Crisis Services

2015

What's the definition of crisis?

NAMI's definition: "A mental health crisis is a "behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including but not limited to, inpatient hospitalization."

That definition is "system centered", "objective", and "rehabilitation oriented"

- The "system centered" component implies a three level system: 1) community services, 2) crisis services, and 3) hospital and institutional services. That perspective helps delineate the kinds of services that are included in the crisis level and the target goals (to provide strong enough community services, both preventative and for people with ongoing needs) so people don't need crisis services, and to provide enough crisis services so people don't need hospital and institutional services.
- The "objective" component implies that there can be objective criteria determining the need for crisis services, rather than the "subjective" statement of need of the person, their family, or others. Within that perspective the power and responsibility lie with whoever makes the objective assessment, rather than the other people involved.
- The "rehabilitation orientation" implies that crisis services should be used to preserve functioning and community integration, rather than to reduce symptoms and treat illnesses. This is a "rehabilitation necessity" rather than a "medical necessity" which impacts the funding.

An alternative definition could be, "A crisis is when someone –either the person themselves, family, mental health professionals, or others in the community – can't take it anymore and something has to change. The person's own coping skills, their interpersonal relationships, and/or their community connections are either at risk of breaking apart or have already broken apart."

This is a "person centered", "subjective", recovery oriented" definition.

- The "person centered" component implies that whoever "can't take it anymore" whether it's the identified client or not should be listened to, assessed, and supported to re-compose themselves (and to either sustain or break their relationship with the person)..This perspective helps delineate services being sought by the person

themselves and by others in their environment and begins to form a basis for voluntary and involuntary crisis services.

- The "subjective" component implies that a variety of people m ay see things differently, all their perspectives should be included, and services will require shared decision making rather than being professionally driven.
- The "recovery orientation" implies that there are three important domains that are desirable outcomes of crisis services: 1) helping the person regain self-control, 2) helping sustain and restore interpersonal relationships, 3) helping sustain and restore community connections. These three domains form the backbone of recovery and resilience to protect against further crisis. They are also protective factors against dangerousness.
- This definition also implicitly includes the presumption that the crisis itself is not the problem, but that there is something underlying the crisis that is unbearable and needs to be changed. If the crisis is managed without that change it is likely the crisis will just reappear

Starting with the alternative definition will lead us into somewhat different services, ways of delivering services, and desired outcomes and accountability.

The crucial question shouldn't be "Do we have crisis response services?", but instead "Do we have crisis response capabilities within our services?" This opens up the possibilities of asking things like "Do our hospitals have the capability of responding to housing crisis? Or in a trauma informed way to a rape victim or drug addict? Or to a family member of someone who has become violent? The honest, but counterintuitive, answer might be that our hospitals and ERs – as well as our community programs and police and even outreach teams - have very limited crisis capabilities. We can go from there to asking if we have "crisis spectrum capabilities" (prevention, early intervention crisis response post-crisis).

Viewing the hospital as separate from the crisis system with the dual expectations that a good crisis system will keep people out of the hospital and a good community system will keep people out of the crisis system takes us away from figuring out what crisis spectrum capabilities we need and who could provide them best. The accountability isn't for keeping people away from other providers, but in providing services each agency is best capable of providing and is being funded to provide.

There would be clear expectations on hospitals to provide a large array of crisis spectrum services beyond the reduction in acute dangerousness they are currently funded for and held accountable for.

These should include:

1) Welcoming and system navigation for people new to behavioral health

2) Linking to, sharing data with, and communicating with all other providers both to understand what pre-crisis services have been provided and what post-crisis services are needed
3) Collaboration with other dangerousness responders, assessors, and preventers – police, ER, probation, DCFS, mobile crisis teams, paramedics
4) Trauma informed care
5) Building people's understanding of and collaboration with services and our understanding and collaboration with them
6) Evaluating for the need for and providing an array of condition-specific interventions
7) Peer support
8) Support to families and other community members
9) Assessment and facilitation of indefinite community removal
10) Collaboration with survival needs supports and services

Similarly, community programs should have these capabilities:

1) Continuity of prevention, earl intervention, crisis, and post-crisis services
2) Data collection to identify at risk clients
3) Implementing proactive crisis planning – WRAP, advanced directives
4) Building protective factors – resilience
5) Proactively identifying and addressing condition specific crisis issues
6) Proactively identifying and addressing person centered recovery based crisis issues
7) Building relationship / community based crisis responses – especially family
8) Providing trauma informed and peer support relationships when crisis occurs
9) Collaboration and communication with crisis partners including police and hospitals
10) Data collection about impact of services
11) Financial awareness of cost and sustainability of crisis services
12) Staff support to maintain compassion and avoid helplessness, withdrawal and burnout throughout crisis

There is a need to integrate person-driven recovery based interventions and condition – driven interventions. If only condition-specific interventions are provided, it's likely that a great deal of harm will be done to the person's recovery in the meantime. The common logic that first conditions need to be stabilized and then someone can work on recovery often creates severe and sometimes irreparable damage to welcoming and engagement, trust, empowerment, self-responsibility, and community integration before these issues are even begun to be appreciated and addressed. On the other hand, providing only recovery based interventions forces the person to adapt to potentially treatable conditions that may be very severe or even dangerous barriers to their recovery. Running the two systems in parallel deprives the condition based interventions of the greater efficacy they would have if they were implemented in engaging, collaborative, empowering, trauma informed ways.

Key issues from the community's point of view that are sidestepped in a recovery only perspective:

1) Predicting and preventing dangerousness and protecting public safety
2) Hospitals and ERs are perceived as the crisis system and there are inadequate beds and too short of stays to actually meet the community's needs
3) Pills are a very usefully, and trusted, part of treatment and much of crisis triggering and response is around getting access to the right medicine" and getting people to take their medicines
4) Some people have so few financial resources they are perpetually in survival mode grabbing whatever resources they can get. Crisis systems tend to see these people as inappropriate, manipulating, and abusing the system
5) Some people are so disruptive and/ or dangerous that the community wants them to be forcibly removed indefinitely. Crisis systems cannot meet this expectation / need.