# Illinois Hospital Association

## Behavioral Health Steering Committee

## Best Practices Task Force

**FINAL REPORT**

# Best Practices for the Treatment of Patients with Mental and Substance Use Illnesses in the Emergency Department

**Updated October 2007**

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*The information contained in this Report reflects the views of the authors of the research cited and of the members of the Illinois Hospital Association Behavioral Health Constituency Section Steering Committee and its Best Practices Task Force. The "best practices" described in this Report are offered to aid in the consideration and discussion of practices that might be appropriate for an institution, based upon the circumstances at that institution. They do not constitute either clinical or legal advice. It is also important to remember that "best practices" reflect current knowledge and practice, and necessarily evolve with time and experience.*

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## A B S T R A C T

In recent years, hospitals across the nation have experienced a significant and growing number of patients with mental and substance use illnesses presenting in their emergency departments (EDs). This recent upsurge can be attributed to several factors, including the loss of acute hospital psychiatric capacity in both the public and private sectors; lack of access to primary and other outpatient care; an under funded community mental health system; lack of insurance for mental or substance use illnesses; lack of any health insurance; a rising incidence of drug use; and a large population of persons with mental and substance use illnesses that go untreated until a crisis occurs. The hospital ED has become for many a safety net when other alternatives are unavailable, inaccessible or unaffordable.

Recognizing the demands being placed on our EDs by an increasing number of patients with mental and substance use conditions, as well as the need for us to provide high quality care, compassionately and efficiently, the IHA Behavioral Health Steering Committee established a Task Force to consider and document best practices associated with treatment of the patient with mental and substance use illnesses in the emergency department. This multidisciplinary committee of psychiatrists, emergency medicine physicians, psychiatric nurses, psychologists, social workers, counselors and hospital management executives met on several occasions during 2006 and 2007. The document that follows is the result of their work, experience, and expertise. It considers emergency departments in a variety of hospital settings, from the large urban academic medical center to the small rural hospital. It also considers EDs with dedicated psychiatric space and staff as well as those that do not have these resources.

It is the Task Force's goal to provide this information for hospitals in Illinois to use as a resource. As healthcare providers, we exist to serve our patients and believe the use of evidence-based or best practices will support the delivery of better care. Among the practices identified by the Task Force that are provided in this report for your consideration are the following:

- Use a predetermined triage system or scale to ensure timely and appropriate evaluation and treatment of psychiatric patients.
- The Psychiatric Medical Clearance Checklist developed by Illinois emergency and psychiatric physicians. (See Appendix A)
- The Consensus Statement on Medical Clearance from the Massachusetts College of Emergency Physicians and the Massachusetts Psychiatric Society. (See Appendix B)
- Routine urine toxicologic screens need not be routinely performed as part of the assessment (in medically stable patients). Drug screens should not delay patient transfers to psychiatric facilities.

- The patient's cognitive abilities, rather than a specific blood alcohol level, should be the basis upon which psychiatric assessment begins.
- The examining physician should determine whether and what tests to order based on the patient's presentation.
- The recommendations of the American Psychiatric Association regarding the Emergency Psychiatric Assessment. (See page 22)
- The variance in throughput between psychiatric and medical patients should be measured and evaluated to determine ways in which disparities can be improved.
- In circumstances in which there is a question whether the patient meets medical necessity criteria for inpatient admission, provide special areas in the ED or in an alternative location, in which the patient can remain from 24-48 hours for crisis stabilization and linkage to the appropriate level of treatment.
- The special areas in the ED should be soothing and supportive, promote healing, and help to deescalate agitated and psychotic patients.
- Depending upon the model of service in use, if a hospital does not have dedicated, psychiatrically trained staff, the emergency department physicians and medical staff need substantive training regarding psychiatric patients. This may include bringing in outside consultants to provide the training and education. The task force also recommends on-going continuing education for the ED staff in the care of the psychiatric patient.

# T A B L E  O F  C O N T E N T S

# I N T R O D U C T I O N

Hospitals in Illinois and across the nation are treating a large and growing number of patients with mental and substance use illnesses in their emergency departments (EDs). Illinois hospitals experienced a 47.6% increase in behavioral health ED visits between 2002 and 2004, according to a recent Illinois Hospital Association (IHA) survey.[1] A 2004 national American College of Emergency Physicians survey showed a 61.38% increase in the number of patients presenting with psychiatric emergencies during the six to 12 months preceding the survey. Six of 10 physicians surveyed indicated the increase in psychiatric patients was causing long wait times, patient frustration, and was negatively affecting access to emergency medical care for all patients.[2]

The growing use of the emergency department by patients with mental or substance use conditions reflects the evolving role of the ED from primarily a critical care setting to one that also serves as a community and patient safety net. It parallels overall ED increases and occurs at a time when there are fewer hospitals and emergency departments available.[3] Consider this: Between 1993 and 2003, the U.S. experienced a net loss of 703 hospitals, 198,000 hospital beds, and 425 hospital EDs.[4] (Illinois experienced the loss of 45 hospitals between 1980 and 2005.)[5] During the same period, ED utilization increased by 26%.[6] The number of mental health related ED visits increased by 38%, from 4,371,112 to 6,721,540 visits, in the decade 1992 to 2001.[7]

Patients with mental or substance use illnesses are seeking care in our emergency departments for a variety of reasons:

- There are fewer hospitals that offer acute psychiatric services. Illinois has closed several state-operated hospitals and downsized others, so that there are now only 1400 public psychiatric beds available to treat persons with mental illness.[8] Since 1990, private hospitals have decreased the number of available psychiatric beds by 23%; since 1999, fifteen hospitals have closed their psychiatric units.[9] The American Hospital Association in 2004 documented a loss of 98,666 psychiatric beds, a 42% decrease in inpatient capacity. From 1960 to 2000, there was a 91.3% decrease in public psychiatric beds in the U.S.[10]

- Community services and supports are not available or accessible to the extent needed by many persons with serious mental illness who in past years may have been living in state institutions. Without adequate treatment, including medication, medical and psychiatric care, psychosocial rehabilitation, case management, and housing, these individuals may cycle in and out of shelters, jails and hospitals.[11]

- The emergency department has become the primary treatment center for those who do not or cannot use traditional outpatient settings, for care of even routine illness. The Kaiser Foundation found that over 40% of uninsured patients do not have a usual source of care compared with 9% of those with coverage. About 20% of the uninsured say the ED is their usual source of care.[12] EDs serve more than twice the percent of Medicaid and uninsured patients as physician offices, according to the National Center for Health Statistics.[13]

- Persons with mental illness are among the poorest in our nation. They have the highest unemployment rate of any group with disabilities. Only one in three is employed, according to the President's New Freedom Commission on Mental Health.[14] High unemployment means they must rely on publicly funded health care programs such as Medicaid and Medicare. And, as noted, Medicaid recipients and the uninsured have higher use of EDs.[15]

- For those who have access to primary medical care, mental illness is often misdiagnosed or if detected, not properly treated.[16] Moreover, private insurance policies may discourage the use of mental health services through benefit design, high deductibles, and limits on the number of outpatient visits permitted and through stringent managed care. Patients may be waiting too long to seek care, and they use the ED in a crisis.

- Many rural communities do not have access to acute hospital psychiatric or substance use services because they do not exist or they are too far. Frequently they do not have access to psychiatrists and other mental health professionals. Fifty-nine counties in Illinois do not have a psychiatrist.[17] The emergency department becomes the only resource available in many circumstances, and it is used when a condition becomes a crisis.

- Drug misuse or abuse accounted for an estimated 1,449,154 million out of the 108 million ED visits to general hospitals in the U.S. in 2005, according to a new report from the Substance Abuse and Mental Health Services Administration (SAMHSA). Over half of the drug misuse or abuse ED visits involved an illicit substance; alcohol abuse accounted for 34% of ED visits during this time period. Emergency department visits related to the non-medical use of prescription and over the counter drugs (e.g. anti-anxiety, methadone) drugs jumped 21% in 2005, to 598,542.[18]

- Emergency departments are treating the homeless mentally ill and substance abusers. Of the 2.1 million adults who experience homelessness over the course of a year, 10% are chronically homeless, and it is they who tend to have disabling health and behavioral health problems. According to SAMHSA, approximately 40% have substance use disorders and 25% have a serious mental illness.[19]

The increased use of hospital emergency departments by all patients but especially persons with mental and substance use illnesses is troubling and deserves serious attention. EDs were designed to treat acute and urgent aspects of illness and injury, but they are also serving as primary care for those who do not have access to other health care. We are placing enormous demands on these departments and may need to rethink their role, their design and ways in which to support their functioning. In addition, what happens in the ED affects all patients; 40% of all inpatients are admitted from the ED, [20] according to AHA. If the ED is overcrowded or nearing capacity, every patient is receiving care in a less timely fashion. The use of the ED by persons with mental illness and substance use disorders is a symptom of a fragmented, inaccessible and unaffordable amalgam of mental health and substance use services. Patients with these conditions are using the ED because they do not have any place else to go.

# P R O J E C T  D E S C R I P T I O N

## PROJECT GOALS

The IHA Behavioral Health Steering Committee established a Task Force on Best Practices in 2006. As its initial project, the committee chose the ED. Its charge was to (1) examine from a clinical perspective emergency care delivered in Illinois hospital emergency departments to patients with mental or substance use disorders; (2) research the literature and evidence-based/ best practices for emergency services, as applied to patients with these conditions; (3) identify models of care and practices used in Illinois hospitals that were viewed by the committee as being exemplary or worthy of note; and (4) keeping in mind the six aims of quality health care articulated by the Institute of Medicine, to make recommendations about practices that could be used in emergency departments.

The committee recognized that any recommendations are intended to be - and can only be - voluntary; however, it was their desire to make a concerted effort to address the need to improve the patient experience in the emergency department. National quality of care entities have called upon all health care providers to deliver care according to evidence-based practices, and it was timely and appropriate for the behavioral health community to view the ED within the framework of best practices and the evidence. The committee also wanted to contribute to the development of policies related to the treatment of patients with mental illness and substance use disorders in Illinois that improve patient care, the patient's experience in the ED, and ultimately to their recovery.

## TASK FORCE MEMBERS

The Task Force was comprised of physicians specializing in emergency medicine and psychiatry; nurses, psychologists, social workers and administrators of hospital-based mental health and/or substance use services. They represent the full spectrum of acute care providers, from academic medical centers, to community hospitals, freestanding psychiatric hospitals and rural hospitals. A list of the Task Force members is available at the beginning of this document.

## REPORT COMPONENTS

The Report considers the following: the structure of emergency departments; common staffing, patient flow, emergency department settings such as the physical design and lay out, including whether or not there are separate spaces designated for psychiatric patients; the literature relevant to best practices and evidence-based practices related to the treatment of patients with mental illness and substance use disorders in the hospital emergency department; survey of a representative sample of hospital emergency departments about systems of care, structural and operational components in their respective EDs; and makes recommendations about practices and structures that benefit patients. The committee also identifies areas for future research.

## ILLINOIS STATISTICS

In 2004, there were 273,911 or 19.3% of adult inpatients discharged from Illinois hospitals with a principal or secondary diagnosis of mental disorder. Of these, 80,350 were hospitalized with a principal diagnosis of a mental condition. Just over half of these patients were admitted as an emergency. In that same year, there were 185,623 adult inpatients discharged with a principal or secondary diagnosis of substance abuse. Of these patients, substance abuse was a secondary diagnosis of 178,750; it was the principal diagnosis for 12,344 cases. Forty five percent of patients with a principal diagnosis of substance use disorder were admitted through the ED, a slightly lower number than patients with a principal mental disorder, but a large number nonetheless. There were 5,472 inpatient cases of attempted suicide during that same time period; 83% of which were admitted through the emergency department. [21]

The numbers speak for themselves.

A survey of Illinois hospitals conducted in 2005 found that the number of behavioral health visits grew overall by an average of 47.6% between 2002 and 2004, with 88.7% of hospitals reporting an increase in the number of visits. Patients under the age of 18 represented, on average, 14.8% of all behavioral health ED visits in 2004, representing a 35.8% increase between 2002 and 2004. Of those hospitals maintaining statistics on patient turn-around time from triage to discharge from the ED in 2004, they report an average throughput of five hours—almost twice as long as the ED stay for other patients. [22]

## NATIONAL STATISTICS

Illinois statistics are consistent with those across the nation. A survey was conducted by the American College of Emergency Room Physicians, in behalf of NAMI, the American Psychiatric Association, and the National Mental Health Association in 2004 to research the potential effects recent trends in access to care for psychiatric patients were having on emergency department environments. Among the survey's findings was 61.38% of respondents had seen an increase in the number of patients presenting with psychiatric emergencies during the previous 6-12 months of the time of the survey; 70% of emergency physicians reported an increase in people with mental illness "boarding", i.e., waiting in the ED until inpatient beds are available in the hospital or elsewhere. Also, psychiatric patients were boarding more than twice as long as other patients—a finding that is consistent with the Illinois survey. The ACEP survey also found that it took staff twice as long to find a psychiatric bed as it did to find a bed for a non-psychiatric patient. The survey respondents attributed the increased volume and time for disposition of patients with mental illness to state budget cuts for mental health services and decreases in the number of public and private psychiatric hospital beds.

## REVIEW OF CURRENT PRACTICES

Through its members, the Task Force polled several facilities throughout the state regarding current practices in the emergency department. Details regarding physical space, such as where patients were housed prior, during and post evaluation; whether patients had access to showers; types of waiting areas; and whether psychiatric patients were separated from general patients, were compiled. Information was also solicited regarding staffing, education level of staff, whether differences between psychiatric and substance abuse patients existed, what medications patients could receive and by whom were they given, as well as patient mix and percentage of emergency department presentations that were psychiatric patients. Finally the respondents were asked what they would like to see in the future to support the treatment of psychiatric patients in the emergency department.

### PROTOCOLS

Across the board, hospitals surveyed indicate there are no differences between the treatment protocols for general psychiatric patients and substance abuse patients, with the exception of a patient's level of intoxication requiring medical intervention. Larger urban/suburban hospitals reported a significant number of dual diagnosis patients more so than rural hospitals.

### SPACE

In most facilities, psychiatric patients are housed in regular emergency department rooms or bays, either near a nursing station or with a security officer. Hospitals with a dedicated space transfer psychiatric patients to the area after medical clearance, utilizing regular emergency department beds for overflow as necessary. Nearly every facility requested either a dedicated area, if they did not have one, or an expansion of existing space if they did.

### STAFF

In most facilities the patient receives medical care, such as medications, from the general emergency department nursing staff and psychiatric staff evaluates the patient's psychiatric symptoms (typically LCSWs). However, only in the large facilities found in urban settings does care and monitoring after medical clearance become the responsibility of the psychiatric staff. This can be attributed to the fact that most of the smaller rural hospitals rely on Community Mental Health Centers (CMHCs) to do psychiatric evaluations and do not have trained psychiatric personnel on staff twenty four hours a day, seven days a week (24/7).

Also evident is the fact that the smaller hospitals tend to have more entry level trained staff, if any, other than consultants. Some of the larger urban facilities are utilizing highly skilled, advanced degree personnel such as Psychiatric Advanced Practice Nurses for the majority of their 24/7 staffing patterns; some even staff Board Certified Psychiatrists for regular hours in the emergency department. (Survey can be found in Appendix E)

## C O R E I S S U E S A N D R E C O M M E N D A T I O N S

Related to the Care of the Psychiatric Patient in the emergency department

### TRIAGE

For the purposes of this paper, we are defining "triage" as a brief intervention that occurs when a patient initially presents to the emergency department during which the patient is interviewed to help determine the nature and severity of his or her illness. Patients with acute illnesses are admitted to the department more rapidly than those with less severe symptoms or injuries. The brief intervention should include, but is not limited to, the patient's or significant other's description of presenting symptoms or complaints, vital signs and an assignment of disposition based on gathered information.

Smart et al. developed a Mental Health Triage Scale (MHTS) which integrated psychiatric patients into the National Triage Scale (NTS) used throughout emergency departments in Australia. The authors stated, "Motivating factors for the development of the mental health triage scale included a perceived unfairness in the way mental health presentations were integrated leading to long delays in medical assessment and long transit times."

**Table 1**

| National Triage Scale for Emergency Departments in Australia | | | |
|---|---|---|---|
| National Triage Scale | Numerical Code | Treatment Acuity: Time to be seen by a doctor | Color Code |
| Resuscitation | 1 | Immediate | Red |
| Emergency | 2 | 10 Minutes | Orange |
| Urgent | 3 | 30 Minutes | Green |
| Semi-urgent | 4 | 60 Minutes | Blue |
| Non-urgent | 5 | 2 Hours | White |

*Source: Smart, D., Pollard, C. & Walpole, B. (1999). Mental health triage in emergency medicine. Australian and New Zealand Journal of Psychiatry, 33:57-66.*

Coupled with comprehensive training of the nurses, staff using the MHTS reported they felt well equipped and more confident, reporting a greater understanding of mental health presentations. The mean waiting time was reduced from 34.3 minutes (26.4 minutes for medical patients) to 29.1 minutes. Proper triage level also positively impacted mean time to disposition which was reduced from 149.2 minutes to 131.8 minutes. Through education and implementation of a mental health triage scale, the authors realized for their 306 patients over a three month period, a reduction of 88.9 patient hours.[23]

**Table 2**

*Mental Health Triage Scale*

| Triage Category | Patient Description | Treatment Acuity |
|---|---|---|
| 2 "Emergency" | Patient is violent, aggressive or suicidal, or is danger to self or others, requires police escort | Within 10 minutes |
| 3 "Urgent" | Very distressed or acutely psychotic, likely to aggressive, may be a danger to self or others | Within 30 minutes |
| 4 "Semi Urgent" | Long-standing or semi-urgent mental health disorder and/or has supporting agency/escort present | Within 1 hour |
| 5 "Non-urgent" | Patient has a long-standing or non-acute mental disorder/problem but has no supportive agency/escort - may require a referral to an appropriate community Resource. | Within 2 hours |

*It is considered advantageous to "up-triage" mental health patients with carers present because carers' assistance facilitates more rapid assessment.

*Source: Smart, D., Pollard, C. & Walpole, B. (1999). Mental health triage in emergency medicine. Australian and New Zealand Journal of Psychiatry, 33:57-66.*

**Table 3**

*Factors Considered in Assigning Mental Health Triage Categories****

i. Manifest behavioral disturbance
ii. Presence of or threatened deliberate self harm
iii. Perceived or objective level of suicidal ideation
iv. Patient's current level of distress
v. Perceived level of danger to self or others
vi. Need for physical restraint/accompanied by police
vii. Disturbances of perception
viii. Manifest evidence of psychosis
ix. Level of situational crisis
x. Descriptions of behavior disturbance in the community
xi. Current level of community support
xii. Presence of carer/supportive adult

The first six factors favor triage to categories 2 or 3.

*Source: Smart, D., Pollard, C. & Walpole, B. (1999). Mental health triage in emergency medicine. Australian and New Zealand Journal of Psychiatry, 33:57-66.*

**RECOMMENDATIONS FOR TRIAGE**

The Task Force strongly recommends the use of a predetermined triage system or scale to ensure timely and appropriate evaluation and treatment of psychiatric patients.

## MEDICAL ASSESSMENT / MEDICAL CLEARANCE – "FOCUSED MEDICAL ASSESSMENT"

The term "medical screening" is frequently used interchangeably with "medical assessment." For our purposes we will define medical screening as a determination of need for further evaluation, however, to establish the existence of an emergency medical illness or condition by a physician or, in limited cases, another qualified medical person. During the medical assessment the ED physician would conduct a history and physical examination, determine if the patient is intoxicated or under the influence of a drug, establish if the patient's symptoms are caused by or exacerbated by a medical illness, and stabilize any acute medical illness that necessitates intervention.

It is generally accepted that "medical clearance" occurs after completion of the medical assessment and any pertinent laboratory or radiological tests to conclude there is no organic etiology. The patient is considered, within reasonable medical probability, to be medically stable and to have the appropriate cognitive status to undergo psychiatric evaluation. Medical clearance does not indicate the absence of ongoing medical issues that can be easily managed and that will not interfere with psychiatric evaluation and treatment. If such conditions exist, the clearing physician should include the recommended level of medical observation and treatment.

Lukens, et al, from the American College of Emergency Physicians published a clinical policy in 2006 for the adult psychiatric patient in the emergency department.[24] The authors recommend using the term "focused medical assessment" as they believe the term "medical clearance" can imply different things to psychiatrists and emergency physicians. They believe the term "focused medical assessment" better approximates the process "in which a medical etiology for the patient's symptoms is excluded and all other illness and/or injury in need of acute care is determined and treated." The authors recognized "a difficult aspect of the focused medical assessment is clearly determining when a patient is not only medically stable, but has the cognitive status suitable for the psychiatric interview."

According to Zun, the components of the medical clearance process include taking a history and conducting a physical examination, a mental status examination, testing, when appropriate, and treatment, when necessary. He notes there is no clearly accepted protocol adopted by emergency physicians as to the standard procedures to perform on psychiatric patients presenting to the emergency department.[25]

Notwithstanding this, a decade ago a group of psychiatrists and emergency physicians in Illinois developed a mutually agreeable protocol for the medical clearance process that occurs in emergency departments for patients with psychiatric complaints. The group authored a paper on the process that evolved into a medical clearance checklist, this checklist may be found in Appendix A. [26] The medical clearance checklist was designed to walk the emergency physician through the process and provide the psychiatrist assurance that the patient had

an adequate medical clearance process. The checklist does not require any testing, unless the patient has a new onset of psychiatric illness. The checklist has been tested in a before and after study, finding no difference compared to the emergency physician's usual assessment.[27] The usual medical clearance performed by emergency physicians and that required by psychiatrists varies from physician to physician but there is a discordance of testing between specialists.[28] Another study demonstrated that the costs using significantly reduced by utilizing this medical clearance protocol.[29]

In 2003 the Massachusetts College of Emergency Medicine, together with the Massachusetts Psychiatric Society, published a Consensus Statement on medical clearance exams that also challenges the use of the term but deemed it too "ingrained" to eradicate. Massachusetts is one of at least two states where emergency physicians and psychiatrists worked together to reach consensus on guidelines for medical clearance. The Task Force found this document useful. It is included in Appendix B in its entirety.[30]

**RECOMMENDATIONS FOR MEDICAL ASSESSMENT/CLEARANCE**

The Task Force solidly endorses the use of the term "focused medical assessment" in place of medical clearance but, like our Massachusetts Colleagues, believes that it is likely too deeply embedded in emergency department culture to be changed.

The Task Force also strongly endorses the Consensus Statement on Medical Clearance from the Massachusetts College of Emergency Medicine and the Massachusetts Psychiatric Society

The Task Force endorses the protocols of the "Psychiatric Medical Clearance Checklist".

## PATIENTS WITH SUBSTANCE USE DISORDERS OR CO-OCCURING SUBSTANCE USE AND PSYCHIATRIC DISORDERS

We recognize that many patients presenting to the emergency department abuse drugs or alcohol, and these drugs may mask or exacerbate other psychiatric symptoms. For purposes of this paper we are defining terms and care levels for these patients as follows: Intoxication is a nervous system abnormality (usually involving the Central Nervous System) due to a drug. Inebriation is the inability to perform activities of daily living (ADL) due to a drug. Impairment is an increased risk for being involved in an accident.[26]

Intoxication without psychiatric illness or chemical dependence – patient is simply under the influence of a drug and intoxicated and does not require psychiatric intervention and should remain solely a patient of the medical portion of the emergency department

Intoxication, primary chemical dependence diagnosis, without psychiatric illness - patient should be maintained in the medical portion of the emergency department until he/she is deemed to be sober enough to undergo psychiatric assessment. In most instances this patient will require referral to an addictions treatment facility.

Intoxication with co-morbid psychiatric illness and chemical dependence – patient should be maintained in the medical portion of the emergency department until he/she is deemed to be sober enough to undergo psychiatric assessment. A patient who is inebriated cannot undergo psychiatric assessment.

In the article, "Clinical policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department," the authors consider issues surrounding testing in alert patients with normal vital signs; urine drug screens; point of time at which a psychiatric exam can be conducted in an intoxicated patient; and the most effective pharmacologic treatments for acutely agitated patients. Their recommendations are based on a thorough review of the literature and the guidance of physicians with relevant clinical experience. Their recommendations for patient management are classified according to their level of clinical certainty, which reflects the strength of the evidence of the literature: Level A is a high degree of clinical certainty, level B is a moderate degree of clinical certainty, and level C strategies are based on preliminary, inconclusive, or conflicting evidence, or committee consensus.

For purposes of this paper, we are focusing on the recommendations of Lukens et al related to urine drug screens and the time to conduct the psychiatric evaluation in an intoxicated patient. The specific question posed and answered is as follows: "Do the results of a urine drug screen for drugs of abuse affect management in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and a psychiatric complaint?" Ranking this issue as Level C, they concluded that routine urine toxicologic screens do not affect ED management and need not be performed as part of the assessment. They also conclude that if these tests are performed for a receiving psychiatric facility, they should not delay patient evaluation or transfer.[31] The Massachusetts College of Emergency Physicians and the Massachusetts Psychiatric Society Joint Task Force reached a similar conclusion that drug screens of medically stable psychiatric patients should not delay transfers of patients to psychiatric facilities.[32]

Regarding the initiation of a psychiatric evaluation of a cooperative patient with normal vital signs and a noncontributory history and physical examination, the authors conclude that "The patient's cognitive abilities, rather than a specific blood alcohol level, should be the basis on which clinicians begin the psychiatric assessment." They further recommend that the clinician use a "period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves."[33] In making this Level C recommendation, they note that there are no evidence-based data to support a specific blood alcohol concentration at which the psychiatric evaluation should begin. They further note that there are no studies that show an individual regains adequate decision

making capacity when he or she reaches the legal limit for driving. There also is no evidence in the literature to support the delay of the evaluation.

**RECOMMENDATIONS RELATED TO URINE TOXICOLOGY SCREENS**

Routine urine toxicologic screens need not be performed as part of assessment (in medically stable patients); Drug screens should not delay patient transfers to psychiatric facilities.

**RECOMMENDATIONS REGARDING LABORATORY TESTS**

The examining physician should determine whether and what tests to order based on the patient's presentation**.**

**RECOMMENDATIONS RELATED TO TIME AT WHICH TO CONDUCT THE PSYCHIATRIC ASSESSMENT OF AN INTOXICATED PATIENT**

The patient's cognitive abilities, rather than a specific blood alcohol level, should be the basis upon which psychiatric assessment begins.

## MEDICATIONS

In response to Task Force inquiries of emergency physician's in Illinois, we found that they generally do not endorse standard medications for psychiatric patients. The American College of Emergency physicians do make limited recommendations for agitated patients who may or may not have a psychiatric illness such as the use of benzodiazepines (lorazapam or midazolam) and/or an oral antipsychotic (risperidone) for agitated and cooperative patients.[34]

**RECOMMENDATIONS REGARDING MEDICATIONS**

Psychiatrists on the task force and with substantive experience in managing the acutely decompensated psychiatric patient report using the following medications:

- Acutely agitated (non-psychotic) patients - oral benzodiazepine
- Acutely agitated (not psychotic) and uncooperative with oral medications - IM benzodiazepine
- Acutely agitated, psychotic, cooperative - dissolving oral antipsychotic (Zyprexa Zydis or Risperdal M tabs)
- Acutely agitated, psychotic, uncooperative - injection of Zyprexa IM or haldoperidol IM

- Psychiatric history, without agitation but with other presenting symptoms such as irritability or anxiety - benzodiapine for anxiety or antipsychotic for psychotic symptoms

Finally, the Task Force notes that the use of benztropine whenever haloperidol is given to reduce the possibility of a dystonic reaction. Although the occurrence rate is low, it can be such an unpleasant experience for the patient that it may discourage them from future medication use.

## EMERGENCY PSYCHIATRIC EVALUATION

The American Psychiatric Association in 2006 adopted "Practice Guidelines for the Psychiatric Evaluation of Adults"[35] which set forth parameters of practice for several different types of psychiatric evaluations and examination, including the emergency psychiatric evaluation. The guideline notes that there are several specific approaches to the emergency psychiatric evaluation, and that they include the following:

"1. Assess and enhance the safety of the patient and others."
"2. Establish a provisional diagnosis (or diagnoses) of the mental disorder(s) most likely to be responsible for the current emergency, including identification of any general medical condition(s) or substance use that is causing or contributing to the patient's mental condition."
"3. Identify family or other involved persons who can give information that will help the psychiatrist determine the accuracy of reported history, particularly if the patient is cognitively impaired, agitated, or psychotic and has difficulty communicating a history of events. If the patient is to be discharged back to family members or other caretaking persons, their ability to care for the patient and their understanding of the patient's needs must be addressed."
"4. Identify any current treatment providers who can give information relevant to the evaluation."
"5. Identify social, environmental, and cultural factors relevant to immediate treatment decisions."
"6. Determine whether the patient is able and willing to form an alliance that will support further assessment and treatment, what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary."
"7. Develop a specific plan for follow-up, including immediate treatment and disposition; determine whether the patient requires treatment in a hospital or other supervised setting and what follow-up will be required if the patient is not placed in a supervised setting."

**RECOMMENDATION REGARDING EMERGENCY PSYCHIATRIC ASSESSMENT**

The Task Force agrees with the recommendations of APA regarding the Emergency Psychiatric Assessment.

## THROUGHPUT

According to the Illinois Hospital Association's 2005 Emergency Department Utilization Survey, 59% of Illinois hospitals reported that their throughput times in the emergency department had increased between 2002 and 2004. The average wait time was 163 minutes with a median of 144 minutes, an average increase of 5.4%. According to the report, only 9.6% of hospitals maintain statistics specifically for behavioral health patients, but of those that did, the average turnaround time was 297 minutes. The longest throughput times take place in large urban areas. Also of note is that hospitals that provide psychiatric services reported longer throughputs in the emergency department than those that do not provide services. The Hospitals with inpatient psychiatric services reported an increase in throughput time in the emergency department of 11%.

The largest reported influencing factor for increases in throughput time was difficulty in finding placement, including placement at State Operated Hospitals (SOH). Reporting hospitals also cited increases in total patient volume and behavioral health volume; insufficient staffing in the ED; and procedures instituted with Screening Assessment and Support Services (SASS) and Crisis and Referral Entry Services (CARES) systems, a state-mandated prescreening program for youth.

As this survey and experience would indicate, increased ED throughput time is related to both extrinsic and intrinsic factors. Many of the extrinsic factors in our environment, such as a lack of sufficient substance abuse facilities or insufficient inpatient acute psychiatric beds, confound our ability to expedite a disposition for the psychiatric patient. Yet, if we are to deliver patient centered care that recognizes the essential connection between mental and overall health, we must address disparities between mental and physical health. Differences in throughput or wait times in the ED for psychiatric, substance abuse and other medical patients is a disparity that is worthy of our attention and study.

To improve care, we need to measure and evaluate care processes. The ability to measure the elements in the ED processes, including the timelines of care, will enable us to create benchmarks against which to evaluate performance. We are not aware of standardized metrics regarding the elements in the ED process or the timelines of care. Regulatory bodies such as the Centers for Medicare and Medicaid Services are interested in rewarding performance, and the Joint Commission is developing core measures, including patient flow standards that will eventually provide metrics (see Joint Commission standard LD3.15 10). But, there are none against which we are currently being evaluated at the present time.

**RECOMMENDATIONS REGARDING THROUGHPUT**

In the interest of creating a seamless system of care for all of our patients, the Task Force recommends that hospitals measure and evaluate the variance in throughput for psychiatric and other medical patients, in order to better understand those factors contributing to longer lengths of stay in the ED and to determine ways in which throughput can be improved.

## STAFFING MODEL

Larger hospitals with a significant number of psychiatric presentations have dedicated psychiatric staff to assess and treat patients within the emergency department. The Task Force recognizes that facilities in rural areas as well as those with low psychiatric presentations, may consider alternate forms of treating the psychiatric patient that presents to the emergency department. Many of the facilities utilize non-medical staff, such as emergency department social workers or use a licensed mental health professional for consultation services. It is not uncommon for facilities to employ a combination of approaches when caring for psychiatrically ill patients. For example social worker may be on duty for 16 hours per day and a consultant on call for the remaining 8 hours. Although none of the facilities the Task Force surveyed utilized a mobile assessment team, the concept is a viable one and is successful in other areas either in lieu of or as an adjunct to emergency department care or as a mechanism to prevent emergency department presentations by linking the patient directly from the community to the proper level of care. When considering the needs of the state of Illinois, the Task Force found the following table to be a reasonable guideline.[36]

**Table 4**

Models of Emergency Psychiatric Services to Emergency Departments

| | Staffing cost | Hospital size | Mental Health take early responsibility | Acceptance by ED staff | ED staff mental health skills |
|---|---|---|---|---|---|
| Consultation model CAT or CL Service | + | <250 beds | No | + | +++ |
| ED based mental health nurses | ++ | 250-500 beds | No | ++ | ++ |
| Psychiatric Emergency Centre | +++ | >500 beds | Yes | +++ | + |

CAT – Crisis and Assessment Team, CL – Consultation Liaison, ED – Emergency Department
+, low; ++, medium; +++, high

*Source: Frank, R., Fawcett, L. & Emmerson, B. (2005). Development of Australia's first psychiatric emergency centre. Australasian Psychiatry. 13(3):266-272.*

One large urban facility commented that although their bed size was over 500, their psychiatric presentations were far lower than most urban hospitals. They cautioned that percentage of psychiatric presentations should also be considered when determining the appropriate model and space for each facility. The Task Force does not consider bed numbers to be an absolute guideline. Each facility needs to factor in their unique characteristics. For example, downstate hospitals may draw from a broader geographic area, that combined with a Level I or Level II trauma level designation of the facility may indicate a model that differs from what is recommended by the corresponding bed size.

**RECOMMENDATIONS REGARDING STAFFING**

Facilities with significant psychiatric presentations should consider dedicated, psychiatrically trained staff.

## PHYSICAL SPACE

No matter the size or location of the facility, patient safety, privacy and comfort should be paramount in the psychiatric emergency department. Most emergency departments struggle with lack of patient privacy. Proximity of bays or rooms, overflow patients in half-beds in corridors all contribute to not only lack of privacy but an environment that exacerbates some patients' illness.

Some psychiatric patients are vulnerable to the environment of the waiting room. Often crowded, noisy and sometimes chaotic, the waiting room can aggravate psychiatric symptoms. Although most facilities report trying to place agitated patients into a room immediately, a quiet room or separate waiting area for psychiatric patients is ideal. In an article in the *International Journal of Mental Health Nursing*, Timothy Wand cautions that we should take care not to "generate the impression of a segregated system of healthcare that further stigmatizes mental health" by completely separating the psychiatric component from the emergency department.[37] However, providing "special care areas" within the emergency department for those in need is optimal. One hospital calls their dedicated psychiatric rooms "SNUs" – Special Needs Units, and another hospital has both a separate low stimulus waiting area available as well as a "family friendly" interview room.

With time in the ED increasing, comfort is a concern. Many facilities report throughput of well over 8 hours with the patient in a stark environment. Although most emergency departments are built for function and leave little room for ambiance, psychiatric rooms typically are even more austere by virtue of patient safety concerns. Most rooms contain only a bed – which often is fixed to the floor- and little else. It is important to consider what effect 8 hours in this environment will have on the patient. Some facilities report soft murals or subdued colors and decorative border trim in the rooms. One facility has an enclosed television in the room for the patient, and another has a small table and chair fixed to the floor in the corner of the room. This allows the patient an alternate to the bed/gurney in order to take a meal at the table or sit with staff to fill out paper work. Any furniture that does go into the room should be stationary and not pose any type of potential physical harm to the patient.

Sometimes it may be possible to prevent an inpatient psychiatric admission by stabilizing the patient psychiatrically. For example, there could be beds devoted to a 24-48 hour stay for crisis stabilization and linkage to appropriate level of care. It is imperative that the physical space be designed to effectively care and treat these patients while maintaining their safety; and the environment should be soothing and supportive.

## SAFETY CONCERNS

Keeping a patient safe from harm is our obligation; however, doing so may require the use of restraints or seclusion when a patient is at risk of immediate physical harm to himself or to others. These devices only should be considered when all other less restrictive alternatives have been considered and applied by staff trained in their safe use, pursuant to federal and state law. It is essential that each facility have the means to safely contain an agitated patient, ideally, in, a room which can function as a seclusion room, if necessary. If this physical space is not possible, a patient room/area should have a stationary or fixable bed and ensure privacy.

In addition to the staff that evaluates the patients, facilities may utilize security or public safety officers to monitor the safety of patients in the emergency department. Smaller facilities that lack sufficient security support may rely on local police to assist with violent patients. Some areas also rely on specially trained police officers (e.g. Crisis Intervention Teams) to assess disturbances in which a mentally ill individual may require evaluation. Emergency departments should work closely with hospital security and local police to establish protocols regarding the care of psychiatric patients and to maintain the safety of staff. Psychiatric rooms and/or staff should have panic alarms to summon emergency help. In order to deter elopement, psychiatric rooms and patients should not be housed near entrances/exits and should be in the direct line of sight of the nursing station, if not separately staffed.

In summary, the Task Force recognizes each hospital is as unique as is its needs. Specially trained staff and dedicated space would be the ideal for the care of the psychiatric patient in the emergency department. Wherever this is not achievable, at a minimum, the model should include the assurance of patient privacy, comfort and safety; qualified staff; and space that may range from a flexible room to an area specifically designed for psychiatric patients. Bed size is a fair predictor of needs, but when considering the impact psychiatric patients presenting to the emergency department will have on resources, it is just as pertinent to consider the number of psychiatric admissions, what types of mental health services are provided and the complexity of associated responsibilities.

### RECOMMENDATIONS FOR PHYSICAL SPACE, PATIENT SAFETY, AND COMFORT

The physical space should be soothing and supportive, promote healing and help to deescalate agitated and psychotic patients.

For circumstances in which there is a question whether the patient meets medical necessity criteria for inpatient admission, provide special areas in the ED, or in an alternative location, in which that patient can remain from 24-48 hours for crisis stabilization and linkage to the appropriate level of treatment.

## A D D I T I O N A L  R E C O M M E N D A T I O N S

Related to the Care of the Psychiatric Patient in the Emergency Department

**REFERRAL SOURCE GUIDE**

The Task Force recommends every hospital maintain a comprehensive Referral Source Guide which contains at a minimum:

- Other area hospitals, including levels of treatment available
- Area treatment centers (such as substance abuse, psychiatric clinics), including diagnoses and populations they serve
- Area clinicians – discipline, specialty
- Community Centers
- State Operated Facilities
- Other resources – Pastoral care, self-help groups, NAMI consumer guides

Notations for each should include details such as ages served, diagnoses served, accepted funding sources, “catchment area” or network information, etc. Although local and state agencies do publish directories, the Task Force recommends each hospital maintain this smaller, readily available resource manual that details their respective area in a quick and concise manner.

Related to Staff

## STAFF QUALIFICATIONS

According to American Psychiatric Association standards and The Illinois Mental Health and Developmental Disabilities Code, psychiatric evaluations must be conducted by Licensed Independent Mental Health Practitioners/"qualified examiners".[38] The IHA Emergency Department Utilization Survey revealed that most emergency departments that have access to staff trained in behavioral health typically utilize Licensed Clinical Social Workers (82.5%). All EDs have physicians and registered nurses; however, access to 24 hour behavioral health professionals is much more limited in hospitals that do not provide inpatient psychiatric services. Less than one – fifth of these providers have 24 hour access to trained mental health personnel.[39] Not surprisingly, lack of psychiatric staff can contribute significantly to overall length of stay.

## MEDICAL EMERGENCY DEPARTMENT STAFF EDUCATION

In reviewing the Graduate Medical Education Guidelines for Emergency Medicine, minimal training in psychiatry is present. Most facilities with dedicated psychiatric staff find the medical emergency department staff has limited interaction with psychiatric patients as there is no need to hone these skills with trained personnel immediately available.

Surveyed hospitals reported few psychiatrically focused presentations, educational sessions, or professional consultations for the emergency department staff. Academic medical centers reported few grand rounds on psychiatric presentations in the emergency department, but those that did occur were not attended by emergency department staff. Wright et. al. found that emergency department staff members with more training or "a personal connection to someone with a psychiatric problem increased the staff members subjective understanding of a mental health patient's needs."[40] One urban academic medical center utilizes an Advance Practice Nurse as clinical coordinator within the emergency department. Via patient coordination, this position provides both formal and informal education for the emergency department staff as well as fostering the relationship between the medical emergency department staff and the dedicated psychiatric staff. Wright would contend that the improved relationships would change the organizational climate, thereby enhancing the emergency department staff's positive perception of their working environment. The authors found that "work group cooperation and facilitation emerged as the strongest predictor of more clinical involvement" with psychiatric patients.[41]

**RECOMMENDATIONS REGARDING STAFF QUALIFICATIONS, EDUCATION AND TRAINING**

Depending upon the model of service in use, if a hospital does not have dedicated, psychiatrically trained staff, the emergency department physicians, medical staff, and nursing staff need substantive training regarding psychiatric patients. This may include bringing in outside consultants to provide the training and education. The task force also recommends on-going continuing education for all medical and nursing staff in the ED staff regarding the care of the psychiatric patient

## C O N C L U S I O N

Future Research and Best Practices Development

This paper did not consider legal issues associated with medical screening and stabilization under EMTALA or Mental Health Code requirements related to such issues as involuntary treatment or admission. It also did not address issues related to financing of ED services, which are significant, given the large number of ED patients who are uninsured or whose care is covered by public payors at below the cost to deliver it.

The Task Force recommends additional work be done to address the needs of older adults, and child and adolescent patients in the ED. We also recommend that attention be given to emerging technologies that are available to improve access to care, patient throughput, staff communication about patients in the ED, medication management and patient information in general. We are experiencing the rapid adoption of information and other patient technologies that promise new efficiencies and safer, evidence-based care. Electronic message boards in the ED, for example, provide up to the minute information about a patient's status, lab tests ordered, their status, and the time in which the patient has been in the ED. The use of telemedicine can bring psychiatrists and mental health professionals with special skills to rural communities, as well as to settings in which patients do not speak English or have physical handicaps.

And finally, the best practice is that which delivers safe, effective, and compassionate care.

# A P P E N D I X  A

## Psychiatric Medical Clearance Checklist

| | Yes | No |
|---|---|---|
| 1. Does the patient have new psychiatric condition? | ☐ | ☐ |
| 2. Any history of active medical illness needing evaluation? | ☐ | ☐ |
| 3. Any abnormal vital signs prior to transfer | ☐ | ☐ |

Temperature >101°F
Pulse outside of 50 to 120 beats/min
Blood pressure systolic <90 or>200; diastolic >120
Respiratory rate >24 breaths/min
(For a pediatric patient, vital signs indices outside the normal range for his/her age and sex)

| | | |
|---|---|---|
| 4. Any abnormal physical exam (unclothed) | ☐ | ☐ |

a. Absence of significant part of body, eg, limb
b. Acute and chronic trauma (including signs of victimization/abuse)
c. Breath sounds
d. Cardiac dysrhythmia, murmurs
e. Skin and vascular signs: diaphoresis, pallor, cyanosis, edema
f. Abdominal distention, bowel sounds
g. Neurological with particular focus on:
   i. ataxia
   ii. pupil symmetry, size
   iii. nystagmus
   iv. paralysis
   v. meningeal signs
   vi. reflexes

| | | |
|---|---|---|
| 5. Any abnormal mental status indicating medical illness such as lethargic, stuporous, comatose, spontaneously fluctuating mental status? | ☐ | ☐ |

**If no to all of the above questions, no further evaluation is necessary. Go to question #9**
**If yes to any of the above questions go to question #6, tests may be indicated.**

| | | |
|---|---|---|
| 6. Were any labs done? | ☐ | ☐ |
| 7. What lab tests were performed? _____ | | |
| What were the results? _____ | | |
| Possibility of pregnancy ? | ☐ | ☐ |
| What were the results? _____ | | |
| 8. Were X-rays performed? | ☐ | ☐ |
| What kind of x-rays performed? _____ | | |
| What were the results? _____ | | |
| 9. Was there any medical treatment needed by the patient prior to medical clearance? | ☐ | ☐ |
| What treatment? _____ | | |
| 10. Has the patient been medically cleared in the ED? | ☐ | ☐ |
| 11. Any acute medical condition that was adequately treated in the emergency department that allows transfer to a state operated psychiatric facility (SOF)? | ☐ | ☐ |
| What treatment? _____ | | |

12. Current medications and last administered? _____
13. Diagnoses: Psychiatric_____
Medical_____
Substance abuse_____
14. Medical follow-up or treatment required on psych floor or at SOF: _____
15. I have had adequate time to evaluate the patient and the patient's medical condition is sufficiently stable that transfer to ___SOF or ___ psych floor does not pose a significant risk of deterioration. (check one)

_____MD/DO
Physician Signature

# A P P E N D I X  B

The Massachusetts College of Emergency Physicians and the Massachusetts Psychiatric Society in 2003 developed consensus guidelines on the components of the medical clearance exam. We present it verbatim and in its entirety:

## The Medical Clearance Exam

1. There was general agreement by task force members that the term medical clearance may convey unwarranted prospective security regarding the absence of any prospective medical risks. However, given the deeply ingrained use of the term, task force members felt it would not be possible to eliminate its use or introduce an alternative term.

2. Medical clearance reflects short term but not necessarily long term medical stability within the context of a transfer to a location with appropriate resources to monitor and treat what has been currently diagnosed.

3. Any patient with psychiatric complaints who is examined by the emergency physician should be assessed for significant contributing medical causes of those complaints. Medical clearance of patients with psychiatric complaints in an emergency facility should indicate that:

- within reasonable medical certainty, there is no known contributory medical cause for the patient's presenting psychiatric complaints that requires acute intervention in a medical setting;
- within reasonable medical certainty, there is no medical emergency;
- within reasonable medical certainty, the patient is medically stable enough for the transfer to the intended dispositional setting (e.g. a general hospital, a psychiatric hospital, an out patient treatment setting or no follow-up treatment);
- the emergency physician who has indicated medical clearance shall, based on his or her examination of the patient at that point in time, indicate in the patient's medical record the patient's foreseeable needs of medical supervision and treatment. This information will be used by the transferring physician who will make the eventual disposition of the patient (See item # 13).

4. Medical clearance does not indicate the absence of ongoing medical issues which may require further diagnostic assessment, monitoring and treatment. Neither does it guarantee that there are no as yet undiagnosed medical conditions.

5. Task force members agreed to make reference to and use of the EMTALA definition of the medical screening and stabilization exam. By that definition, transfer of a patient requires that the patient be medically stable for transfer or that the benefits of transfer outweigh the risks.

6. No consensus in the literature was found that delineated a proven, standardized approach to the evaluation and management of psychiatric patients requiring medical evaluation in the emergency department. There was general agreement, based on clinical experience, to establish Criteria for Psychiatric Patients with Low Medical Risk.

7. The Criteria for Psychiatric Patients with Low Medical Risk recommended by the task force included:
- Age between 15 and 55 years old
- No acute medical complaints
- No new psychiatric or physical symptoms
- No evidence of a pattern of substance (alcohol or drug) abuse
- Normal physical examination that includes, at the minimum:

- a. normal vital signs (with oxygen saturation if available.
- b. normal (age appropriate) assessment of gait, strength and fluency of speech
- c. normal (age appropriate) assessment of memory and concentration

8. A typical physical examination in the emergency department is focal, driven by history, chief complaints and disposition, and is not a replacement for a general, multisystem physical examination. The extent of the physical examination performed on a psychiatric patient by the emergency physician should be documented in the patient's medical record.

9. It was agreed and recommended that routine diagnostic screening and application of medical technology for the patient who meets the above low medical risk criteria is of very low yield and therefore not recommended.

10. Patients who do not meet the low medical risk criteria are not automatically at high medical risk. For patients who do not meet the low medical risk criteria, selective diagnostic testing and application of medical technology should be guided by the patient's clinical presentation and physical findings.

11. Once a patient has been medically cleared and accepted by the receiving facility, the receiving facilities may nevertheless request that the emergency department initiate laboratory tests (e.g. drug levels, renal function etc.) only if such tests will facilitate the patient's immediate care at the receiving facility. However, awaiting the results of these lab tests should not delay the transfer process.

12. It was agreed that during a psychiatric patient's medical assessment, the decision of when to begin the patient's psychiatric evaluation should be a clinical judgment. The psychiatric component of a patient's emergency department evaluation should not be delayed solely because of the absence of abnormality of laboratory data.

13. When crisis or inpatient psychiatric treatment is recommended for a patient who has been cleared by an emergency physician, the transferring physician should consider:

- a. the patient's anticipated needs for medical supervision and treatment as outlined in the medical record by the examining emergency physician and
- b. the medical resources available at an intended receiving psychiatric facility. The receiving facility's medical resources should be accurately represented to the transferring physician by a qualified professional of the receiving facility.

14. To facilitate the transferring physician's choice of an appropriate inpatient psychiatric facility, the task force recommends the development of a list of New England psychiatric

units indicating the respective availability of concurrent medical care, nighttime and weekend medical coverage, locked and unlocked beds and separate and concurrent substance abuse treatment.

15. In the event that transfer to a crisis or inpatient psychiatric facility is recommended, it is often desirable to have direct communication between the transferring physician and the psychiatrist accepting the transfer at the receiving facility.

- a. Prior to having accepted a medically cleared patient for transfer, a potential receiving facility's request for additional diagnostic testing of the patient should be guided by that individual patient's clinical presentation and physical findings and should not be based on a receiving facility's screening protocol. (See paragraphs 6 - 10)
- b. After having accepted a medially cleared patient for transfer, a receiving facility may request that the emergency department initiate laboratory tests (e.g. drug levels, renal function etc.) only if such tests will facilitate the immediate care at the receiving facility. Awaiting the results of these laboratory tests should not delay the transfer process.

16. Task force members felt that direct physician to physician communication was required to resolve concerns arising between the transferring physician and the receiving facility regarding:

- a. the need for an inpatient psychiatric hospitalization;
- b. the appropriateness of one facility versus another;
- c. a request for certain diagnostic testing;
- d. any general clinical disagreement;
- e. significant ongoing medical issues or treatment recommendations.

17. In view of the focal nature of the emergency physician's medical assessment and clearance, task force members strongly recommend that all psychiatric patients transferred to an inpatient facility be considered for a timely, comprehensive medical evaluation during the course of their hospitalization.

**Massachusetts College of Emergency Medicine and Massachusetts Psychiatric Society Consensus Statement, 2003**

## A P P E N D I X C

The Six Aims of Quality Healthcare [42]

The Institute of Medicine has identified six aims for improvement in quality of healthcare delivery:

Safe - avoiding injuries to patients from the care that is intended to help them
Effective - providing services based on scientific knowledge
Patient-centered - providing care that is responsive to individual patient preferences, needs and values, assuring that patient values guide all clinical decisions.
Timely - reducing wait and sometimes harmful delays for both those who receive care and those who give care
Efficient - avoiding waste, including waste of equipment, supplies, ideas and energy
Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status

The Quality Chasm's Ten Rules to Guide the Redesign of Health Care [43]

1. Care based on continuous health relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.
2. Customization based on patient needs and values. The system of care should be designed to meet the most common types of needs but have the capability to respond to individual patient choices and preferences.
3. The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. Evidence-based decision making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. Anticipation of needs. The health system should anticipate patient needs, rather than simply reacting to events.
9. Continuous decrease in waste. The health system should not waste resources or patient time.
10. Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

## A P P E N D I X  D

The following statistics were considered during discussions and writing. They are excerpts from NAMI fact Sheet "Mental Health: An Important Public Health Issue – Know the Facts" revised January 2006.

National Statistics

- 62.5 million Americans (22.2%) experience some form of mental disorder each year
- 8.76 percent of the US population have a severe mental Illness
- More than 50% of adults and 70-80% of Children are not receiving any treatment for their mental illness
- Between 85 and 90% of adults with severe mental illness end up unemployed
- Mental illness accounts for more than 15% of the overall burden of disease from all causes (slightly more than that of cancer
- By the year 2020, depression alone will be the third leading cause of disability worldwide
- Nationally, the direct treatment costs in 1997 were estimated at 150 billion, the estimate for 2005 is 200 billion
- The average annual growth for national healthcare expenditures from 1986-1996 was 8.3%, for mental health 7.2%
- The cost of treating serious mental illness is comparable to the cost of treating many other chronic medical conditions.
- For every $1 spent on mental health services, $5 is saved in overall healthcare costs

State Statistics

- Illinois ranks 32$^{nd}$ nationally in per capita spending on treatment for mental illness ($63.54 per person annually)
- In Illinois, the direct and indirect cost of mental illness totals more than 2.6 billion a year
- Nearly 1 million Illinoisans had a severe mental illness during the past year. The conservative estimate is that 7.7 percent of Illinois adults, or more than 700,000 had a severe mental illness during the past year
- An estimated 720,000 Illinois residents have been homeless at some point. A conservative estimate is that at least 140,000 of these individuals suffer from a severe mental illness
- 90 percent of suicides are the result of mental illness and among youths 15-24, suicide is the third leading cause of death

## A P P E N D I X  E

| Name/Location | A | B | C |
|---|---|---|---|
| Description of Space | 28 beds, plus 3 in extended care, 2 trauma bays and multiple half beds as needed. Psych has 2 dedicated beds after patients are medically cleared and use nearby ED bays for overflow. Psych also has a separate low-stimulus waiting room and a private interview room. | Does not have dedicated space for psychiatric patients in the ED. Covered by residents day and night with back up by attending during day. Social work is provided by ED social worker | 2 psych rooms near nursing station. Patients triaged along with other patients; on 1-5 scale, psych usually triage just 3 |
| **Psych Patients** | | | |
| Where are patients housed prior to evaluation | Main ED waiting room, unless the psych low stimulus waiting room is indicated, ED med waiting medical clearance | In ED beds like other patients | In general they're housed anywhere from exam room to hallway.<br>Seen by triage nurse |
| For evaluation | Some evaluations occur bedside in main ED, psych beds, or psych interview room (Psych evals are started as soon as possible and can take place in any of these areas so long as privacy is maintained, even if med clearance is not established yet | Same as above | Seen by MD and psych social workers |
| After evaluation | Same as above | Same as above | Psych social worker monitors patient |
| Care while waiting | Any care necessary, while in main ED, care is directed by ED RNs, after cleared, psych RNs direct care | Triage, physical exams, laboratory, psychiatric assessment and intervention if this can be accomplished by the resident along with disposition | Medication |
| Meds given – psych and/or medical | Yes to both. ED RNS will give psych meds after consultation with Psych | Both | Yes |
| General care – food, shower | Pts get food in the general ED, psych also has access to general foods (turkey sands, juices, ginger ale, crackers) if pt is there during a meal time, trays are ordered. Bathrooms are adjacent to psych area. Showers are available for those with poor hygiene and those who need medical txs such as Kwell. | Yes – Meals & Shower | Meals provided<br><br>Showers |

| CD Patients | A | B | C |
|---|---|---|---|
| Where are patients housed prior to evaluation | Same as above, Intoxicated patients may go directly to an ED bed if medical condition or level of agitation warrants | Same as above | Same as above |
| For evaluation | Same but evaluation only occurs once patient is sober enough to actively participate | Same as above | Same as above |
| After evaluation | Same as above | Same as above | Same as above |
| Care while waiting | Same | Same as above | Same as above |
| Meds given – psych and/or medical | Same | Same as above | Same as above |
| General care – food, shower | Same | Same as above | Same as above |
| Patient Mix (ages, diagnoses, insured, CD prevalence | Most are adults; rare occasion may get adolescent or child, large amounts of unfunded patients and Medicare/Medicaid. Also get insured that require percent. | Estimate is probably similar to entire ED 66% public aid and Medicare; 33% commercial | Mostly insured with Medicaid growing<br>Mostly adults<br>CD in 40% of cases |
| Number of patients, percentage of psych presentations (if available | 681 patients present to Psych ED March-May in 2006. Currently ED seeing an average of 232 (+/-38) patients per day. (roughly 3-4% psych patients) | | 80,000 ED presentations per year<br>8-10% Psych CD |
| Type/level of education of staff | All psych RNs and Counselors are master's level. Many RNs are certified in adult psychiatric nursing. During the daytime M-F Psych ED has attending psychiatrist, after hrs and on weekends, Psych ROC sees patients. | MD, Resident | All staff are licensed social workers or LCPC |
| Staffing | 2 RNs or RN and counselor. Most staff work 12 hour shifts which aids in continuity. Clinical Coordinator works 8 hrs M-F to help coordinate tx | See above | Staffed 24/7 |
| Like to see in ER | Larger area, at least 2 more beds and better work space – machines have taken over (fax, copier, Electronic medical records require computers and COWs (computer on wheels) for bedside... | Dedicated staff, better physical space for security and privacy | Dedicated psych area for psych patients/Psych ED |

| Name/Location | D | E | F |
|---|---|---|---|
| Description of Space | 20 beds | 26 rooms available, 24 hrs a day<br>Fast Track available with 5 rooms available from 0900-0200<br>Four rooms designated for psychiatric patients-these rooms adjacent to trauma rooms and next to ambulance entrance | Comprehensive ED with 9 beds |
| **Psychiatric Patients** | | | |
| Where are patients housed prior to evaluation | Psychiatric patients put in a cubicle close to the nurse's station so they can be visualized | ED waiting room for triage<br>Once triaged one of four psychiatric rooms or another room | In assigned room within the ED throughout the process |
| For evaluation | Stay here during entire stay<br>ARC interviews all suicidal ideation/attempts | Patients wait in ED room | Same as above |
| After evaluation | Same | Same as above | Same as above |
| Care while waiting | Physical and emotional Security to stand by on suicidal and violent patients | Patients receive a medical screening evaluation by medical MD or PA; Psychiatric evaluation by assessment and referral team (all psych certified); RNs assist with care as do ED techs; care includes labs, xrays, meds; Security may be involved | Treated by an MD and RNs, provide evaluation, medical screening and any urgent intervention |
| Meds given – psych and/or medical | Medication and food as needed | Yes ED physician orders all | Yes if indicated and ordered by the physician |
| General care – food, shower | Restraints rarely used, personal needs monitored and addressed per policy | Food is often provided, shower is available | Meals are provided, clothing if necessary |

| Name/Location | D | E | F |
|---|---|---|---|
| **CD Patients** | | | |
| Where are patients housed prior to evaluation | Same as above | Same as above | Same as above |
| For evaluation | | Same as above | Same as above |
| After evaluation | Same as above | Same as above | Same as above |
| Care while waiting | Same as above | Same as above | Same as above |
| Meds given – psych and/or medical | Same as above | Same as above | Same as above |
| General care – food, shower | Same as above | Same as above | Same as above |
| Patient Mix (ages, diagnoses, insured, CD prevalence | Limited volume of psychiatric patients | | For psychiatric patients we see adults 18 and over; about 24% are self pay |
| Number of patients, percentage of psychiatric presentations (if available | | Calendar year 2005, ED volume 56, 586 with 7.5% psychiatric diagnosis; So far this year percentage of psychiatric patients has risen to 8.4% | Over a 6 month period less than 1% of the patients were referred for a psychiatric evaluation |
| Type/level of education of staff | Emergency room physicians for professional evaluation ARC staff are LCPCs, LCSWs, PhDs and MDs | ED physician, ED RN, assessment and referral staff (Bachelors and Masters psychiatric professionals), ED tech, security | MD, RN, LSW, LCSW, and consultation from the Community Mental Health Center (LCSW, LCPC) |
| Staffing | | | 24/7- 2 RNs, 1 Physician |
| Like to see in ER | Rarely encounter patient flow problems in the ED | Better space for care of these patients, more secure environment not near an exit; dedicated psychiatric staff | Seclusion room in the ED for prisoners and the occasional psychiatric patient |

| Name/Location | G | H | I |
|---|---|---|---|
| Description of Space | Adult emergency services has 3 major areas: an observation area, asthma resuscitation area , ob/gyn fast track, AES accommodates 74 stations and has 130,000 visits a year | | Health system has 3 separate EDs, each of these contains a room that can be used for psychiatric patients. Will refer to as H1, H2, and H3. |
| **Psychiatric Patients** | | | |
| Where are patients housed prior to evaluation | In ER ASC and on the medical floors | | Prior to evaluation, upon registration taken to an individual room and assigned a public safety watch (security) |
| For evaluation | Same as above | | Same as above |
| After evaluation | | | If patient is not acute risk, public safety can be cleared by crisis worker in collaboration with ED staff |
| Care while waiting | Medical, psychiatric and social services, telephone, TV, food, beverages, health care delivery may be given by RNs, PCAs, MDs and specialty consultants | | |
| Meds given – psychiatric and/or medical | Patients receive psychotropic medications, may also receive IV fluids, antibiotics and others as indicated per medical conditions | | Both – as needed |
| General care – food, shower | See above | | Food available, no shower |
| **CD Patients** | | | |
| Where are patients housed prior to evaluation | Same as above | | Same as above |
| For evaluation | Same as above | | Same as above |
| After evaluation | Same as above | | Same as above |

| Name/Location | G | H | I |
|---|---|---|---|
| Care while waiting | Same as above | | Same as above |
| Meds given – psych and/or medical | Same as above | | Same as above |
| General care – food, shower | Same as above | | Same as above |
| Patient Mix (ages, diagnoses, insured, CD prevalence | All SES and cultures range from 18 to over 60. Majority have dual diagnosis and are uninsured | | |
| Number of patients, percentage of psychiatric presentations (if available) | For July 2006 506 patients were evaluated; 336 patients had psychiatric presentation and dual diagnosis; 170 presented with primary alcohol without another psychiatric disorder | | H1 had a mean number of visits per month about 170; H2 65; H3 27 |
| Type/level of education of staff | MD, DO, PCLN (RN BSN to Doctorate), MHW (BA/BS to Masters), LCSWs with certifications, PA and med students | | Crisis staff are either LSW, LCSW or LCPC; Review cases with the ED physician and psychiatrist on call as indicated; ED nurses provide general nursing care |
| Staffing | | | Crisis staff available 24/7; on call for weekends, night shifts and holidays; regular FTEs are located at each hospital, medical social work covers day shift during the week, all others are on call |
| Like to see in ER | An additional PCLN or psychiatric APN; increased privacy-patients in their own rooms | | Need for more space that is separated from general population; even though each bay is private would be ideal to have designated psychiatric area at higher volume hospitals |

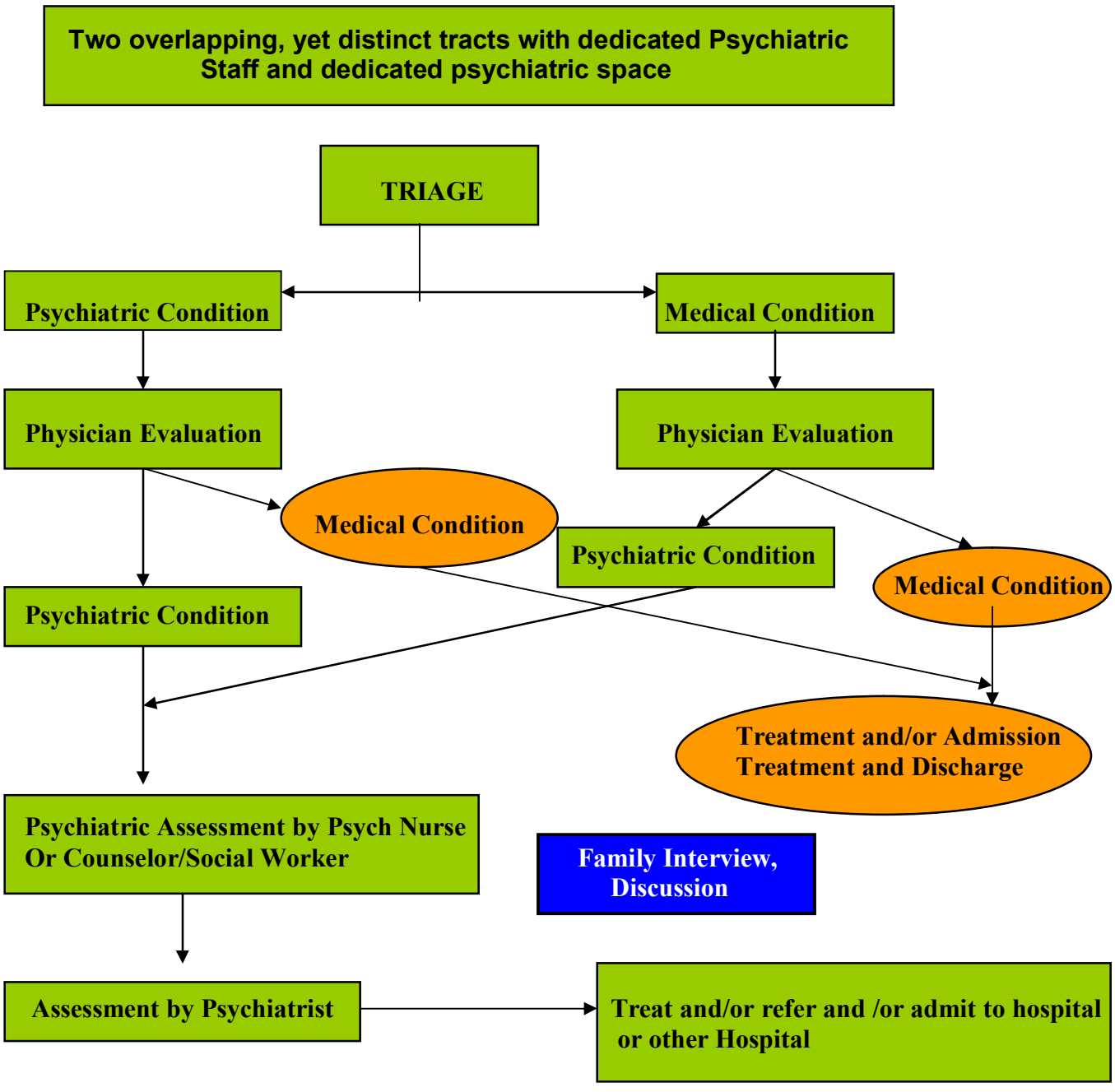
| Name/Location | J | K | L |
|---|---|---|---|
| Description of Space | 20 acute beds; 7 urgent care | 20 beds, 2 beds equipped for psych and CD patients with monitors and locked doors if seclusion and restraints are needed. Pediatric ED has 7 beds and ED annex has 14 beds | Approximately 18 beds in the hospital |
| **Psychiatric Patients** | | | |
| Where are patients housed prior to evaluation | Private waiting room/family room if patient room not immediately available | Patients brought into ED where they stay in mental health rooms or nearby rooms for duration of stay | In a room in the ER along with medical patients (after triage) |
| For evaluation | Private monitored room | Same as above | In the same room, unless an elopement risk or under petition, then a secure/seclusion room |
| After evaluation | Same as above | Same as above | Same room |
| Care while waiting | Meds as needed, labs and other prerequisites, comfort measures | Medical examinations, routine labs, patients who are a danger to themselves or others have a continuous sitter for observation.<br>Psych and CD patients are asked to undress and given gowns to wear to decrease contraband incidents | Nursing staff initially provide triaging, filling out MHDD-5 petitions, coordinate lab testing protocols and obtain limited history regarding reason for visit.<br>Meals and medical care provided. |
| Meds given – psych and/or medical | Both, if needed | As indicated | Yes, as appropriate |
| General care – food, shower | Yes | Offer patient meals, but no showers are available | Yes for food, no for shower. Although able to access restroom and nursing services |
| **CD Patients** | | | |
| Where are patients housed prior to evaluation | Same as above | Same as above | Same as above |
| For evaluation | Same as above | Same as above | Same as above |
| After evaluation | Same as above | Same as above | Same as above |

| Name/Location | J | K | L |
|---|---|---|---|
| Care while waiting | Same as above | Same as above | Same as above |
| Meds given – psych and/or medical | Same as above | Same as above | Same as above |
| General care – food, shower | Same as above | Same as above | Same as above |
| Patient Mix (ages, diagnoses, insured, CD prevalence | | All ages with all types of psychiatric and chemical dependence issues | All ages, predominantly adults-depression, anxiety and psychosis.<br>Most have some form of insurance, including Medicaid and Medicare; smaller portion are indigent.<br>CD prevalence averages 10-15% |
| Number of patients, percentage of psychiatric presentations (if available) | | 350 patients per month | 9625 total for first six months of 2006, of which 194 were psychiatric (approximately 2%) |
| Type/level of education of staff | | Ed Physicians, Staff ED Nurses, Mental Health Liaison Specialist (Psychiatric RNs with 3-5 years experience or Licensed Clinicians) | RNs (most without psych cert) provide triaging, assessments; ED physician conducts initial assessment of mental status and refers to family counseling department for eval by Masters Degree level mental health clinician (MA, MS, LCPC, LCSW, LISW, PsyD, PhD), ER physician completes all MHDD-6 certificates with input from Mental Health Consultation |
| Staffing | Techs, LPNs, RNs, ER Physician, Intake Coordinator from Psych, transition assistance when appropriate | | At least 2 nurses with LPNs, secretary and physician present |
| Like to see in ER | Psych Intake Coordinator staffed in ED | Currently have future plans to expand number of rooms and space that will be used by psychiatric and CD patients | Greater understanding for mental illness in terms of respecting the client in verbal and nonverbal communication |

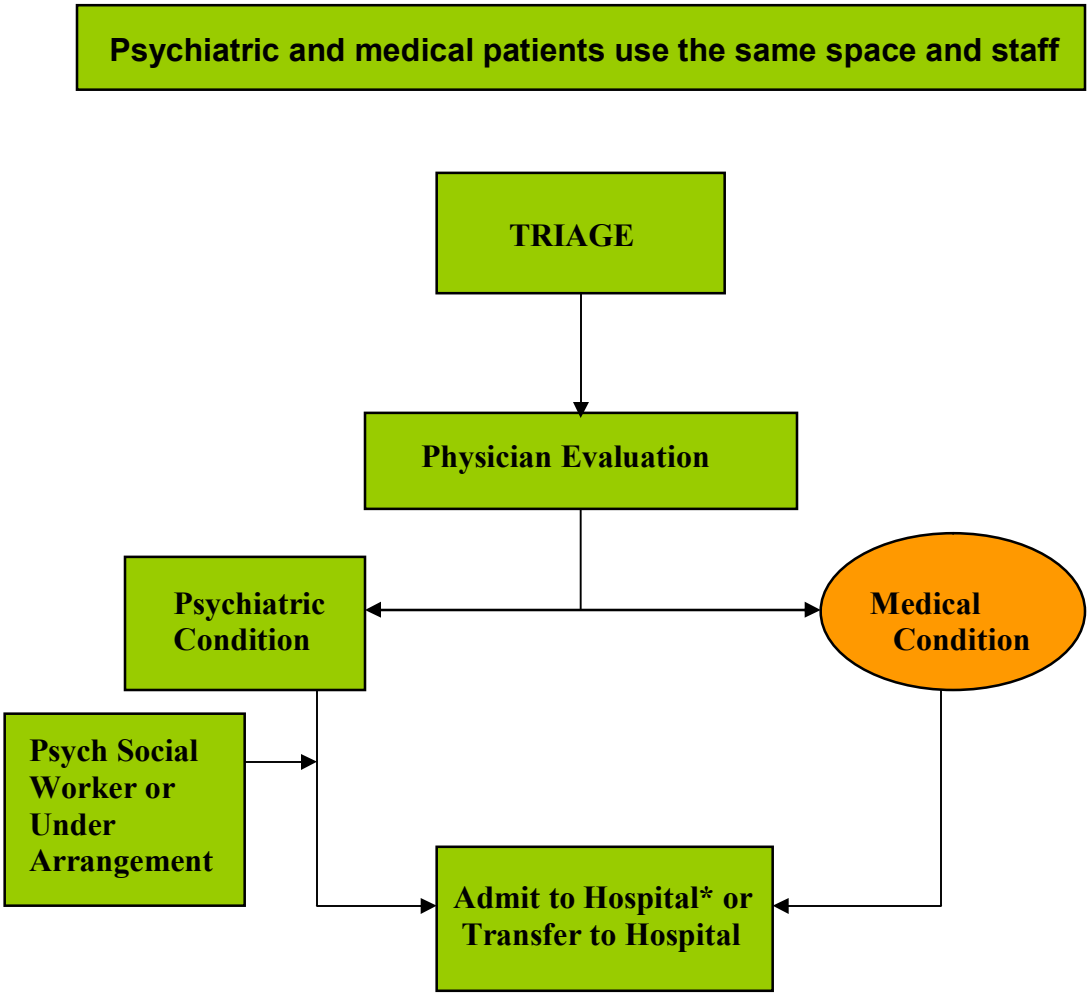
## A P P E N D I X F

MODELS OF EMERGENCY SERVICES

MODEL A: General Hospital with Dedicated Psychiatric Unit

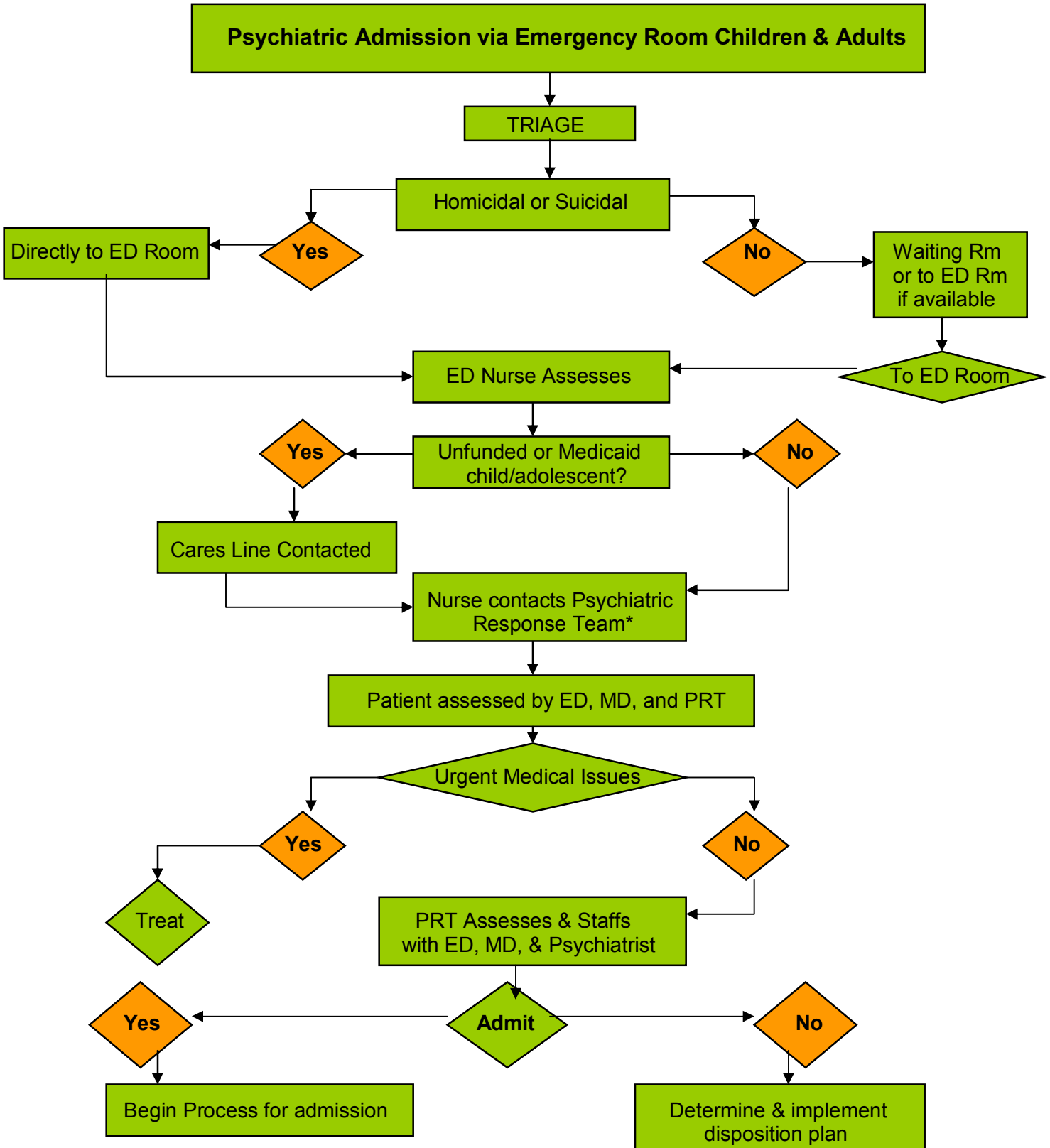


MODEL B: General Hospital without Dedicated Psychiatric Unit or Staff




*Admit up to three days.

MODEL C: Hospital with Dedicated Psychiatric Unit & Dedicated Psychiatric Staff




* PRT also serves as SASS Team & CHIPS team

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