 2023).

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 (Title IV-E Prevention Services, 2023).

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 nauseated, 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

It is important to recognize that warning signs are not always present when a mental health crisis is developing. The **most common sign** of crisis is a clear and abrupt change in behavior. Evidence that a person is experiencing a mental health crisis may include:

- Sudden changes in mood
- Agitation
- Aggressive behaviors
- Confused thinking or irrational thoughts
- Verbally stating, writing, or insinuating a desire to hurt one's self or others
- Talking about death or dying
- Extreme energy or lack of energy
- Changes in ability to complete daily tasks
- Withdrawing from typically attended social situations
- Changes in diet, not eating or eating all the time
- Hallucinations, delusions, or paranoia
- Losing touch with reality
- Self-harming behaviors
- Unexplained physical change, such as weight loss or gain
- Sudden poor academic behavior or performance
- Sleeping problems
- Changes in social habits, such as withdrawal or avoidance of friends and family
- Increased substance use (drugs or alcohol)
  (Crisis Response, 2023)

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
- The person appears at risk to evolve into one of the above situations
(Zeller, 2021)

Contributing Risk and Protective Factors

Risk and protective factors may be biophysical, psychological, social, or spiritual in nature, as described in the table below.

RISK AND PROTECTIVE FACTORS FOR MENTAL CRISES		
Category	**Risk Factors**	**Protective Factors**
Biophysical	• Family history of mental health problems • Complications during pregnancy or birth • Personal history of traumatic brain injury • Chronic medical conditions such as cancer or diabetes, especially hypothyroidism or other brain-related illnesses such as Alzheimer's or Parkinson's • Use of alcohol or drugs • Poor nutrition and lack of sleep	• Secure attachment as a child
Psychological	• Stressful life situations, such as financial problems or breaking the law • Traumatic life experiences such as rape or serving in the armed forces • Low self-esteem, perceived incompetence, negative view of life • Poor academic achievement	• Reliable support and discipline from caregivers • Following rules at home, school, work • Emotional self-regulation • Good coping skills and problem-solving skills • Subjective sense of self-sufficiency • Optimism • Positive self-regard

		• Focus on making healthy food and beverages choices
Social	• Being abused or neglected as a child • Being in an abusive relationship or friendship • Having few friends or few healthy relationships • Recent loss, either by death, divorce, or other means • Bullying, either as the victim or perpetrator • Growing up in or currently living in poverty • Poor social skills, poor communication skills • Discrimination • Lack of access to support services	• Ability to make friends and get along with others • Good peer relationships • Supportive relationship with family • Participation in sports, club, community, or religious group • Economic/financial security • Access to support services
Spiritual	• Perception of being irredeemable or inherently flawed beyond repair • Perception of insignificance • Conflicting thoughts or doubts surrounding deep religious beliefs	• Future orientation • Achievement motivation • Set of moral beliefs
(AMWA, 2023)		

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)
(PsychGuides, 2023)

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 family and friends. They may include:

Physical

- Sleep disturbances
- Generalized aches and pains
- Tension headaches
- Intestinal cramps, diarrhea, heartburn, constipation
- Muscle tension, fatigue, cold hands and feet
- Shortness of breath, chest pain, tachycardia, hyperventilation
- Loss of libido
- Increased vulnerability to colds, flu, infections
- Excessive perspiring
- Blurred vision
- Itching skin

Cognitive

- Memory problems
- Inability to concentrate
- Poor judgment
- Seeing only the negative
- Anxious or racing thoughts
- Constant worrying

Emotional

- Depression or general unhappiness
- Anxiety and agitation
- Moodiness, irritability, or anger
- Feeling overwhelmed
- Loneliness and isolation

- Other mental or emotional health problems

Behavioral

- Eating more or less
- Sleeping too much or too little
- Withdrawing from others
- Procrastinating or neglecting responsibilities
- Using alcohol, cigarettes, or drugs to relax
- Nervous habits (e.g., nail biting, pacing)
  (Segal et al., 2023)

[H3] 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.

When a **younger child** (1–12 years) is experiencing stress, the following signs and symptoms may be evident:

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
- Inability to relax
- New or recurring fear or displaying fearful reactions
- Clinging behavior to parent or teacher
- Emotional lability
- Anger, crying, whining
- Aggressive or stubborn behavior

- Regression back to younger behaviors (e.g., thumb-sucking, bedwetting)
- Withdrawal from family or school activities
(Kaneshiro, 2022)

Adolescents in crisis may experience or exhibit the following:

- Anger or irritability
- Frequent crying or tearfulness
- Withdrawal from activities and people
- Abandoning long-time friendships for a new set of peers
- Poor concentration
- Expressing hostility toward family members
- Neglecting responsibilities
- Decrease in academic performance
- Increased risk-taking behaviors
- Complaints of headaches or stomachaches
- Lethargy
- Uses drugs or alcohol
(Vorvick, 2022; APA, 2022)

MENTAL HEALTH CRISIS INTERVENTION PROCESS

Crisis intervention is a short-term therapy (usually a single session) that aims to help an individual deal with an event that is presently occurring and that is producing emotional, mental, physical, and behavioral distress or problems. Crisis intervention is appropriate for all ages and can take place in a wide 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

- Assist in building self-awareness and self-confidence
- Teach prevention strategies for self-harm
- Ensure that services are clinically appropriate and in the least intense or restrictive setting
- Provide assistance and referral for ongoing care
  (Halter, 2022)

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, individual's home, school, homeless shelter, and jail. Mental health triage tools are clinician-administered scales that specify signs or symptoms, propose a corresponding response, and determine priority categories based on the level of perceived acuity.

The **aims** of triage are to:

- Determine if the person is at risk for self-harm or harm to others
- Establish priority for response
- Provide support when and where it is needed so that individuals will not require hospitalization but can be stabilized and linked to less urgent levels of care
- Determine what intervention is best suited for the person and to whom the person should be referred
  (State of California, 2023)

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 (see box below).

MENTAL HEALTH TRIAGE TOOL	
Acuity	**Typical presentation**
Immediate	• Definite danger to life (self or others) • Violent behavior • Possession of weapon • Extreme agitation or restlessness • Bizarre/disoriented behavior • Reported recent violent behavior
Emergency (Requires treatment within 10 minutes)	• Probable risk of danger to self or others • Extreme agitation or restlessness • Physically/verbally aggressive • Confused/unable to cooperate • Hallucinations/delusions/paranoia • Requires restraint/containment • High risk of absconding/not waiting for treatment • Reported attempt or threat of self-harm
Urgent (Requires treatment within 30 minutes)	• Possible danger to self or others • Agitation/restlessness • Intrusive behavior • Confusion • Ambivalence/not likely to wait for treatment • Reported suicidal ideation • Presence of psychotic symptoms • Presence of mood disturbance
Semi-urgent (Requires treatment within 60 minutes)	• No immediate risk to self or others • No agitation/restlessness • Irritable without aggression • Cooperative • Gives coherent history • Pre-existing mental health disorder

	• Symptoms of anxiety/depression without suicidal ideation
Nonurgent (Requires treatment within 2 hours; referral to an appropriate community resource)	• No danger to self or others • Cooperative, communicative, follows instructions • Known chronic psychotic symptoms • Pre-existing nonacute mental health disorder
(Adapted from Zun, 2016; Australia DHA, 2009)	

TRIAGE FOR CHILDREN AND ADOLESCENTS

The HEADS-ED is a mental health screening tool used with children and adolescents ages 6–18 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 et al., 2020)		

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
- Teach the person necessary self-care skills
- Recognize the person's needs
- Implement interventions designed to address the needs
- Guide the person toward identifying a plan of action to reach a satisfying and socially acceptable resolution
  (Wayne, 2023)

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 and:

- Directly seeing the person
- Hearing the person's voice as they speak
- Observing how the person's speaking and presence makes the listener feel

Through active listening, the listener communicates both verbally and nonverbally that they are interested in what the other person is saying while also actively verifying one's understanding with the person. 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 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."

Nonverbal awareness is also an important element of active listening. SOLER is a mnemonic for establishing good nonverbal communication with a person (see table below).

SOLER	
S	**Sitting** and squarely facing the person
O	**Open** posture (e.g., not crossing arms in front of the body)
L	**Leaning** toward the person to indicate interest in what they are saying
E	Maintaining good **eye contact**
R	Maintaining a **relaxed posture**

Nonverbally, the listener conveys interest by 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.

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 can build rapport as well. Mirroring may also include speech pacing, vocabulary choices, volume and tone of voice, and speech patterns. Mirroring, however, must be genuine to be effective (Wayne, 2023; Ernstmeyer & Christman. 2022).

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 on 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 (Videbeck, 2020).

EMOTIONAL LABELING

During a mental health crisis, a person's feelings may often be confusing and hard to define. Some people experience greater difficulty labeling their emotions than others do. The less aware a person is of their emotions, the less likely they may be able to regulate them.

Emotional labeling allows the listener to apply a tentative label to the feelings the person is expressing or implying by words and actions. Labeling emotions lets the speaker know they are being heard and helps the person make sense of their emotions 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 (Ernstmeyer & Christman, 2022; 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?"
  (Ernstmeyer & Christman, 2022)

EFFECTIVE PAUSES/SILENCE

Part of effective communication includes the use of silence and waiting or pausing before speaking. The listener does not verbally respond after the person makes a statement, although they may nod or use other nonverbal communication to validate the person's message. 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 (Erstmeyer & Christman, 2022).

"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 (Ernstmeyer & Christman, 2022; Revolution, 2023).

SUMMARIZING

Summarizing involves restating major ideas expressed, including feelings. Progress is reviewed, and important ideas are pulled together. Summarizing establishes a basis for further discussion. Summarizing offers the person permission to make corrections if they feel that is necessary.

Example:

- Listener: "These seem to be the main ideas you've expressed."
  (O'Bryan, 2022)

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 the triage process
- Remembering the caller's name by writing it down immediately
- Ensuring that the caller has enough time to explain the situation
- 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 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 to Daniel receiving two hotline calls and then answers a third call while Daniel listens in. Using all the skills he has honed working with people in the emergency department and the acute psychiatric unit, Jeremy establishes rapport quickly by actively listening, speaking calmly, and giving the caller adequate time to tell their 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 themself, 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.

Theories and Models of Crisis Intervention

A model is used to describe the application of a theory to a crisis situation. It is the conceptual framework for all aspects of preparing for, preventing, coping with, and recovering from a crisis. By viewing events through a model, crisis counselors are able to make contact with a person and to better apply best practices.

THEORIES OF CRISIS MANAGEMENT

Theories of crisis management include:

- System Crisis Theory: States that all crises have to do with the relationships people have with one another or their relationship to a traumatic event
- Adaptational Theory: Implies that a person who can change their negative attitude toward a situation can overcome their crisis
- Interpersonal Theory: Encourages people to gain personal control of a situation rather than relying on others for support or validation
- Ecological Theory: Deals with crises on a massive scale, usually resulting from a natural disaster, and considers the impact of the crisis on people as well as their environment
(Hull, 2023)

MODELS OF CRISIS INTERVENTION

Common elements of crisis counseling are part of all models of crisis intervention. These include:

- Assessment of the person's current situation. This is done by asking questions and actively listening to the person's responses in order to define their problem. It is important for the counselor to be empathic, accepting, and supportive during this process.

- Education to help the person to understand their situation and recognize that what they are experiencing is normal. The counselor emphasizes that a person's reaction is temporary and that they will eventually be able to return to normal functioning.

- Developing an action plan for the person to deal with the crisis. This involves developing a set of skills, including stress relief and positive thinking, that the person can use now and in the future.

- Offering nonjudgmental support. This is the most important part of crisis intervention. The person must know they are accepted and feel reassured that they will get the help they need, whether directly from the person intervening or through referral to other resources.
(Hull, 2023)

There are many crisis intervention models available for the crisis counselor to utilize, all of which abide by the following **common principles**:

- Simplicity: People in crisis respond best to simple measures; these have the best chance of having a positive effect.
- Brevity: Psychological first aid needs to remain short, from minutes up to one hour in most cases.

- Innovation: Creativity is important since specific instructions do not exist for every case or circumstance.
- Pragmatism: Impractical suggestions can cause the person to feel more frustrated and out of control.
- Proximity: The most important thing about proximity is that support must be given in a safe zone.
- Immediacy: Crises demand rapid interaction, and delays can undermine the effectiveness of support services.
- Expectancy: Setting up expectations of a reasonable positive outcome helps the person know that, although the situation is overwhelming right now, most people can and do recover from crisis experiences.
  (Grace College, 2020)

INTERVENTIONS

SAFER-R

One of the most commonly used interventions, SAFER-R helps patients return to their mental baseline following a crisis. It is based on the same principles as other methods but outlines them in a more concise manner (see table below).

SAFER-R MODEL	
Element	**Description**
S – Stabilize	Introduce oneself, establish rapport, meet basis needs, and reduce stressors.
A – Acknowledge	Allow the person to tell their "story."
F – Facilitate understanding	Frame reactions as normal; reinforce cognitive processing.
E – Encourage adaptive coping	Assess the person's ability to function; explore and identify coping skills; develop a plan for immediate action.
R – Restore functioning	Assess emotions, appearance, alertness, and speech.
R – Referral	As appropriate
(Wang & Gupta, 2023)	

ABC

ABC model of crisis intervention involves practices that use reframing of perception of events. By helping a person to change the way they see the event, a crisis worker can do the work of intervention in a short amount of time (see table below).

ABC MODEL	
Element	**Description**
A – Develop a strong rapport	• Use basic active-listening skills
B – Identify the nature of the crisis and alter perceptions (the most important phase of the crisis intervention model)	• Identify the precipitating event, the person's perspective of the event, subjective distress, current and previous functioning • Provide new ways for the person to think about, perceive, and process the information
C – Offer coping skills	• Encourage and listen to the person's ideas for coping before offering one's own ideas • Plan for follow-up of some type
(Lyons, 2023)	

Robert's Seven-Stage Crisis Intervention Model (R-SSCIM)

Robert's intervention model identifies seven stages a person will usually pass through on the way to stabilization, resolution, and mastery (see table below).

R-SSCIM	
Stage	**Description**
1. Psychological and lethality assessment	Using an interviewing style that allows information to come out as a narrative, assess the situation and determine if there is any risk of lethality or imminent danger. A quick psychosocial assessment is completed, which includes: • Environmental support and client stressors • Medical needs and medications • Current use of drugs and alcohol • Internal and external coping methods • The person's suicide history • Presence of suicidal thoughts and feelings • Strength of psychological intent to inflict deadly harm • Access to a means of self-harm, such as drugs or a firearm • How lethal the suicide plan is • Whether the person is in imminent danger as a target of domestic violence, a violent stalker, or sexual abuse

	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.)
2. Make contact and establish rapport	To establish rapport, a sense of genuine concern, care, respect, and acceptance of the person must exist. This requires behaviors and traits of the crisis counselor to help create a sense of trust. Some prominent strengths include: • Good eye contact • Nonjudgmental attitude • Creativity • Flexibility • Positive mental attitude • Reinforcing small gains • Resiliency
3. Identify the major problems or crisis precipitants	Crisis intervention focuses on the person's problems that led to the current crisis, prioritizing the problems to be addressed and determining how the situation escalated to become a crisis. This also aids in understanding the person's coping style.
4. Deal with emotions and feelings	During this time, a crisis worker allows the person to express feelings and explain their story about the current crisis. The crisis counselor relies on active listening skills, gradually working challenging responses into the dialogue. Responses can include giving information, reframing, interpretations, and playing "devil's advocate." In this role, examples can be used to draw different insights and conclusions. Challenging responses help to loosen the person's maladaptive beliefs and consider other behavioral options.
5. Generate and explore alternatives	This stage is often the most difficult to accomplish. If stage 4 has been achieved, the person in crisis has probably worked through enough feelings to re-establish some emotional balance. This is the time to offer the person options and to collaborate on determining what will work for them. It is important to keep in mind that alternatives are better when they are generated collaboratively and "owned" by the person.
6. Implement an action plan	At this point, strategies become integrated into an empowering treatment plan or coordinated intervention, The action plan taken at this stage is critical for restoring the person's equilibrium and psychological balance. Another aspect to this stage is the cognitive dimension, which involves making some meaning out of the crisis event by asking questions such as, "Why did it happen? What does it mean? Who was involved? How did actual events conflict with expectations? What responses (cognitive or behavioral) to the crisis made things worse?" Working through the event is important in order to gain mastery over

	the situation and for being able to cope with similar situations in the future.
7. Follow-up	Follow-up contact with the person after the initial intervention is done to ensure the crisis is on moving toward resolution and to evaluate the post-crisis status of the person. This evaluation can include: • Physical condition of the person (e.g., sleeping, nutrition, hygiene) • Cognitive mastery of the precipitating event • Assessment of overall functioning (social, spiritual, employment, academic) • Satisfaction and progress with ongoing treatment • Any current stressors and how those are being handled • Need for possible referrals
(Black & Flynn, 2021; & Nalbo, 2020)	

Assessing for Risk of Harm to Self or Others

Individuals experiencing a mental health crisis are always assessed for the risk of harm to self or others. In a facility setting, the routine practice of asking all patients to undress and don 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. Ideally, two exits should be available, and doors should swing outward. The clinician should have unrestricted access to the door and should never sit behind a desk (Moore & Moore, 2023).

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.

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?"
Patient Safety Screener-3 (PSS-3)	Validated for those ages 18 and older; consists of three items (with one follow-up question depending on the patient's response to the third item)	• "Over the past 2 weeks, have you felt down, depressed, or hopeless?" • "Over the past 2 weeks, have you had thoughts of killing yourself?" • "In your lifetime have you ever attempted to kill

		yourself?" If yes, "When did this happen?"
(ZeroSuicide, 2022)		

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, 2022).

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 a 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 a 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
(CDC, 2020b)		

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 emergency department (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, a registered nurse, 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 that the gun belonged to his father.

Alan then began an assessment of the risk for harm to others by asking questions 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 information 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, 2022).

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 referred to as *chemical restraints*) are implemented.

The primary goals of de-escalation are to help the distressed person reduce the intensity of their emotions and behavior quickly and effectively and to maintain the person's safety as well as the safety of others in the area. In addition to reducing the intensity of the current situation, de-escalation also prevents further escalation of the problem (Ferlick, 2022).

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 arm's lengths distance from the patient and maintain an unobstructed path out of the room for both the patient and staff.

- **Establish verbal contact.** If possible, the first to contact the person should be the staff leader. Otherwise, designate one or limited staff members to interact with the person. Introduce self and staff and orient the person to place and what may be expected. Reassure the person 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 common, everyday language.** Elaborate and technical terms are hard for an impaired person to understand.

- **Use active-listening skills.** After listening, restate what was said to improve mutual understanding.

- **Set clear limits and expectations.** Tell the patient that injury to self or others will not be allowed.

- **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.

- **Allow adequate time for processing.** 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.

- **Be empathetic.** 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:**
    - Be provocative; instead, keep hands relaxed, maintain a nonconfrontational body posture
    - Stare at the person
    - Criticize the person
    - Argue with the person
    - Interrupt the person
    - 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 & Moore, 2023)

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. Restraints and seclusion have no therapeutic value, cause human suffering, and frequently result in severe emotional and physical harm. They can also result in a person's death. They are safety measures of the last resort. It is important to understand that restraint use is regulated by federal and state agencies.

Seclusion is the involuntary confinement of a patient alone in a room or area from which the person 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 person 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 person, a staff member, or others in the vicinity, and they must be removed as soon as the person and other persons in the vicinity are safe.

Restraints should not cause harm or be used as punishment. Other methods to control a patient and ensure safety should be tried first. 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, 2023; Dugdale, 2021).

SEDATION

Sedation with medication, formally 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 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.

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.

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." The Code of Federal Regulations outlines conditions that must be followed when such restraint is used.

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 (Moore & Moore, 2023; CFR, 2023b).

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 store, 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. Verbal 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 verbally, 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 the 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 AND MANAGING THE PERSON EXPERIENCING A MENTAL HEALTH EMERGENCY

Once the person's behaviors are under control and safety is secured, assessment continues in order to determine the underlying cause of the person'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. This 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.

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, medical records, 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.)

If the patient is in restraints, the initial step is 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 the 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**. The interview includes what prompted the need for psychiatric assessment,

including the degree to which the presenting symptoms affect the patient or interfere with the patient's social, occupational, and interpersonal functioning. 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 includes information about how the patient was functioning prior to the episode, the current symptoms, and whether there is a **past history** of prior episodes. 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 is 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 a patient's unwillingness to disclose such a history.

Medical, social, and developmental histories are reviewed to check for other symptoms not described in the psychiatric history.

A **review of systems** is done to attempt to discover other issues not brought up during the history of present illness. This includes new or recent physical symptoms, diagnoses, and current drugs and treatments in order to identify potential physical causes of mental symptoms.

Observation during an interview may provide evidence of mental or physical disorders. Body language may reveal evidence of attitudes and feelings denied by the patient, e.g., the patient fidgets or paces back and forth despite denying anxiety. General appearance may provide clues as well.

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 and attitude	• Body build, posture, dress, grooming, hygiene, prominent physical abnormalities • Level of alertness: somnolent, alert • Emotional facial expression • Cooperative, noncooperative • Verbal, nonverbal • Interested, bored, sarcastic, guarded, aggressive

Psychomotor activity	• Eye contact: intermittent, occasional and fleeting, sustained and intense, no eye contact • Posture • Disinhibited behavior • 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 • Coherent, spontaneous • Organized, disorganized • Volume: loud, soft, muted • Content: fluent, talkative, minimal, impoverished • Speech impairments (stuttering, dysarthria)
Perception	• Illusions, hallucinations, depersonalization (sensation of unreality concerning the self) • Preoccupations • Obsessions and compulsions • Suicidal or homicidal ideas
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
(Newman, 2022; Alosaimi, 2020)	

Assessing for Medical Causes

Medical assessment of patients with mental symptoms seeks to identify three conditions:

- Physical disorders mimicking mental disorders
- Physical disorders caused by mental disorders or their treatment
- Physical disorders accompanying mental disorders

Medical assessment by history, physical examination, and often, brain imaging and laboratory testing is necessary for patients who present with:

- New-onset mental symptoms (e.g., no prior history of similar symptoms)
- Qualitatively different or unexpected symptoms (e.g., in a patient with a known or stable mental disorder)
- Mental symptoms that begin at an unexpected age (e.g., new-onset psychosis in an older person)

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 may include:

- Abnormal vital sign (e.g., fever, tachycardia, tachypnea)
- Meningeal signs and symptoms (e.g., headache, photophobia, neck rigidity)
- Abnormalities noted during neurologic examination
- Disturbance of gait, balance, or both
- Incontinence
- Confusion and inattention suggesting delirium, especially if of sudden onset, fluctuating, or both

Some findings help suggest a specific cause, especially when signs and symptoms are new or have changed from a long-standing baseline:

Dilated pupils (especially if accompanied by flushed, hot, dry skin): Anticholinergic drug effects

- Constricted pupils: Opioid drug effects or pontine hemorrhage
- Rotary or vertical nystagmus: Phencyclidine (PCP, “angel dust”) intoxication
- Horizontal nystagmus: Phenytoin (Dilantin) intoxication
- Garbled speech or inability to produce speech: Brain lesion (e.g., stroke)
- Preceding history of relapsing-remitting neurologic symptoms: Multiple sclerosis or vasculitis
- Stocking-glove paresthesia: Possibly thiamin, vitamin B_{12} deficiency, diabetes
- Evidence of head injury or focal neurological findings

Laboratory testing varies depending on signs and symptoms. Patients with a known mental disorder who have an exacerbation of their typical symptoms with no medical complaints, a normal sensorium, and normal physical examination do not typically require further laboratory testing other than fingerstick glucose testing and measurement of therapeutic drug levels. Some clinicians perform one or more of the following to screen for potential disorders:

- Complete blood count
- Electrolytes (including calcium and magnesium, blood urea nitrogen, and creatinine)
- Erythrocyte sedimentation rate or C-reactive protein
- HIV testing
- 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 for those taking lithium, with signs or symptoms of thyroid disease and those >40 years with new-onset mental symptoms
- 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 or physical signs suggesting intoxication or recent drug use (e.g., needle marks)
(First, 2022)

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, those described in the table below.

ORGANIC CAUSES FOR SEVERE MENTAL STATUS CHANGES	
Category	**Causes**
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) • Pellagra 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
Trauma	• Traumatic brain injury
Progressive neurological diseases	• Alzheimer's disease • Pick's disease • Lewy body dementia
Space-occupying lesions	• Brain tumors • Bleeding (subarachnoid hemorrhage, subdural hematoma) • Brain abscess
Systemic infections	• Neurocysticercosis: parasitic infection with tapeworm larva • Tuberculosis • Lyme disease • Herpes encephalitis • Hepatitis C

Other	• Stevens-Johnson syndrome
	• Sepsis
	• Urinary tract infections (often missed)
	• Medications with reactions known to include possible psychotic side effects:
	  ○ Muscle relaxants
	  ○ Antihistamines
	  ○ Antidepressants
	  ○ Cardiovascular medication
	  ○ Antihypertensive medications
	  ○ Analgesics

	• Delirium tremens • Hypoxia • Poisoning • Sleep apnea/deprivation
(Gardiner, 2021; Fortenberry, 2023)	

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:

- Assessing level of anxiety and behaviors that indicate anxiety is increasing
- Monitoring for changes in mental status
- Providing a calm environment with low level of stimuli (increased levels of visual and auditory stimulation can be misinterpreted)
- Orienting the patient frequently to time, place, and person, as well as the surroundings, staff, and necessary activities; identifying self by name with each contact (increased orientation ensures greater degree of safety)
- Medicating or restraining the patient as prescribed
- Maintaining a calm manner and providing continual reassurance and support
- Repeating questions if necessary and allowing adequate time for response
- Promoting the patient's safety by removing all potentially dangerous objects from the patient's environment that could be used to harm self or others
- Observing suicide precautions with one-on-one supervision and having staff available to provide for physical safety of patients and/or caregivers
(Belleza, 2021a)

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.

Adults with dual diagnosis were estimated to constitute 25.8% of those with any psychiatric disorder, 36.5% of those with any substance use disorder, and 17.8% of the 75.8 million adults with either disorder (Jegede et al., 2022).

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
- Other known or 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-Parkinson's medications
- Chemotherapeutic agents
- Corticosteroids
- Disulfiram
- Gastrointestinal medications
- Muscle relaxants
- Nonsteroidal anti-inflammatory drugs (NSAIDS)

Additional toxins to rule out that may induce psychotic symptoms include:

- Organophosphate insecticides
- Carbon monoxide
- Carbon dioxide
- Volatile substances such as fuel or paint
- Anticholinesterase
(EMD, 2023)

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 observe for typical signs of stimulants, depressants, inhalants, hallucinogens, intoxicants, opiates, and other drugs.

Alcohol Intoxication

Alcohol abuse can cause psychosis, but most often only after days or weeks of intense use. Those who have a chronic alcohol abuse problem lasting for several years are vulnerable to intense paranoia and hallucinations due to damaging of the brain and thiamine deficiency, which can lead to Wernicke-Korsakoff syndrome. Signs of alcohol intoxication may include the following:

- Disinhibition of sexual or aggressive impulses
- Slurred speech
- Decreased alertness
- Slow and deliberate movements
- Loss of coordination, difficulty walking
- Odor of alcohol on person
- Droopy eyelids, sleepiness
- Lack of eye focus
- Flushed face
- Drowsy
- Mood lability
- Argumentative or belligerent
- Irrational statements
- Losing one's train of thought
- Dilated pupils
- Slowed reflexes
- Loss of consciousness
  (State of California, 2023)

Marijuana Intoxication

Marijuana (cannabis) is a widely used drug. The concentrated form of cannabis is known as *hashish*. Acute cannabis intoxication is a rare complaint in adolescents and adults. But neurological abnormalities are more prominent **in children** and include:

- Ataxia
- Excessive and purposeless motor activity of extremities
- Seizures
- Lethargy
- Prolonged coma, which may be life-threatening

In adolescents and adults, **signs** of cannabis intoxication can include:

- Tachycardia, tachypnea, increased blood pressure especially in older adults, orthostatic hypotension
- Conjunctival injection (red eye)

- Dry mouth
- Increased appetite
- Nystagmus
- Ataxia
- Slurred speech
- Changes in mood, perception, thought content
- Impaired attention, reaction time, concentration, short-term memory
- Impaired motor coordination for 8 to 12 hours
- Difficulty completing complex tasks
- Impairment of cognition, coordination, judgment
- Hallucinations
- Auditory, visual, or tactile illusions
  (Wang & Gupta, 2023)

Stimulant Intoxication

Stimulants range from prescription ADHD medication to cocaine and are abused for their effects, including increased alertness or euphoric high. Stimulants include:

- Cocaine
- Crack
- Methamphetamine
- Amphetamine
- Methylphenidate (Ritalin)
- MDMA (ecstasy) (also a hallucinogenic)

Signs of stimulant intoxication include:

- Dilated pupils
- Restlessness
- Hyperactivity
- Loss of appetite and/or weight loss
- Sweating
- Exhibiting excessive energy
- Hypertension, tachycardia

- Irregular heartbeat
- Chest pains
- Aggressive behavior or anger outbursts
- Mood swings
- Jitteriness
- Flight of ideas, racing thoughts
- Delusions/hallucinations
- Anxiety or nervousness, panic attacks
- Increased sense of confidence
- Dry mouth and nose
- Stroke and heart attack (ecstasy)
  (Addiction Center, 2023)

Opioid Intoxication

Opioids include opiates, synthetic drugs, and semi-synthetic drugs (see table below). Opioid overdose deaths are numerous and increasing worldwide.

OPIOIDS	
Types	**Examples**
Natural	• Morphine • Codeine
Synthetic	• Meperidine • Methadone • Tramadol • Fentanyl
Semi-synthetic	• Hydromorphone • Oxycodone • Hydrocodone • Diacetylmorphine

Signs and symptoms of opioid toxicity include:

- Euphoria
- Bradycardia

- Bradypnea (slowed and eventually may stop)
- Hypotension
- Hypothermia
- Hypokinesis
- Slurred speech
- Decreased bowel sounds
- Nausea and vomiting
- Sedation or coma
- Pupillary constriction
- Lack of pupillary response to light
- Seizures
- Needle marks
  (Stolbach & Hoffman, 2023)

Depressant Intoxication

Depressants include sedatives, hypnotics, and antianxiety medications. Drugs in this category include:

- Benzodiazepines
- Benzodiazepine-like drugs
- Carbamates
- Barbiturates
- Barbiturate-like hypnotics
- Z-drugs (insomnia medications)

As a group, the **criteria for intoxication** include:

- Slurred speech
- Incoordination
- Unsteady gait
- Nystagmus
- Impaired thinking
- Possible coma
- Inappropriate behavior

- Mood fluctuations
- Impaired judgment
(Halter, 2022)

Hallucinogen Intoxication

Hallucinogens include both natural and synthetic substances and are associated with flashbacks, panic attacks, psychosis, delirium, and mood and anxiety disorders. Common hallucinogens include:

- D-lysergic acid diethylamide (LSD)
- Psilocybin ("Shrooms" or "magic mushrooms")
- Peyote
- Dimethyltryptamine (DMT)
- Mescaline
- Phencyclidine (PCP)

Hallucinogen intoxication is **characterized by**:

- Paranoia
- Impaired judgment
- Intensification of perceptions
- Depersonalization
- Derealization
- Hallucinations
- Illusions
- Synesthesia (e.g., hearing colors or seeing sounds)
- Dilated pupils
- Tachycardia
- Sweating
- Palpitations
- Blurred vision
- Tremors
- Incoordination
(Halter, 2022)

Inhalant Intoxication

Volatile hydrocarbons are toxic gases inhaled through nose or mouth and are primarily used by youth. Such products include:

- Solvents for glues and adhesives
- Propellants in aerosols
- Paint thinner and correction fluid
- Fuels such as gasoline and propane

Inhalants may have the following **signs and symptoms** of intoxication:

- Disinhibition
- Euphoria
- Fearfulness
- Illusions
- Auditory and visual hallucinations
- Distorted body image
- Apathy
- Diminished social and occupational functioning
- Impaired judgment
- Impulsive and aggressive behavior
- Nausea
- Anorexia
- Nystagmus, depressed reflexes, diplopia

High doses and long exposure can lead to:

- Stupor
- Unconsciousness
- Amnesia
  (Halter, 2022)

RECOGNIZING SUBSTANCE WITHDRAWAL

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, causing withdrawal symptoms.

Withdrawal is most dangerous in those using alcohol, opiates, and depressants (sedatives and tranquilizers). Suddenly stopping alcohol or depressants can lead to seizures, stroke, or heart attacks in high-risk patients (Melemis, 2021).

Alcohol Withdrawal

The classic sign of early alcohol withdrawal is tremulousness (the "shakes"). As withdrawal progresses, signs and symptoms increase, leading to alcohol withdrawal delirium (delirium tremens). This is a medical emergency that requires sedation, since seizures can be directly life-threatening. **Signs and symptoms** of alcohol withdrawal include:

- Agitation
- Nausea
- Vomiting
- Insomnia
- Impaired cognition
- Mild perceptual changes
- Hypertension
- Tachycardia
- Agitation/excitement
- Confusion/disorientation
- Delirium
- Body tremors
- Tonic-clonic seizures
- Visual and tactile hallucinations
(Halter, 2022; AAC, 2023)

Marijuana (Cannabis) Withdrawal

Cannabis withdrawal occurs within one week of cessation. **Signs and symptoms** include:

- Irritability
- Anger
- Aggression
- Anxiety
- Restlessness
- Depressed mood

- Insomnia and disturbing dreams
- Decreased appetite and weight loss
- Abdominal pain
- Shakiness
- Diaphoresis
- Fever
- Chills
- Headache
(Halter, 2022)

Stimulant Withdrawal

Depression and suicidal thoughts are the most serious side effects of stimulant withdrawal. Other **signs and symptoms** include:

- Hypersomnia or insomnia
- Fatigue
- Anxiety
- Irritability
- Poor concentration
- Psychomotor retardation
- Increased appetite
- Paranoia
- Drug craving
(Halter, 2022)

Opioid Withdrawal

Withdrawal from opiates is extremely uncomfortable but not dangerous, unless opiates are mixed with other drugs. Heroin withdrawal on its own does not produce seizures, heart attacks, strokes, or delirium tremens (Melemis, 2021). **Symptoms** of withdrawal from opiates include:

- Dysphoric mood
- Tachycardia, tachypnea
- Hypertension
- Hyperreflexia
- Nausea or vomiting

- Bone and muscle pain
- Abdominal cramping
- Teary eyes
- Rhinorrhea
- Dilated pupils
- Piloerectors (goose bumps)
- Diaphoresis in males
- Spontaneous ejaculations while awake
- Diarrhea
- Yawning
- Fever
- Insomnia
(Halter, 2022)

Depressant Withdrawal

Withdrawal from depressants can last up to 5 weeks and can be dangerous and even life-threatening. **Signs and symptoms** of withdrawal include:

- Autonomic hyperactivity
- Tremor
- Insomnia
- Psychomotor agitation
- Sweating
- Tachycardia
- Hypertension
- Hyperthermia
- Hallucinations
- Grand mal seizures
(Halter, 2022)

Hallucinogenic Withdrawal

Signs and symptoms of withdrawal from hallucinogens include:

- Flashbacks

- Muscle spasms
- Loss of coordination
- Aggressive, hostile, or violent behavior
- Zombie-like state
- Hypertension
- Tachycardia
- Hyperthermia
- Depression
- Long-term psychosis
- Permanent post-hallucinogenic perceptual disturbance
  (Recovery Connection, 2023)

Inhalants Withdrawal

For individuals participating in continued inhalant abuse, suddenly stopping or reducing of the substance can cause uncomfortable withdrawal **symptoms**, including:

- Agitation and irritability
- Powerful headaches
- Nausea
- Diaphoresis
- Tremors
- Convulsions
- Abdominal cramping
- Intense cravings
  (Azure Acres Recovery Center, 2023)

MANAGEMENT OF INTOXICATED PATIENTS

Most intoxicated person do not need medical attention, but some may present to an emergency department. The reasons for seeking medical attention may be either related to the substance use itself, such as extreme agitation or violent behavior that may endanger both the person or others around them, or due to the advanced consequences of the substance use, such as an injury due to an accident while driving intoxicated, or to symptoms of substance withdrawal.

Evaluation 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.

Management for specific substances is described in the table below.

MANAGING INTOXICATED PATIENTS	
Intoxicant	**Management interventions**
Alcohol	• Largely supportive, including airway protection and maintenance of respiratory status • For severely intoxicated persons, admission and management in an intensive care unit • IV fluids for signs of dehydration • 5% dextrose IV for hypoglycemia
Cannabis	• Hospitalization or outpatient treatment • Abstinence and support • Antianxiety medication for short-term relief of symptoms • Antidepressant therapy for underlying anxiety and depression
Hallucinogens	• "Talking down" (i.e., providing reassurance that symptoms will subside) • Placement in quiet room with minimal stimulation • Possible physical restraint because PCP intoxication is a medical emergency that can result in dangerous and violent side effects • Short-term use of antipsychotic medication (haloperidol or a benzodiazepine)
Inhalants	• Monitoring for potentially fatal responses (coma, cardiac arrhythmias, bronchospasm) • Cautious use of haloperidol for psychotic response
Opioids	• Inpatient or outpatient use of methadone or sublingual buprenorphine • Loperamide for diarrhea • Promethazine for nausea/vomiting • Ibuprofen for myalgia • Clonidine to reduce blood pressure
Stimulants	• Inpatient admission

	• Depending upon the drug used, short-term use of antipsychotics or diazepam • Once withdrawal is completed, antidepressant such as bupropion to treat depression
Depressants	• Gradual reduction of benzodiazepine to prevent seizures • Use of long-acting barbiturate (phenobarbital) for barbiturate withdrawal
(Sha & Huecker, 2023; Sarkar et al., 2023; Halter, 2022)	

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 (Skodol, 2023; Halter, 2022).

Crisis management requires:

- Establishing boundaries to increase patient's sense of safety and trust
- Asking direct questions about suicide, prior attempts, and current level of risk to self or others
- Inquiring about effective management strategies used in the past
- Encouraging use of coping skills to alleviate anxiety
- Medications:
    - Psychotropics geared toward maintaining cognitive function, symptoms relief
    - Antidepressants for mood and emotional dysregulation
    - Naltrexone to reduce self-injurious behaviors
    - Second-generation antipsychotics to control anger and brief episodes of psychosis

(WCHM, 2023; Halter, 2022)

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.
- 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, 2023)

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.

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 person or others at imminent risk of harm. Severely ill patients generally require hospitalization.

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 mostly 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 the manic phase of the disorder, 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 themselves 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, 2023).

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, and generally require hospitalization and stabilization with medications (Stovall, 2023).

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:

- Establish external controls emphatically and nonjudgmentally using a firm approach to provide structure and control
- Decrease environmental stimuli to help reduce anxiety and manic symptoms
- Use short and concise statements and explanations, as short attention span limits understanding to small pieces of information
- Frequently assess behavior for increased agitation to avoid 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
- Manage medications (e.g., periodic serum lithium levels) to monitor safety and ensure the dose given is at treatment level or reduced to maintenance level
  (Belleza, 2021b)

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 (fixed false beliefs not based in reality)
- Hallucinations (seeing or, most commonly, hearing things that do not exist but have the full impact of normal experience)
- Disorganized speech
- Grossly disorganized or catatonic behaviors
- Disturbed thought process
- Flattened affect

Other manifestations can include:

- Inappropriate laughter
- Paranoia
- Disordered or abnormal motor behavior
- Acting on hallucinations

These abnormal behaviors can make it difficult to carry on daily activities and can result in incapacitation (Hany et al., 2023).

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

Acute psychosis is a common mental health emergency, and verbal de-escalation is 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. Other **interventions** include:

- Speaking in a calm, low voice and as slowly as possible
- Using clear or simple words and keeping directions simple as well
- Using simple, concrete, and literal explanations
- Intervening with one-on-one, seclusion, or medication if necessary
- Not pretending to understand what the patient is saying and letting the patient know one is having difficulty understanding them
- Keeping the environment calm, quiet, and as free of stimuli as possible
- Recognizing that delusions are the patient's perception of the environment and drawing focus away by directing attention to concrete things in the environment
- Identifying feelings related to delusions in order to reduce anxiety and letting the patient know they are being understood
- Looking for themes in what is being said, since word choice is often 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 suspicious patients 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; but not acting as if one believes them
- 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, 2023)

MAJOR DEPRESSION (UNIPOLAR)

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. 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.

Psychotic depression is a subtype of major depression that occurs when a severe depressive illness includes hallucinations, delusions, or some break with reality.

The most dangerous aspect of major depressive disorder is a preoccupation with death, and those who have a plan and means to carry it out require emergency intervention (Bruce & Bhandar, 2022).

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

- Anger, irritability, or annoyance even over small matters
- Crying for no apparent reason
- Frequent somatic complaints, such as stomach aches or headaches
- Extreme sensitivity to criticism, rejection, or failure
- Symptoms of other disorders such as anxiety, eating disorders, or substance abuse
- Conflict with family and friends
- Poor performance in school
- Self-harming activities such as hitting or cutting

The symptoms of depression in children vary and are often undiagnosed and untreated because symptoms are passed off as normal emotional and psychological changes. 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. Although relatively rare in youth under 12, suicide may be attempted impulsively by young children when they are upset or angry (Mayo Clinic, 2022; Brennan, 2022).

Initial management of a patient with major depressive disorder is to ensure safety. These patients are assessed for suicidal ideation, suicide plans, and psychotic symptoms that place them 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 setting. 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, 2023; Bruce & Bhandar, 2022).

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 by which women die by 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 (ED), 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 DISORDER

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 lose touch with reality and experience false sensory perceptions.

People experiencing a panic attack may come to the emergency department because they feel they are experiencing a heart attack, and evaluation must ensure that there is no underlying medical condition. Anxiety-related complaints are commonly associated with alcohol and substance abuse, which further complicates emergency assessment.

Panic attacks cannot be predicted, and there is usually no trigger that starts the attack. Patients experiencing a panic attack may present with the following **signs and symptoms**:

- Palpitations, pounding heart, tachycardia
- Diaphoresis
- Trembling or shaking
- Dyspnea or sensation of smothering
- Choking sensation
- Chest pain or discomfort
- Nausea or abdominal distress
- Dizziness, unsteadiness, light-headedness or fainting
- Derealization or depersonalization
- Fearing loss of control or "going crazy"
- Fear of dying or impending doom

The most important step in crisis management is to abort the panic attack. This may include administering a benzodiazepine with rapid onset of action. For long-term treatment of anxiety and panic disorder, selective serotonin reuptake inhibitor antidepressants are first-line medications (Raju, et al., 2023). Other **interventions** include:

- Providing reassurance and maintain a calm manner
- Always remaining with the person to reassure safety and security
- Minimizing environmental stimuli

- Using clear and simple statements and repetition
- Speaking slowly and with a low-pitched voice
- Reinforcing reality if distortions occur by focusing on validating what is going on in the immediate environment
- Avoiding asking or forcing the patient to make choices
- Listening for themes in communication, which may be the only indication of the patient's thoughts or feelings
- Attending to physical and safety needs, which helps to relieve anxiety
- Setting limits and speaking in a firm, authoritative voice to protect the patient and others from harm
(Halter, 2022)

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 in which 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. Bioethical principles in particular are described below:

Respect for autonomy means respecting every individual's right of self-determination, independence, and freedom to make their own choices. In healthcare, this concept is most concerned with the ethical obligation of the practitioner to respect a person's right to make decisions about their own health.

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.

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 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.

Fidelity means maintaining loyalty, faithfulness, and commitment to the patient, doing no wrong, and maintaining expertise through continuing education.

Veracity is the duty to communicate in a truthful and non-misleading way (Halter, 2022; Patel 2023).

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 (e.g., 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 and allows appointment of a health proxy to interpret those preferences during a crisis. A psychiatric advance directive may be drafted when a person is well enough to consider preferences for future mental health treatment and is used when a person becomes unable to make decisions during a mental health crisis (NRCPAD, 2023).

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 (2023a) states that restraints and seclusion may be used only when absolutely necessary or when patients request seclusion to reduce sensory stimulation. Restraints are to 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. The Code also states that their use be limited to no longer than the duration of the emergency safety 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.

HOSPITAL CONFINEMENT

Admission to the hospital related to a mental health crisis or 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 the patient 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. The United States has 50 different approaches to this issue, with no two states taking the same approach. As a result, whether or not an individual receives timely, appropriate treatment for an acute mental health crisis or chronic psychiatric disease is entirely dependent on which state the person resides in when the crisis arises (TAC, 2020).

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, was declared "morally insane," lost custody of her children, and was placed in a mental hospital, where she remained for three 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" (Miller & Hanson, 2018).

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, which was a crisis situation, it was readily accepted that treatment with medications was clinically indicated and likely to be of benefit (beneficence). Providers 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 her danger to others as 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.fema.gov/emergency-managers/individuals-communities/preparedness-activities-webinars/community-emergency-response-team

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.jointcommission.org/standards/standard-faqs/critical-access-hospital/provision-of-care-treatment-and-services-pc/000001359/

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

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

988 Suicide & Crisis Lifeline
https://988lifeline.org/

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

Sober Recovery
https://www.soberrecovery.com

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

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TEST

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1. Which statement describes the definition of "mental health crisis"?

a. An emotional disturbance
b. A psychiatric behavioral emergency
c. An acute disruption of psychological homeostasis
d. A disruptive psychological episode

2. Which type of crisis might a young mother be experiencing if she has feelings of anger toward her newborn child?

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

3. Which sign is the **most** common indicator of a mental health crisis?

a. A clear and abrupt change in behavior
b. Agitation and irrationality
c. Talking about death or dying
d. Confused thinking

4. Which statement describes one of the **goals** of crisis intervention?

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

5. Which communication technique asks the question "What were you feeling when that happened?"

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

6. Which crisis model involves practices that use reframing of one's perception of events?

a. SAFER-R model
b. Burnett model
c. ABC model
d. Robert's 7-Stage model

7. Which action does the clinician take when attempting to de-escalate a mental health emergency with a patient who is threatening violent behavior?

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

8. Which patient information is assessed during the mental status examination?

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

9. Which behaviors are **typically** observed by clinicians in a patient with schizophrenia?

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

10. 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