

Crisis Response in Mental Health: Do we have a protocol?

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When we think in terms of mental health, crisis occurs when a person is confronted with a critical incident or stressful event that is perceived as overwhelming despite the use of traditional problem-solving and coping strategies.¹ Number of events or circumstances can be considered a crisis: life-threatening situations, such as natural disasters (an earthquake or tornado), sexual assault or other criminal victimization; medical illness; mental illness; thoughts of suicide or homicide; and loss or drastic changes in relationships (death of a loved one or divorce).² Mental illness per se make an individual vulnerable to collapse in terms of coping and hence pose huge demands on mental health services. Situations like non-compliance with the medications, poverty, unemployment, homelessness and loss of social supports are especially alarming. Apart from this, the unforeseen national disasters, violence, terrorism and forced displacement are other aggravating as well as precipitating factors. The developed world has a number of systems developed for crisis like situations specifically designed for people with mental health issues. In order to address the problem of mental health morbidity, Crisis Response Systems have been proposed to provide a better approach. A number of key players can help with this system, like the general practitioners, community workers, religious leaders, counselors and mental health professionals. In the western world, crisis mobile teams also form part of a wider Crisis Response Service System. The goals under which these teams operate are: able individuals experiencing a mental health crisis or distress to a wide range of services and to improve overall capacity of the community to address concerns related to such individuals. Their particular objectives are: supporting individuals self-determination in balance with safety of self and others, timely intervention to reduce the risk, distinguish between mental health crisis and psychiatric emergency, provide short term crisis management, outreach to individuals as well as their caregivers, provide formal educational sessions, information sharing and onsite consultation with advocacy for ongoing development of services.³ It is important to remember that a number of serious mental illnesses can be prevented by addressing 'crisis' in timely manner. In some models, psychiatrists have been identified as the key persons who should be able to put in place effective intervention methods in order to avert or resolve the crisis. The features required from crisis psychiatrist are identified as:

- ◆ ability of the psychiatrist to perform a complete psychiatric

assessment in a limited amount of time (approx 60 min).

- ◆ flexibility to be able to see clients on short notice or fit in urgent cases with little background information.
- ◆ ability to obtain and distribute samples of medication for clients who lack the financial means to pay for prescriptions.
- ◆ ability of the psychiatrist to see clients outside of the office when necessary.
- ◆ the psychiatrist being comfortable with the knowledge that they will only see the majority of clients one or 2 times without long-term follow up.
- ◆ available for consultation and providing clinical directions through scheduled time slots, as well as through regular meetings with the supporting team.

There are a number of problems associated with psychiatric services due to lack of adequate resources in most of the cases to handle all crisis in the community, furthermore, the issue of stigma with contacting psychiatric services is troubling for the person in crisis. Under the circumstances, availability of some community services with facility of hot line can manage a number of such issues.⁴ Moreover, the family practitioner may address a number of issues at primary care level with adequate training.⁵ The local scenario in Pakistan appears different when it comes to crisis and emergency psychiatry. With the availability of philanthropic social services it has become relatively easier to contact a psychiatric service if the problem of stigma is ignored. However, the concept of crisis psychiatry is still ill-understood. There is still no organized service in terms of addressing the crisis situation that may risk the mental health in a bad way. Sometimes ago, there was a publicised venue for 'crisis line' specifically attempting to help the potential suicide planners. Services in bits and pieces can not help the health system of the country that is already in doldrums. It is important that the hospitals do have a full-fledged crisis team with mobile services. Organizing such an efficient service may have financial implications, hence, the welfare organizations can take a lead in initiating at least the basic services. Subsequently, support of government should be solicited. These services may cut down the disease burden in terms of mental health and will open new educational avenues in the field of 'crisis psychiatry'. Adding a component of 'crisis psychiatry' in undergraduate and postgraduate curriculum, training of

family physicians and allied mental health professionals, allocation and mobilisation of resources towards preventive psychiatry, with massive advertisement of available services will be beneficial for our current health care system. Is this the right time for setting the ball in motion?

References

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