PRACTICE GUIDELINES:

CORE ELEMENTS IN RESPONDING TO MENTAL HEALTH CRISES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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I. INTRODUCTION

CRISES HAVE A PROFOUND IMPACT ON PEOPLE WITH SERIOUS MENTAL HEALTH OR EMOTIONAL PROBLEMS.

Adults, children and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization.

Homelessness, police contact, institutionalization and other adverse events are in themselves crises, and may also contribute to further crises. The statistics below paint a sobering picture of how crises affect the lives of people who have mental or emotional disabilities:

- From one third to one half of homeless people have a severe psychiatric disorder.[1]
- Approximately 7 percent of all police contacts in urban settings involve a person believed to have a mental illness.[2]
- The likelihood of mental illness among people confined in state prisons and local jails is three to four times higher than in the general population[3] and, compared with other inmates, it is *at least twice as likely* that these individuals will be injured during their incarceration.[4]
- About 6 percent of all hospital emergency department visits reflect mental health emergencies.[5]
- Due to a lack of available alternatives, 79 percent of hospital emergency departments report having to "board" psychiatric patients who are in crisis and in need of inpatient care, sometimes for *eight hours or longer.*[6]
- Almost one in 10 individuals discharged from a state psychiatric hospital will be readmitted within 30 days; more than one in five will be readmitted within 180 days.[7]
- About 90 percent of adult inpatients in state psychiatric hospitals report histories of trauma.[8]
- About three quarters of youth in the juvenile justice system report mental health problems and one in five has a serious mental disorder.[9]
- Mothers with serious mental illnesses are *more than four times as likely* as other mothers to lose custody of their children.[10]
- People with serious mental illnesses die, on average, *25 years earlier* than the general population.[11]

These statistics are incomplete; they reflect just a sampling of scenarios that, while commonplace, constitute significant life crises for individuals with serious mental illnesses.

Many such individuals experience a cascade of crisis events that place them in more than one of these statistical groups. For instance, readmission to a psychiatric institution—a high probability for adults who have been discharged from a state psychiatric hospital, based on these data—may feature a series of crisis events for the individual: the psychiatric emergency itself; forcible removal from one's home; being taken into police custody, handcuffed and transported in the back of a police car; evaluation in the emergency department of a general hospital; transfer to a psychiatric hospital; a civil commitment hearing; and so on. And at multiple points in this series of interventions, there is a likelihood that physical restraints, seclusion, involuntary medication or other coercion may be used. Intense feelings of disempowerment are definitional of mental health crises, yet as the individual becomes the subject of a "disposition" at each juncture, that person may experience a diminishing sense of control.

In the wake of rare but highly publicized tragedies attributed to people with mental illnesses, there is often a temporary surge in political concern about mental healthcare and expanding crisis interventions. Sadly, the more commonplace crises endured every day by many thousands of adults, older adults and children with serious mental or emotional problems tend to generate neither media attention nor political concern.

While no one with a mental or emotional disorder is immune from crises, people with what are termed serious mental illnesses—defined as schizophrenia, bipolar disorder and major depression—may be most reliant on public systems. They also may be at great risk of recurrent crises and interventions that exacerbate their clinical and social problems. These guidelines focus most specifically on individuals with serious mental or emotional problems who tend to encounter an assortment of governmental or publicly funded interveners when they are in crisis. Nevertheless, the values, principles and strategies embedded in the guidelines that follow are applicable to all individuals with mental healthcare needs, across populations and service settings.

Individuals whose diagnoses do not fit "serious mental illnesses" may be vulnerable to serious mental health crises that can have devastating outcomes. Interventions on their behalf are more likely to occur within the private healthcare sector, which mirrors public mental health systems' problems in providing early and meaningful access to help. Within these parallel systems, crisis services are provided in a broad array of settings that ultimately will require translation of the guidelines presented here into specific protocols that break cycles of crises and advance the prospects of recovery for people with mental illnesses.

WHAT IT MEANS TO BE IN A MENTAL HEALTH CRISIS

Too often, public systems respond as if a *mental health crisis* and *danger to self or others* were one and the same. In fact, *danger to self or others* derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated.

While behaviors that represent an imminent danger certainly indicate the need for some sort of an emergency response, these behaviors may well be the culmination of a crisis episode, rather than the episode in its entirety. Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Because only a portion of real-life crises may actually result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late or no help at all in addressing the root of the crisis. And a response that does not meaningfully address the actual issues underlying a crisis may do more harm than good.

THE NEED FOR CRISIS STANDARDS

Individuals experiencing mental health crises may encounter an array of professionals and non-professionals trying to intervene and help: family members, peers, healthcare personnel, police, advocates, clergy, educators and others. The specific crisis response offered is influenced by a number of variables, among them:

- where the intervention occurs,
- at what time of day it occurs,
- when it occurs within the course of the crisis episode,
- the familiarity of the intervener with the individual or with the type of problem experienced by the individual,
- interveners' training relating to crisis services,
- resources of the mental health system and the ready availability of services and supports, and
- professional, organizational or legal norms that define the nature of the encounter and the assistance offered.

The guidelines presented here define appropriate responses to mental health crises across these variables. They were developed by a diverse expert panel (see below) that includes individuals with and without serious mental illnesses who are leaders within mental health professions and mental health advocacy.

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This report of the panel's findings is not intended to be an exhaustive resource on crisis services and best practices, but rather an explanation of factors essential to any response to mental health emergencies. In organizations that may already have protocols for responding to individuals in mental health crises (for instance, police departments, hospitals and mental health clinics), these guidelines offer an opportunity to assess the adequacy of current practices based on a set of underlying values and principles. In foster care, schools or other settings where protocols may not currently exist, the guidelines can serve as a framework for examining current activities and the need for more explicit standards. In either instance, these crisis guidelines promote two essential goals:

1. Ensuring that mental health crisis interventions are guided by standards consistent with recovery and resilience and

2. Replacing today's largely reactive and cyclical approach to mental health crises with one that works toward reducing the likelihood of future emergencies and produces better outcomes.

II. RESPONDING TO A MENTAL HEALTH CRISIS

TEN ESSENTIAL VALUES

Ten essential values are inherent in an appropriate crisis response, regardless of the nature of the crisis, the situations where assistance is offered or the individuals providing assistance:

1. **Avoiding Harm.** Sometimes mental health crises place the safety of the person, the crisis responders or others in jeopardy. An appropriate response establishes physical safety, but it also establishes the individual's psychological safety. For instance, restraints are sometimes used in situations where there is an immediate risk of physical harm, yet this intervention has inherent physical and psychological risks that can cause injury and even death. Precipitous responses to individuals in mental health crises—often initiated with the intention of establishing physical safety—sometimes result in harm to the individual. *An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of "watchful waiting." In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions used.*

> **"To promote patient-centered care, all parties involved in health care for mental or substance-use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with mental/substance use problems and illnesses"**
>
> Institute of Medicine (2006) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Recommendation 3-1, p. 126

2. **Intervening in Person-Centered Ways.** Mental health crises may be routine in some settings and, perhaps, have even come to be routine for some people with serious mental health or emotional problems. Nevertheless, appropriate crisis assistance avoids rote interventions based on diagnostic labels, presenting complaint or practices customary to a particular setting. *Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response.*

3. **Shared Responsibility.** An acute sense of losing control over events or feelings is a hallmark of mental health crises. In fact, research has shown "feeling out of control" to be the most common reason consumers cite for being brought in for psychiatric emergency care.[12] An intervention that is done *to* the individual—rather than *with* the individual—can reinforce these feelings of helplessness. One of the principal rationales for person-centered plans is that shared responsibility promotes engagement and better outcomes. While crisis situations may present challenges to implementing shared, person-centered plans, ultimately an intervention that considers and, to the extent possible, honors an individual's role in crisis resolution may hold long-term benefits. *An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.*

Personal Safety Plan

Some state mental health systems encourage consumers to complete a form intended to help staff understand an individual's preferred ways of addressing emerging crises. The following is the introduction presented from Florida's adaptation of the Massachusetts form; it affirms the perspective of a partnership between staff and the individual.

"This form will allow you to suggest calming strategies IN ADVANCE of a crisis. It will allow you to list things that are helpful when you are under stress or are upset. It will also allow you to identify things that make you angry. Staff and individuals receiving services can enter into a 'partnership of safety' using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions."

Massachusetts Department of Mental Health (1996) *Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused*, Report and Recommendations.

Florida Department of Children and Families, Form CF-MH 3124, http://www.dcf.state.fl.us/DCFForms/Search/DCF-FormSearch.aspx

4. **Addressing Trauma.** Crises, themselves, are intrinsically traumatic and certain crisis interventions may have the effect of imposing further trauma—both physical and emotional. In addition, people with serious mental illness have a high probability of having been victims of abuse or neglect. *It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available (for instance, by executing advance directives).*

5. **Establishing Feelings of Personal Safety.** An individual may experience a mental health crisis as a catastrophic event and, accordingly, may have an urgent need to feel safe. What is regarded as agitated behavior may reflect an individual's attempts at self-protection, though perhaps to an unwarranted threat. *Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.*

6. **Based on Strengths.** Sharing responsibility for crisis resolution means understanding that an individual, even while in crisis, can marshall personal strengths and assist in the resolution of the emergency. Individuals often understand the factors that precipitated a crisis as well as factors that can help ameliorate their impact. *An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.*

7. **The Whole Person.** For individuals who have a mental illness, the psychiatric label itself may shape—even dominate—decisions about which crisis interventions are offered and how they are made available. *An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount.* That the individual may have multiple needs and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty. An individual's emergency may reflect the interplay of psychiatric issues with other health factors. And while the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real-world concerns that significantly affect an individual's response: the whereabouts of the person's children, the welfare of pets, whether the house is locked, absence from work, and so on.

8. **The Person as Credible Source.** Assertions or complaints made by individuals who have been diagnosed with a serious mental illness tend to be viewed skeptically by others. Particularly within the charged context of mental health

crises, there may be a presumption that statements made by these individuals are manifestations of delusional thinking. Consequently, there is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded. Even when an individual's assertions are not well grounded in reality and represent obviously delusional thoughts, the "telling of one's story" may represent an important step toward crisis resolution.[13] *For these reasons, an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person's strengths and needs.*

9. **Recovery, Resilience and Natural Supports.** Certain settings, such as hospital emergency departments, may see individuals only transiently, at a point when they are in acute crisis and in a decidedly high-stress environment. Even when not occurring within hospitals, mental health emergency interventions are often provided in settings that are alien to the individual and the natural supports that may be important parts of his or her daily life. It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person or that individual's broader life course. *An appropriate crisis response contributes to the individual's larger journey toward recovery and resilience and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.*

10. **Prevention.** Too often, individuals with serious mental illnesses have only temporary respite between crises. An appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements.*

The National Consensus Statement on Mental Health Recovery identifies *recovery* as an individual's journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. It also cites 10 fundamental components for systems:

- **Self-Direction**
- **Individualized and Person-Centered**
- **Empowerment**
- **Holistic**
- **Non-Linear**
- **Strengths-Based**
- **Peer Support**
- **Respect**
- **Responsibility**
- **Hope**

US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2004) National Consensus Statement on Mental Health Recovery. For the complete report, see: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

PRINCIPLES FOR ENACTING THE ESSENTIAL VALUES

Several principles are key to ensuring that crisis intervention practices embody these Essential Values:

1. **Access to supports and services is timely.** Ready access to assistance is important not only because it holds the promise of reducing the intensity and duration of the individual's distress, but also because as a crisis escalates, options for interventions may narrow. Timely access presupposes 24-hour/7-days-a-week availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site.

2. **Services are provided in the *least restrictive* manner.** Least-restrictive emergency interventions not only avoid the use of coercion, but also preserve the individual's connectedness with his or her world. Individuals should not be unnecessarily isolated from their routine networks of formal and natural supports and should be encouraged to make contact with outside professionals, family and friends who can provide assistance through the crisis event and beyond.

Staff Behaviors that Consumers Feel Are Most Important to Individuals in a Mental Health Crisis

- Having the staff listen to me, my story and my version of events
- Being asked about what treatment I want
- Trying to help me calm down before resorting to forced treatment
- Being asked about what treatments were helpful and not helpful to me in the past

Allen, M., Carpenter, D., Sheets, J, Miccio, S., & Ross, R. (2003) What do consumers say they want and need during a psychiatric emergency? Journal of Psychiatric Practice (9) 1, 39-58.

3. **Peer support is available.** Services should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis.

4. **Adequate time is spent with the individual in crisis.** In settings such as hospital emergency departments, there may be intense pressure to move patients through quickly.[14] People who provide assistance must have an adequate understanding of the crisis situation, not only objectively, but also as it is being experienced by the individual who is in crisis. Unfortunately, individuals in acute crisis—particularly following involuntary transport to an evaluation setting—may not be in a position to discuss their presenting complaints clearly and concisely. Personnel in healthcare and similar settings must regard face-to-face time with the individual not as a distraction, but as a core element of quality crisis care. Settings that cannot accommodate the individual in this way may not be appropriate venues for psychiatric crisis intervention; as is discussed elsewhere in these guidelines, such a determination should be regarded as a problem in care and drive performance improvement at both the organizational and systemic levels.

5. **Plans are strengths-based.** It may be fairly routine for professional staff to concentrate on clinical signs and other deficits to be addressed, particularly when an individual is in a crisis state and, therefore, "symptomatic." Yet appropriate crisis intervention gives at least equal attention to the individual's immediately available and potentially available assets. A strengths-based plan helps to affirm the individual's role as an active partner in the resolution of the crisis by marshalling his or her capabilities. A strengths-based approach also furthers the goals of building resilience and a capability for self-managing future crises.

6. **Emergency interventions consider the context of the individual's overall plan of services.** Many individuals with serious mental illnesses go into mental health crises while receiving some sort of services and supports. Appropriate crisis services consider whether the crisis is, wholly or partly attributable to gaps or other problems in the individual's current plan of care and provide crisis measures in ways that are consistent with services the individual receives (or should receive) in the community. In addition, appropriate crisis services place value on earlier efforts by the individual and his or her service providers to be prepared for emergencies, for instance, by having executed psychiatric advance directives or other crisis plans. Incorporating such measures in a crisis response requires that interveners be knowledgeable about these approaches, their immediate and longer-term value, and how to implement them. Appropriate crisis interventions also include post-event reviews that may produce information that is helpful to the individual and his or her customary service providers in refining ongoing services and crisis plans.

7. **Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented.** Crisis intervention may be considered a high-end service, that is high-risk and demanding a high level of skill. Within the course of a psychiatric emergency, various types of crisis interventions may occur—some by healthcare professionals, some by peers and some by personnel (such as police) who are outside of healthcare. Throughout, the individual experiencing a mental health crisis should be assured that all interveners have an appropriate level of training and competence. What that means may vary considerably between scenarios. For instance, a significant number of instances of police involvement with individuals in mental health crises result in injuries or even death.[15] Accordingly, some police departments have taken special measures to train officers in identifying and de-escalating mental health crises. Many have also established links with mental health professionals who can provide timely on-site assistance. These efforts have required police and health care professionals to connect across traditional bureaucratic boundaries.

8. **Individuals in a self-defined crisis are not turned away.** People who seek crisis services but do not meet the service criteria of an organization should receive meaningful guidance and assistance in accessing alternative resources. This is particularly applicable in organizations or programs that carry out a screening or gatekeeping function. For instance, it is not sufficient, upon determining that an individual fails to meet the criteria for hospitalization, to tell the individual or family members to make contact again if the situation worsens. Such practices tacitly encourage the escalation of crises. Individuals and their families should be assisted in accessing services and supports that resolve issues early on, and an organization providing screening or gatekeeping services should be fluent with alternatives for when service thresholds are not met. When these alternatives are lacking, the organization should consider this a problem in care and take action accordingly. Likewise, an organization providing early intervention that routinely receives referrals from hospital gatekeepers might consider improving its outreach so that individuals seeking help are more likely to access their services directly, without placing demands on programs designed for late-stage emergencies.

9. **Interveners have a comprehensive understanding of the crisis.** Meaningful crisis response requires a thorough understanding of the issues at play. Yet, for people with serious mental illnesses, interventions are commonly based on a superficial set of facts: behaviors are seen to present a safety issue, the individual has reportedly failed to take medications as prescribed, or an encounter with the police has occurred. An appropriate understanding of the emergency situation not only includes an appreciation for what is happening at the moment, but also *why* it is happening and how an individual fares when he or she is *not* in crisis. Crises—particularly recurrent crises—likely signal a failure to address underlying issues appropriately. When crisis intervention occurs outside of the individual's customary setting, such as in a hospital emergency department or a psychiatric inpatient unit, it may be challenging to gain a good picture of the individual's circumstances.

An Alternative Approach

"The Hospital Diversion Program at the ROSE HOUSE is currently available to residents of Orange and Ulster counties [New York State]. This peer-operated house is designed to assist fellow peers in diverting from psychiatric distress, which may lead to a hospitalization. The program is located in a three-bedroom home set up and furnished for comfort. The house is equipped with a variety of traditional self-help and proactive tools to maintain wellness. Trained peer companions are the key ingredients in helping others learn self-help tools. Peer companions are compassionate, understanding and empowering. We exist to fill a gap in the mental health system that can brake the cycle of going from home to crisis to hospital.

The ROSE HOUSE offers a stay of up to five days to take control of your crisis or potential crisis and develop new skills to maintain your wellness. Peer companions staff the house 24 hours a day to address the needs of guests as they arise. Participation in the program is completely voluntary and free of charge. You are free to come and go as you please. We also will maintain contact and support for you, at your request, after you finish your stay. We have found that occasional calls and visits reinforce recovery and self determination."

From the website of Projects to Empower and Organize the Psychiatrically Labeled (PEOPLe, Inc.) at http://www.projectstoempower.org

Mobile outreach services, which have the capacity to evaluate and intervene within the individual's natural environment, have inherent advantages over facility-based crisis intervention, especially when an individual who has personal experience with mental illness and mental health crises is a part of the intervention team. Such mobile outreach capacity is even more meaningful when it is not restricted to a special crisis team, but rather when staff and peers familiar with the individual have the ability to literally meet the individual where he or she is. When intervention within an individual's normal living environment is not feasible, hospitalization is not the inevitable alternative; for many individuals facing civil commitment, consumer-managed crisis residential programs can represent a viable, more normalized alternative that produces good outcomes.[16]

10. **Helping the individual to regain a sense of control is a priority.** Regaining a sense of control over thoughts, feelings and events that seem to be spinning out of control may be paramount for an individual in mental health crisis. Staff interventions that occur without opportunities for the individual to understand what is happening and to make choices among options (including the choice to defer to staff) may reinforce feelings that control is being further wrested away. The individual's resistance to this may be inaccurately regarded as additional evidence of his or her incapacity to understand the crisis situation. Incorporating personal choice in a crisis response requires not only appropriate training, but also a setting with the flexibility to allow the exercise of options. Informed decision-making in this context is not a matter of simply apprising the individual of the empirically derived risks and benefits associated with various interventions; it also includes an understanding among staff that an ostensibly sub-optimal intervention that is of the individual's choosing may reinforce personal responsibility, capability and engagement and can ultimately produce better outcomes. The specific choices to be considered are not limited to the use of medications, but also include the individual's preferences for what other approaches are to be used where crisis assistance takes place, involving whom and with what specific goals. While the urgency of a situation may limit the options available, such limitations may also highlight how earlier interventions failed to expand opportunities to exercise personal control. Post-crisis recovery plans or advance directives developed by the individual with assistance from crisis experts are important vehicles for operationalizing this principle.

11. **Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served.** Given the importance of understanding how an individual is experiencing a crisis and engaging that individual in the resolution process, being able to effectively connect with the individual is crucial. A host of variables reflecting the person's identity and means of communicating can impede meaningful engagement at a time when there may be some urgency. Establishing congruence requires more than linguistic proficiency or staff training in cultural sensitivity; it may require that to the extent feasible, an individual be afforded a choice among staff providing crisis services.

National Resource Center on Psychiatric Advance Directives

Psychiatric advance directives (PADs) are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment, in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Almost all states permit some form of legal advance directive (AD) for healthcare, which can be used to direct at least some forms of psychiatric treatment. In the past decade, 25 states have adopted specific PAD statutes.

http://www.nrc-pad.org

12. **Rights are respected.** An individual who is in crisis is also in a state of heightened vulnerability. It is imperative that those responding to the crisis be versed in the individual's rights, among them: the right to confidentiality, the right to legal counsel, the right to be free from unwarranted seclusion or restraint, the right to leave, the right for a minor to receive services without parental notification, the right to have one's advance directive considered, the right to speak with an ombudsman and the right to make informed decisions about medication. It is critical that appropriately trained advocates be available to provide needed assistance. Correctly or not, many individuals with serious mental illnesses have come to regard mental health crisis interventions as episodes where they have no voice and their rights are trampled or ignored. Meaningfully enacting values of shared responsibility and recovery requires that the individual have a clear understanding of his or her rights and access to the services of an advocate. It is also critical that crisis responders not convey the impression that an individual's exercise of rights is a hostile or defiant act.

13. **Services are trauma-informed.** Adults, children and older adults with serious mental or emotional problems often have histories of victimization, abuse and neglect, or significant traumatic experiences. Their past trauma may be in some ways similar to the mental health crisis being addressed. It is essential that crisis responses evaluate an individual's trauma history and the person's status with respect to recovery from those experiences. Similarly, it is critical to understand how the individual's response within the current crisis may reflect past traumatic reactions and what interventions may pose particular risks to that individual based on that history. Because of the nature of trauma, appropriately evaluating an individual requires far more sensitivity and expertise than simply asking a series of blunt, potentially embarrassing questions about abuse and checking off some boxes on a form. It requires establishing a safe atmosphere for the individual to discuss these issues and to explore their possible relationship to the crisis event.

14. **Recurring crises signal problems in assessment or care.** Many organizations providing crisis services—including emergency departments, psychiatric hospitals and police—are familiar with certain individuals who experience recurrent crises. They have come to be regarded as "high-end users." In some settings, processing these individuals through repeated admissions within relatively short periods of time becomes so routine that full reassessments are not conducted; rather, clinical evaluations simply refer back to assessments and interventions that were conducted in previous (unsuccessful) episodes of care. While staff sometimes assume that these scenarios reflect a patient's lack of understanding or willful failure to comply with treatment, recurrent crises are more appropriately regarded as a failure in the partnership to achieve the desired outcomes of care. And rather than reverting to expedient clinical evaluations and treatment planning that will likely repeat the failed outcomes of the past, recurrent crises should signal a need for a fresh and careful reappraisal of approaches, including engagement with the individual and his or her support network.

"Confounding and complicating the prevalence of trauma in public mental health service recipients is the fact that mental health services themselves are often experienced as traumatic. The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment vs. empowerment and choice often cause unintentional re-traumatization in already vulnerable populations."

National Association of State Mental Health Program Directors (2005) NASMHPD Position Statement on Services and Supports to Trauma Survivors

15. **Meaningful measures are taken to reduce the likelihood of future emergencies.** Considering the deleterious impact of recurrent crises on the individual, interventions must focus on lowering the risk of future episodes. Crisis intervention must be more than another installment in an ongoing traumatic cycle. Meaningfully improving an individual's prospects for success requires not only good crisis services and good discharge planning, but also an understanding that the crisis intervener—be it police, hospital emergency department, community mental health program, or protective service agency—is part of a much larger system. Performance-improvement activities that are confined to activities within the walls of a single facility or a specific program are sharply limited if they do not also identify external gaps in services and supports that caused an individual to come into crisis. Although addressing certain unmet needs may be beyond the purview of one facility or program, capturing and transmitting information about unmet needs to entities that have responsibility and authority (e.g., state mental health programs, housing authorities, foster care and school systems) is an essential component of crisis services.

"Most performance measurement efforts tend to operate in isolation from one another to meet the specific needs of their sponsors. Frequently, data collection efforts are particular to specific care settings—such as hospitals or ambulatory care organizations—or to particular payers, whether private or public... Since data are collected and used in fragmented ways, they rarely provide a picture of the overall quality of performance for a specific clinician or organization, or how well patients fare, or the state of the public's health at large."

Health Care at the Crossroads: Development of a National Performance Measurement Data Strategy. The Joint Commission, 2008, p.8.

III. INFRASTRUCTURE

An organization's infrastructure should support interventions consistent with the values and principles listed above. Given the nature of crises affecting individuals with serious mental or emotional problems, these values and principles are applicable to a very broad array of organizations—hospital emergency departments, psychiatric programs, foster care, education, police, schools, and courts. While needed infrastructure will necessarily vary by setting, population served and the acuteness of crises being addressed, there are some important common denominators:

- **Staff that is appropriately trained and that has demonstrated competence** in understanding the population of individuals served, including not only a clinical perspective, but also their lived experiences.
- **Staff and staff leadership that understands, accepts and promotes the concepts of recovery and resilience,** the value of consumer partnerships and consumer choice, and the balance between protection from harm and personal dignity.
- **Staff that has timely access to critical information,** such as an individual's health history, psychiatric advance directive or crisis plan. Such access is, in part, reliant on effective systems for the retrieval of records, whether paper or electronic.
- **Staff that is afforded the flexibility and the resources,** including the resource of time, to establish truly individualized person-centered plans to address the immediate crisis and beyond.
- **Staff that is empowered to work in partnership with individuals being served** and that is encouraged, with appropriate organizational oversight, to craft and implement novel solutions.
- **An organizational culture that does not isolate its programs or its staff** from its surrounding community and from the community of individuals being served. This means that the organization does not limit its focus to "specific" patient-level interventions, but also positions itself to play a meaningful role in promoting "indicated" strategies for the high-risk population it serves and "universal" strategies that target prevention within the general population. The intent here is not to dissipate the resources or dilute the focus of an organization, but to assure recognition that its services are a part of a larger spectrum and that it actively contributes to and benefits from overall system refinements.
- **Coordination and collaboration with outside entities** that serve as sources of referrals and to which the organization may make referrals. Such engagement should not be limited to service providers within formal networks, but should also include natural networks of support relevant to the individuals being served.
- **Rigorous performance-improvement programs** that use data meaningfully to refine individuals' crisis care and improve program outcomes. Performance improvement programs should also be used to identify and address risk factors or unmet needs that have an impact on referrals to the organization and the vulnerability to continuing crises of individuals served.

IV. MAKING IT HAPPEN

The need for major improvements in crisis services for adults, children and older adults with serious mental or emotional problems is obvious. The statistics presented in the introduction to these guidelines make a clear case that people with mental illnesses are vulnerable to repeated clinical and life crises that can have deleterious effects on the individual, families and social networks, and communities. Many interventions could have a significant, positive impact on the frequency and severity of mental health crises, but they are not readily available to most of the individuals who need them.[17]

Properly applied, these guidelines should work to improve the quality of services for people who are in or are vulnerable to mental health crises. Embedded in the guidelines is the notion that crisis services should not exist in isolation; crises are a part of an individual's life experiences and the assistance provided during crisis periods is part of a larger set of services and supports provided to the individual. While the values, principles and infrastructure recommendations presented here focus on crises affecting people with serious mental illnesses, they also have wider application; they reflect generally accepted approaches to working with individuals who have mental or emotional problems, whether or not they are in crisis. Stated differently, these guidelines challenge any disjuncture between responses to mental health crises and routine mental healthcare. They demonstrate how appropriate emergency mental health responses should affirm the principles of recovery and resilience that are the benchmarks for appropriate mental healthcare even though crisis scenarios may test the application of these values.

From a practice standpoint, these guidelines may be most effectively enacted when they are embedded in the various quality-control and performance-improvement mechanisms that operate within an organization. When appropriately conducted, quality control and performance-improvement processes should be data-driven and attuned to demonstrating not only what segments of the service population are prone to mental health crises, but also what factors underlie their vulnerability. An adequate understanding of these factors requires much more than the "encounter" data now routinely collected by both healthcare organizations and police. Data collection should clearly reflect the premise that mental health crises represent problems in care (whether individual or systemic) and should facilitate the root-cause analyses that are required when significant problems in care occur. Similarly, data should be used as tools for identifying gaps, developing remedies and monitoring the impact of these remedies. Providers and provider organizations should have access to these data for purposes of ensuring the quality of care and the appropriate use of resources. To the extent that the causes of mental health crises extend beyond the domains of an emergency department, a hospital, a mental health system, a police department, and/or a housing authority, data without personal identifiers should be routinely shared across systems. Entities having oversight responsibility should ensure that these performance-improvement activities are being carried out and that opportunities exist for cross-agency/cross-system analysis of information and the implementation of strategies to reduce mental health crises. And the partnerships between providers and consumers that are appropriate in the context of individual crises should be mirrored at the performance-improvement level.

In addition to the human case for improving crisis services, a strong business case can be made and data should be collected accordingly. Current approaches to crisis services needlessly perpetuate reliance on expensive, late-stage interventions (such as hospital emergency departments) and on settings that have inherent risks for harm for people with mental health needs (for instance, jails and juvenile justice facilities). Resources and personnel that might otherwise be available for more effective, less risky and less expensive interventions are now channeled into these costly and suboptimal settings. The factors that sustain late-stage crisis interventions may be linked to reimbursement practices and political considerations, yet in some ways the service system is itself complicit. Performance-improvement data derived from on-the-ground case experience can paint a compelling story of how "the right services at the right time" would look for individuals who are currently at high risk for future crises. These data can also set the stage for concrete discussions of the costs and the benefits of changes in policies governing the provision and funding of services and supports.

In short, the approach to crisis services must be forward-looking rather than merely reactive, with success seen as the ability of the individual served to return to a stable life in the community. Rather than leading merely to an increase in the number of beds available for mental health care, it must have as its goal a reduction in the number of crises among people with mental illnesses and therefore a reduced need for emergency services.

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