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WHEN A MENTAL HEALTH CRISIS HAPPENS, IT IS IMPORTANT TO UNDERSTAND WHAT IS HAPPENING, WHY, OR HOW

NAVIGATING MENTAL HEALTH CRISES

by Melissa Prusko, Psy.D.

Covid-19 has changed our world and our lives. As a result, we have all become intimately acquainted with crisis. For those with mental health diagnoses, crisis is an ever-present possibility, and this past year has only increased the crises experienced. We often see the impact in our emergency rooms. In fact, over the past year, there has been an overall increase in mental health and substance abuse visits to emergency rooms (CDC; Holland, Jones, & Vivolo-Kantor, 2021). According to the CDC, visits to the emergency room for individuals with a mental health diagnosis increased by 44% from 2016 to 2018. From 2006 to 2014, 1 in 8 visits to the emergency room were due to mental health and/or substance use (Kalter, 2019; Moore, Stocks, & Owens, 2017). During that time, there was an increase in suicide and suicide attempts by 415%. This trend is only increasing (Kalter, 2019; Moore, Stocks, & Owens, 2017). During the pandemic, these rates have increased across the board (Holland, Jones, & Vivolo-Kantor, 2021).

Following World War II, there became a focus on mental health, not only in terms of prevention but also in terms of improving care (Erickson, 2021; Torrey, 2014). In the 1950s, the antipsychotic drug Thorazine was developed, and it became a new intervention to treat mental illness. In 1954, the Joint Commission on Mental Illness and Health described, among other things, the deplorable and dismal conditions within our state hospitals. The push for transitioning individuals who were institutionalized for years back to the community began to gain traction during John F. Kennedy's presidency; this was largely believed to happen because of his sister Rosemary, who publicly struggled with mental illness (Torrey, 2014). In 1962, the year before Kennedy's assassination, community mental health was a hallmark of his presidency, and individuals began transitioning from institutions back into the community.

Following Kennedy's assassination, deinstitutionalization continued. One of the products of this movement was the development of criteria to determine who and under what conditions someone could be hospitalized as well as how long someone could be hospitalized (Erickson, 2021; Torrey, 2014). There was a concerted effort to never return to the state of long-term institutional care. Throughout this movement, people used the refrain, "Treat and release." Thus the goal of hospitalization became to resolve the mental health crisis to the point that someone no longer meets criteria, and then discharge them back to the community. Yet, upon discharge, managing mental illness became difficult. There were gaps in the transition to community care, with conflicts over who was responsible for funding mental health care: state or federal government (Torrey, 2014).

As a result, we are often left with individuals too ill to be maintained in outpatient care and not yet severe enough to require higher levels of care. Individuals often are unable to access care, with month-long wait lists for treatment programs and limited accessible providers. Collectively, this has resulted in the emergency room becoming the central place for evaluation and management of acute mental health crises (Kalter, 2019; Larkin, Beautrais, Kirrane, Lippman, & Milzman, 2009).

When a mental health crisis happens, there is a high likelihood that you or your loved one will need to go to the emergency room for further evaluation and safety. Everything happens so fast, and we never have a moment to understand what is happening, why, or how. It is important to take care of yourself throughout this process and allow compassion, as this can be overwhelming and daunting.

Now let us break down all the moving parts of navigating a mental health crisis, beginning with definitions of crisis, crisis intervention, and psychiatric hospitalization. Then, we will explore the criteria for mental health hospitalization and how to determine if you or your loved one needs to go to the emergency room for safety and evaluation. Third, we will review what to expect in the emergency room in general as well as by age. Lastly, there will be a review of common questions and their answers as well common reactions throughout the navigation of a mental health crisis.

DEFINITIONS

According to Medicaid Rule 132:

- Crisis is defined as, "a deterioration in the level of role functioning of the client within the past 7 days or an increase in acute symptomatology."
- Crisis intervention refers to interventions intended to stabilize an individual to avoid more restrictive levels of care, of which psychiatric hospitalization is the most restrictive level of care. The goal of crisis intervention is symptom reduction, stabilization, and restoration to role functioning without being hospitalized (Rule 132).
- If crisis intervention fails to reduce symptomatology, then an individual meets criteria for psychiatric hospitalization. Psychiatric hospitalization often consists of medication management with the possibility of therapy (i.e. milieu/group, individual, couples, and/or family) depending upon the facility. (Rule 132 59 ILAC, 2014).

The next question often is: what is the criteria for inpatient hospitalization?

While you or your loved one are not deciding whether someone should be hospitalized, it is important:

1. To understand the criteria against which a crisis team and the emergency room physician are evaluating you or your loved one's current mental health crisis.

2. To understand what to look for as an indicator of a mental health crisis.

According to Illinois law, an individual with a mental health diagnosis meets criteria for inpatient hospitalization if they meet one or more of the following (Mental Health and Developmental Disabilities Code, 405 ILCS 5, 1979):

1. Imminent harm to self and/or others

a. "a person with mental illness who: because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed"

b. The important word here is imminent. This means that without the decision of hospitalization, the individual will leave the emergency room and hurt themselves and/or others.

i. Often, I had families tell me that they are worried in the next month that their loved one will be a danger. We cannot hospitalize for the prospect of deterioration within a month, and this is a result of the 1970s and deinstitutionalization. Imminent means it will and/or is happening.

c. This does not simply include statements such as, "I'm so mad I could kill him."

i. While a concerning statement, the emergency room will evaluate to determine intent, access, and plans.

ii. What will be important for you or your loved one is to share whether this type of statement is a departure from baseline.

d. This does include attempts to harm oneself and/or others.

e. This does not necessarily include non-suicidal self-injury (NSSI) behaviors, such as cutting or burning. NSSI can meet criteria for hospitalization if:

i. There is an acute change in the behavior: deeper cutting, inability to stop cutting, change of instrument to cut with to something more lethal, etc.

ii. This will not be on you to determine and/or assess, but this information will be very helpful to convey in the emergency room.

2. Inability to care for self:

a. "a person with mental illness who: because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or others, unless treated on an inpatient basis"

b. This looks like days without showering to the point of observable poor hygiene, days without eating and noticeable weight loss, poor dental

care, days of not sleeping, days of staying in bed, wearing unclean clothes, etc.

3. Non-compliance with treatment

a. "a person with mental illness who: refuses treatment or is not adhering to prescribed treatment; because of the nature of his or her illness is unable to understand his or her need for treatment; and if not treated on an inpatient basis, is reasonably expected based on his or her behavioral history, to suffer mental or emotional deterioration and is reasonably expected, after such deterioration, to meet the criteria of either paragraph one or paragraph two above"

b. This criterion is tricky as people have the right to refuse medications. This criterion is often difficult as the sole reason for hospitalization as the definition even indicates there needs to be an established history. In my experience, this criterion was often accompanied with an individual also presenting with harm to self, harm to others, inability to care for self or psychosis.

4. Developmental Disability

a. "An individual who: is developmentally disabled and unless treated on an inpatient basis is reasonably expected to inflict serious physical harm upon himself or herself or others in the near future"

b. This does not mean that just the presence of a developmental disability is enough for hospitalization. There needs to be harm to self and/or others.

Based on this criteria, how do I know if myself or a loved one needs to go to the emergency room?

After using the above criteria to inform the decision to go the emergency room or not, it is important to highlight that the process may be different for children/adolescents and adults. Throughout this decision-making process, it will be important for you or your loved one to note how changes in behavior depart from how you or your loved one typically behaves. This information will be invaluable to share with the emergency room.

CHILDREN AND ADOLESCENTS

This process may begin with a call to Screening, Assessment, and Support Services (SASS) if your child meets one of the following criteria (https://www2.illinois.gov/hfs/MedicalProviders/behavioral/sass/Pages/sasshome.aspx)

1. Your child is 20 years old or younger and has Medicaid coverage (managed Medicaid or Public Aid)

2. Your child is age 17 or younger and has no insurance coverage

3. If your child meets the criteria above, call **1-800-345-9049**.

a. Here you will provide the information about the crisis to the caller, who will then contact a SASS worker to come to your location. This could be your home, but it could also be the school if your child's crisis is happening at school. Someone should arrive within 90 minutes to two hours.

b. Once the SASS worker arrives, they will conduct

an evaluation to determine if you need to bring your child to the emergency room or not. If they decide not to send your child to the emergency room for further evaluation, then they will coordinate other services for you.

If your child is covered under a third-party insurance (i.e., Blue Cross Blue Shield, Aetna, etc.), bring them to the emergency department, and the process will look very similar to that of an adult.

FOR EVERYONE

Trust that you know yourself and/or your loved one.

Do not dismiss if a child/adolescent or adult tells you that they feel unsafe with themselves, if they want to harm themselves, if they want to harm someone else, and/or if they are expressing ideas and feelings that are not grounded in reality (i.e., psychosis).

Do not assume that a child does not understand what they are saying. Take these expressions seriously.

If you feel there is time, and you have questions about whether you should go to the ER or not, you can call your local hospital and ask to speak with the crisis team. Ask specific questions about what to expect upon arrival to the emergency room. They will not be able to assess over the phone, but they will help encourage you to bring them to the emergency room and explain how to do this.

If you recognize one or more of the criteria for hospitalization and decide to go to the emergency room, here are a few considerations:

1. Is it safe for me to take myself and/or my loved on to the ER? Can I drive safely?

2. If the answer is no, then call 911.

a. When you call:

i. Identify this is a mental health crisis

ii. Explain the safety concern

iii. Provide any medication information

3. Regardless of how you or your loved one arrive to the emergency room, is there someone who can come with, or be contacted, to provide more information about what is happening?

a. Once you arrive in the ER, that will be the time to contact your therapist, psychiatrist, etc.

b. Consider signing a Release of Information so the emergency room can have as much information as possible as they evaluate your or your loved one.

Myself or my loved one is abusing substances. Can I or my loved one be brought to the emergency room for psychiatric evaluation?

This is a gray area when it comes to inpatient hospitalization, as there are a few scenarios to consider.

Scenario 1: The person is only abusing substances, and there are no mental health symptoms or concerns exhibited. In this instance, you can bring yourself or your loved one to the emergency room; however, you or your loved one will not meet criteria for inpatient hospitalization. While the argument can be made that abusing substances is a harm to self and/or a harm to others, the law is very clear about this. The criteria are specifically about mental health conditions and not the effect of substance abuse/use. The emergency room may help

with identifying substance abuse treatment centers. However, you or your loved one will not meet criteria for inpatient psychiatric hospitalization on the basis of substance abuse alone.

Scenario 2: The person is acutely intoxicated and expressing harm to self, others, and/or psychosis while intoxicated. In this instance, you can bring yourself or your loved one to the emergency room. Ideally, providers will conduct an initial evaluation with an assessment of how intoxicated the person is. For example, if it is alcohol, they will obtain a blood alcohol level; if it is another substance, a blood test will confirm the presence of the substance(s), and you or your loved one will be monitored in the emergency room until a re-evaluation can be conducted. In the initial evaluation, statements and symptoms will be documented. Once you or your loved one are sober, there will be a re-evaluation to see if the statements are still being said and/or symptoms are present. Many behaviors exhibited while intoxicated can mimic mental health symptoms, and the emergency room needs to be clear that the symptoms are due to mental health and not substance abuse. If the concerning statements of harm and/or mental health symptoms are still present and meet criteria, then hospitalization will be pursued. If not, then discharge will happen.

Scenario 3: The person attempts suicide and/or harms someone while intoxicated. This is a situation where you or your loved one will meet criteria and may not have a re-evaluation. In this instance, the substance is not the focus of the crisis, but instead the action that was taken. This is in contrast to the second scenario described above because the second scenario is words without action; this third scenario is action.

While there are differences across emergency rooms, the below outlines in general what to expect once you arrive in the ER.

WHAT TO EXPECT IN THE EMERGENCY ROOM

1. When you arrive, be sure to share with the receiving/triage nurse that you are there for a mental health crisis. If you arrive by ambulance, the EMTs will give this report.

2. You will then be placed in a room, and you will be asked to remove all your clothes and belongings for safety.

    a. Some hospitals have rooms specifically for individuals experiencing a mental health crisis. This area may be locked and with restricted access. This is done for safety until there is a determination of whether someone meets criteria for hospitalization.

3. Visitors may be limited, if allowed at all. If allowed, all visitors will/should have their belongings checked prior to being in the room. This is to ensure there will be no attempt to abscond from the emergency room, be given anything to hurt self or others, etc.

    a. Other considerations for visitors include:

        i. Is the visitor part of the reason the crisis? For example, was there an argument that left someone feeling suicidal, and has that person now accompanied them to the emergency room? In my experience, we often did not let any visitor with the individual if they were a contributing factor to the crisis in any way.

ii. Does the individual want the person to stay?

iii. Is there something about the relationship between the individual and who wants to stay that would be unhealthy or perhaps involve ulterior motives? For example, is the relationship abusive?

iv. Is the person staying disruptive in any way? Due to the distressing nature of crisis, it can understandably cause distress to loved ones, and they act in uncharacteristic ways.

v. If the individual is restrained and/or aggressive and agitated in any way, often visitors may not be allowed — for safety as well as the distressing nature of seeing a loved one restrained.

4. Providers will need to collect blood and urine. Prior to hospitalization, we need to rule out any potential medical explanation for what is causing the symptoms in crisis.

5. Someone, most likely from a crisis team, will come to evaluate you and speak with anyone you consent to obtain information about the current crisis.

a. This is when crisis intervention begins. Per Medicaid Rule 132, "Crisis intervention services shall include an immediate preliminary assessment that includes written documentation in the clinical record of presenting symptoms and recommendations for remediation of the crisis. Crisis intervention services may also include, if appropriate, brief and immediate mental health services or referral, linkage and consultation with other mental health services. Specific documentation of the delivery of crisis service must include a preliminary assessment, a description of the intervention and the client response to service."

b. For children who came to the emergency room by way of SASS:

i. The SASS agency will be contacted again once your child is medically cleared in order to determine the level of appropriate care:

1. Inpatient hospitalization

2. Intensive outpatient

3. Partial hospitalization

6. Once medically cleared, providers will determine whether you or your loved one meets criteria for hospitalization.

a. For adults:

i. If criteria is met, then two legal documents will be completed, and these will be necessary for hospitalization. The two documents are: **Petition** and **Certificate**.

1. The **Petition** can be completed by anyone over the age of 18 who witnessed the mental health crisis and can factually describe it. If your therapist or psychiatrist sends you to the ER, they may complete this and send it with the ambulance. Petitions remain valid for 72 hours.

a. Note: By law, your loved ones have a right to receive a copy of the completed Petition.

2. The **Certificate** can only be completed by a licensed professional, and this will often be the emergency room physician. Certificates remain valid for 24 hours.

a. The certificate confirms what was reported in the Petition and expresses that an individual meets the criteria and requires further evaluation in the hospital and stabilization. Stabilization often means medication.

b. Note: By law, your loved ones have a right to receive a copy of the completed Certificate.

b. For children:

i. Parents act as the Petition and Certificate, and you will be required to follow your child to the hospital where they are being admitted.

ii. You will need to complete paperwork upon admission.

iii. If parents refuse and/or are not present, then the hospital can take temporary custody, and the Petition and Certificate will be completed *in loco parentis*, or "in place of the parent."

1. This was very rare, in my experience.

2. In this instance, DCFS would also be contacted as minors cannot be left unaccompanied.

c. If you or your loved one do not meet criteria, you will be discharged.

REMINDERS AND COMMON REACTIONS

1. **You are not expected to conduct a full mental health evaluation prior to deciding to go to the emergency room.**

2. **You are not the one hospitalizing your loved one.**

   There is often a misconception that if you bring someone to the emergency room, you are hospitalizing them. This is not accurate. You are bringing them to the emergency room for further evaluation where a licensed individual will make a determination about hospitalization.

3. **What if my loved one is mad at me for bringing them to the emergency room?**

   This is a common reaction, and it is important to recognize that your loved one is also not acting themselves. They may say things that are not characteristic, and they may say things that they do not mean. Remind yourself that you are bringing them to the emergency room for safety. Many understand this once they are stabilized.

4. **The emergency room physician and crisis team say myself or my loved one needs to be hospitalized, and I disagree. Can I sign out AMA (Against Medical Advice) from the emergency room?**

   The short answer is no.

The long answer is: this comes up often, and it is completely understandable. With the flood of emotions this process can evoke, we sometimes want to take our loved one back home because we see them distressed with this news or because they may feel betrayed that we shared what they said, etc. Sometimes, family members make promises about what will or will not happen in the emergency room, and there is guilt. Sometimes we want to leave because we do not want to miss work, school, etc. When someone meets criteria, there is the legal right by the emergency room physician to hold someone against their will. This is what makes hospitalization the highest and most restrictive level of care. As such, these decisions are not made lightly.

5. **A psychiatrist will not come to the emergency room for evaluation.**

   There is often a misconception that psychiatry will come to the emergency room to conduct an evaluation. This often will not happen. Instead, assessments are made collaboratively between a crisis team and the emergency room physician. There are always exceptions to this; however, generally, this is not standard practice.

6. **Create a plan for crisis, whether it is for yourself or with a loved one.**

   Having a plan of what to do in the future can be very helpful.

7. **Be aware that if your loved one is physically unsafe, there will be an order for sedating medication and/or physical soft restraints.**

8. **Take care of yourself.**

   Crisis is difficult. It can feel like the weight of the world is on your shoulders and like the crisis will never end. Please know you are not alone. It is often true that the hardest decisions we make for ourselves and others are borne out of deep love, care, and concern. There is no greater show of love than ensuring yourself or those you love are safe. Whether you are the one in crisis or a loved one, be gentle with yourself. The crisis will end.

SOURCES

Centers for Disease Control and Prevention. (2020, December 4). QuickStats: Emergency department visit rates related to mental health disorders, by age group and sex – National Hospital Ambulatory Medical Care Survey, United States, 2016-2018. *Morbidity and Mortality Weekly Report, 69*(48), 1838. doi:10.15585/mmwr.mm6948a13

Erickson, B. (2021). Deinstitutionalization through optimism: The Community Mental Health Act of 1963, *The American Journal of Psychiatry Residents' Journal, 16*(4), 6-7. https://doi.org/10/1176/appi.ajp-rj.2021.160404

Holland, K. M., Jones, C., & Vivolo-Kantor, A. M. (2021). Trends in US emergency department visits for mental health, overdose, and violence outcomes before and during the COVID-19 pandemic, *JAMA Psychiatry, 78*(4), 372-379. doi:10.1001/jamapsychiatry.2020.4402

Illinois Healthcare and Family Services. (n.d.). Screening, assessment, and support services. https://www2.illinois.gov/hfs/MedicalProviders/behavioral/sass/Pages/sasshome.aspx

Kalter, L. (2019, September 3). Treating mental illness in the ED. Association of American Medical Colleges. https://www.aamc.org/news-insights/treating-mental-illness-ed

Mental Health and Developmental Disabilities Code, 405 ILCS 5 (1979)

Larkin, G. L., Beautrais, A. L., Spirito, A., Kirrane, B. M., Lippman, M. J., & Milzman, D. P. (2009). Mental health and emergency medicine: A research agenda, *Academic Emergency Medicine*, 16(11), 1110-1119. doi:10.1111/j.553-2712-2009.00545.x

Moore, B. J., Stocks, C., & Owens, P. L. (2017). Trends in emergency department visits, 2006-2014. *Healthcare Cost and Utilization Project*, (Statistical Brief #227).

Rule 132 59 ILAC (2014)

Torrey, E. F. (2014). *American psychosis: How the federal government destroyed the mental illness treatment system.* New York: Oxford University Press.

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Dr. Melissa Prusko, PSY.D. strives to provide a compassionate and empathic therapeutic relationship that allows for feeling safe enough to explore and to make sense, together, what may bring someone to therapy. While she practices from a psychodynamic perspective, she is skilled at delivering techniques in a relational manner for those who are seeking new skills for symptom relief. Dr. Prusko's primary clinical focus is trauma, and she also welcomes treating individuals with depression, anxiety, emotion dysregulation and grief/loss. Dr. Prusko has worked in a variety of settings from hospital emergency rooms to inpatient hospitals to jails to residential substance treatment centers. Dr. Prusko is committed to socially responsible therapeutic practices and understands that we cannot be understood separate from our contexts. She strives to allow space for exploring various aspects of our lives, such as race, gender, oppression and inequity, and how they impact our work in therapy.

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