CRISIS RESPONSE TO MENTAL ILLNESS

Overview of mental health disorders, suicide risk, and telephone triage of these issues

WIPSCOM Training
April 15, 2015

UNDERSTANDING MENTAL ILLNESS

Mood/Affective Disorders

- Approximately 9% of Americans suffer from depression
- Factor in 2/3 of suicides
- Types
  - Seasonal
  - Post-partum
  - Chronic (dysthymia)
  - Bipolar (mood cycling)
  - Psychotic
- *High comorbidity with other physical and mental illnesses

Symptoms of Depression

- Persistent low mood
- Appetite changes
- Sleep disruption
- Irritability
- Loss of interest or enjoyment of activities
- Decreased energy, lack of motivation
- Feeling helpless, hopeless, burdensome
- Social withdrawal
- Suicidal thoughts or behaviors

Symptoms of Mania

- Extended period of substantially elevated mood
- Decreased need for sleep
- Excessive, pressured talking
- Rapidly changing or racing thoughts
- Grandiosity
- Easily distracted
- Agitation
- Risky behavior

Anxiety Disorders

- General anxiety symptoms
  - Excessive worry
  - Fatigue, difficulty sleeping
  - Irritability
  - On edge, unable to feel at ease
- Obsessive-Compulsive Disorder (OCD)
  - Obsessions: thoughts that feel outside of one's control
  - Compulsions: repetitive actions that feel outside of one's control, often designed to counteract the obsessions

Post-Traumatic Stress Disorder

- Individual effect of experiencing incident that leaves person feeling extremely fearful, helpless
- Symptoms of PTSD
  - Flashbacks
  - Nightmares, difficulty sleeping
  - Gaps in memory of the traumatic incident
  - Easily agitated
  - Exaggerated startle response
  - Anxiety, depressed mood

Psychosis

- Schizophrenia
- Schizoaffective disorder
- Delusional disorder
- Can occur with other illnesses including bipolar, depression, PTSD
- Consider demoralization that occurs following acute psychotic episode

Psychosis Cont.

- "Positive" Symptoms
  - Delusions
  - Hallucinations
  - Paranoia
  - Disorganized speech/behavior
- "Negative" Symptoms
  - Limited range of emotions
  - Reduced speech, gestures, activities
  - Decreased motivation
  - Disinterest, inability to experience pleasure

Personality Disorders

- Characterized by rigid, unhealthy patterns of thinking and behavior that lead to difficulty relating to others
- Behavior patterns are inflexible and pervasive
- Integral part of person, therefore very difficult to treat
- Often unrecognized by individual

Personality Disorders Cont.

- Cluster A: eccentricity, odd thinking
  - Paranoid: overriding suspicion and distrust
  - Schizoid: emotional and social detachment
  - Schizotypal: odd behavior, social deficits, discomfort with relationships
- Cluster B: dramatic, unpredictable behavior
  - Antisocial: disregard for others, socially unacceptable/illegal behavior
  - Borderline: unstable and intense relationships, emotional instability
  - Histrionic: attention-seeking behavior, dramatic emotional expression
  - Narcissistic: grandiosity, need for admiration
- Cluster C: anxious, fearful thinking
  - Avoidant: feelings of inadequacy, social inhibition
  - Dependent: need to be taken care of, fear of abandonment
  - Obsessive-compulsive: rigidity, excessive fixation on perfectionism

Substance Use Disorders

- Includes tobacco, alcohol, illicit drugs, prescription medicine
- Abuse - use of substances persists despite negative impact on person's life
- Increased tolerance - need more and more to achieve desired effect
- Dependence – abuse continues despite serious negative consequences; withdrawal symptoms

…And More

- Attention Deficit Disorders
- Disruptive Behavior Disorders (oppositional defiant disorder, conduct disorder)
- Pervasive Developmental Disorders (autism, Asperger's)
- Eating Disorders (bulimia, anorexia)
- Dissociative Disorders
- Dementia/Alzheimer's

Mental Illness Causes

- Genetics/family history
- Biology/organic disorder
- Substance use
- Environmental
- Situational stressor

* Often some combination of these

Triggers for Mental Health Episode

- Loss of loved one or other traumatic event
- Loss of job, home, relationship, other major aspect of individual's life/identity
- Financial concerns
- Illness or injury
- Excessive stress
- Substance abuse
- Poor lifestyle choices (diet, sleep habits, etc.)

Treatment for Mental Illness

- Psychotherapy (individual, group, family)
- Psychiatric medication
- Acute inpatient hospitalization
- Residential care
- Self-care (exercise, diet, structure etc.)
- Support groups
- Psycho-education
- ECT, magnetic stimulation

Mental Illness and Violent Behavior

- Vast majority of people who engage in violence do not suffer from mental illness
- Individuals with mental illness are far more likely to be victims than perpetrators of violence
- Potential for violence exacerbated by substance abuse
- Violence most likely to be directed at family/friends
- Stigma leads to social isolation, lack of treatment

SUICIDE RISK

Demographic/Static Risk Factors

- Age: 45-54 highest risk age group
- Gender: males outnumber females 4:1 in completed suicides, females 3x more attempts
- Culture/ethnicity: rates are highest for whites, lowest for blacks but increasing
- Family history of mental illness, AODA, suicidal behavior, domestic violence, increase risk
- History of trauma: child abuse, sexual assault

Destabilizers/Dynamic Risk Factors

- Mental illness and/or substance abuse disorders are factors in over 90% of suicide deaths
- Social stressors: interpersonal loss, lack of supports/structure, legal issue, medical illness
- History of suicidal behavior: those with previous attempts 23x more likely to suicide, but half of deaths occur on first attempt
- Access to firearms – ½ of suicides and increasing
- Self-harm behavior

Psychology of Suicide

- Mental anguish is experiential state that leads person to seek death as escape
- Suicide ideation/talk are not emotional feelings, but thoughts on how to solve problem of not wanting to feel bad
- Motivation behind suicidal act is the need to relieve pain and suffering
- As tolerance for pain exhausted and problem solving strategies not working, awareness of death increases

Why Does Suicide Happen?

- Humans are solution-oriented
- Suicide works as a solution to pain: life ends=pain ends
- People kill themselves because they decide to kill themselves
- Decision made after weighing pros and cons, internal dialogue, preparation and planning
- Knowing thoughts/actions will help determine severity of pain and proximity of death

Components of Suicidality

- Desire to Die
- Suicidal Capability
- Suicidal Intent
- Buffers/Protective Factors

What About Self-Harm Behavior?

- It is NOT a clear indicator of suicidal intent
- But does NOT mean the individual is not at risk
- Most common example is cutting; also burning, head banging, scab picking etc.
- Most commonly associated with PTSD and personality disorders, but also can be psychosis induced
- May be done for attention, frustration, release of tension or anger, aggression turned inward
- May be planned or impulsive

Chronic Suicidal Behavior

- Suicidal crises are self-limiting, usually 24-48 hours
- Is there anything different or unusual compared to past presentation?
- What other stressors can be identified and addressed?
- Specific individualized safety/crisis response plan is in place; is it appropriate to follow today?
- Frequent hospitalization reinforces individual's perception that he/she requires institutional care and is not capable of maintaining safety

Dispelling Suicide Myths

- "Leakage myth" – a person's suicide risk may not be evident to others
- Talking about suicide does not cause a person to become suicidal
- Mental health clinicians cannot read minds
- Even when a person is determined to kill him/herself, preventive actions can be effective in reducing risk
- People with chronic suicidal behavior are not always acutely suicidal
- People who frequently engage in self-harm behavior are at risk to complete suicide

Cultural Considerations

- Suicide is taboo across all cultures to some degree.
- How do individuals – and their families/cultural groups – conceptualize suicide and mental health issues?
- Examine your own views about suicide:
  - Do you feel it's wrong, immoral, "easy way out"?
  - Countertransference related to our own experiences with suicide

Talking to Suicidal Person

- Invite discussion by asking about their pain
- Avoid false reassurances
- Acknowledge things are difficult, *without* agreeing things are impossible
- Express empathy and caring
- Identify even small things you can do to provide support/decrease stress
- Identify things that tie the person to life

MENTAL HEALTH COMMITMENTS

A brief overview of Chapter 51

What is Chapter 51?

These Wisconsin state statutes provide legal procedures for voluntary and involuntary admission, treatment and rehabilitation of individuals (adults and minor children) afflicted with mental illness, developmental disability, drug dependency, or alcoholism.

Criteria for Involuntary Civil Commitment

1) The individual has a mental illness, developmental disability, or drug/alcohol dependence.
2) The individual's illness/disability/ dependence is treatable.
3) The individual is dangerous to him/herself or others, due to the illness/disability/ dependence

Standards of Dangerousness

1) Recent acts, attempts or threats of suicide or serious bodily harm to self.
2) Recent acts, attempts, or threats of serious bodily harm to others, or violent behavior which places others in reasonable fear of serious physical harm.
3) A pattern of recent acts or omissions which evidences impaired judgment causing the individual to be an inadvertent danger to self.

Standards of Dangerousness Cont.

4) Mental illness causes the individual to be so gravely disabled that he/she is unable to satisfy life's basic needs for nourishment, medical care, shelter, or safety.
5) Individual's psychiatric treatment history, coupled with his/her present mental deterioration due to incompetent decision to refuse psychotropic medication, causes likelihood that the individual will lose ability to function independently in the community.

Emergency Detention (ED)

- Law enforcement takes individual into protective custody for mental health evaluation
- Individual is detained at an approved mental health detention facility
- Must be approved by police AND Crisis
- Based upon belief, from either personal observation or reliable reports of others, that the individual is mentally ill, developmentally disabled, or drug dependent, and dangerous to self or others.

Other Ways to Initiate Ch 51

- Petition for Exam (Three-Party Petition): petition is filed with court, signed by three witnesses, who may testify to individual's dangerousness due to mental illness.
- Treatment Director's Hold: individual voluntarily admits to inpatient psychiatric facility, and refuses treatment or requests discharge; treatment director believes individual poses danger without further treatment – files statement of detention with court.

Four Outcomes of Ch 51 Process

1) Case is dismissed, patient is discharged.
2) Individual stipulates to Settlement Agreement – contract with court to hold commitment proceedings and continue treatment for 90 days. *
3) Converted to Ch 54/55 – Guardianship, Protective Placement
4) Commitment – patient must comply with outpatient treatment conditions or risks return to hospital. Usually 6 months and can be extended. *

* Compliance monitored by Crisis.

Recent Changes to Ch 51

- 2006: Parents/legal guardians of youth under the age of 18 may provide consent for the youth's admission to a psychiatric facility.
- 2009: County department of community programs in which the individual is detained must approve the need for detention.
- 2014: An individual is in custody when the individual is under the physical control of the law enforcement officer

Contact Information

Emergency Services Unit
Journey Mental Health Center
625 West Washington Avenue
Madison, WI 53703
24-hour Crisis Line: 608-280-2600

Sarah Henrickson, LCSW
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