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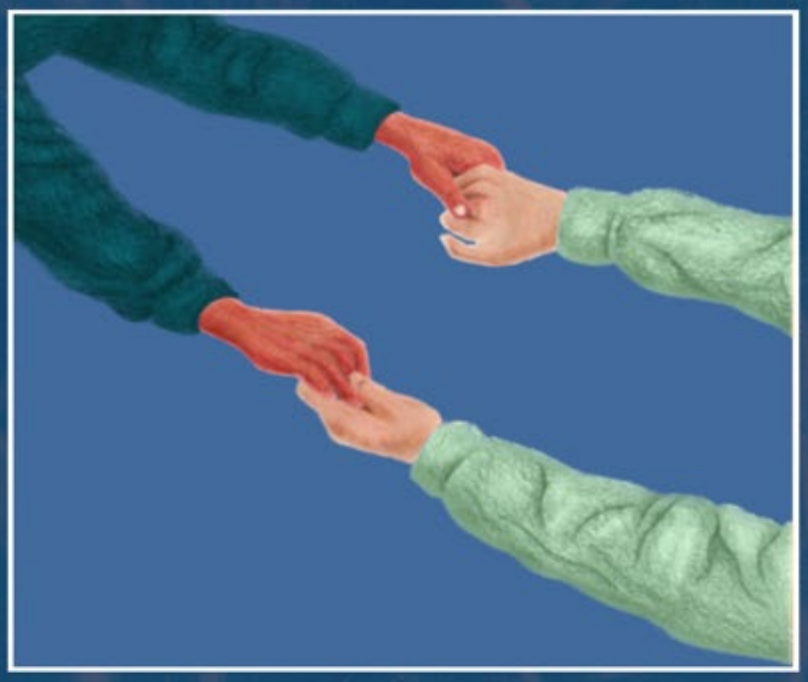
Crisis Services: General Medical and Psychiatric Approaches to Care Delivery



Connected and Strong

Fourth in a Series of Ten Technical Assistance Briefs to Foster Unity and Strengthen Continuity Across Crisis Response and Treatment Systems

SAMHSA
Substance Abuse and Mental Health Services Administration

Crisis Services: General Medical and Psychiatric Approaches to Care Delivery

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Abstract

The nationwide rollout of 988, a new three-digit number to call when individuals are in a mental health crisis, can dramatically improve access to crisis care. Core behavioral health crisis care services equivalent to those in emergency medical care include components such as a 24/7 call center, crisis mobile response teams, and crisis receiving and stabilizing services. For community and out-of-hospital crisis/emergency response to be effective for people with mental health challenges, substance use disorders, intellectual and developmental disabilities, and other behavioral-health-related conditions, there is a need for partnerships, comprehensive protocols, and a range of response options to meet the requirements of the particular crisis. When responses are considered across perspectives, persons in crisis have an opportunity for an inclusive, recovery-oriented, trauma-informed, and collaborative encounter with the crisis system. Additionally, initiating biopsychosocial treatment properly to maximize later engagement while maintaining safety remains a significant concern, necessitating that the range of responses—including medical responses—be considered for particular situations. At times, the best care for those in crisis can be complex, with challenges that include identifying which, or if, medications are needed; ensuring medical stability for care outside of hospital emergency departments; and coordinating with emergency medical services when indicated. This paper outlines many important considerations in delivering medical psychiatric crisis care and provides information and recommendations to improve practices and ultimately better meet the needs of individuals served.

Highlights

- Multiple medication options for mental health care needs, substance use treatment, and protocols for managing medical conditions seen in crises are necessary for crisis care facilities to be able to accept anyone in the community who is experiencing a behavioral health emergency. Without the proper medical infrastructure, facilities cannot be prepared to provide care to any individual at any time.
- When people encounter obstacles to accessing medical care, it increases the likelihood of disparities in treatment for marginalized populations, including those of different races. Therefore, it is crucial to have proper medical infrastructure, which must be in place to provide excellent crisis care, minimize barriers to accessing medical care, and avoid perpetuating existing care disparities. Medications are one of many tools to support those in crisis and are often necessary for providing complete care. Medications for mental health, substance use, and physical health issues may be required to support individuals in crisis and play an integral role in best practices for some situations. These medications may include a broad base of psychotropic medications, and many needs are managed with primarily generic, affordable options.

- Often, a mental health crisis care encounter is either the first time a person has exposure to medications for behavioral health needs or presents at a time when the person is considering restarting medications after not adhering to a previous regimen.
- Systems of care should approach persons served in a collaborative, person-centered way that prioritizes education and choice rather than control and management. Helping individuals be a partner in their care and use medications along with other personal wellness tools is important.
- Most individuals receiving crisis care can be safely treated without obtaining medical clearance through an emergency department. Medical triage and assessment protocols, correct medical staffing, and appropriate staff training are necessary to evaluate the minority of individuals who require more intensive medical care than can be offered in a behavioral health emergency crisis center. Even in these limited situations, more than half of the persons sent to a hospital emergency department for medical clearance can return to the crisis receiving center.
- Coordination with emergency services such as paramedics / emergency medical services (EMS) and emergency departments of hospitals is an integral part of creating access to crisis care that is safe and effective. Smooth transitions between crisis responders across the continuum decrease emergency department boarding, increase the use of appropriate resources, and maintain medical safety for those needing care without unnecessarily funneling persons through an emergency department process not designed to care for behavioral health crisis needs.

Recommendations

1. With the establishment of national standards for behavioral health crisis response, best practices and national standards for the use of medications and biological approaches in crisis care situations should also be established.
2. Treatment interventions outside hospital emergency departments should be explored in order to develop specific protocols and quality analyses. Their development should involve multidisciplinary perspectives, including the views of individuals who have experienced hospital emergency department care during psychiatric emergencies.
3. Data should be collected in various forms across sites delivering behavioral health emergency crisis responses, including regarding medication use and effective medical care practices. This data should be reported upon routinely and examined with an equity lens for public awareness and quality improvement.

4. Facility licensing for out-of-hospital emergency behavioral health facilities should be developed to maximize the provision of care or screening and triage to care that is equivalent to what is afforded to those needing emergency medical care. This would include a licensing structure that creates appropriate funding for sites to provide "no wrong door" care as well as pharmacy licensing and standards that allow facilities to provide immediate medications to those presenting in need.
5. Policymakers should assist providers in evaluating and working toward eliminating silos and barriers to accessing care for those with mental health and substance use comorbidities, as most persons served in emergency behavioral health crisis services have needs in both domains.
6. National standards for EMS/mobile out-of-hospital care and emergency department coordination regarding behavioral health crises should be developed. Policymakers should evaluate the barriers and opportunities the Emergency Medical Treatment and Labor Act can create by ensuring that stabilizing treatments are offered in emergency department settings for all conditions, including mental illness and substance use disorders.
7. An appropriate national standard for funding and matching billing codes for providers offering the highest level of emergency behavioral health crisis care, equivalent to emergency and urgent physical medical care, should be established. This funding should compare the cost of necessary tools, appropriate medical staffing, and training upkeep to serving this core function in the health care crisis system continuum.

Introduction

The promise of 988 and the new *National Guidelines for Behavioral Health Crisis Care* offer a different path for individuals experiencing a crisis related to mental health, substance use, or other emotional or trauma-related challenges.[1] The guidelines outline the ideal of immediate access to care for anyone, anytime, anywhere.[2] This care is designed to be the best practice for behavioral health care emergency crisis response and, in its implementation, providers should collaborate effectively and sensitively with the persons served. There is often a tension present in crisis care, involving balancing safety with minimizing trauma by using the least restrictive supports for an individual's needs. In this context, it is important to realize that crisis contacts can help set the stage for subsequent engagement and entry into longer-term treatment. In the emerging crisis continuum of services, the role of law enforcement and hospital emergency department (ED) use is de-emphasized in favor of utilizing first responders through crisis call centers, mobile behavioral health teams, and behavioral health crisis receiving centers (CRCs) equipped and staffed to manage the full range of crisis mental health and substance use challenges in the community.[3] Even with a shift in roles, partnerships—including with law enforcement and EDs—are important across crisis systems, as these entities are still needed. Yet it will be increasingly critical to help demonstrate ways for these partnerships to improve and to coordinate and build a system that serves people in the least restrictive way.[4]

Beyond examining coordination, the crisis care response for behavioral health systems has emerged as its own complex interplay of services across a continuum that is receiving a great deal of national attention. The Management of Medical Stabilization Within Crisis Receiving Centers model, for example, with its "no wrong door" principles, reduced hospital costs, and matching of appropriate service levels, helps to improve access to care in ways that provide better outcomes in spaces that are safe, trauma-informed, and inclusive of both clinical staff and people with lived experience of mental health issues, substance use, or trauma recovery.[5] To realize the full benefit of this model, CRCs must always say yes to law enforcement or other first responder drop-offs, even when both medical and behavioral health challenges coexist. Emergency behavioral health CRCs should have the infrastructure of medications; staff with medical care expertise; and training in triaging and managing medical, psychiatric, and substance use needs using the appropriate medical tools to accomplish this directive safely and effectively and to help avoid overreliance on EDs. In the 2024 technical assistance brief *Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services*, these points are emphasized given the importance of uniting to strengthen system capacity in multiple domains.[6]

Often, out-of-hospital responses delivered through receiving centers require the capability to prescribe and administer medications as one of the tools to support persons in crisis in an emergency moment, and they require medications to start or restart treatment according to best practices for a range of mental health and substance use care needs. When persons present for short-term stays in out-of-hospital facilities, they often also have acute or chronic medical

conditions. There may be concerns about the role of medical issues in their psychiatric presentation. There may also be concerns about managing their medical problems safely and effectively during crisis care. Persons presenting in crisis often do not need medical clearance in an ED before starting behavioral health emergency crisis care. However, requiring people to pass through a hospital ED is too often a prevailing pattern in much of the country. When the behavioral health crisis system cannot serve all and say yes to everyone who enters its doors (just like a hospital ED), more people will begin their journey in an ED or the justice system or may not seek access to needed care due to the barriers at entry. The current trajectory presents a particular risk for criminalizing behavioral health needs within marginalized populations, as demonstrated by significant racial disparities in outcomes and care in the current system.[7,8,9]

A response to an individual in crisis must take into account a biopsychosocial perspective and must offer recovery-minded support to meet an individual where they are in their own recovery. Individuals in crisis must rely upon their own wellness and coping strategies as part of the whole-person approach to their crisis needs.[10] Helping individuals feel and understand that they are a partner in their care and the expert regarding themselves is a vital step in supporting the recovery process of people even while they are in crisis.[11] Beyond these critical elements, the need to understand medical approaches to crisis care is also important, as medications are part of the infrastructure of supports.

This paper is written for state behavioral health leaders, medical directors, and other interested system partners and intends to explore the types of medications used in behavioral health crisis care systems, discuss how to use them in best practice, and suggest considerations for policymakers and practitioners in establishing systems that support these practices. It also discusses the recommended types of coordination between crisis services and medical emergency services. Finally, the paper reviews best practices in evaluating and managing medical stability, including the types of staffing, training, and tools that are needed, along with requirements for quality monitoring tools and systems.

Important note: This paper should not be considered medical advice. Rather, the paper highlights examples of common clinical presentations and treatment considerations to support medical capacity building in crisis settings.

Crisis Presentations: What May Arise on Any Given Day

People present to behavioral emergency CRCs 24 hours a day, 7 days a week, 365 days a year. Usually they arrive voluntarily, but sometimes they are brought against their will while experiencing a behavioral health crisis. For policymakers working at a distance from the actual service, it can be helpful to consider situations that may affect that person's ability to be served. The examples below highlight real concerns about medical needs that could impact the ability of

the person to be safely served at the crisis care facility as opposed to being turned away and sent back to the community or being sent to an ED not designed to meet their behavioral health care needs. All scenarios are based on actual but de-identified clinical examples provided by the authors from their experiences.

"42-year-old male presents voluntarily while intoxicated with alcohol, with a breathalyzer of 0.18 level, and reports feeling shaky. He wants help with depression, alcohol use, traumatic nightmares causing insomnia, and thoughts of suicide that worsen when he drinks. He has a history of complicated alcohol withdrawal with some seizures. He has hypertension and non-insulin-dependent diabetes mellitus but has not been on medications or seen by a primary care physician in over a year."

"63-year-old female, post overdose attempt, who was medically cleared in the emergency department and sent to the behavioral health crisis center as a referral on involuntary commitment. She uses a walker, has been taking a blood thinner for atrial fibrillation, and is on 12 different medications for multiple medical issues."

"23-year-old presents with frank mania symptoms and not sleeping for the past few days, brought in by his family. He has been having significant harm reduction on 120 mg methadone at an opioid treatment program for the past 6 months and is worried about how he can stay for care without going to the clinic to get his daily dose."

"24-year-old houseless male brought in against his will by law enforcement with high levels of aggression and agitation, threatening officers and trying to harm self by running into traffic. Known in the community and from prior visits to have a history of schizophrenia, he reports he has not been on his medications for over 2 months and has been using methamphetamine on the streets daily since leaving a longer-term hospitalization a few months ago."

"15-year-old teen brought in by parents due to finding written recent threats of plans to harm self by overdose. She has a diagnosis of insulin-dependent diabetes mellitus and presents with an insulin pump."

What Medications Are Needed for Crisis Care?

Medications are one of many tools used in crisis care. They can be lifesaving and can help immediately treat symptoms. It would not be possible to deliver effective emergency physical health care for a broad range of issues presenting in a hospital ED without medications and best practices of emergency care. This is also true for emergency crisis services for a broad range of behavioral health issues. Having access to medications can make the difference in being able to say yes to everyone in crisis coming to a crisis facility. Medications can be best practice in some situations, offering relief, symptom improvement, or harm reduction, especially when combined with other crisis care therapeutic tools.

People may present to crisis facilities with challenges such as suicidality, sleep disturbances, depression, mania, psychosis, trauma, substance use, and many other concerns. Sometimes they come into facilities voluntarily, and sometimes on an involuntary basis. Occasionally, individuals may have severe agitation, causing them to be at imminent risk of self-harm or harm to others at the time of arrival. This risk of imminent harm may be related to mental health challenges, substance use effects such as intoxication or withdrawal, traumatic experiences, or medical causes. Without medications as one of the available tools, those people may not be able to be served safely and effectively.

Additionally, people often present for short-term stays of several days in crisis units. They may need medications for fundamental medical issues such as hypertension, diabetes, skin infections, pain, and other concerns. They may or may not have their medications with them, they may not have been on their medications for some time, and they may face social or economic barriers to obtaining their medications. Sometimes, they may not have received medical care for a prolonged period and may be open to starting work toward improving their physical health as part of their crisis response plan.

Regarding classes of medications for mental health concerns, facilities should have a variety of medications for use with mood disorders, including antidepressants and mood stabilizers. They should have several options for antipsychotics and for treating anxiety, insomnia, and agitation, including injectable medications for emergency administration that are used only in situations in which there exists an imminent danger to self or others that allows for emergency involuntary treatment under a strict policy framework.

For best practices in supporting individuals with substance use needs, facilities should have medications for withdrawal management, especially for substances that can result in potentially medically dangerous withdrawal, such as alcohol and benzodiazepines. Best practices in crisis care would include medicines that ensure the provider's ability to continue administering medications for opioid use disorder (MOUD) for those already receiving them, as well as being able to manage inductions with buprenorphine. Medication for alcohol use disorder should also be considered.

Basic medications on the formulary for hypertension and diabetes (including insulin); some essential oral antibiotics, antiemetics, and antidiarrheal medication; some comfort medications for upper respiratory symptoms, fever, and pain; and medications for emergencies (cardiac arrest, epinephrine pen, naloxone) are vital tools for ensuring the well-being of persons served by CRCs. A vital withdrawal medication often overlooked is nicotine replacement. Nicotine replacement patches can provide comfort for those served in a nonsmoking facility.

How Do We Think About Using Medications in Crisis Care?

This paper discusses how medications are used in emergency behavioral health crisis services and identifies future directions for medication use in crisis care. Although medical details are delineated for providers and systems of care to follow as best practices related to prescribing, perhaps the most critical factor in medication use is knowing how to discuss medications with those served. Input from multiple perspectives influences this person-centered approach to the use of medications, including the perspectives of those with lived experience of receiving care with medications in crisis scenarios. The approach follows best practices for person-centered and recovery-oriented care.[12]

Medication can be a valuable component of the treatment plan for some individuals in crisis. All psychiatric approaches to medication should be a true collaboration between the two experts in the room: the provider and the person served. The provider's role is to provide expertise in medications that fit the clinical need and in the risks, benefits, and side effects of these medications. Providers are often in a powerful position during a crisis, and individuals served may not feel empowered to discuss their concerns about medications. Only when these individuals are empowered to speak up and honestly share are they truly included as partners in their care. A saying used in crisis care to emphasize collaboration is "Do with, not to." It is critical to take time in the process of working with those served to identify what they want from medication use, listen to their concerns, educate them about possible side effects, and discuss the purpose of a medication related to the crisis as opposed to their longer-term care. This process can be a very engaging collaborative partnership or a directive process that diminishes the person's participation, depending on the provider's approach. The scenario described in **Table 1** illustrates the difference.

Table 1: Directive Versus Collaborative Approach to Crisis Care

A 35-year-old female often comes to the crisis center. She has a diagnosis of schizophrenia and has always taken her medication as prescribed. Her family has had her petitioned for treatment, due to recent difficulties in hygiene self-care related to bathing and concerns that she was talking to herself more. On arriving at the CRC, she is guarded and talks little to staff or others, remaining isolated.
Directive Approach:
While in a rush on the weekend doing rounds, a new provider talks with her briefly. He decides her self-care issue and behaviors at the facility are consistent with paranoid delusions and exacerbation of other psychosis symptoms and that her current medications are inadequate to treat her symptoms. He tells her they need to change her medication if she is going to be able to improve and be safe enough to go home. She agrees to the change at the crisis facility but immediately switches back to her previous medications upon returning home. Her family is frustrated that no change occurred related to the concerns they raised.
Collaborative Approach:
A provider talks to her about what is happening with regard to her avoidance of bathing. The provider has already heard from peer support on the unit that she expressed a logical reason in an early discussion. She reports having damaged her shower curtain and not having transportation or extra money to purchase a new one. She notes a history of abuse in the bathtub that makes it terrifying for her to sit in the tub. She also admits to having had traumatic experiences as a young teen in the hospital and feeling very unsafe, with increased auditory hallucinations and anxiety since being in the facility. The provider and team recommend choosing between temporarily increasing her current medications or changing to a different medication to help with the increased symptoms. The provider explains the reason behind both options and the potential side effects that could occur with each. The team partners with her to identify how they could help her feel safer on the unit and steps to empower her to obtain a shower curtain again at home so she can feel safe in her bathroom. She reports feeling much less distress and more support. She chooses to increase the dose of her current medication due to side effects experienced with the other medication in the past. The team also helps her connect with her sister, who comes to visit later that day and offers support with regular visits in the future. She demonstrates improvement over the next few days. She is discharged home with improved symptoms and a commitment to follow through on an increased dose and plan to begin trauma recovery–oriented therapy.

A recovery-oriented approach can include medication as a tool for crisis care. However, it requires understanding that many other factors are essential to enabling the improvements that occur during crisis care, including paying attention to social and economic determinants of health. Clinical outcomes will suffer if a crisis service focuses exclusively on developing a psychiatric diagnosis and prescribing medication for that concern. Another essential aspect of recovery-focused care to include in medication considerations is a whole-person wellness

approach. Discussing an individual's medical needs in addition to their mental health and substance use issues can increase overall engagement and feelings of being cared for while the individual is in crisis care. This intentional dialogue about physical health is important, given the known risk of people with serious mental illness dying early due to medical issues.[13]

Although most of this recovery-oriented guidance on using medications is focused on providers, other disciplines impact a person's crisis experience as well. Nurses can have a very positive impact by adding to medication information and being aware of the experience of the person served when distributing the medication. Workflows that prioritize creating a warm, welcoming engagement with the person served over the timing and efficiency of medication distribution have a calming, healing impact on the person in crisis. These can be opportune moments to partner with the person taking medication and create space for them to better understand the medication's role, especially if their thoughts may not have been clear at first arrival. AIDET training is one example of using a rubric to ensure that individuals in care feel well informed and heard.[14] AIDET is an acronym that stands for **A**cknowledging the person by name, **I**ntroducing staff and their roles, explaining the anticipated **D**uration of the care delivery, **E**xplaining each step, and **T**hanking the person.[15] Use of the AIDET model, along with hourly rounding and bedside shift reports, was shown to improve individuals' satisfaction with the quality of care they received in an ED.[16] Although this study addressed ED settings, some of the same principles could be extrapolated to crisis care settings.[17]

Additional "SMART" Ways to Approach Care in Crisis Services

Acronyms in psychiatric services can be confusing. Two similar acronyms that stand for very different things in the crisis and emergency psychiatric services arena are described below.

The SMART Tool for Medical Clearance

The SMART tool for medical clearance is an example of a framework used in several jurisdictions to help determine whether an individual is medically stable for transfer to a psychiatric setting. The SMART form was developed through the Sierra Sacramento Valley Medical Society, which published a paper on it in 2015.[18] The SMART form represents an acronym: **S**uspecting a new psychiatric condition, examining for other **M**edical conditions for screening, recognizing specific areas of **A**bnormal findings, examining for **R**isky presentations that are known to present certain medical concerns, and considering whether there are medications that require **T**herapeutic levels.

As noted elsewhere in this paper, most people in a behavioral health crisis do not need to go to an ED, yet at times it is difficult to know when an individual is medically stable to receive treatment in a non-ED setting. Wisconsin and Michigan, among other locations, have therefore

developed means of determining whether an individual who presents at an ED is medically stable enough to go somewhere else for care.

A task force from the Wisconsin Chapter of the American College of Emergency Physicians and psychiatrists from the Wisconsin Psychiatric Association worked together to develop a protocol for a medical clearance tool to determine when an individual was stable for transfer. They adopted the Wisconsin SMART form model.[19] In adopting the SMART form, the Wisconsin partners involved in developing a means to triage having individuals go to the right level of care, also adopted a position statement that outlined a number of principles, including that a history and physical exam should incorporate the minimum information required for most medical assessments, and that requiring routine protocolized testing should be abandoned in favor of a clinically guided approach. The task force also noted that emergency physicians should be cognizant of the limited medical services available in specialized psychiatric facilities and that a routinized medical evaluation algorithm should help increase standardized medical assessments for individuals needing psychiatric care.[20]

The Michigan Department of Health and Human Services took a similar approach with leaders from the state's hospital association and other partners from psychiatry and emergency medicine, community mental health, and others, working together to develop the "MI-SMART" protocol, using the SMART form.[21] This approach, based on the idea of determining, in a routinized way, who is medically stable for transfer, has taken hold and is being discussed across regions, with various tools being developed to provide support.

The SMART Tool from the American Association for Community Psychiatry

Another "SMART" tool relates to efforts to help achieve an equitable response across populations receiving behavioral health crisis services. In response to the national dialogue on systemic racism brought to the fore by the COVID-19 pandemic and the publicized killing by police of several unarmed Black persons during this time, the American Association for Community Psychiatry (AACP) committed to developing a tool to support concrete and meaningful action in addressing structures and policies that promote racism.

The AACP developed the **S**elf-assessment for **M**odification of **A**nti-**R**acism **T**ool (SMART) to support self-directed organizational change toward improved health equity, focusing on community behavioral health.[22] This tool includes a "Clinical Care" section that tracks multiple diagnostic and treatment-related metrics that may reflect racial disparities in access, engagement, and quality. Several of these metrics are based on known disparities such as disproportionate diagnoses of schizophrenia versus mood disorders in certain racial groups or significant race-based differences in the likelihood of being admitted to involuntary care.[23] This tool suggests metrics to be considered more globally in crisis care relative to medications, including measuring

and addressing disparities in access to clozapine, access to care applied to specific programs such as early psychosis and MAT, and choice of treatments such as medication choices and chemical restraint events. As a quality improvement framework, this tool can potentially promote the examination of responses and policies in community behavioral health crisis care that support equity in action.[24]

A continuing national push to evaluate access to and effectiveness of care approaches for all people who present for crisis care, using tools such as the SMART tool, is necessary to achieve best practices in an inclusive, trauma-informed manner.

Management of Medical Stabilization Within the Crisis Continuum

Coordination with emergency services such as EDs and EMS is essential to creating safe, efficacious care pathways for those in crisis. Smooth transitions between providers decrease ED boarding, increase the use of appropriate resources, and maintain medical safety for those needing minimal medical assistance. Without coordination between community crisis services and emergency services, most individuals in crisis will be diverted through EDs, causing bottlenecks in throughput for the crisis continuum and incorrect "care fit to needs."

The Crisis Now Model

The Crisis Now model, with its "no wrong door" principles, reduced cost, and accurate service-level matching, helps to improve access to care in ways that provide better outcomes within trauma-informed environments.[a] For systems to realize the full benefits of the Crisis Now model, behavioral health emergency CRCs must always accept law enforcement or other first responder drop-offs, even when medical and behavioral health challenges coexist. Ease of access is crucial. The Recovery Response Center in Peoria, Arizona, a behavioral health emergency crisis receiving facility, accomplished this obligation with an average drop-off time and law enforcement release of 3 minutes while receiving 5,974 individuals in 2022. Only 5.7% of those served were ever sent to an ED for a medical evaluation. Of those individuals who received a medical evaluation, 60.6% returned to the CRC to complete their behavioral health crisis intervention.

[a] About Crisis Now. Alexandria, VA, National Association of State Mental Health Program Directors. https://crisisnow.com/about-crisis-now/. Accessed August 3, 2023

Crisis call centers play a part in the coordination of care. They should have workflows that allow them to know when and how to reach out to 911 for emergency medical care when callers have sudden emergency medical events, such as loss of consciousness or shortness of breath. Callers who have just experienced an overdose attempt also need emergency medical care. Call center

staff should also be trained to warn callers of withdrawal complication risks if they are using substances such as alcohol or benzodiazepines and let them know that they may need to seek medical support if they stop using suddenly. Systems should be in place to coordinate community crisis services with community resources for substance use withdrawal management.

Mobile teams that perform crisis outreach within the community also need to be able to coordinate with EMS. Many communities are working out how to coordinate sending both EMS and mobile behavioral health crisis response teams to specific locations. Some of the triaging involves dispatching both EMS and mobile behavioral health teams when there is a significant concern that medical evaluation may be needed on-site but also a considerable need for specialists trained in behavioral health crisis response. Like the call center staff, mobile team staff should receive basic training on a variety of topics related to behavioral health responses, including substance use withdrawal complication risks with alcohol and benzodiazepines; this information can be shared with persons served and can help guide collaborative decision-making on community care resource utilization. Mobile teams should carry naloxone kits for emergency use if needed out on a call. Some communities are coordinating harm reduction principles by equipping mobile teams with naloxone kits and educational materials to be distributed to persons identified with OUD. Some mobile team models also use telehealth resources to connect persons in the field to providers who can help support individuals with an immediate need for a diagnostic assessment by a trained professional or an immediate need for medication prescribing.

Additionally, CRCs must coordinate workflows to allow immediate drop-off of individuals by EMS so personnel can return to the community and respond to physical health emergencies. Many areas nationally have created models for EMS to be reimbursed for the drop-off of persons at CRCs, just as they would at hospitals. Since EMS has traditionally been reimbursed for transporting individuals undergoing a medical emergency, the need to involve EMS in behavioral health crises has started calling into question what constitutes emergency services as opposed to an urgent need, and what mechanisms should fund each of these. Currently, the failure to fund certain EMS responses can be the most significant barrier to maximizing crisis diversion out of EDs.

CRCs need to establish collaborative relationships with local EDs to safely serve persons with particular medical issues who are in need of evaluation and stabilization. Where Certified Community Behavioral Health Clinics (CCBHCs) are part of the crisis services, agreements with entities such as local schools, police and sheriff's departments, and others are required, and this can be an important practice even outside a CCBHC arrangement, given the interplay between these entities and behavioral health crisis services.

ED staff need to understand the medical capacity of out-of-hospital centers. Crisis centers need to communicate specific medical situations they want to have evaluated or stabilized to maximize effective coordination of care. Specific protocols between these entities vary but may include shared medical records systems, phone conversations between nurses and medical

providers, medical evaluation forms identifying specific concerns sent with a person going to the ED, and peer support for transport to the ED or embedded in the ED. Regularly scheduled crisis community collaboratives that help all members of the crisis continuum to manage processes and maintain continuous quality improvement can effectively eliminate barriers to access and minimize ED presentations for behavioral health crises.

Crisis centers should have tools and key performance indicators (KPIs) that measure the number of persons sent to the ED for medical stabilization and the number that return to the crisis center. Monitoring trends in these KPIs is valuable for organizational quality improvement in managing medical needs as well as for supporting the value of ED diversion to all community partners.

Management of Medical Stabilization Within Crisis Receiving Centers

When CRCs are providing crisis services without requiring a medical evaluation in an ED, it is essential to identify which medical conditions can and cannot be managed safely at the jurisdiction's behavioral health crisis level of care. Some medical conditions, such as hemodialysis, complex wound care, chemotherapy, and intravenous antibiotics, are unmanageable in out-of-hospital care. However, many conditions can be safely managed without assistance or require additional consideration and assessment by behavioral health nurses and behavioral health medical professionals (physicians, nurse practitioners, and/or physician assistants) to determine whether an initial medical evaluation in a hospital ED is necessary. When a medical evaluation is necessary, transportation should be arranged by the CRC to an ED so that the appropriate medical professional can develop a management plan. Communication and care coordination between the ED and the CRC is vital to achieving the best outcome for individuals in care and maintaining a good working relationship between the two facilities. Best practice would return individuals who receive a medical evaluation to the CRC upon completion of the medical evaluation, stabilization, and treatment.

In addition to understanding what can and cannot be managed at the behavioral emergency crisis receiving facility, it is important to understand the initial medical screening assessment process at the CRC and the team members and tools required to operationalize it. The initial medical screening assessment should consist of a complete set of vital signs, a point-of-care blood alcohol level assessment, a urine drug screen, a urine pregnancy test for individuals capable of bearing children, and a blood glucose level for those individuals with a history of diabetes mellitus. Of course, urine drug tests may have limited ability to show certain substances and must be interpreted with knowledge of how long substances will show in urine testing after being taken. All testing can be administered by a well-trained peer support specialist, behavioral health technician, or nurse. The results of these point-of-care tests should then be reviewed by a psychiatric registered nurse, physician assistant, or psychiatrist who also obtains an initial history of the present illness, a physical review of systems, a medical history, a psychiatric history, and a

list of current medications collected from the individual and by medication reconciliation with external sources. The nurse or other appropriately trained practitioner should also perform a mental status examination, including an assessment of orientation and appropriate screening assessments. Appropriate screening assessments should include a screening assessment for transmissible respiratory illnesses such as influenza or COVID-19, a fall risk assessment, and a skin assessment. Once all the assessments are completed, the information should be discussed with a behavioral health medical provider, and a care plan should be determined. A psychiatrist medical director may also be involved. Their role in the multidisciplinary team is to lead the operations medically, supervising implementation of clinical best practices, working with administration to ensure that services support positive clinical care, and leading quality improvement efforts in medical care. Medical directors should be available for consultation on complex cases and be a part of clinical performance review processes. They can play a valuable role in the coordination of care with EMS and ED medical leadership.

The literature continues to indicate a lack of consensus about whether the initial plan of care should include routine serum laboratory studies and/or imaging studies when evaluating someone in a behavioral health crisis. The estimated utility of screening labs and radiologic imaging varies widely depending on the study reviewed. Many medical conditions are known to cause behavioral health symptoms. Some studies estimate a medical etiology in as few as 2.8%[25] of behavioral health presentations, while others estimate as many as 46%.[26] Many of these studies are biased in one way or another. However, a set of conditions have emerged that are reasonable indicators that a thorough medical evaluation should be considered, including screening laboratory studies and/or radiologic imaging:

- a new onset of a psychiatric condition after 30 years of age
- hyper/hypoglycemia unresolved according to individual facility standard protocols
- pregnancy
- unexplained abnormal vital signs
- disorientation or a fluctuating level of consciousness
- toxic ingestion
- disordered eating patterns
- an ill-appearing physical presentation and/or abnormal physical examination.

As previously stated, only some individuals arriving at a crisis receiving facility will satisfy the above criteria to the point where a more robust medical assessment may be warranted. Therefore, no screening laboratory studies or radiologic imaging is necessary at admission. The SMART protocol for medical clearance, described above, is consistent with these concepts. If an individual's presentation falls into one of the scenarios that point to the need for further assessment, a medical evaluation at an ED should be considered for a more thorough physical assessment and any laboratory and/or imaging studies that are clinically indicated. After the medical evaluation and physical care plan formulation, the individual should be transferred back

to the behavioral health emergency CRC whenever possible to complete the behavioral health crisis intervention.

Because most individuals will not pass through an ED, and many of those who do will still be able to be sent back to the CRC, CRCs should be equipped with proper resources to care for the most common medical conditions. This practice minimizes the number of individuals requiring a more in-depth ED medical evaluation and maximizes the ability to care for individuals who present in behavioral health crises while challenged with comorbid medical conditions.

Essential medications should be kept on formulary to manage dermatosis or erysipelas (skin infection), epilepsy, gastrointestinal distress, hypertension, hyper/hypoglycemia, hyperlipidemia, infections of the urinary or respiratory tract, pharyngitis, seasonal allergies or allergic reactions, and mild to moderate pain. There should also be protocols to manage those at risk for, or currently experiencing, the dangerous and potentially lethal sequela of sudden alcohol or benzodiazepine withdrawal. Processes and medications for the management of withdrawal from other substances, such as opioids, are also needed. All staff should be trained in the principles of basic first aid. All nurses should have the necessary materials to provide basic wound care, such as adhesive bandages, gauze, sterile eye pads, medical tape, triple antibiotics, washbasins, staple remover kits, wound closure strips, disposable gloves, and normal saline. Staff should have the tools and training to assess and treat conditions that are often more prevalent in resource-poor populations. These may include issues like epidermal parasitic skin diseases such as scabies and lice.[27] They also can include conditions related to exposure to extreme weather, depending on geographic location, such as heat-exposure-related illnesses, burns, and frostbite.

In addition to non-life-threatening medical conditions, facilities may occasionally need to address medical emergencies. All CRCs should be equipped with medical emergency kits (e-kits) that contain items such as a glucagon injection kit, sublingual nitroglycerin, an epinephrine pen, naloxone nasal spray or injectable naloxone solution, trauma shears, a ligature cutter, and an adult resuscitation bag. These kits should be checked regularly for expired items and restocked as needed. Kits should be stored in an area that is accessible to any staff member responding to a medical emergency and near an automated external defibrillator (AED). Where permitted, sites should also maintain an oxygen therapy cart. The AED and oxygen cart should have maintenance documentation and be stored as the manufacturer recommends. At the time of hire, all staff members should be trained in basic life support skills, with the training renewed at least every 2 years. Staff members should also be trained to perform the standard operating procedures for medical emergencies within the facility. Learning objectives should include the method used for announcing medical emergencies to other staff and the appropriate language, such as “code blue,” accompanied by the location. New staff should also be made aware of the location of the emergency kit, AED, and oxygen therapy cart, if available. Because medical emergencies are relatively uncommon in the behavioral health setting, code blue drills should occur at least every 6 months. During these drills, the staff should be made aware of the drill only after they arrive on the scene, and all aspects of the medical emergency protocol should be followed.

Pregnancy deserves serious attention and should be identified at admission for all individuals capable of bearing children. Only 75% of all pregnant individuals across the United States received adequate prenatal care in 2021.[28] That percentage declines further when considering additional factors such as a disadvantaged socioeconomic status, a lower level of education, lack of health insurance, and other factors. Individuals with serious mental illness and substance use disorders tend to fall into many of these categories and seek care less often.[29] Some individuals presenting in behavioral health crisis will have had no prenatal care and, at times, will be unaware that they are pregnant. Pregnant individuals experiencing behavioral health crises are often considered high risk, with frequent co-occurring maternal risk factors including use of tobacco and other substances, comorbid medical concerns, and poor nutritional status.

It is prudent that pregnant individuals not actively engaged in prenatal care at admission receive a medical evaluation in an ED for confirmation of their pregnancy and an assessment of the status of their fetus. Because these individuals are often considered at increased risk for preterm labor and early delivery, consideration should also be given to their estimated delivery date. If the pregnancy is stable, the individual is showing no signs of labor and is safely outside the range of delivery, and no other medical contraindications exist, the CRC should feel confident bringing the individual back to assist them through the resolution of their behavioral health crisis. All pregnant individuals must be connected with an obstetrician at discharge for close follow-up.

Additionally, outpatient follow-up for ongoing behavioral health services should be established before discharge. A daily prenatal vitamin should be administered throughout the individual's stay. Medications should be recommended only after carefully considering the risks versus the benefits for both the individual and their fetus. It should be understood that there is also a risk to the individual and their fetus when treatment is withheld during an episode of disordered mood, anxiety, or psychosis. When medications are recommended, a thorough informed consent process should be documented prior to medication administration, and all options should be presented to the individual for consideration. Although it is an issue that is beyond the scope of this paper, some psychotropic medications can have risks for the fetus, and prescribers should familiarize themselves with the range of choices and what the risks and benefits might be.

Throughout the crisis intervention for all individuals, the nursing staff, behavioral health technicians, and peer support specialists must follow appropriate protocols for monitoring each individual's physical well-being. A complete set of vital signs should be collected for every willing individual at least every 12 hours or as dictated by protocol to monitor for emerging changes in blood pressure, heart rate, temperature, and oxygen saturation. All individuals should have documented observations by trained behavioral health technicians or peer support specialists at least every 15 minutes, regardless of the individual's assigned level of observation. These observations should include monitoring and documenting bathroom visits, eating habits, and hours of sleep. Those same staff should be trained to identify and report signs of disorientation, somnolence, behaviors indicative of visual hallucinations, tremors, and other typical symptoms of worsening physical status. Follow-up nursing assessments should be

conducted at least every 12 hours, or more often if needed, so that any complaints or changes in status can be explored further and addressed when needed.

A specific protocol should be followed for every individual who presents with a history of, or who is at risk of, seizures, which is a risk in alcohol withdrawal. In these cases, a unique identifier (such as a color-coded charm) should be applied to the individual's identification, and their bed or chair assignment should be near the nursing station or island. The area around their bed or chair should also be padded for safety. Individuals currently receiving treatment for epilepsy should continue to take all of their antiepileptic medications for the duration of their stay at the CRC. Should the individual experience an epileptic event during their stay, the behavioral health medical provider should be notified as soon as possible, and a prophylactic benzodiazepine should be administered to prevent further occurrences. Post-ictal (post seizure) individuals should be placed in the recovery position and assessed for injury immediately. The nurse should then provide any post-ictal care that is warranted. The decision to obtain a medical evaluation following an epileptic event should be made collaboratively between the nurse and the behavioral health medical provider.

A specific protocol should also be followed for every individual with a history of diabetes mellitus whose condition is managed with insulin. Although each person in care should receive an individualized assessment and plan, the following information provides some general guidance for broad consideration across circumstances. An initial blood glucose level measurement should be taken at the time of admission. In addition to the individual's vital signs and current mental status, that information should indicate to the nurse and the behavioral health medical provider if a medical evaluation is warranted before moving the individual to the unit. For those individuals who are medically stable, hyperglycemia and hypoglycemia should be treated accordingly. For individuals experiencing hyperglycemia, regular insulin is generally administered, with dosing based on a predetermined sliding-scale protocol. Nursing staff should then reassess the individual's blood glucose level after 2 hours, particularly for blood glucose levels above 400. For those experiencing hypoglycemia, sugary provisions such as orange juice or glucose gel are often administered. Nursing staff should be trained to recheck the blood glucose level within 15 minutes following the intervention to determine whether further action is needed. When a hyper- or hypoglycemic event persists despite actions taken per protocol, a consultation with the behavioral health medical provider should be sought for a collaborative discussion regarding the next steps for medical management. All individuals with diabetes should receive dietary accommodations based on the recommended American Diabetes Association diet, which should be documented in the admission orders. Blood glucose readings should be repeated according to the person's treatment plan, though typically they are repeated at least daily before each meal and at bedtime. All previously prescribed anti-hyperglycemic medications should be continued throughout the individual's stay unless there are person-specific reasons to change them, and a spontaneous blood glucose level check should always be performed when the person appears ill or appears to have altered mental status.

Given the frequency of co-occurring substance use disorders, protocols for substance withdrawal management should also be implemented, which should go beyond what were historically referred to as "comfort measures" and "detox," and now may include induction with medications to avoid withdrawal and to immediately begin treating a specific substance use disorder. At admission, the usage pattern for all common substances should be reviewed, including alcohol, stimulants, cannabis, opioids, and hallucinogens, with particular attention paid to substances requiring a regimented detoxification plan or induction to treatment plan. For alcohol use, most presentations can be managed with a tool designed to measure the severity of alcohol withdrawal symptoms, such as the Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-Ar) tool, administered every 4 hours.[30] Lorazepam or an alternative benzodiazepine (preferably one with minimal liver impact) is then typically administered based on the symptom severity score outlined in the facility protocol. This symptom-triggered approach will allow for rapid withdrawal management in a crisis setting and is sufficient for most individuals experiencing alcohol use disorder. For individuals with a history of complicated alcohol withdrawal, such as withdrawal-related seizures or delirium tremens, or for lucid individuals presenting with high levels of blood alcohol at the time of admission, it is prudent to consider a gradual taper of a long-acting benzodiazepine such as diazepam or chlordiazepoxide. For additional decision support, tools such as the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) can be implemented to ensure consistent management of all individuals.[31] This questionnaire can be administered rapidly. The resulting score is based on historical factors and clinical presentation.[32] For individuals experiencing opioid use disorder, the Clinical Opiate Withdrawal Scale (COWS) can be administered every 4 hours as a symptom-triggered protocol with a standard set of medications dosed accordingly to relieve withdrawal symptoms such as autonomic hyperactivity, rebound pain, muscle spasms, gastrointestinal distress, anxiety, and insomnia.[33] For individuals interested in MAT/MOUD, buprenorphine, a partial agonist at the opiate receptor, should be kept on-site whenever permissible based on state and federal regulations. Individuals may wish to taper off opioids, which can present risks to them. It is important that any tapers be discussed with the person receiving services, and efforts to encourage continuity with MOUD can be lifesaving. Regardless of the trajectory of treatment through medications, all individuals with OUD should receive a naloxone kit at discharge.

Another issue arises when individuals are identified during admission as at risk for falls. Fall risk protocols are very important to have in place. Fall precautions should also be considered any time an individual receives as-needed psychotropic medications when experiencing agitation or psychosis. The protocol aims to make individuals easily identifiable throughout the facility, minimize the amount of independent ambulation required of these persons, and serve as a reminder to behavioral health medical providers considering prescribing new or increased doses of medications known to increase the risk of falls. A specific color band or charm on a band should be attached to the identification bracelet of all individuals at risk for falls to improve ease of identification. Uniquely colored anti-slip socks are also helpful in improving visibility. All persons at risk for falls should be assigned strategically to a bed or chair that minimizes the

distance to a restroom and to the nursing station or island. Behavioral health technicians and recovery support specialists should be trained to assist individuals in ambulating while on fall precautions. It is important that support for walking be provided in a way that does not constrain movement for the individual, or it could be considered a restraint. Gentle guidance with open arms and hands to support and stabilize the person while walking can be helpful in this regard. For individuals using assistive devices such as canes or walkers to ambulate, a wheelchair should be provided throughout the stay in place of devices that could be used to strike other persons served and/or staff members. Fall precautions should be ordered in the health record and alerts considered so that behavioral health medical professionals prescribing medications known to increase fall risk do so carefully to avoid exacerbating the individual's condition.

The Basic Types of Medications Used in Crisis Situations

In addition to taking a recovery-oriented approach, it is necessary to understand how to use medications in a crisis. Most care decisions revolve around mood disorders, anxiety, trauma, psychosis, substance use treatment, and substance withdrawal treatment. The following sections are not exhaustive but address general considerations in several of these categories and will provide further information regarding other specific situations such as those involving long-acting injectable (LAI) medications and first episode psychosis care. These sections are not meant to serve as a definitive guide or protocol regarding the treatment of individual conditions or the use of specific medications, but to describe the complexity of decision-making and resources that are necessary to provide person-centered whole health care for an individual experiencing a crisis.

Medications targeting particular symptoms can usually begin to provide relief in minutes or days. However, the effects of some medications will only be seen after the person leaves the crisis facility. It is critical to partner with the person served on their finances and insurance and also to offer medication options that are sustainable if they will be needed once the person is back at home. Some crisis facilities partner with pharmacies to obtain medications for discharge using the person's insurance or local funder aid/programs for the uninsured. This allows individuals to take home some of their medications at discharge. The number of days' worth of medication prescribed or sent home with the individual varies greatly across the country. Most recommendations are around 7 days, but some providers make case-by-case decisions to prescribe more (often as much as 30 days) to bridge persons with limited resources to their first medication follow-up appointment.

Mood Disorders

An accurate assessment is critical in selecting the most appropriate pharmacologic regimen for individuals with mood disorders who present in emergency behavioral health crisis care settings.

Depressive symptoms should be quantified with a brief rating scale such as the nine-item Patient Health Questionnaire.[34] If an individual is experiencing a major depressive episode, initiating an antidepressant medication may be appropriate in a crisis care setting. The decision would depend on the individual's preference (identified through discussion), a review of the person's medication history, the services available in the community, the severity of the depression, the individual's medical and psychiatric comorbidities, and insurance coverage. Before initiating an antidepressant, prescribers must screen carefully for prior mania episodes. Some clinical features to help differentiate bipolar from unipolar depression include a family history of bipolar disorder, an earlier age of onset, and a more significant number of prior depressive episodes.[35] Rating scales such as the Mood Disorder Questionnaire can be helpful as a screening tool,[36] and if this history is unclear, interviewing collateral informants could be beneficial.

For individuals in an acute manic episode, prescribers often must consider whether to start a mood stabilizer, an antipsychotic medication, or combination therapy. Combination therapy may work faster, but this decision depends on the response to prior trials, individual preference, and prior tolerability.[37]

Laboratory assessment for therapeutic drug monitoring should be available for lithium, valproic acid, and lamotrigine in crisis care settings. If hospitalization is not needed and the individual is discharged, a supply of medication should be provided that is adequate to last until the individual can see an outpatient provider.

Anxiety

Anxiety disorders are the most prominent behavioral health disorders in the United States.[38] Individuals in acute crisis are commonly experiencing symptoms of an anxiety disorder, so the ability to relieve these symptoms is crucial. The first step in providing care for anxiety is to perform an adequate diagnostic assessment to determine the general etiology of the presenting symptoms. Syndromes to consider should always include acute substance intoxication or withdrawal, generalized chronic anxiety disorders, panic attacks, psychosis, affective disorders with anxious features, trauma, and anxiety related to cognitive impairment. Having a standardized interview approach leads to a more nuanced understanding of the presenting symptoms and will help support more evidence-based treatment decisions.

To achieve immediate symptom relief, benzodiazepines are extremely effective in many situations, particularly in aborting anxiety-related agitation or panic attacks. It is essential to consider the duration of action and the presence or absence of active metabolites before prescribing a specific benzodiazepine. When treating uncomplicated alcohol withdrawal or acute intoxication from psychostimulants, short-acting benzodiazepines are generally the agent of choice.[39] Long-acting benzodiazepines are preferred for individuals with severe alcohol withdrawal or delirium tremens. Long-acting benzodiazepines or benzodiazepines with many active metabolites should be offered only with caution to individuals who are older than 65 or

who have significant renal or hepatic disease. For individuals experiencing symptoms related to a neurocognitive disorder or a personality disorder, benzodiazepines should generally be avoided because of the risk of depressing cognitive function further or of disinhibition, respectively.[40,41] Long-term use of benzodiazepines, for individuals with a history of a substance use disorder, should be avoided because of the risk of tolerance and rebound anxiety. Benzodiazepines are also known for their potential for misuse and increase the risk of falling, cognitive impairment, slowed reaction times, and somnolence. Because they suppress respiration and decrease blood pressure, benzodiazepines can be fatal upon overdose and when mixed with other substances such as opioids and alcohol. Alternatives to benzodiazepines often used in crisis care settings to address acute anxiety include beta-blockers, alpha-adrenergic blockers, and antihistamines.

For the spectrum of anxiety disorders, a selective serotonin reuptake inhibitor (SSRI) or a serotonin and norepinephrine reuptake inhibitor (SNRI) should be considered as a first-line option for long-term treatment. Both medication classes have been shown in research studies to have a moderate effect size with a relatively low side effect burden.[42] They are not helpful in instances of acute anxiety because significant symptom relief is not achieved for multiple weeks. All individuals considering an SSRI or SNRI should be warned of the risks of sexual side effects, an increased risk of bleeding/bruising, difficulty with sleep, irritability, gastrointestinal disturbances, and worsening suicidality, particularly in the first month of treatment. SNRIs carry the additional risk of developing hypertension. For both medication classes, the risk of medication withdrawal symptoms upon abrupt discontinuation should be discussed, as should the risks and benefits of antidepressant agents in persons with coexisting bipolar disorder. Additional agents to consider when SSRIs or SNRIs are not acceptable include atypical antidepressants (mirtazapine, trazodone, or nefazodone), buspirone, prazosin, anti-epileptic drugs (lamotrigine, topiramate, gabapentin, valproic acid, or carbamazepine), and atypical antipsychotics (quetiapine, olanzapine, ziprasidone, and risperidone). Evidence suggests that all these agents have some therapeutic value in individuals diagnosed with an anxiety disorder, but their efficacy has not been proven to match that of SSRIs and SNRIs overall in scientific studies.[43]

Psychosis

Psychosis is a symptom with multiple potential underlying causes, including mood disorders, medical conditions, substance or medication use, and primary psychotic disorders (e.g., schizophrenia or schizoaffective disorder). Antipsychotic medications are the mainstay of pharmacologic treatment for psychosis. However, the underlying cause must also be addressed (e.g., treatment of a major depressive disorder if the individual has depression with psychotic features).

For an individual in a crisis care setting who is already taking antipsychotic medication, prescribers should assess the medication's current effectiveness, the individual's recent adherence, and the medication's tolerability, and conduct a clinical assessment for antipsychotic-induced movement disorders. This initial clinical assessment should include an evaluation for

parkinsonism, akathisia, dystonia, and tardive dyskinesia. If such movements are present, crisis care systems should be able to perform a structured assessment for antipsychotic-induced movements with an instrument such as the Abnormal Involuntary Movement Scale.[44] *The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia* recommends that individuals with "moderate to severe or disabling tardive dyskinesia" be treated with a vesicular monoamine transporter type 2 (VMAT2) inhibitor.[45] For individuals with schizophrenia, antipsychotic medication discontinuation is a frequent reason for relapse,[46] and abrupt discontinuation can be associated with more somatic symptoms.[47]

Relapse overall can be a common presentation in emergency and crisis care settings. In these scenarios, individuals may present with a temporary worsening of tardive dyskinesia symptoms, also called withdrawal-emergent dyskinesia.[48] Tachycardia can occur with antipsychotic medications, particularly clozapine,[49] and crisis care facilities should have the ability to perform, and a mechanism to interpret, an electrocardiogram (ECG) for individuals presenting with significant tachycardia (heart rate above 100 beats per minute). Use of an ECG should be standard practice. An ECG may also be considered before initiating antipsychotics such as ziprasidone, iloperidone, chlorpromazine, and thioridazine, which may cause QTc prolongation.[50]

Specific Areas of Consideration in Crisis Care

Early Psychosis

Research on pathways to care suggests that individuals with early psychosis most commonly enter care through emergency medical services (EMS), EDs, schools, primary care, or the forensic mental health system.[51] The median duration of untreated psychosis (DUP) identified in the National Institute of Mental Health's RAISE-ETP study was 74 weeks,[52] and multiple studies have demonstrated that a longer DUP is associated with a poorer prognosis.[53] Therefore, for individuals with early psychosis, behavioral health emergency crisis care settings may be able to help limit the DUP by providing early detection, evaluation, treatment, and connection to specialized services, such as first-episode psychosis programs.[54]

First impressions of the mental health system can significantly impact an individual's perception of care, their ability to recover, and their hope and possibilities for their life. Very often EDs see people who have had difficulty adhering to antipsychotic medication. This is a reminder that in crisis care, it will be important to help individuals who need medications embark on a journey in which these medications are taken over time.[55] Crisis services therefore should be person-centered, recovery-oriented, inclusive of family and other supporters, and transparent, and they should provide consistent messages of hope.

Education should be provided to help crisis care prescribers and teams differentiate how the pharmacologic needs of individuals with early psychosis may differ from those of individuals who have had multiple episodes, focusing on using the lowest possible dose of antipsychotic

medications, both scheduled and as needed.[56] Referring individuals for a medical workup when signs and symptoms of psychosis appear atypical is of paramount importance.[57] Clinicians should avoid jumping to preliminary conclusions about the underlying diagnosis, since there may be uncertainty and potentially diagnostic evolution over the first few months.[58] Crisis care providers should also be aware of racial and ethnic disparities in diagnosis, as Black and Hispanic individuals are more likely to be disproportionally diagnosed with psychotic disorders when compared to White individuals.[59]

If an individual is antipsychotic naïve (i.e., they have never taken an antipsychotic medication), medications with a higher cardiometabolic liability such as olanzapine and clozapine should be avoided as first-line agents.[60] If it is apparent that the individual is experiencing a substance-induced psychotic disorder (SIPD), prescribers may consider using time-limited antipsychotics, with potential gradual discontinuation in the outpatient setting.[61] In a study of 319 individuals with SIPD who presented to a psychiatric emergency room, ultimately 25% were diagnosed with a primary psychotic disorder at year one.[62]

In addition to medication management, crisis care settings should have resources available to refer the individual to a coordinated specialty care (CSC) program if such a resource is available locally.[63] If an individual is already receiving CSC services for early psychosis, care should be coordinated with those teams.

Long-Acting Injectable Antipsychotic Medications

The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia recommends that "patients receive treatment with an LAI antipsychotic medication if they prefer such treatment or if they have a history of poor or uncertain adherence."[64] Meta-analytic data suggests that LAI antipsychotics have advantages in preventing relapse or hospitalization compared to oral antipsychotics.[65]

Crisis care settings should have various LAI medications available. They should have the ability to administer LAIs to individuals who have missed a scheduled appointment. Knowledge of the specific medication and its pharmacokinetics can be helpful in understanding whether that medication may be wearing off in the person's system. LAIs are available for injection durations ranging from 2 weeks to 6 months. If applicable, providing individuals with clear instructions about how (dose and duration) to take an oral supplement as an LAI is initiated can be helpful. If someone is already on an LAI and is having breakthrough symptoms, as is relatively common,[66] a careful assessment of the causes requires consideration. Considerations include ruling out any medical issues, considering the possible role of substances in the current concerns, and evaluating for new or changes in psychosocial stressors. In these settings, several off-label strategies such as reducing the injection interval or supplementing with oral doses of the same antipsychotic[67] may be helpful.

Additionally, crisis care settings are well suited to initiate LAIs for those who may benefit from them. LAIs should be conceptualized as another way that an individual can take medication, rather than as a punishment or only for those who have been nonadherent. To facilitate LAI use, prescribers must first acknowledge any existing bias (either for or against LAIs) and then present various options to the individual while taking a flexible approach, creating a pro/con matrix. It may be helpful to use the GAIN model (G = goal setting, A = action planning, I = initiating treatment, and N = nurturing motivation).[68]

Clozapine

Clozapine is the only medication approved by the Food and Drug Administration (FDA) for treatment-resistant schizophrenia (TRS). Although one-quarter of people with schizophrenia may experience treatment resistance,[69] only 4%–5% of people with schizophrenia are prescribed clozapine in the United States.[70] Individuals who have already been prescribed clozapine may present to crisis care settings with an exacerbation of symptoms due to an interruption of clozapine, which could be caused by various factors, including an inability to obtain clozapine from the pharmacy because of coordination issues between the prescriber, lab, and/or pharmacy, as well as the Clozapine Risk Evaluation and Mitigation Strategy (REMS) system.[71] The REMS system is required by the FDA for certain medications deemed to carry particular risks. Clozapine is one of the medications that requires monitoring via the REMS system, which adds regulatory and administrative burden but is important when prescribing this medication.

Even just a few days without clozapine can cause an exacerbation in symptoms and/or symptoms of anticholinergic withdrawal. Anticholinergic withdrawal symptoms can include insomnia, anxiety, nausea, diarrhea, sweating, delirium, altered mental status, and even catatonia.[72,73] Prompt identification of these symptoms and consideration of adding benztropine may be a helpful approach. Roughly 50 mg of clozapine is equivalent to 1 mg of benztropine in a nonsmoker, and 100 mg of clozapine is equivalent to 1 mg of benztropine in a smoker.[74] Additionally, the US package insert recommends that when two or more days have passed since the individual's last clozapine dose, treatment should be reinitiated with 12.5 mg clozapine once or twice daily.[75]

Sometimes in crisis settings, individuals may present with elevated blood levels of clozapine, which can increase their risk for specific side effects such as seizures.[76] Elevated blood levels of clozapine may be due to drug-drug interactions (addition of fluvoxamine or ciprofloxacin) or abruptly smoking cigarettes, for example.[77] Clozapine has a recommended reference range between 350 and 600 ng/mL,[78] though higher levels can be tolerated as well, depending on a number of factors; obtaining blood levels in the crisis setting can clarify whether the level is too high, too low, or within the therapeutic range. Even if there is a delayed turnaround in obtaining the level (which can take up to a week), this data can help inform inpatient and outpatient teams moving forward.

If an individual is being discharged from the crisis care setting, the prescriber should ask about the individual's current supply of clozapine, and, if a new prescription is needed, the provider can assume responsibility for the individual in Clozapine REMS, to check how frequently the current hematologic monitoring is taking place and manage a prescription (e.g., with monthly monitoring, a month's supply can be dispensed).

Additionally, providers in crisis settings have a unique vantage point to help identify clozapine candidates. Clozapine is FDA-approved for two indications in the United States: (a) TRS and (b) reduction in the risk of recurrent suicidal behavior in individuals with schizophrenia or schizoaffective disorder. Crisis care providers can help to establish whether or not someone is taking their prescribed medication for their mental illness and clarify whether the symptoms are a result of a medication consistency issue or more likely treatment resistance. Identifying individuals who may be experiencing suicidal thoughts may be critical. Even if clozapine is not started in the crisis care setting, if a prescriber documents that it may be a consideration, this may prompt an inpatient or outpatient team to initiate it. Finally, crisis care settings should be familiar with clozapine providers in the surrounding areas to make appropriate referrals and facilitate transitions of care.

Medication for Treatment of Substance Use Disorder

Medication for treatment of substance use disorder (commonly referred to as medication-assisted treatment or MAT, and also more specifically as MOUD), refers to using medications such as methadone, naltrexone, or buprenorphine to treat individuals with opioid use disorder (OUD), typically along with counseling. MAT/MOUD decreases premature death among individuals with OUD.[79,80]

Crisis care settings should be able to monitor for physical withdrawal symptoms using evidence-based tools such as the Clinical Opiate Withdrawal Scale (COWS).[81] Crisis care facilities ideally should have the ability to continue buprenorphine or methadone for OUD when individuals need to stay at a CRC for crisis needs other than OUD. This minimizes the risk of withdrawal and maintains the stability of this treatment while they are at the facility. Facilities also need the infrastructure to conduct inductions of buprenorphine to initiate care. Withdrawal management protocols using buprenorphine tapered over several days have shown promise in helping give greater comfort during withdrawal and decreasing the risk that persons will leave the facility early in treatment because they are overwhelmed by distress from withdrawal and cravings.

Methadone can be continued without an inpatient opioid treatment program (OTP) license if OUD is secondary to another reason for crisis presentation. Verification of dosage and last date administered is necessary to set up safe prescribing decisions. It is important to partner with community OTPs to establish processes for the coordination of dosing verification on weekends or holidays. It is also imperative that swallowing of medication be observed when administering opioid agonists to minimize diversion to other persons served on the floor. Protocols for

appropriate use of MAT/MOUD and coordination for next-day outpatient dosing at the person's OTP are needed in crisis settings.

Induction protocols for buprenorphine replicate best practices developed for ED inductions that have been emerging as a national trend. These protocols create immediate access to best practice treatment with MAT/MOUD. With the Drug Enforcement Agency waiver for buprenorphine prescribing discontinued, and new training requirements for all prescribers as of June 27, 2023 (8 hours of training for treatment of individuals with opioid or other substance use disorders), it is essential that providers have met these broad requirements.[82,83] At the same time, for prescribers working in crisis settings, specific training in induction dosing and related workflows is important to minimize precipitated withdrawal while maximizing engagement in the best practice of MAT/MOUD. Also, the change in the waiver should, over time, increase the ease of setting up bridge dosing of 3 to 7 days' worth of buprenorphine in the follow-up to outpatient care after crisis care.

Finally, harm reduction methods should include access to naloxone for persons discharged and subsequent follow-up with education for their families and support on how to use the kits to combat the risk of fatal opioid overdose.

Agitation

Medications for agitation are a necessity in crisis care. Persons in crisis may present with agitation that disrupts their ability to work on their crisis in the moment and, in the worst cases, may cause danger to themselves or others. Agitation is nonspecific and is exhibited, for example, by difficulty sitting still; difficulty relaxing; and appearing shaky, excitable, or angry. These behaviors can be related to trauma, acute grief, intoxication, anxiety, psychosis, or any number of other underlying conditions or factors. Thus, it can be difficult to sort out, though it is common in individuals presenting for emotional crisis help.

The American Association of Emergency Physicians' Project Beta sets forth general principles vital to managing safety and maximizing collaboration with persons served.[84] The first is recognizing acute agitation early during presentation and having processes in place for the treatment team to assess and determine the likely etiology of differential types of agitation. Although the type of agitation cannot always be identified, determining the major category—psychosis, mania, substance-induced or withdrawal-related agitation, or delirium—can help guide best care medically. Understanding the type of substances used, such as stimulants versus benzodiazepines or alcohol, impacts the choice of medications recommended.

Project Beta emphasizes offering appropriate voluntary oral medications first as best practice.[85] For example, when a person intoxicated with methamphetamine is exhibiting significant agitation, offering oral medication allows them to have choice, starts early treatment of distressing agitation (decreasing the time before they can participate more effectively in their

care), and decreases the chances of their agitation escalating to a dangerous clinical situation that results in emergent medication and seclusion or restraint events.

The guidelines also advocate for use of benzodiazepines for certain types of agitation not involving psychosis, and, when psychosis is involved, use of atypical antipsychotics in both oral voluntary and emergent dissolvable or injectable forms.[86] This guideline supports using the combination of haloperidol options as second-line treatment due to side effects and prolongation of sedation and dysphoria affecting the person's ability to engage in their own care earlier.[87] Finally, benzodiazepines should be avoided in clinical situations in which delirium not related to alcohol or benzodiazepine withdrawal or agitation related to central nervous system depressants is part of the picture.

Ketamine

Ketamine may be encountered in various contexts in crisis care settings, and knowledge of the formulation, route of administration, dose, and context is essential to assessment and decision-making. Ketamine hydrochloride is a Schedule III controlled substance with an FDA approval for general anesthesia induction and maintenance.[88] This formulation of ketamine has been studied off-label to treat severely agitated individuals in emergency settings.[89,90,91,92] The use of ketamine in out-of-hospital contexts has also raised a number of questions—especially when it appears that law enforcement may be weighing in on when to use it.[93,94] This was one of the controversial issues in the tragic death of Elijah McClain.[95] Yet, ketamine was identified as the 13th most common medication given, according to a 2021 report by the National Emergency Medical Services Information System, and when monitored and utilized appropriately and with medical indications and oversight, it can have some benefits.[96] Thus, given that ketamine is a medication used by EMS, it is important for crisis receiving facilities to be prepared to work with individuals who have been administered it. If individuals receive ketamine from EMS personnel prior to arrival, for example, crisis care settings should be able to monitor basic respiratory and cardiovascular functions and provide treatment if needed (e.g., providing oxygen if oxygen saturation is low), given that respiratory suppression is one of the serious risks associated with this medication.[97]

Individuals may also present to crisis care settings after using ketamine as an illicit substance, and symptoms of intoxication/toxicity can include impaired consciousness, dissociation, ataxia, nystagmus, nausea, vomiting, hyperthermia, tachycardia, and hypertension.[98] Ketamine can be a substance of misuse presenting in crisis. Esketamine, the S-enantiomer of ketamine (an alternative chemical structure), is a Schedule III controlled substance that is FDA approved for treatment-resistant depression in adults and depressive symptoms in adults with major depressive disorder with acute suicidal ideation or behavior in conjunction with an antidepressant.[99] In 2022, the FDA published a warning about the health risks associated with compounded ketamine nasal spray, which included hemodynamic instability, respiratory depression, and liver injury.[100] At the time of this writing, crisis stabilization units are not generally set up to administer these

types of treatments for acute depression or trauma-related conditions. That may change someday, but it is important for crisis care workers to be familiar with the various ways ketamine can be used medically or by someone with a substance use disorder.

Medication Summary and Considerations for the Future

There is an opportunity to further emphasize an inclusive approach to crisis care that embraces the voices of people with lived or living experience; those with intellectual and developmental disabilities; family members; and Black, Indigenous, and other people of color as well as other members of underserved communities that have not typically been included as key informants in the design of services and systems in developing crisis guidelines for medications. For example, as the behavioral health systems of care are shaped, it will be critical to evaluate racial bias and its effects on diagnosing and prescribing practices. Policymakers and medical personnel and psychiatric leaders must work together to improve practices using a system specifically designed to ensure and measure continuous quality improvement that enhances medical guidance in behavioral health emergency crisis care, just as has been done for medical emergencies such as cardiac care and stroke. Developing and implementing a national data collection system for evaluating outcomes is imperative. Consensus guidelines must be in place to educate and train providers and systems and to monitor fidelity to evolving best practices.

Other policy changes are needed to decrease barriers to offering necessary medications and to enable crisis systems to work with anyone who presents for stabilization in crisis care. A local area's legislation and licensing of CRCs in combination with the Board of Pharmacy's standards for that licensing affect the type of care they are allowed to provide, such as the kinds of medications that are permitted to be stored and administered. Board of Pharmacy recognition of crisis centers' ability to keep and administer medications safely is currently variable, and for CRCs not located in a hospital with in-house pharmacy services, lack of authorization can make it difficult to keep medications at the ready. Further detailed recommendations for Board of Pharmacy standards and CRC management of their medications are forthcoming in a 2024 technical assistance paper from SAMHSA on medications in crisis care.

Conclusion

The impact of a fully functional crisis continuum can markedly improve access to care for all people in need of behavioral health crisis services. The continuum can be designed to fit each person's unique situation in a trauma-informed, engaged, and caring way. These systems must be able to serve anyone at any time to minimize contact with law enforcement and ED boarding. It is vital to have certain people, processes, and systems in place to support the medical and physical needs of many in crisis and community coordination. This paper provides an outline of

steps and approaches that can help CRCs support the whole person, including their physical health needs, when they are experiencing a behavioral health crisis.

To consider implementing this paper's recommendations, community infrastructure and cohesiveness will need to evolve as crisis stabilization services for behavioral health become part and parcel of a community.

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