Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature

Created by members of the ACEP Emergency Medicine Practice Committee

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OVERVIEW

Psychiatric patients seeking emergency mental health evaluation, perhaps more than any other patient group, face one of the most complex, and at times labyrinthine processes for treatment and management in the US health care system. Not only is the system complex and at times incomprehensible, secondary to varying state, insurance, and hospital regulations, but patients are left with an ever shrinking system to meet their needs.

Over the past 40 years, services for psychiatric patients have become increasingly deinstitutionalized, shifting away from inpatient facilities. As a result, inpatient beds have dwindled to less than 50,000 nationwide, forcing patients to seek other avenues for treatment, including outpatient facilities, outpatient medical management groups, and community resources. Unfortunately, those resources have also become increasingly constrained by widespread budget cuts, leaving patients with the health care system's last remaining safety net—the emergency department (ED).

Because EDs are seeing increasing numbers of patients, government agencies and hospital administrators have recognized the importance of improving throughput and the quality of care delivered in EDs. For example, the Centers for Medicare and Medicaid Services (CMS) have included several measures that evaluate operational metrics, patient length of stay, and boarding times within the ED. Of those metrics mentioned, psychiatric patient boarding times represent a significant concern for health care professionals, administrators, and regulators.

While many academic researchers and even governmental regulatory agencies such as the Department of Health and Human Services (DHHS) have looked at the issue of boarding, all have identified a relatively common culprit—a mismatch between supply and demand. This simple, yet doomed equation of shrinking psychiatric patient resources with an ever-expanding psychiatric patient population represents the main cause for reduced psychiatric patient capacity in the ED. Not only has the operational capacity within the mental health system decreased, medical clearance and patient disposition have become significantly more complex, with disparate state-by-state regulatory requirements, insurance verifications, and institutional requirements for the management, medical clearance, evaluation, and disposition of patients seeking psychiatric services. As a result, hospital systems, clinicians, and administrators have begun to assess ways to improve the evaluation of psychiatric patients, including streamlining the intake process, reducing variances in care, and improving outpatient services.

In an effort to develop a reference tool and guide for members of the American College of Emergency Physicians (ACEP), the Emergency Medicine Practice Committee summarized relevant, recent literature and reviewed resources from various community entities to address many of the problems facing psychiatric patients in the ED. The following subjects are summarized in this document:

- Evaluation of Psychiatric Patients in the ED
- Medical Clearance of Psychiatric Patients in the ED
- Boarding of Psychiatric Patients in the ED
- Best Practices for Reducing ED Boarding of Psychiatric Patients
- Medical Management of Psychiatric Patients in the ED
- Disposition of Psychiatric Patients from the ED
- Community Resources for Emergency Psychiatric Patients

EVALUATION OF PSYCHIATRIC PATIENTS IN THE ED

Emergency physicians face two difficult challenges when evaluating acutely ill psychiatric patients. One relates to how physicians appropriately manage and accurately assess agitated patients, and the second relates to the difficulty physicians face when treating involuntarily admitted patients. The American Association of Emergency Psychiatry has proposed an assessment algorithm for procedures that should be performed prior to the initial evaluation, including an attempt at de-escalation to facilitate patient participation in the evaluation process. The first step—the initial assessment—is performed to place the patient into one of five categories with an emphasis on identifying patients with delirium. Patients identified with delirium then warrant a detailed medical evaluation and treatment; those placed in any of the four other categories are considered to have a psychiatric concern and require only a brief medical evaluation to rule out acute medical conditions.[1]

Specific statutes that govern the process for involuntary emergency hospitalization for a psychiatric evaluation vary significantly from state to state. In some states, the responsibility lies with law enforcement, while in others, responsibility falls to a medical professional. The Treatment Advocacy Center has compiled a state-by-state list of the relevant regulations and standards for such admissions (http://www.treatmentadvocacycenter.org/legal-resources/state-standards/emergency-hospitalization-for-evaluation). This listing summarizes the crucial provisions of the pertinent statutes and provides advice for emergency physicians who are uncertain of the laws in their state governing the holding of psychiatric patients.[2]

MEDICAL CLEARANCE OF PSYCHIATRIC PATIENTS IN THE ED

Many EDs are required to perform numerous medical clearance tests on psychiatric patients prior to the patient's evaluation by a psychiatrist or psychiatric liaison provider. Multiple articles discuss the latest recommendations regarding medical clearance of the psychiatric patient.

- In 2006, ACEP published comprehensive and definitive guidelines regarding medical clearance of the psychiatric ED patient.[3] The clinical policy makes three summary recommendations regarding medical clearance:
  - For adult ED patients with primary psychiatric complaints, diagnostic evaluation should be directed by the patient's history and physical examination. In such cases routine laboratory testing of all patients is of very little benefit and need not be performed as part of the ED assessment. (Level B recommendation)
  - Routine urine toxicology screens for drugs of abuse in patients who are alert, awake, and cooperative do not affect ED management and should not be performed as part of the ED assessment. Additionally, toxicology screens obtained in the ED for use by the receiving psychiatric facility or service should not delay patient evaluation or transfer. (Level C recommendation).
  - For patients with alcohol intoxication, the psychiatric assessment of the patient should be based on the patient's cognitive abilities, rather than a specific blood alcohol level. ACEP suggests that clinicians consider using a period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves. (Level C recommendation).

- The recommendations promulgated in the ACEP clinical policy were based on a review of the literature prior to 2005 and expert consensus. Several studies and reports published since 2005 have supported these recommendations.

- Parmer et al[4] directly address the issue of mandatory laboratory and radiographic screening studies for psychiatric patients and conclude that "policies that require panels of testing prior to psychiatric admission are costly and appear to be unnecessary."
- In a prospective study of psychiatric ED patients, Amin and Wang[5] conclude that psychiatric patients with "benign histories and normal physical exams have a low likelihood of clinically significant laboratory findings." Other researchers have found that urine toxicology screens do not add significant diagnostic value to all ED psychiatric evaluations.[6]
- In scenarios where alcohol intoxication is a factor, there are limited data demonstrating actual clinical utility of alcohol testing, and research has suggested that blood alcohol levels cannot solely be used to define clinical impairment.[7]

- In order to assist with the identification of psychiatric patients who may require further testing for medical clearance, several screening tools have been developed, but none has been prospectively validated to date.[8-10]

BOARDING OF PSYCHIATRIC PATIENTS IN THE ED

Boarding is a significant problem in emergency medicine. For psychiatric patients, the problem is significantly worse, with psychiatric patients remaining in the ED far longer than medical patients. Research indicates that boarding negatively affects patient quality of care, hospital operations, and the system's finances.

- **Steps to alleviate boarding.** Crowding in the ED caused by psychiatric patients awaiting inpatient beds utilizes scarce resources. Alakeson et al[11] have proposed seven broad steps as tools for reducing ED boarding. Although the steps to improvement listed below are broad, the authors provide specific examples that address overall health care delivery problems:
  - Quantify and monitor the problem
  - Improve ED care of psychiatric patients
  - Make more efficient use of existing capacity
  - Implement low-cost collaboration
  - Work with law enforcement
  - Invest in comprehensive community crisis services
  - Invest in continuity of care

- **Multiple factors contribute to long psychiatric boarding times.** Research has found that longer boarding times significantly correlate with lack of insurance, public insurance, restraint use, positive alcohol levels, and need for transfer to an outside facility. Providers also cite a lack of inpatient beds globally as one of the biggest contributors to boarding.[12]

- **Reductions in spending and reimbursement result in a mismatch between supply and demand.** Health policy experts have concluded that the minimum number of psychiatric beds per 100,000 persons should be 50; however, 15 states have only 10 psychiatric beds per 100,000 persons. Some of the causes cited are a reduction in total state spending on public mental health services, a reduction in reimbursement for psychiatric admissions, and closure of state and private psychiatric hospitals.[13] ED physicians tend to be more conservative and admit patients for liability risk mitigation rather than for clinical reasons. Unfortunately, there are few incentives for ED physicians to conduct the detailed assessments necessary to discharge psychiatric patients.[14] These factors lead to mismatch in supply and demand.

- **Reductions in outpatient services compound the problem of decreased numbers of psychiatric beds.** The DHHS has recognized that psychiatric patient boarding in the ED is a significant problem in the US health care system and attributes this problem to a decline in short-term psychiatric hospital beds.[14] Further complicating the issue of boarding is a reduction in outpatient services. Patients with psychiatric illnesses living in the community cannot access timely outpatient care, because resources have become more limited. This creates a "revolving door" in the ED, with patients failing to link into long-term, outpatient care.[14] DHHS also emphasizes the need for shared responsibility between mental health facilities and EDs as contributors to the psychiatric patient boarding problem.

BEST PRACTICES FOR REDUCING ED BOARDING OF PSYCHIATRIC PATIENTS

A number of best practices have been identified to reduce psychiatric inpatient admissions, thereby reducing patient boarding.

- **Psychiatry consultations live or via telemedicine**. Having a psychiatrist available to see patients—either in person or via telemedicine—has been shown to decrease the need for inpatient admissions. Additionally, the psychiatrist can begin a treatment regimen.[15]
- **Telemedicine in psychiatry.** When a psychiatrist is not available, telemedicine can be an effective tool for patient evaluation, facilitating access to care in many populations and in the emergency setting. A recent study[16] provides support for the use of telepsychiatry as a strategy to evaluate ED patients with behavioral health complaints, which could potentially expedite dispositions when an on-site psychiatrist is not available. However, additional research is needed to look at the incorporation of telemedicine with other community services, how individual patients are affected, and the cost effectiveness of this type of service.[17]
- **Treatment protocols**. If a psychiatrist is unavailable, hospitals and EDs can use treatment protocols, reducing the length of stay within the department.
- **Psychiatry ED observation unit.** Another best practice to alleviate psychiatric patient boarding is to keep psychiatric patients in a quiet environment separate from the chaotic environment of the main ED. Studies indicate that patients in a psychiatric crisis have worsened outcomes with increased boarding times.[11]
- **ED case management.** Case managers in the ED have proved invaluable for psychiatric patient disposition, reducing the hours spent by ED nurses and physicians to find appropriate inpatient beds or outpatient treatment follow-up.[11,15]
- **Mobile crisis intervention teams/crisis management prevention.** Coordination between EDs, community mental health services, and public mental health departments can facilitate faster placement of boarded patients. Some states and communities have invested in crisis prevention and management resources including mobile crisis intervention teams (Delaware, Louisiana), urgent walk-in clinics that provide refills and crisis counselors (Mississippi, Nevada, DC, Harris County), and 24-hour phone lines (Georgia, Rhode Island) that can de-escalate crises before patients get to the ED.[11]
- **Developing statewide patient dashboards.** To help EDs match boarded patients to available inpatient beds more quickly, some states, including Virginia and Maryland, are creating statewide electronic dashboards. These tools allow ED staff to view all available beds simultaneously, eliminating the need to call each individual psychiatric facility to locate an available bed.[18]
- **Changing billing and reimbursement guidelines.** Increasing reimbursement for psychiatric services would encourage providers to increase supply, halting or reversing the massive closure trend. Medicaid currently excludes "Institutions for Mental Disease" or any predominantly psychiatric facility from receiving matching federal Medicaid funds, leaving psychiatric facilities

vulnerable to fluctuations in state and local budget allocations. However, Montana guarantees access to short-term inpatient psychiatric care regardless of insurance status, and some states reimburse treatment of psychiatric disease for the uninsured. Utah has excluded psychiatric drugs from Medicaid prescription drug limits. Funding and research is needed to translate these best practices to a national standard.[13]

MEDICAL MANAGEMENT OF PSYCHIATRIC PATIENTS IN THE ED

Medical therapy for the acute psychiatric patient in the ED is a complicated subject with many questions unanswered by the literature. Therapy includes both pharmacologic and physical aspects. Psychiatric therapy is typically considered to be acute; however, one study has demonstrated that 70% of institutions have to board psychiatric patients for more than 24 hours and 10% for a week or more,[19] showing that there are implications for more than acute therapy. Some conditions, such as chronic depression, are not as amenable to acute treatment because of the slow actions of first- and second-generation antidepressants. In this circumstance, screening for suicide threat is imperative. Most therapy in emergency psychiatry, however, will deal with the agitated patient. The first step in approaching an agitated patient is to determine if there is an underlying organic cause such as a toxidrome, delirium, or medical disease that will need to be addressed. All patients should have a detailed history and physical and mental status evaluation performed. The emergency physician must assess whether alcohol intoxication or drugs (prescription or recreational) are involved but the literature does not support mandatory urine toxicology screens for medical management of all psychiatric patients in the ED. Consensus exists among emergency physicians that laboratory and other diagnostics need to be individually determined, based on history and clinical presentation rather than blanket profiles.

The use of restraint or seclusion is a controversial aspect of dealing with the agitated ED patient. Prior to applying restraints, other interventions should be attempted, including using verbal, noncoercive de-escalation, decreasing physical stimuli (eg, excessive noise), and negotiating with the patient. Knox et al[20] have described an algorithm for the use of restraints. CMS guidelines and The Joint Commission guidelines give guidance for observation and reevaluation. CMS regulations define a medication as a restraint “when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.”[21]

Concurrent medications and diagnoses guide medication choice to calm agitated patients. The preferred route is oral, followed by IM, followed by IV. The onset of effect is the inverse order. Many clinicians traditionally use a butyrophenone such as haloperidol with or without a benzodiazepine such as lorazepam. Second-generation atypical antipsychotics are becoming more common because of their side-effect profiles, although not all are available in all dosage forms. Haloperidol is considered a possible preferred medication in alcohol-induced agitation. Benzodiazepines are useful in alcohol withdrawal but are less useful for agitation during intoxication. Antipsychotics have been associated with QT prolongation such as the Black Box Warning with droperidol, although the clinical significance is debated. First-generation antipsychotics are associated with extrapyramidal side effects and anticholinergic effects. Some reduce seizure threshold. A good algorithm for drug choices in particular circumstances is presented in Wilson et al.[22]An older paper discusses expert opinion on medications.[23]

DISPOSITION OF PSYCHIATRIC PATIENTS FROM THE ED

If the emergency physician, using reasonable judgment, expresses concern about a patient's imminent risk of harm to him/herself or others, the patient should be held for psychiatric evaluation and treatment. If the patient does not voluntarily consent to such treatment, the patient may be involuntarily held until such

treatment can be provided. The emergency physician must be authorized to make this determination, without requiring approval by an outside entity (eg, police, court) or consultant. This emergency hold should be for a minimum of 12 hours and a maximum of 72 hours to allow psychiatric evaluation and initial treatment to commence. The emergency physician should be held immune from civil liability resulting from any involuntary psychiatric patient hold.

For patients who require inpatient psychiatric admission or patients being involuntarily held, several barriers exist to disposition out of the ED. The major determinant is psychiatric bed availability, whether at the treating facility or at a site that would accept transfer. Patients who are uninsured or publicly insured and those who are homeless tend to have longer disposition-to-discharge/transfer times,[24,25] and access to inpatient care for these patients should be the focus of ongoing advocacy efforts.

For patients being discharged from the ED after evaluation for a behavioral health complaint, coordination of aftercare prior to ED discharge reduces hospitalization and ED recidivism rates.[26] Ideally, this consists of scheduling outpatient appointments prior to ED discharge.

COMMUNITY RESOURCES FOR EMERGENCY PSYCHIATRIC PATIENTS

Regionalization of psychiatric services. A recent article by Zeller et al[27] demonstrated that having a regional psychiatric service reduced boarding time, supporting the argument for regionalization of psychiatric emergencies. Zeller reported an average boarding time for psychiatric patients that had holds for involuntary admissions of 108 minutes, and the rate of admission from this unit was 25%.

Comprehensive crisis systems. A report by the Colorado Division of Public Health describes key components of a comprehensive crisis system (CCS)—round-the-clock services that provide stabilization for acute psychiatric conditions in the community. This report addresses the social, legal, psychiatric, and substance abuse needs of psychiatric patients and discusses the importance of crisis hotlines, walk-in psychiatric urgent cares, and mobile response units (rather than law enforcement). Additional services may include a mechanism to perform medical clearance screening tests for psychiatric hospitalization outside of the ED, as well as options for acute care outside of the hospital/ED such as safe houses where a person can stay briefly away from an inciting home environment.[28]

The following state-specific examples illustrate efforts to enhance community resources for psychiatric patients:

- **Texas**: Legislation was enacted in 2008 to appropriate $82 million for the purposes of redesigning the crisis service system to enable statewide access to rapid response services, avoiding hospitalizations and reducing transportation issues.[28]
- **Pima County, Arizona**: Since 1995, the Community Partnership of Southern Arizona has administered publicly funded psychiatric and substance abuse services to all residents of Pima County regardless of their insurance status or ability to pay. In addition to walk-in acute services and a substance abuse/detox center, the county has built a center with a psychiatric ED, 24-hour psychiatric observation, and psychiatric inpatient beds; this center is the hub for a 24-hour crisis hotline and mobile response unit deployment.[28]
- **Minnesota, Maryland, and Louisiana**: These three states all have legal provisions for crisis system licensing, whereas **Florida, Montana, and Arizona** legally recognize and license crisis stabilization units. The Colorado Division of Public Health report does not, however, indicate whether such programs actually exist and if so, how they function in these states.[28]

Individualized treatment plans improve disposition time. Cheng et al[29] describe a community-based program in San Francisco to address psychiatric “frequent fliers.” In this program, psychiatric patients

have case managers and individualized treatment plans developed and implemented by multidisciplinary teams in an effort to keep them out of EDs and acute psychiatric facilities. San Francisco General Hospital and Trauma Center created notes in the electronic medical record that were flagged every time the patients in this program checked into the ED. These notes included the patient's psychiatric history, individual treatment plan (eg, how to handle acute psychiatric emergencies), contact info for family/friends who could give collateral information, and case manager contacts who could help with disposition and/or redirecting them appropriately. An evaluation of five patients revealed that although they still made almost the same number of ED visits, when they came to the ED, providers knew what to do with them and where to send them, thereby decreasing length of stay in the ED and resulting in faster disposition. Furthermore, the number and length of psychiatric hospitalizations was also decreased.[29]

The role of EDs in suicide prevention. A paper by the Suicide Prevention Resource Center discusses the importance of continuity of care from the ED perspective, emphasizing the importance of screening for suicide risk and providing an assessment to those who are at risk. The paper also notes the need to offer treatment options with written educational materials that include safety planning and follow-up instructions. In particular, early follow-up is recommended with a team approach, to include mental health care workers, social workers, and community partnerships to help link patients with the appropriate resources.[30]

Dedicated psychiatric center eases behavioral health holds in EDs. In a recent discussion of psychiatric patient boarding and the impact boarding has on ED wait times in large health care systems, Little-Upah et al[31] describe the use of a “psychiatry center” that is staffed by psychiatrists and open 24 hours a day, 7 days a week. The center receives patients around the clock via ambulance, as well as through transfers from the ED. The benefit of a dedicated and standardized regional transfer center to handle all transfer calls and maintain an inventory of beds available in every health care center in the region is also described.[31]

Utility of community databases to decrease ED utilization. Abello et al[32] recently reviewed a retrospective cohort study performed between three hospitals servicing approximately 1 million people in Central Texas. The study goal was to determine if enrollment in a community database that identifies frequent ED utilizers, creates a care plan for them, and distributes this to community ED providers resulted in decreased ED utilization by this cohort. Although the power of the study is limited—only 42 of over 184,000 ED patients assessed qualified for the study (less than 0.02% of the ED population in question)—the study found a reduction in ED visit frequency from 8.9 to 5.9 during the study period. It is important to note, however, that the number of visits reported on average by this population (8.9 at baseline) appears inconsistent with the typical frequent utilizers seen in most ED populations; thus, translation of this data to most ED populations would be questionable.

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