

**APA Task Force on  
Psychiatric Emergency Services**

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**Report and Recommendations  
Regarding Psychiatric  
Emergency and Crisis Services**

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A Review and Model Program Descriptions

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# 1

## Report and Recommendations Regarding **Psychiatric Emergency and Crisis Services**

The History of this Task Force and a Summary of Available Data

### **Introduction**

#### **Toward "Organizationally Unique Treatment Facilities"**

In 1980, Gerson and Bassuk articulated a philosophy of psychiatric emergency service (PES) administration reflective of the typical service under siege. (1) In what Barton for the first APA Task Force on Psychiatric Emergency Care called the *triage model*, Gerson and Bassuk described the goals as “rapid evaluation, containment and referral” and the focus was “the patient’s and community’s adaptive resources and competence ... minimizing subtle diagnostic considerations...”.

This approach was dictated by a massive increase in the volume and complexity of emergency presentations and reduced access to inpatient care. Deinstitutionalization and later efforts at cost containment including managed care have tended to place more fragile patients in the community. From 1970 to 1994, the inpatient bed rate per 100,000 civilian population declined by more than half from 264 to 112. In 1955, there were 1.7 million episodes of psychiatric care of which 77% were inpatient. In 1994, there 10 million but only 26% were inpatient (2). This change was coupled with the availability of low cost crack and methamphetamine in many parts of the country and other social ills including homelessness and AIDS. By 1980, the PES had become a chief entry point and the sole source of treatment for many of the chronically mentally ill. A 16-fold increase in PES visits in New York City was documented between 1976 and 1988. (3) There was a 69% increase in involuntary presentations from 1983-89.(4) Almost half of emergency department visits were thought to be substance related. Emergency services were overwhelmed leading Bassuk to wonder if they could cope as “last-resort facilities”. (5) There were a number of serious adverse outcomes such as the Staten Island Ferry killings that attracted media attention.(6)

Gerson and Bassuk recognized the limitations of the services available at the time and called for psychiatric emergency services to be conceived of as “organizationally unique treatment facilities”. This has since been realized to some extent in the expansion and diversification of emergency services in some regions, often, ironically, as a result of cost containment efforts elsewhere in the “system”. The triage model of psychiatric emergency services has been replaced in some settings by more comprehensive services that still serve the triage function but are capable of providing comprehensive assessment and a broader range of services. This has been described by one of the authors as the *treatment model* of psychiatric emergency services to distinguish it from the triage model.(7)

## **Lack of Standards**

However, emergency services generally remain rather haphazard in their planning and organization. Most communities have had only two tools in their armamentarium: hospital admission or crisis intervention in the emergency department followed by referral to low intensity outpatient treatment. There was a brief period of innovation in the 1960's that witnessed the creation of many successful pilot programs but these approaches were not systematically studied or widely embraced. Although the typical PES treats patients whose needs are greater, standards for psychiatric emergency services have been poorly specified and generally lower than any other category of organized service. The product of an episode of inpatient care or an outpatient visit is reasonably well defined but not the product of an emergency visit.

Psychiatric emergency services are unpredictable from facility to facility and hour to hour within the same facility. A wide range of assessment from focal screening to comprehensive assessment is offered in different settings. The scope of care similarly ranges from emergency medication and supportive counseling to intensive care. In most emergency services, thorough assessment and treatment planning are deferred until the patient is seen by an inpatient attending or an outpatient provider, often days or weeks later. The role of the psychiatrist in emergencies is highly valued in theory but limited in practice. If any group of stakeholders were to design a system *a priori*, the most common service currently available could not emerge from the deliberative process.

The lack of a standard for emergency assessment will serve as an example. More than 135,000 people receive emergency psychiatric evaluation each year in New York State alone.(8) The American Psychiatric Association (APA) practice guideline for psychiatric evaluation of adults calls for establishing a provisional diagnosis, the assessment of social environmental and cultural factors, ability and willingness to cooperate, precautions necessary and a plan for immediate treatment.(9) The literature suggests that reliable diagnosis can be performed in emergency settings (10, 11). However, guidelines promulgated by the American Association for Emergency Psychiatry do not appear to require diagnostic assessment (12).

In practice, emergency services often do not have staff available to meet the APA standard. Instead, emergency services, formally or informally, narrow the focus to particular aspects of the presenting problem including the legal and financial aspects of the hospitalization decision. There is a substantial body of research concerning emergency department decision-making (13) and a number of tools have been developed to improve emergency department disposition decisions. Bengelsdorf and colleagues (14) developed a very simple dispositional assessment that focuses on dangerousness to self and others, support and motivation. Roy-Byrne, et al (15) have reviewed this literature and offered a brief medical necessity scale. While the reliability of such tools has been measured and that of Bengelsdorf's Crisis Triage Rating Scale has been replicated elsewhere, there is little evidence of validity and none of these is in wide use. In a study of typical emergency assessment interviews at four institutions in New York State, it was found that there was poor agreement among experienced psychiatrists concerning key findings such as impulse control and dangerousness.

It therefore appears that there is disagreement as to the proper scope and content of emergency assessment. One set of models might be envisioned if the goal is disposition, another if the goal is treatment.

## **Funding Problems**

Lack of agreement about such a basic parameter as the scope of assessment is a striking problem. There are probably a number of reasons for the lack of standards in psychiatric emergency care including a lack of consensus about the role of emergency services in a

hypothetical system of care but ultimately confusion about the product is linked to confusion about payment.

This may have been less problematic historically, when patients with behavioral emergencies were likely to be admitted, to state facilities if indigent or private hospitals if insured. Historically, the cost of emergency care was folded into reimbursement for admission to the hospital although the cost of the preadmission assessment and care was not added back to the budget of the emergency service. Reimbursement for admissions indirectly supported the emergency services. As hospitalization became less available for both populations, the burden on emergency services increased without a commensurate increase in funding.

Emergency services now have very complex and unpredictable funding streams. Most health care organizations are able to reduce the complexity by focusing on a segment of the market that allows for relatively stable and predictable funding. Emergency services can not do that and in fact are legally required under the Emergency Medical Transportation and Labor Act to provide at least a screening examination to all comers and stabilizing care if an emergency is identified.

One funding stream is fee for service. Tyrance et al have argued that the costs of emergency services are overstated (16) but the cost is substantial. This derives in part from the need to maintain 24-hour staffing coupled with the inability to predict utilization. The largest hospital psychiatric emergency services register less than one patient per hour on average. However, there is usually a peak of volume that in the evening. Several very disturbed patients may arrive at once. Such patients often require a period of crisis stabilization before a detailed assessment is possible and they may still be uncooperative hours later. Collateral contacts for basic history may take hours to reach and interview. Agencies able to assist with information and aftercare are usually not available night and weekends. Patients in various stages of care then accumulate. The service must have some excess capacity to absorb peaks in flow, census or patient acuity with a margin of safety. This results in tension between readiness and productivity. This problem can be relieved in part by utilizing the excess capacity of emergency services to support other elements of the system at times.

Fee for service systems generally do not take account in their pricing of the wide range of complexity or the need for excess capacity. Emergency services receive no compensation for admitted patients, which is generally attributed to the receiving inpatient service. The amount an emergency service can receive is generally capped at the day rate for inpatient care even though a disproportionate amount of effort goes into a day of emergency assessment and stabilization. Considered in isolation, emergency services can not be supported solely by the fees generally provided in fee for service arrangements.

Grants and contracts have also been an important force in emergency service evolution. The Community Mental Health Center Act of 1963 funded services including emergency services as a part of deinstitutionalization. However, McClelland (17) stated 20 years later, that most psychiatric emergency care was still provided by police officers and medical emergency department personnel rather than mental health professionals. At the same time, Kiesler observed that though the official policy favored community care, financial incentives continued to favor hospitalization. Emergency services had a limited role in that type of arrangement reflected in the large number of articles devoted to making admission decisions (13). As recently as 1990, Sateia et al (18) reported that the vast majority of psychiatric evaluation and treatment in two large New England emergency departments was provided by nonpsychiatric physicians. In the 1996 NASHMPD Survey of state mental health agencies, only three indicated a statewide reliance on community mental health centers for emergency services. Only nine appeared to have a regional or statewide system of any kind. A system of emergency mental health care did not develop as planned and then the link between funding of CMHC's and provision of emergency services became attenuated. Mental health centers became increasingly dependent

on Medicaid and Medicare fee for service arrangements with the associated problems previously described.

Managed care has brought another set of threats. Private sector managed care has viewed emergency services as costly, often unnecessary and duplicative and attempted to avoid paying traditional emergency service providers. Managed care companies support their own urgent care clinics or mobile crisis teams to control utilization. This has the effect of "creaming", adding complexity and reducing the support available to safety net providers.

On the other hand, emergency services are a magnet for free care. The Colorado Hospital Association recently reported to the Legislature that the number of unreimbursed emergency visits to 29 acute care hospitals in the state had risen 42% in just three years. Funds for indigent care such as DISH subsidize hospitals that provide care including emergency care to the indigent but these cover a fraction of the cost of care and have also been declining. Although funds of this type may be intended in part to support psychiatric emergency care at a given institution, there is no formula for allocating such funds of which the authors are aware. Emergency services are also associated with high malpractice risk. Failure to prevent suicide results in the highest average indemnity awards in emergency medicine. (19) Hence there are significant financial disincentives associated with delivering emergency care.

Nonetheless, no one suggests that emergency services be eliminated. Considered from the standpoint of government or large capitated systems of care, they may even save money while improving care. Some of the focus of the refinancing of mental health care has been on diverting patients in emergencies from the hospital to the community while maintaining or improving access through enhanced emergency care and crisis alternatives (20). Schuster has discussed the complex and potentially beneficial effects of managed care on emergency psychiatry. But large numbers of covered lives are necessary to generate efficiencies and "caps" still do not include everyone. Understanding and improving the funding of emergency services will be intimately connected to any effort to standardize and improve the quality of care in the crisis sector. This Task Force was formed in an effort to focus attention on these issues and bring some order to an important but neglected domain of psychiatry.

## The History of the Task Force

This is actually the second task force on psychiatric emergency services. The first was formed in 1978, chaired by Gail Barton, M. D., and filed its final report, *Psychiatric Emergency Care: A Task Force Report of the American Psychiatric Association*, in 1983. In an apparently controversial decision, the APA did not publish the report. The APA permitted the authors of the report to publish portions without reference to APA under other imprints. In retrospect, the first task force was quite timely and captured much that was important about emergency psychiatry then and now.

This Task Force was created, without much knowledge of the first, in May 1998, exactly fifteen years later, and given the charge of developing a formal definition of Emergency Psychiatry and characterizing the host of emergency and crisis services that have arisen to divert patients from hospital admission with particular attention to the role of the psychiatrist in these services. Members were appointed in the following months and the task force then held its first formal meeting in conjunction with the Institute on Psychiatric Services in October 1998.

A number of data sources were considered relevant and the TF, with the assistance of staff, first began compiling information. Dr. Barton was contacted for the history of that TF. Beth Stroul, PhD, formerly of CMHS, was contacted for important primary source documents that are not widely available but frequently cited. In order to avoid duplication, she was also invited to

participate in the role of consultant and agreed to review the TF's work for comment. Dr. Hunter McQuiston, AACP delegate to the CPS Consortium on Special Delivery Settings was also queried, as was Dr. Tom Hester, then chair of the Medical Directors Council of NASHMPD. TF members and staff also began collecting data of a regulatory nature from the states and other entities. It was determined that the Joint Commission has no specific standards. Information was obtained from the following sources and circulated for review and comment. This included state regulations from those states known to have relevant, detailed regulations on the assumption that the states were pragmatic in the drafting of such regulations.

1. Psychiatric Emergency Care: Task Force Report, 1983
2. New York State Code
3. New Jersey Code
4. California Code
5. Maryland Code
6. Florida Code
7. American Accreditation Health Care Commission / URAC Standards for Telephone Triage...
8. American Association for Emergency Psychiatry (AAEP) Standards
9. APA's Practice Guideline for the Assessment of Adults
10. Community Mental Health Center Act of 1963
11. AAEP Survey of Psychiatric Emergency Services and Practices
12. National Association of State Mental Health Program Directors Research Institute State Mental Agency Profiling System Survey, 1996

## A Review of the Literature

### **Psychiatric Emergency Defined**

This service domain includes both urgent and emergency care. The first Task Force defined an emergency "as an acute disturbance of thought, mood, behavior or social relationship that requires an immediate intervention as a defined by the patient, family or the community. A psychiatric emergency might also be defined as a set of circumstances in which (1) the behavior or condition of an individual is perceived by someone, often not the identified individual, as having the potential to rapidly eventuate in a catastrophic outcome and (2) the resources available to understand and deal with the situation are not available at the time and place of the occurrence. Thus, emergencies frequently involve a mismatch of needs and resources for which the emergency service must compensate. Central to the concept of an emergency are the subjective quality, the unscheduled nature, lack of prior assessment or adequate planning and resultant uncertainty, severity, urgency and conflict or failure of natural or professional supports all of which contribute to the need for immediate access to a higher level of care. Urgent problems as opposed to emergencies can be thought of as situations that have some or all of these features but where the situation is evolving more slowly, the feared outcome is not imminent and attention can be delayed for a short time.

### **Conceptualizing Emergency Services**

Inherent in this definition is the concept that urgent/emergency services complement other services. The organization of emergency services in a given locale is largely driven by volume and the volume of emergencies is in turn dependent on the differentiation and adequacy of other elements of the mental health system. Thus, a very well developed case management system may have sufficient resources to manage many of its patients' crises without the intervention of a separately organized emergency service. However, when such a system does require an emergency response, the problems, though less frequent will be correspondingly more severe. Emergency services cannot be thought of in isolation from the systems they serve. Different

communities favor different forms of care and their emergency services then evolve to fill the gaps.

Some more or less universal values have influenced most services. These include the desire to reduce hospital admission and readmission particularly to state facilities. Thus, many services are conceived explicitly as "diversion" services. A similar trend involves diversion from jails and prisons. Various efforts have been fueled by the desire to identify the mentally ill in the community and involve them with mental health providers rather than police. This has influenced in particular the development of mobile outreach as an alternative to police involvement.

In general, the task force recognized two broad categories of service, hospital and community based services and two approaches to providing the service, residential and ambulatory or mobile and generally two levels of access within each type of service, emergent or urgent. Urban and rural programs seem to differ in emphasis rather than type, i.e., mobile outreach may be more than important facility based services.

## **Hospital Based Services**

### **Consultation Liaison**

A key component of the psychiatric emergency system is the "emergency room". It would seem that this could be taken for granted. In fact, the requirements for this type of service are not well established.

As it was during the first TF, psychiatric emergency services in most facilities are probably delivered as a consultation to an emergency physician. There is little data concerning this variant but what does exist suggests low levels of mental health expertise. At one time, psychiatrists could recruit patients in crisis into their private practice. For various reasons, this incentive is no longer adequate. As general hospitals close their inpatient services, there are also fewer hospital-based psychiatrists to share this function. A hospital may then employ other mental health providers for this function but the qualifications and supervision of these providers vary greatly from licensed masters level clinicians to unlicensed bachelor level technicians. Only civil commitment law governs this in many states and since the mental health provider is technically consulting to an emergency physician, the physician may be in the uncomfortable position of taking responsibility for releasing a patient on the advice of poorly qualified consultants. Other issues include interview space, timeliness, ancillary staff, pharmacologic management and continuity of care.

### **Specialized Psychiatric Emergency Department**

Generally, the PES begins simply as a stretcher in the medical emergency department (ED). This poses a number of problems for both the host ED and mental health consultants as well as the patient. At some point, hospitals must confront the issue of whether to devote space to a separate PES. In the authors experience, services with 3000 visits or more per year tend to have a separate psychiatric ED.

### **Space**

Space is often the most vexing issue confronting emergency services. A properly constructed PES should take into account the needs of the irritable or over stimulated patient who requires a quieter environment, the impulsive or paranoid patient who may elope, the agitated patient who requires restraint or seclusion and the suicidal patient who requires an environment free of "sharps" and other hazards. Many patients will require a high level of supervision so it is helpful

to be able to observe the entire area from a central location. Interior windows or monitors that permit staff to see into interview and bedrooms contribute to a sense of security for the staff. The privacy needs of patients must be balanced against this need for supervision. Anything that might be used for hanging needs to be tested for load bearing. Appropriate toilet and shower facilities contribute to patient comfort and cooperation but mirrors must be shatterproof, shower heads recessed, etc. In most cases, doors should have locks but should swing both ways to prevent patients from barricading them. It is important to be able to dim the lights so they are consistent with diurnal variation without extinguishing them completely. Furniture must be selected and installed in a way to prevent its use as a weapon. Television and reading materials should be available for distraction and a telephone must be provided. However, all electrical outlets, electrical devices and, especially, medical equipment must be viewed as hazardous. Exam rooms must be equipped with adequate locked storage. Rooms that are not in use should be kept secured. A written security policy including key control and regular safety rounds are important features of the security plan.

A special room should be available for voluntary or unlocked seclusion (“quiet room”), locked seclusion and restraint. These rooms should have no permanent furnishings or appurtenances.

The Bellevue Hospital CPEP occupies approximately 6000 square feet, not including the offices of the permanent staff. This encompasses a waiting area, triage office, clerical office, a large central nursing station, separate lounges for admitted and non-admitted patients, six bedrooms, four interview rooms, a physical exam room, a restraint room with capacity for four beds, a locked medication room, and appropriate utility and storage rooms. The waiting area and triage office are open and are used for voluntary patients and families. The remainder is controlled by electrical locks. Despite its size, almost the entire area can be visualized from the nursing station. Uniformed police officers are responsible for the open waiting area while nursing staff are responsible for monitoring the locked area.

### **Core Staff**

More important than the security and comfort of a dedicated space is appropriate staff. Medical emergency departments often view the mentally ill as a nuisance. A cadre of nursing and other professional staff sympathetic to the needs of the patient with emotional disturbances is critical. In a separate space and with appropriate staff, a controlled and supportive milieu can develop despite high levels of disturbance and rapid turnover. Using the Ward Atmosphere Scale to compare the Bellevue CPEP to Bellevue inpatient services, Rosenberg et al found that the milieu of the emergency room was similar in most respects with some greater emphasis on control and problem orientation. (21)

A major focus of hospital emergency services staff is safely and legally containing behavioral emergencies. Staff who are appropriately recruited and trained learn to handle behavioral emergencies as a team with less confrontational methods and fewer adverse outcomes.

The numbers and training of the mental health staff will determine the role of security officers. Smaller services tend to rely more heavily on uniformed security. However, if security officers are to be used to control patients, they should also be appropriately trained and work under the supervision of skilled nursing personnel.

A key measure of quality in psychiatric emergency services is the availability and involvement of attending psychiatrists. This ranges from inconsistent telephone availability to 24 hour, 7-day presence in the hospital. One reason physician direction of crisis services is critical is the frequency and severity of medical syndromes which masquerade, complicate or coexist with mental illness. A high index of suspicion for “organic” conditions is necessary and the skills to

identify them are essential in emergency settings. Unfortunately, this has received little attention and there is no agreement concerning appropriate cognitive assessment in the PES (22).

“Medical clearance” alone is probably not sufficient. Tintinalli (23) has reported that 4% of patients who were described as “medically clear” in the record went on to require acute medical care in the subsequent 24 hours. On the other hand, an elaborate routine medical assessment is probably also wasteful in the absence of clinical signs or symptoms. This issue has been reviewed elsewhere.(24)

When consequential medical conditions are identified, it is important to have rapid access to appropriate care. For this reason, it is useful to have the PES adjacent to the medical ED and to have policies concerning the movement of patients and consultants between the services.

In addition to screening for so called “medical masquerades”, psychiatrist participation helps achieve more rapid diagnosis and initiation of psychiatric treatment. Medicolegal issues are also best addressed by a psychiatrist.

### **Support Services**

In addition to the core staff of the PES, it is important that certain ancillary services are available. Under the best of circumstances, patients reveal only 50% of substance use (25). Therefore Currier, et al (26) and Claassen, et al (27) have recommended routine urine toxicology in emergency settings.

Another useful and underutilized laboratory tool is drug levels. Patients often present an exacerbation of a known psychiatric condition that is theoretically being treated. It is often assumed that the exacerbation is due to noncompliance. Blood levels provide critical information in this regard.

At one time, an electrocardiogram would have been considered essential to medicating patients. However, most modern medications do not require an EKG prior to administration though EKG remains the best measure of tricyclic intoxication in overdose.

### **Extended Observation or Crisis Hospitalization**

Many psychiatric crises are a function of a transient mental state that occurs in the setting of a personality disorder or substance abuse episode. Given the brief course of many crises, the importance of serial observations and the necessity of collateral involvement for information and support, some form of 24-hour residential service is useful. Extended observation or crisis hospitalization utilizes a hospital setting for this function. This may range from a formal or informal status within another organized medical or psychiatric service or may be organized as a separate unit associated with the PES. Length of stay is short but capability is high. Involuntary and dangerous patients are acceptable in contrast to community based crisis services where patients must be cooperative.

### **Variants**

**Observation or 23 hour beds.** Breslow (28) has identified two models with somewhat different goals. The so-called 23 hour bed model has been described by Lanzito et al (29) and Gillig et al (30) and was adopted by the New Jersey screening system. (31) This type of service is limited more to clarification of the reasons for the presentation and can take advantage of the rapid spontaneous resolution of many crises. “Filtering” of substance abuse emergencies is one example. (32) Observation alone can potentially divert inappropriate admissions due to

misdiagnosis and limit the need for appropriate but predictably brief admissions. This type of service may be relatively informal (e.g., a stretcher in the medical ED), or may occur in the setting of several certified beds in a more formally organized PES.

**Crisis Hospitalization or 72 hour beds** This model was originally characterized by Weisman et al (33), later described by Breslow and colleagues as crisis hospitalization (28, 34), and adopted as part of the New York State model (3), (35). This model permits a longer length of stay, usually up to 72 hours. The length of stay in the earlier phases of New York State CPEP implementation was close to 50 hours. But during 1996, the 14 licensed CPEP's reported 9620 admissions to Extended Observation Units (EOU) for an average of 40.8 hours. (36) Bellevue, with six beds serving an inner city catchment with significant numbers of homeless individuals, also averaged 40 hours. In recent years in New York State, a consistent 13-15% of all presentations have been admitted to EOU beds (37).

### **Structure**

As the average length of stay and census increase and the focus shifts from assessment and spontaneous recovery to treatment, it is important to consider the factors that contribute to good care in a crisis service. Probably most important and least tangible is community orientation. The focus of this type of service should not be on adaptation to the hospital but on resources available to the patient outside the hospital. To be effective, these units must help the patient to identify reasons that functioning in the community became too difficult, to recruit support and to address the challenges that precipitated the crisis.

Even more than for an inpatient unit, structure is important. Flexibility is necessary as patients come and go at all hours but, in general, patients should sleep and eat on schedule, attend to their personal hygiene, take their medications at regular times and speak or visit with their friends and family. Group meetings with patients can be held to help reinforce expectations about performance and build motivation. Often these focus on the links between the present crisis and substance abuse or other forms of self-defeating behavior. Individual contacts with staff should help to ameliorate distress and plan the return to the community.

Forster (38) and Allen (7) have advocated specific pharmacologic treatment in emergency settings. For example, a technique for the rapid administration of divalproex sodium has been reported as safe and effective (39) and is now common practice in some services. Due to concerns about toxicity in overdose, prescribing antidepressants was once specifically discouraged. However, newer antidepressants associated with much less toxicity in overdose (40), (41), (42), can now be prescribed (43) by emergency psychiatrists. (44)

### **Special Situations**

Certain types of patient crises have been thought of as particularly well suited to this model of care. Suicidal ideation is a focus of approximately 40% of emergency visits (45) and warrants careful assessment and intervention but seldom warrants psychiatric hospitalization. Overnight admission to the PES is often sufficient to either achieve some improvement, mobilize other resources or to clarify risk factors.

Substance abuse emergencies are another such category. Many episodes of suicidal ideation are driven by alcohol use and completely resolve with sobriety.

The seriously mentally ill may also benefit from this type of care, not for major exacerbations but for assistance with transient stressors or relapse prevention.

## **Advantages and Outcomes Data**

Little systematic data exists as to the benefits of this type of service. One putative benefit is diversion from conventional inpatient care. Although hospitalizations may be prevented in this way, some patients will utilize this service that otherwise would have been released immediately to the community if the service were not available. However, the rate of inpatient admission declined from 41% to 35% as crisis hospitalization increased in Breslow's service (34). This is consistent with the 6% drop in conventional admissions observed across the 13 CPEP's in New York State in 1995.(46)

Both reports are subject to a variety of criticisms. Other influences were clearly at work. However, this represents a rather significant drop across a large area involving various types of institutions and payor mixes and occurred at a time when cost containment efforts were fairly sporadic in New York.

One hypothesis is that crisis units simply delay admission. However in New York, 70% of EOU admissions were discharged to the community. It is possible that hospitalization was only postponed to a subsequent visit or that patients were shifted to other facilities. Recidivism data is sparse but Gillig reported that 7.5% of 134 patients in a 23-hour service were admitted within the subsequent 30 days.(30) Breslow found 8% of 63 patients in a 72 hour service were admitted during the next two weeks.(28)

Other advantages cited for such programs include improved diagnosis, increased time to develop alternatives, respite for both patients and providers, and support for autonomy rather than institutional dependency.

## **Community Services**

### **Crisis Residential Services and Respite Care**

Although it also is a form of 24-hour care, the crisis residence (CR), in contrast to the hospital, attempts to create a normalized environment. (47-50) Apartments, group and foster homes, even the client's own home have been used for this purpose. CR's typically serve smaller cohorts of 1-15 residents. Stroul (51) has surveyed this category of provider and separated them into those that serve individual clients and those that serve groups. Group residences operate in a social rather than a medical model. They are not equipped to prevent elopement or manage the aggressive or seriously suicidal patient. They are more consumer oriented and, although expectations are high, a high level of support is offered in what has been described as an "intentional community".

#### **Variants**

CR's may take clients exclusively from emergency services to prevent hospitalization or may also help to shorten hospitalization by taking patients from inpatient services who have been stabilized but are not ready to return home. For the purposes of this discussion, only the situation in which patients are diverted from emergency services will be considered.

**Acute Diversion Programs** Fields and Weisman have described three levels of care within this category. (49) The acute diversion program is the most intensive version of CR. In theory, such programs are equivalent to voluntary hospitalization in terms of their capability. They take referrals from hospital emergency services on a "no refusal" basis including suicidal, potentially violent or psychotic clients as long as they are cooperative. Such programs operate outside hospitals but with significant numbers of full time professional and paraprofessional staff and a part time psychiatrist. Maryland regulations for this category, called an admission alternative,

require a staff to patient ratio of 1:4 with a capacity for 1:1 observation. Staff must be awake 24 hours and additional staff must be available on call. A psychiatrist must be available by phone 24 hours and must perform an examination within 24 hours. Medication must come with the patient who self-administers them obviating the need for a nurse or pharmacist.

**Crisis Residence** The next level, the crisis residence, is designed to serve those with moderate psychopathology. Bellevue Hospital's CR was once situated in a five bedroom apartment staffed during the day with a masters level social worker and around the clock with housing counselors. The patients generally had the benefit of 72 hours in the program's EOU and were followed by the Mobile Crisis Unit until alternative treatment arrangements were in place. Maryland regulations for this category, admission prevention, also require an awake staff to patient ratio of 1:4. They also require that there be adequate capability to provide one to one intervention with patients, and that there be access to psychiatric consultation at all times.

**Crisis Respite** The lowest level of care in this category is the respite program. These programs principally serve those patients with housing disruptions. Although 24-hour programs, direct care by the respite program is limited as these typically have a single, less trained staff member present. Sledge (52) has described an arrangement linking respite with day hospitalization in a program designed for the severely and persistently mentally ill. The respite component provided housing for up to four clients using mental health workers and a masters level program director.

### **Special Populations**

Recent reports have focused particularly on efforts to reduce the cost of care for the seriously and persistently mentally ill who predictably suffer episodes requiring higher levels of care. Fenton reported on a population of 1600 patients under the care of Montgomery County, Maryland of whom 12% experienced an exacerbation requiring one or more hospitalizations each year. (53) A service designed to assess and stabilize unknown patients will operate differently from one designed to serve a defined group of enrollees whose history and needs are already documented. Use of CR in both situations and for adolescents as well adults have been described.

### **Role and Outcomes**

The impact of the CR is difficult to measure but several lines of evidence suggest that they are at least as effective and much less expensive than hospital care. There are numerous reports describing particular CR's in the US and the UK, which suggests they are effective in the view of providers and popular with consumers. Finally, Stroup and Dorwart (54), reporting on the implementation of Massachusetts's Section 1915(b) Medicaid waiver, observed a 16% drop in emergency department visits leading to inpatient admission while admission to various forms of CR rose comparably. They state "quality ...was not systematically assessed, but egregious problems were not noted." A task force that examined the death rate of persons under the care of the Massachusetts Department of Mental Health in the wake of adverse publicity actually found the death rate declining (55) although no relationship between the decline and changes in the system was asserted.

### **Controversies**

In screening 922 presentations for random assignment to conventional or respite care/day care, Sledge found that only 28% percent of the total sample was eligible for whom an alternative bed was available when needed. 40% of candidates were excluded due to involuntary legal status. In all New York CPEP's in 1997, there were only 282 CR admissions compared with 8,956 EOU admissions perhaps reflecting this problem of eligibility and alternative bed availability.

Critics of CR services also question whether patients utilizing CR are truly equivalent to hospitalized patients. However, the recent studies by Fenton et al (53) and Sledge et al (52)

have attempted to address this criticism by randomly assigning voluntary patients to inpatient or alternative care after the admission decision had been made.(52).In Fenton's study, 90% of patients were considered voluntary and had no choice but to participate in random assignment, though they could then refuse the assignment and seek care elsewhere if they wished. In general, both studies found outcomes for the two conditions quite similar.

Another criticism is that if patients were disturbed enough to require hospitalization, that hospitalization was only postponed. Fenton reported that 17% in the alternative treatment group required transfer to an inpatient facility during the index episode but that utilization of inpatient services over the following six months was comparable.

### **Mobile Response**

A system that begins at the hospital neglects the fact that emergencies originate in the community and often persist there for long periods of time at a moderate level of intensity. Someone must decide to bring the intended patient to the hospital and provide transportation. What distinguishes mobile crisis from other kinds of mobile outreach is the perception of urgency surrounding the referral and the capability of the agency providing the service to respond in consistently rapid fashion.

### **Variants**

While types of mobile crisis overlap to some extent, they also differ in terms of readiness, tactical training, equipment and cross training of police in mental health techniques and vice versa. Like most services, mobile teams may be understood in terms of whom they serve, how quickly and for how long. Stroul found that 80% of these services were available on a 24-hour basis.(56) These services may be based anywhere and see patients anywhere. Mobile teams can cover wide areas and may be particularly useful in rural communities where mental health services are distant and public transportation is lacking. Mobile teams sometimes service several hospital emergency departments in a region. For the smaller hospital or other agency without the volume to support standing specialized services, the mobile team brings expertise when needed at a cost that is reasonable.

Public mobile teams, traditionally operated by community mental health centers, serve the entire community and are more likely to go wherever the referral leads them without regard to ability to pay. This service is not covered by most insurance plans including Medicare although it is covered by Medicaid in some states and is often publicly supported through grants. Where covered by Medicaid, the reimbursement is significantly below the cost of the service. Gillig has described three levels of mobile outreach, two of which can be considered part of an emergency service system. (57)

**Emergent** Emergent services offer assistance to the authorities in the most aggravated circumstances including negotiating with individuals who are armed and threatening.(58) The result of this activity is often removal to an appropriate facility for further examination. This kind of service must be available immediately around the clock and the standard for access may be as little as 1-2 hours. Where immediate access enjoys the highest priority, there may be no provision for continued mobile outreach beyond the initial assessment and intervention.

Mental health practitioners involved in this activity require special training and must interact with the police in a carefully orchestrated manner. Special policies and procedures are required. Such services attempt to take the emergency department into the field and generally include a psychiatrist. The presence of a psychiatrist on the team improves medical and psychiatric diagnostic capability and permits involuntary treatment decisions to be made on the spot.

Medications may also be initiated in the field. Although they deal with the most dangerous patients, these teams are also organized for admission diversion and may reduce hospital admission rates by stabilizing patients in the field and transferring their care to other community services.(59) New York State CPEP's are being encouraged to move toward this model.

**Urgent** Urgent services must be distinguished from emergency services. Demand may not justify the expense and difficulty of staffing around the clock. Many referrals come from agencies rather than the intended patient or their family and require coordination with social service agencies, landlords, and family. It is necessary to arrange appointments with the other parties in order to obtain the necessary data and gain access to the intended client. The problems discovered are often complex, well entrenched and require sustained effort. The standard for access may be 24 hours or more. At Bellevue, 80% of calls resulted in a home visit the day of referral or the following day and only 4% of calls were referred to the 911 system. However, only 24% of patients received a single visit, 48% received 2-6 visits and 15% seven or more.

### ***Special Circumstances or Populations***

**Managed Care** Rather than rely on so called "long line" utilization management of admission decisions by phone, managed care organizations (MCO) have developed mobile teams that intervene in health care settings as a means of cost containment. Teams of this type are employed to examine patients in emergency department's, RTC's or other facilities to make utilization decisions for the MCO and, in some cases, provide intensive care in the home as an alternative to hospitalization. This service may be provided by a contractor for a case rate or the service may be provided directly by the HMO. This type of service has not been described in the psychiatric literature but data has been presented in managed care industry publications.

**Police Emergency** Lamb (60) has described a mental evaluation unit operating in the Los Angeles police administration building that uses specially trained police officers to assess more than 4000 individuals a year, most of whom had been detained for misdemeanors. This unit was a team comprised of four police officers, a detective supervising the officers, four psychiatric nurses or technicians and a licensed clinical social worker supervising the mental health personnel. A team consisting of an officer and a mental health worker was on duty 16 hours a day and was dispatched by the watch commander of mental evaluation. Of 101 consecutive referrals, 49 were either violent or threatening. Eighty were taken to hospitals and 73 were admitted. Only two were arrested leading the author to conclude that most could be successfully diverted from the criminal justice system. However, of the 85 found at 6 months, 20 had been arrested (10 for violent crimes) and 36 had been re-hospitalized leading to concern that improved access to acute care alone was not sufficient.

**Old and young** Patients seen in mobile outreach tend to be older or younger than those seen in typical hospital emergency services. NYSOMH reported 3.5 times as many elderly patients and twice as many medical problems among patients seen in mobile outreach (46). In these populations, issues around ability and competency to obtain or refuse medical care or to comply with recommended care are common. A major role of the MCU in these cases is to clarify issues of responsibility and assist with interagency communication and coordination.

**Resistant clients** Despite varying amounts of training, peace officers and most civilians feel ill equipped to deal with what are referred to in New York City as 'emotionally disturbed persons'. Given that such persons are often suspicious and irritable, a particular temperament and skill set is necessary to secure their cooperation whenever possible or remove them safely when involuntary treatment appears to be warranted. Clear policies and procedures and careful adherence to them are essential because of the potential for intentional torts (57) and

constitutional claims brought under the Fourth Amendment prohibition against unlawful search and seizure.(61)

**Gradual Emergency** Mobile teams often have the opportunity to observe crises developing slowly as the result of gradual deterioration in a client's mental state or circumstances. One situation commonly faced by mobile teams is the patient who is slowly becoming a health hazard due to "hoarding" in the home. Damecour and Charron have reviewed the literature concerning this symptom.(62) These are usually older individuals, without obvious signs of mental illness or cognitive impairment who do not discard things appropriately and who eventually fill their apartments with newspapers and other detritus. They experience discarding apparently useless items as anxiety provoking but are not otherwise impaired or dangerous. In most cases, these patients are simply accompanied to a local coffee shop by the MCU staff while building agents clean and fumigate their quarters and the cycle, usually lasting years, begins again.

### **Role and Advantages**

Mobile outreach often develops as a means of extending mental health expertise to individuals and agencies including the police that are involved with the mentally ill in the community. This is thought to improve access to care both quantitatively and qualitatively, particularly for the resistant client. Mobility may be more critical in rural areas.

Qualitatively, more qualified individuals determine the need for mental health services and the level of care negotiated with more flexibility. Mental health teams develop tight linkages with community agencies and can form a bridge to these services for the client. If hospital services are deemed to be necessary, transportation to the hospital may be accomplished by experienced mental health professionals with less force and more dignity. The Eleanor Bumpers shooting in New York led to evolution of the New York model. Eleanor Bumpers was an elderly mentally ill black woman who was shot to death in her own home by police officers at whom she had brandished a knife.

Quantitatively, mobile outreach permits "case finding". Individuals are referred who would otherwise "fall through the cracks" completely or deteriorate unnecessarily before coming to attention. Individuals at risk may be linked with community resources rather than using hospital services. The combination of case finding on the one hand and early intervention on the other may have offsetting effects on utilization.

Other putative advantages of mobile teams include assessment in the patient's natural environment (56), a systems approach to assessment and intervention (59, 63), public relations, education and training.(64)

Mobile crisis teams have also been used to triage and debrief disaster victims. In New York, these are most commonly transportation related as in the crash of TWA Flight 800.(65)

### **Outcomes**

Little systematic data exist concerning of mobile crisis teams. Geller et al (66) has published a survey of state mental health agencies reflecting the views of 39 states where mobile crisis is available. Reduced admission rates were reported by more than half but this is not supported by controlled studies. Respondents also claimed benefits due to improved access and earlier intervention, particularly with resistant clients, evaluation in the natural setting and recruiting a natural support network.

The New York State Office of Mental Health CPEP program evaluation found that mobile crisis patients were more often referred by family, more often psychotic, twice as likely to be severely ill

and violent and yet were still less likely to be admitted to the hospital than similar patients seen in the emergency department. (35) Zealberg (unpublished) has also reported substantial changes in acute state hospital admissions in Charleston County, South Carolina, after the implementation of a state funded mobile outreach program.

### **Ambulatory Crisis Care**

Crises develop and resolve over time. Timely intervention may halt progression to a frank emergency. For various reasons, the period following an emergency department visit must also be considered a part of the episode of emergency care and will be marked by sustained urgency and intensity. Craig found the patients with the highest risk for suicide had the lowest rates of compliance with appointments after an emergency department visit. (67) In examining a series of 93 suicides that occurred among patients under the care of the New York State Office of Mental Health, Earle et al found that 43% had recently experienced a change in locus of care and many had not yet been admitted to next level of care. Most of these patients had not reported suicidal ideation in their recent contacts with clinicians (68). This highlights the importance of easy access and continuity of care.

Not surprisingly, though most emergency care occurs when other agencies are unavailable to make appointments.

Even when an appointment is available, it may only be for “intake” purposes rather than immediate care. In order to divert the patient from admission, medications may be prescribed or doses altered during the emergency department visit in a way that requires early attention by a psychiatrist. Patients that are not very stable may benefit from a period of more frequent contact with team members. This level of care may not be available at all in routine outpatient settings.

For these reasons, Forster has advocated a continued role for the emergency service when the patient returns to the community. (69) He has described a form of crisis case management as a way of dealing with the risk associated with diverting admissions, providing interim care through continued access to the emergency department psychiatrist if necessary and improving the odds that patients will ultimately receive appropriate care in the community. In New York State, the category of interim crisis visit was created to permit mobile teams to fulfill this function. Approximately 20% of mobile crisis visits were of this type. A crisis version of many conventional psychiatric services has been reported including crisis clinics and crisis day treatment in an effort to meet this need for immediate access and high intensity. However, services of this type have not been reported much in recent years and little data concerning their effectiveness is available.

### **Telemedicine**

Little has been written about the use of telemedicine in crisis services and the Task Force is unaware of on any service organized in large part around this technology. Much of the focus of emergency care is assessment and some emergency services provide this function remotely, perhaps most often where transportation is difficult as in rural areas and forensic settings.



**Section**  
**2**

**Report and Recommendations Regarding  
Emergency and Crisis Psychiatric Services**

**Proposed Categorization and Model Program Descriptions**

**Introduction**

In the course of its work, the Task Force identified the lack of consensus models for Emergency and Crisis Services as a significant problem. The Task Force reviewed available guidelines, standards and regulations from the JCAHO Comprehensive Accreditation Manual for Behavioral Health, the American Association of Suicidology's Organization Certification Standards Manual, New York State Comprehensive Psychiatric Emergency Program Regulations, Maryland State Regulations, American College of Emergency Physicians documents, American Association for Community Psychiatry LOCUS Guidelines, the APA Practice Guideline for the Psychiatric Evaluation of Adults, the Commission on the Accreditation of Rehabilitation Facilities Behavioral Health Standards Manual, Regulations from the New Jersey Division of Mental Health and Hospitals, the American HealthCare Commission 24 Hour Telephone Triage Standards, pre-publication information from the Expert Consensus Guidelines on the Treatment of Behavioral Emergencies, notes from the previous chair of the American Psychiatric Association Task Force on Emergency Care Issues and reviewed the available psychiatric literature on psychiatric emergency and crisis services.

The models in the following section represent a synthesis of this information. It is suggested that they might form the basis for additional collaborative work with other organizations. Preliminary discussions have already taken place with the American College of Emergency Physicians, the American Association for Community Psychiatry, the American Association for Emergency Psychiatry and the International Association for Emergency Psychiatry about the value of models such as these.

**Types of Crisis and Emergency Psychiatric Services**

As can be seen from the first part of this report, there are a wide variety of crisis and emergency psychiatric services. Unfortunately, out of this diversity of approaches has emerged a tendency to develop services that fit available resources and the structure of local institutions, rather than the needs of patients in a psychiatric emergency or crisis.

This problem was already well recognized in 1983 when a previous emergency psychiatry task force made its recommendations. A categorization scheme was proposed that drew on the categories for other emergency services. In that scheme there are "horizontal categories" and "vertical categories". Horizontal categories refer to the abilities of the emergency service to provide care for more or less complicated and specialized problems. Vertical categories refer to the resources available within the facility for care beyond the emergency service. These

categories are, to some extent, incorporated into the current list. Horizontal categories are represented here by referring to three types of service: psychiatric emergency services provided in a non-specialty setting (a medical emergency room), psychiatric emergency services provided in a specialty setting, and urgent psychiatric services provided in a specialty setting. Vertical categories are imbedded, to some extent, in the distinction between hospital or health care facility based services (which often have rapid access to inpatient psychiatric care and related resources) and community based services (which generally do not).

The authors of this report therefore decided to develop a simpler scheme for classifying services. First, it was felt to be very useful to distinguish between urgent and emergency services. An Internet search using the terms “psychiatric emergency” revealed a remarkable heterogeneity of definitions of these services. For instance, some shelters without any licensed staff at night defined themselves as emergency or crisis services.

For the purpose of this report, the authors defined emergency services as services that are able to deal with the full range of behavioral and psychiatric emergencies immediately. Urgent services are services that can provide care today in order to avoid the potential development of a psychiatric or behavioral emergency. Urgent services do not need to provide involuntary treatment; emergency services must be able to deal with patients without the capacity for informed consent or decision-making.

#### ***Proposed Categorization and Models***

- Psychiatric Emergency Services in Medical Emergency Settings
- Psychiatric Emergency Service Facility
  - 23-hour observation,
  - 72 hour extended observation,
  - Crisis case management (not described in this report).
- Psychiatric Urgent Care Facility.
- Mobile Psychiatric Emergency Service
- Mobile Psychiatric Urgent Care Service
- Psychiatric Emergency Residential Facility (Acute Diversion Units)
- Psychiatric Urgent Care Residential Facility (Crisis Residential Facilities)

## **Psychiatric Emergency Services in Medical Emergency Settings**

### **Definition**

The most common setting for psychiatric emergency services is probably the medical emergency department. A wide range of capability necessarily exists within this category. At one end of the continuum, some of the most sophisticated treatment available can be provided in medical emergency settings. On the other hand, basic standards for psychiatric assessment may be difficult to meet in other emergency room settings. In developing these program models, we have tried to identify those components of the psychiatric emergency service model that must be available to provide adequate assessment and determine appropriate level of for any patient.

## **Level of Care**

Where it is possible (e.g., where there are available alternative services) patients with clear psychiatric emergencies are best treated in services with dedicated staff and space. Where these services are not available, medical emergency services must be prepared to stabilize and assess all patients with psychiatric emergencies.

## **Description**

### **Assessments**

#### ***Pre-Hospital Telephone Assessments and Triage***

Where this service is provided it must be performed by appropriately trained and credentialed licensed independent mental health practitioners (LIMHP). Staff should have completed training on telephone assessments, and there should be written guidelines for these assessments. There must be a log of all calls received and the results of those calls that includes basic identifying information and an assessment of risk factors such as risk of suicide or self-harm, risk of violence, and ability to care for self.

#### ***Screening Assessments and Processes***

Patients who present to a medical emergency department for psychiatric reasons should generally receive a full assessment. This is because the risk of adverse events, including suicide, is high in patients who are not adequately assessed.

If there are staff continuously available with psychiatric emergency training and experience (registered nurses with a Masters or Doctoral degree in Psychiatric Nursing and two years experience, or board certified psychiatrists with appropriate training and experience in emergency psychiatry) then screening assessments with referrals to other services may be performed. See the section under Psychiatric Emergency Services below.

Patients should be continuously monitored until they are seen by an individual trained to assess the risk of harm to self or harm to others.

#### ***Full Assessment***

As outlined above, because in many emergency departments there are no staff with adequate training and experience to perform a screening assessment, patients should almost always receive a full assessment. This full assessment will ensure that risk factors that would suggest the need for intensive aftercare are not overlooked. In many settings there may not be a psychiatrist with appropriate experience and training in emergency psychiatry available on site at all times. In those circumstances we outline a mechanism for ensuring adequate assessment that relies on a licensed independent mental health practitioner (LIMHP) who performs a full psychosocial assessment, the emergency department physician, who has responsibility for patient care, assessment and clinical decision-making, and a psychiatrist available by phone for consultation. Where there is more than one psychiatrist providing consultation, one of those psychiatrists should be designated as the lead psychiatric consultant, that individual will work with the director of the emergency department to develop protocols referenced below.

A LIMHP will perform a psychosocial assessment that will include:

1. A patient interview;
2. A review of records of past treatment;

3. History gathering from collateral sources (see also section on confidentiality);
4. Contact with the current mental health providers wherever possible;
5. Identification of social, environmental and cultural factors that may be contributing to the emergency;
6. An assessment of the patient's ability and willingness to cooperate with treatment;
7. A structured assessment of risk factors relevant assessing risk for suicide or harm to others;
8. A detailed assessment of substance use, abuse, and misuse;
9. An assessment for possible abuse or neglect.

There will be explicit written criteria for the training, experience and competence of the LIMHP in conducting these assessments. The criteria will specifically address competence in: identifying social, environmental and cultural factors that may be contributing to the emergency; assessing the patient's ability and willingness to cooperate with treatment; performing a structured assessment of risk factors; completing a detailed assessment of substance abuse; and assessing for possible abuse and neglect. The consulting psychiatrist and the Director of the emergency service will approve these criteria.

The physician in the emergency service with responsibility for the patient's care will:

1. Perform an assessment of the patient's mental status that is adequate to pick up signs of a possible confusional state;
2. Complete an assessment of the patient (including a medical history, review of symptoms, physical evaluation, laboratory studies as indicated) that is adequate to exclude medical diseases that may present with psychiatric symptoms.

When the LIMHP and the emergency physician have completed their assessments they will discuss with each their findings. The emergency physician (EP) is ultimately responsible for all clinical decisions in the service.

There will be a written protocol that specifies:

1. Under what circumstances the LIMHP and/or the physician in the emergency service should consult via phone with the consulting psychiatrist;
2. The criteria for determining the patient's need for aftercare and the appropriate level of care for referrals;
3. How to determine whether the patient meets criteria for involuntary treatment.

The consulting psychiatrist and the Director of the emergency service will approve this written protocol.

When necessary, and as specified in the protocol, the consulting psychiatrist will be available to come into the emergency department to assist the EP in making clinical decisions.

***Child Assessments***

Every patient less than 18 years of age shall have an assessment (including a developmental assessment) performed by a LIMHP with appropriate training and experience in the assessment and treatment of children in a crisis setting.

***Laboratories***

There will be access to urgent (within four hours) urine toxicology screening.

***Staff Scope of Practice***

The scope of practice for the LIMHP involved in the assessment of patients will be approved by the consulting psychiatrist and the Director of the emergency service.

***Coordination of Care***

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers.

**Treatment Planning*****Stabilizing Care***

There is access to immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others).

There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service. This protocol will be reviewed and approved by both the consulting psychiatrist and the Director of the emergency service and will be updated at least annually.

***Definitive Care***

Definitive treatment will generally not be available in this care setting. Patients with a need for emergency psychiatric care will be referred to specialty psychiatric settings (e.g., inpatient services). Selected patients will be referred to outpatient psychiatric clinics or providers.

**Medication Use and Safety*****Access to Appropriate Medications***

There is immediate access to medications commonly used to treat acute psychiatric disorders and behavioral emergencies. This includes medications that are not on the facility's formulary but are commonly used in the community.

***Dispensing and Storage of Medications***

All medications are securely stored and dispensed by appropriate staff. Patient medications are not used to provide treatment in the facility except in an emergency situation.

***Availability of Emergency Medications***

Emergency psychiatric medications are immediately available.

### ***Medication Administration***

Qualified staff administer medications.

Qualified staff assess the response to medications continuously during the first half an hour after administration and at least every two hours thereafter.

## **Seclusion and Restraint**

### ***Staffing***

There are adequate numbers of staff available to ensure that when patients show signs of agitation there is immediate verbal intervention. Also, patients are not required to wait for food, water, or other necessities.

### ***Staff Training***

All staff are continuously trained in alternatives to seclusion and restraint. This training is adjusted to reflect current quality improvement information about the use of seclusion and restraint. At least yearly each staff member receives training in managing behavioral emergencies in the least restrictive, most effective, way.

### ***Assessment of Patients in S&R***

Every time locked seclusion or seclusion and restraint is performed it is based on the order of a physician or licensed independent practitioner (LIP). A physician or LIP performs an in-person assessment of each patient within one hour of seclusion or seclusion and restraint.

All patients in seclusion or seclusion and restraint are continuously observed by nursing staff.

### ***Data Collection and Review***

Data regarding the use of seclusion and seclusion and restraint are collected and reviewed at least quarterly to identify opportunities for improvement in the management of behavioral emergencies. At least yearly the facility's use of seclusion and restraint is compared to the use in at least two comparable facilities and the results of this review are incorporated into staff training and the Quality Improvement process.

## **Aftercare**

### ***Models for Aftercare***

There are written descriptions to assist in the development of appropriate plans for ongoing treatment.

There is a clear process outlined for referrals to other types and levels of care:

1. Substance abuse facilities and providers;
2. Inpatient and outpatient mental health services.

There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

### ***Continuing Care***

The discharge process ensures continuing care for patients with ongoing problems.

The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for continued outpatient mental health treatment within one week of discharge.

Subsequent contact for the purpose of ascertaining the patients status is a routine part of care. The service has a provision for contacting most patients by phone in or in person after they are discharged.

The service routinely monitors its success with making aftercare plans that are most likely to be effective.

## **Space and Equipment**

### ***Security and Safety***

Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.

Provision is made for ensuring that, to the extent possible, there are no dangerous materials accessible to patients who may be dangerous to themselves or others, including: sharp objects, weapons, materials that can be used for hanging, patient medications, etcetera. The space is continuously supervised and monitored by staff. There is controlled access to the space and a process for reducing the risk of elopement.

### ***Waiting and Reception Areas***

Waiting and reception areas are comfortable and large enough to accommodate the patients and visitors.

### ***Assessment Area***

The area where patients wait for assessment is secure, with controlled access.

### ***Patient Privacy***

A telephone is available to all patients with a reasonable degree of privacy balanced with security.

There is no use of hallways for patients waiting for or receiving care. As much as possible there is provision for patient privacy during clinical assessments.

## **Staffing**

### ***Staff Competence***

The competence of LIMHP's is continuously evaluated, monitored and enhanced.

There is a written procedure for ensuring the ongoing assessment of mental health staff competence in core clinical areas. This procedure is developed and approved by the consulting psychiatrist and the Director of the emergency service.

### ***There is Adequate Staffing***

There should be a consulting psychiatrist (s) available at all times by phone.

### ***Consultation and Continuous Learning***

Staff performance evaluation and review processes encourage all LIMHP's to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

### ***Individual Assessments of Staff***

Every LIMHP has an assessment completed at least yearly. The consulting psychiatrist participates in the process of assessing the LIMHP's.

### **Medical Records**

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

### **Quality Improvement**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation. At a minimum, the service should capture information about the patients served including culture and ethnicity, the type and number of emergencies, and the treatment provided.

### ***Critical Events***

There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff who were involved in the assessment and care of the patient. Findings from critical event reviews lead to changes in the way that care is provided.

### **Leadership**

#### ***Leadership Roles***

The consulting psychiatrist is a board eligible psychiatrist with appropriate training and experience in emergency and acute psychiatry.

### **Ethics and Patient's Rights**

Treatment is not denied or delayed because of an inability to pay.

As much as possible patients are involved in all aspects of making decisions.

### ***Consent***

All patients give informed consent for treatment except those who are not competent to make these decisions.

There is a written procedure that describes the evaluation of patients to determine if they are competent to give consent and that deals with the procedures for providing emergency care to such patients.

### ***Confidentiality and Privacy***

Confidentiality of all patients is maintained except:

1. As permitted by law and as specified in written procedures in order to ensure the safety of the patient or others.

2. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
3. To the extent that the patient consents to the release of information to others, especially significant others and health care providers.

### ***Communication with Significant Others***

As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.

To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.

Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

### ***Information on Patient Rights***

All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights. There is immediate access to an advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

### ***Diversity and Communication with Patients and Families***

There is acceptance of and respect for differences that is manifested in a variety of ways including efforts to expand cultural knowledge and resources through consultation with minority stakeholders, continuous assessment and service adaptation and enhancement to meet the diverse needs of the population served.

There is a provision for communication with patients who are speech or hearing impaired.

There is provision for translation in all languages.

### ***Grievance Process***

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.

## **Psychiatric Emergency Service Facility**

### **Definition**

Facility based psychiatric emergency services are generally the most comprehensive services. Many of these services also provide 23-hour crisis stabilization or 72 hour extended observation and treatment. The key advantage of these services is that they provide more effective and immediate treatment because they have adequate staff to complete a full psychiatric assessment and to initiate and monitor response to a treatment plan that derives from that assessment. The

dramatic expansion of the number of these services in the last two decades has been based, in part, on the increasing recognition that such immediate access to treatment improves the quality of care and may reduce the cost of care by avoiding, in some cases, the need for a psychiatric hospital stay.

As an emergency service, these programs must be prepared to provide stabilizing treatment for all patients presenting with behavioral emergencies. Generally, this means that there is also immediate access to medical emergency treatment.

As facility based services, there is usually access to inpatient psychiatric care within the same organization.

### **Level of Care**

These facilities must be prepared to manage patients who, as the result of a psychiatric disorder, are at extreme risk of harm to themselves or others. They must also be prepared to manage patients with extreme impairments in functioning and with severe medical, psychiatric and substance abuse co-morbidities.

### **Description**

The proposed model for these services derive from the essential functions of the services: immediate access to assessment and treatment and the ability to manage the most severely ill psychiatric patients at all times. Facilities should be available at all times. There should be some ability to provide mobile services (either through an agreement with another service or using existing staffing). There must be immediate access at all times to emergency medical care.

### **Assessments**

#### ***Telephone Assessments and Triage***

There should be 24-hour access to licensed independent mental health practitioners (LIMHP) who are trained in the assessment and management of crisis phone calls and who are able to assess the priority of the call and provide interventions that are appropriate to level of acuity of the caller.

There should be written procedures for handling phone calls that include prioritization and coordination with available means of performing outreach to callers.

There should be the capacity for caller identification electronically and call tracing. There should be a process for obtaining immediate assistance from other staff when such assistance is needed to safely manage the call (e.g., threats of harm to self or others).

#### ***Screening Assessments and Processes.***

Patients should receive a screening assessment within 15 minutes of presentation. Until the patient receives that assessment they should wait in a location with restricted access and egress with constant staff observation and monitoring.

A screening assessment should include an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and a medical screening assessment, including vital signs and a medical history, wherever possible.

There should be a written description of the process for performing this screening assessment. This description must address the screening for emergency medical conditions and the process for accessing emergency medical intervention. Where emergency medical services are not available on site there must be staff on site at all times who are prepared to provide first-responder health care (Basic Life Support, First Aid, etcetera).

Staff who perform this assessment should be either registered nurses or physicians who have training in triage and screening assessment.

There should be a log of all patients who present for services. There must be documentation of the screening assessment of all such patients that includes the patient name, date of birth, Social Security Number (if available), address, telephone number and the names and contact information for any significant other who is contacted.

There must be written criteria for determining which individuals presenting for care are referred to another health care facility or provider. These criteria should outline a process of assessment that ensures that those referred for care elsewhere are at low risk of harm to themselves or others, have no more than mild functional impairment, do not have significant medical, psychiatric or substance abuse comorbidity and have adequate understanding and acceptance of the need for treatment (if such need exists) that they will comply with the referral. There should be a written procedure for ensuring continuity of care and successful linkage with the referral facility or provider. There should be a continuous process of monitoring the outcomes of such referrals.

### ***Full Assessment***

Patients who are not referred for care elsewhere after a screening assessment should receive a full psychiatric assessment. This assessment should be initiated within two hours of the patient's presentation to the service. All individuals who receive a psychiatric assessment must see a psychiatrist within 8 hours of presentation to the service. There must be a written process and procedure that ensures that those who require such an evaluation more urgently can be seen and assessed within fifteen minutes of that determination.

The assessment process includes:

1. Patient interview(s) by LIMHP's including board eligible psychiatrists trained in emergency psychiatric assessment and treatment;
2. Review of records of past treatment;
3. History gathering from collateral sources (see section on confidentiality);
4. Contact with the current mental health providers wherever possible;
5. A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
6. Identification of social, environmental and cultural factors that may be contributing to the emergency;
7. An assessment of the patient's ability and willingness to cooperate with treatment;
8. A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance,

and an up-to-date record of all medications currently prescribed, and the name of the prescriber;

9. A general medical history that addresses conditions that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
10. An appropriate physical health assessment (see below);
11. A detailed assessment of substance use, abuse and misuse conducted by an individual trained in assessing substance related disorders;
12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

### ***Physical Health Assessment***

An initial evaluation for physical health should generally include:

1. Vital signs;
2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
3. A screening Neurologic examination that is adequate to rule out significant acute pathology;
4. A medical history and review of symptoms;
5. A pregnancy test in all fertile women;
6. A urine toxicology evaluation (unless there is a protocol that specifies another means of adequately assessing for substance use, misuse, and abuse);
7. Blood levels of psychiatric medications that have established therapeutic or toxic ranges;
8. Other tests and examinations as appropriate and indicated.

All patients should receive a physical health assessment as outlined above within 4 hours of presentation to the service. There must be a written process and procedure that ensures that those who require such an evaluation more urgently can be seen and assessed within fifteen minutes of initial presentation.

There should be immediate access to urgent and emergent non-psychiatric medical assessment and treatment.

Due to the high medical and substance abuse comorbidity in this population there should generally be on site capability for such routine assessments as pulse oximetry, glucometry (or stat blood glucose testing), urgent urine toxicology (results available within 4 hours) and a complete physical examination.

***Assessment for Possible Abuse or Neglect***

Every patient will be assessed for sexual or physical abuse or neglect by a LIMHP with training in this assessment.

***Child Assessments***

Every patient less than 18 years of age shall have an assessment (including a developmental assessment) performed by a LIMHP with appropriate training and experience in the assessment and treatment of children in a crisis setting.

***Laboratories***

There will be immediate access on-site to phlebotomy and same day laboratory studies including:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels;
7. Other studies as appropriate, based on the patterns of illness in the patients served.

***Staff Scope of Practice***

The scope of practice for all staff involved in the assessment or treatment of patients will be defined in writing by the clinical director and will be appropriate to staff training and experience.

***Coordination of Care***

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the patient's assessment in the service.

**Treatment and Treatment Planning*****Stabilizing Care***

There is access to immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others).

There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service that is approved by the clinical director and updated at least annually.

***Definitive Care***

An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. This is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.

Patients receive appropriate education that is relevant to their condition. This should include information about the most effective treatment for the patient's psychiatric disorder.

### ***Reassessment and Response to Treatment***

Response to treatment is assessed at least every four hours by nursing staff trained in the assessment of acute psychiatric patients or by a board eligible psychiatrist.

Whenever it appears necessary, the treatment plan is adjusted to incorporate the patient's response to previous treatment.

### ***Referrals***

There is a mechanism for ensuring that all patients have access to appropriate referrals to public guardians or conservators, legal services, self help organizations, patient advocacy, social services, etcetera.

## **Medication Use and Safety**

### ***Access to Appropriate Medications***

There is immediate access to medications commonly used to treat acute psychiatric disorders and behavioral emergencies. This includes medications that are not on the facility's formulary but are commonly used in the community.

### ***Dispensing and Storage of Medications***

All medications are securely stored and dispensed by appropriate staff. Patient medications are not used to provide treatment in the facility except in an emergency situation.

### ***Availability of Emergency Medications***

Emergency psychiatric medications are immediately available.

### ***Medication Administration***

Qualified staff administer medications.

Qualified staff assess the response to medications continuously during the first half an hour after administration and at least every two hours thereafter.

## **Seclusion and Restraint**

### ***Staffing***

There are adequate numbers of staff available to ensure that when patients show signs of agitation there is immediate verbal intervention. Also, patients are not required to wait for food, water, or other necessities.

### ***Space***

There is adequate space to ensure that every individual who needs space to be alone has access to such space. Also, group-sleeping rooms are not the only options for individuals who may need private space.

Rooms used for seclusion and restraint have adequate air flow, access to a bathroom, adequate lighting that can (whenever possible) be dimmed or brightened at the patient's request, and capacity for continuous observation from outside the room.

### ***Quiet Rooms***

There are enough quiet rooms (single rooms that may be safely used when patients are not in restraints) that every patient who would benefit from such a room has access to one.

### ***Staff Training***

All staff are continuously trained in alternatives to seclusion and restraint. This training is adjusted to reflect current quality improvement information about the use of seclusion and restraint. At least yearly each staff member receives a full day training in managing behavioral emergencies in the least restrictive, most effective, way. The training includes experiences in seclusion and seclusion and restraint for the staff.

### ***Assessment of Patients in S&R***

Every time locked seclusion or seclusion and restraint is performed it is based on the order of a psychiatrist or licensed independent practitioner. Verbal orders for seclusion and restraint are signed within one hour and a psychiatrist or appropriate LIP performs an in-person assessment of each patient within one hour of seclusion or seclusion and restraint.

All patients in seclusion or seclusion and restraint are continuously observed by nursing staff.

### ***Debriefing***

After every episode of seclusion and restraint there is a meeting of the staff who participated in the episode, including the LIP who ordered it, to review the procedure, and to identify opportunities that might have existed to prevent the need for seclusion and restraint. Recommendations that are made in those meetings are incorporated into the Quality Improvement process.

### ***Data Collection and Review***

Data regarding the use of seclusion and seclusion and restraint are collected and reviewed at least monthly to identify opportunities for improvement in the management of behavioral emergencies. At least yearly the facility's use of seclusion and restraint is compared to the use in at least two comparable facilities and the results of this review are incorporated into staff training and the Quality Improvement process.

## **Aftercare**

### ***Plan for Aftercare***

For each patient seen there is a plan for ongoing care that is derived from the initial psychiatric assessment and from the results of treatment and the reassessments performed by the clinical staff. Prior to discharge each patient has an assessment performed by a board eligible psychiatrist with training and/or experience in assessing patients in a psychiatric emergency. The results of this assessment and the plan for ongoing treatment are documented in the chart.

### ***Models for Aftercare***

There are written descriptions to assist in the development of appropriate plans for ongoing treatment. These descriptions assist the clinical staff in developing plans that incorporate the least restrictive alternatives that are consistent with the optimum improvement of the patient's condition.

Unless the plan for ongoing treatment involves involuntary treatment, staff develops plans for ongoing treatment that are the most likely to be implemented after discharge, and that are consistent with the patient's understanding of the nature of their problem, their needs, and the community resources and natural support system that they have access to.

There is a clear process outlined for referrals to other types and levels of care:

1. Medical emergency rooms;
2. Substance abuse facilities and providers;
3. Inpatient and outpatient mental health services.

There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

### ***Continuing Care***

The discharge process ensures continuing care for patients with ongoing problems.

There is a clear procedure to ensure the transfer of appropriate records to the facility or provider who is going to be providing ongoing care.

The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for continued outpatient mental health treatment within one week of discharge.

The service has developed a means of ensuring access to a psychiatrist by phone or in person until the patient's outpatient appointment.

Subsequent contact to ascertain the patient's status is a routine part of care. The service has a provision for such contact with most patients by phone or in person after they are discharged from the emergency service.

The service routinely monitors its success with making aftercare plans that are most likely to be effective.

## **Space and Equipment**

### ***Security and Safety***

Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.

Provision is made for ensuring that there are no dangerous materials accessible to patients, including: sharp objects, weapons, materials that can be used for hanging, patient medications, etcetera. The space is continuously supervised and monitored by staff. There is controlled access to the space and a process of preventing elopement.

***Waiting and Reception Areas***

Waiting and reception areas are comfortable and large enough to accommodate the patients and visitors.

There is a room for family members to wait in and to visit with the patient. While awaiting a screening assessment or full assessment, patients can sit in a comfortable and secure area.

***Screening Assessment Area***

The area where patients wait for a screening assessment is secure, with controlled access. It is monitored continuously by staff, but is otherwise private.

***Restrooms and Showers***

There is one toilet per 6 patients and one shower per 8 patients. Families have access to clean restrooms.

***Patient Privacy***

A telephone is available to all patients with a reasonable degree of privacy balanced with security.

There is no use of hallways for patients waiting for or receiving care. Patient assessments take place in private rooms unless there is a clinical reason not to do so. There is adequate room for meetings with family and for conjoint meetings with mental health clinicians and case managers.

There is a well-equipped room for physical examinations that is private.

***Storage and Security of Property***

There is a written procedure for ensuring the storage and security of patient property. When valuables or money are to be stored, more than one staff member signs the receipt. When items are misplaced the service replaces them. There is an ongoing review of this process to identify opportunities for improvement.

***Other***

Articles for grooming are readily available.

Meals and snacks are provided at appropriate times and on entry into the service for patients who are hungry or thirsty.

Ventilation is adequate for a patient population that is at increased risk for poor hygiene, poor health care, and tuberculosis.

***Staffing******Staff Competence***

The competence of all staff is continuously evaluated, monitored and enhanced.

There is a written procedure for ensuring the ongoing assessment of staff competence in core clinical areas. This procedure is developed and approved by the clinical director. Individual plans

for the development and improvement of clinical skills are part of the yearly performance evaluation process.

### ***Qualifications of Staff***

The clinical director has developed explicit written criteria for the qualifications of staff regarding training, experience and competence. The criteria specifically address the training in crisis or emergency settings. In general, those staff who work without ongoing supervision should have had supervised experience in an acute psychiatric setting.

### ***There is Adequate Staffing***

The Medical Staff credentialing process ensures that all medical staff that work without supervision have adequate experience in medical screening and the assessment and treatment of psychiatric emergencies.

There is at all times at least one psychiatric nurse on site (defined as a registered nurse who has a Master's degree or a Doctorate in Psychiatric Nursing and two years of post Master's level clinical experience in psychiatric nursing) at all times.

There is a social worker available days and evenings.

There is always one staff member on site who is able to do an assessment of substance abuse and to do treatment planning and intervention. Staff who assess substance abuse have competence in history gathering, the natural history of substance related disorders, evidence based treatment, and available community resources.

Staff who assess children have competence in developmental assessment, evidence based treatment and community resources.

There should be a physician on site at all times. A psychiatrist should at all times be available by phone and, if necessary, on site to perform a face-to-face evaluation.

There should be a clinical director who is a board eligible psychiatrist with appropriate training and experience in emergency and acute psychiatry.

### ***Staffing Adjustment***

There is a process for assessing and anticipating staffing needs. There is an on-call roster of clinical and nursing staff.

### ***Staff Orientation and In-Service Training***

There is an ongoing educational program to update staff regarding best practices in emergency and acute psychiatric services.

There is adequate training to ensure that staff are competent to provide services to patients from all of the cultural backgrounds represented in the catchment area of the program.

The ongoing educational program incorporates findings from the Quality Improvement process.

### ***Multi-Disciplinary Team***

The role of each member of the multi-disciplinary team is defined in writing. Every patient is assigned to a psychiatrist who is responsible for the overall care of the patient. These standards are developed and approved by the clinical director.

Staff who are not independent practitioners are supervised on an ongoing basis. There is a licensed clinical staff member who directly supervises all trainees.

Security (police) roles are clearly specified. Where a contractor provides security for the facility there is a clear written agreement that specifies the role of security in the process of care.

There is a process for reviewing the performance of security services and their role in managing assaultive behavior. There is a written protocol that specifies these roles.

### ***Consultation and Continuous Learning***

Staff performance evaluation and review processes encourage all staff to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

### ***Individual Assessments of Staff***

Every staff member has an assessment completed at least yearly. The clinical director participates in the process of staff assessment for all clinical staff.

## **Medical Records**

Medical records are stored in a confidential and secure manner. There is provision for emergency access (within one hour) to records of previous treatment.

There is an individual record for each patient and that record includes: identifying information, marital status, legal status, a description of the emergency care provided before admission to the facility, a record of patient preferences regarding involuntary treatment (if such a document was previously provided to the facility), the assessments, treatment plans, level of care determination and aftercare plan for each patient.

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

## **Quality Improvement**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation. At a minimum, the service should capture information about the patients served including culture and ethnicity, the type and number of emergencies, and the treatment provided.

### ***Key Measures***

Performance on key measures is compared to the performance of comparable services elsewhere. This includes: linkage to aftercare and use of seclusion and restraint.

Linkage with aftercare and the use of seclusion and restraint in the service is continuously measured.

### ***Patient Satisfaction***

There is a process for evaluating patient satisfaction. This process includes an opportunity to obtain detailed information about patient concerns that is gathered in such a way that patients do

not experience concern about being honest (e.g., interviews done by former mental health patients, anonymous surveys that are mailed back).

### ***Grievance Process***

Every patient is provided information about how to file a grievance on entry and exit from the service.

There is a written process for handling grievances or complaints that ensures that there is no adverse consequence (retaliation) for filing a grievance, that grievances are responded to within 30 days and that includes a means for appealing decisions to someone outside the service.

### ***Critical Events***

Every patient death within 30 days of discharge from the service is reviewed as part of a critical event review.

There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff who were involved in the assessment and care of the patient.

Findings from critical event reviews lead to changes in the way that care is provided.

## **Leadership**

### ***Leadership Roles***

The clinical director should be a board certified psychiatrist with appropriate training and experience in emergency and acute psychiatry. Where the roles of clinical and administrative director are separated, there is a written description of the two roles and their relationship. The clinical director is responsible for ensuring the overall quality of care in the service.

### ***Competence and Role of Staff***

Leadership reviews and ensures the competence of all staff. The clinical director approves the definition of the role of each care providing staff member.

### ***Community Liaison***

Leadership ensures ongoing relationships with community services, particularly those involved in providing emergency care and community mental health services.

Leadership ensures that there is consumer and community input in service planning and outreach.

Leadership ensures that there is an up to date and complete list of resources that patients receiving services commonly need.

## **Disaster Plan**

The role of the service in disasters is defined in a written document. Staff are adequately trained to fulfill this role.

## **Ethics and Patient's Rights**

Treatment is not denied or delayed because of an inability to pay.

As much as possible patients are involved in all aspects of making decisions.

Patients are given complete information about their diagnosis and the options for treatment unless there is a clinical contraindication for this.

All staff carry identification that indicates their name, title and affiliation.

### ***Consent***

All patients give informed consent for treatment except those who are not competent to make these decisions.

There is a written procedure that describes the evaluation of patients to determine if they are competent to give consent and that deals with the procedures for providing emergency care to such patients.

### ***Confidentiality and Privacy***

Confidentiality of all patients is maintained except:

1. As permitted by law and as specified in written procedures in order to ensure the safety of the patient or others.
2. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
3. To the extent that the patient consents to the release of information to others, especially significant others and health care providers.

### ***Communication with Significant Others***

As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.

To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.

Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

### ***Restrictions on Patient Rights***

The circumstances under which patient rights may be curtailed are specified in a written policy and procedure. That policy and procedure includes the requirements for documentation and the limitations on such restrictions.

### ***Information on Patient Rights***

All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights. There is immediate access to an

advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

### ***Diversity and Communication with Patients and Families***

There is acceptance of and respect for differences that is manifested in a variety of ways including efforts to expand cultural knowledge and resources through consultation with minority stakeholders, continuous assessment and service adaptation and enhancement to meet the diverse needs of the population served.

There is a provision for communication with patients who are speech or hearing impaired.

There are staff available who can communicate with patients who do not speak English, and whose primary language is spoken by 5% or more of individuals in the catchment area of the service.

There is provision for translation in all other languages.

### ***Grievance Process***

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.

## **23 Hour Observation and 72 Hour Extended Observation**

Facilities that provide 23 hour observation and continuous intensive treatment or 48-72 hour extended observation and continuous intensive treatment should meet all of the guidelines listed above under “Psychiatric Emergency Services – Facility Based” as well as the guidelines outlined below. Models that are relevant only to 23-hour services are marked with “[23]” and models that are relevant to 48-72 hour programs are marked with “[72]”.

In general, programs that provide treatment beyond 72 hours are not significantly different from inpatient services and can reasonably be judged by those models.

Patients that seem to be most appropriate for observation and intensive emergency treatment are patients with:

1. A suicidal crisis that is related to an acute event and/or a pattern of unstable mood or behavior that is longstanding.
2. A substance induced or related emergency that is of relatively short duration.
3. Other conditions that are likely to significantly improve within a short period of time, and where the patient is likely to be able to return to the community if such significant improvement takes place.

### ***Criteria for Treatment***

There should be written models for providing patients with 23 hour or 72-hour observation and intensive treatment. These models should specify the types of patients who are appropriate for such treatment, which types are not appropriate for such treatment, and the expected outcomes of treatment.

### ***Space and Equipment***

Sleeping rooms have doors or other means of ensuring privacy. There is portioning to provide privacy in rooms of 4-8 patients, especially segregation of the sexes. There are no more than 8 patients to a room.

Sleeping quarters meet state standards for inpatient units in terms of space, privacy and equipment. [72]

Single rooms have at least 80 square feet of usable space; rooms with multiple beds have at least 60 square feet of usable space per patient.

There are quiet areas that are accessible to all patients. [72]

There is access to natural light. [72]

There is access to reading material and other recreational activities that are usually available in a home. [72]

### ***Staffing***

There is adequate staff to allow reassessment at least every 8 hours and to provide active therapeutic intervention to the extent that such intervention is consistent with the patient's clinical state.

There is a social worker that completes an assessment of every patient and works with every patient on a discharge plan. [72]

There is a LIMHP who is assigned to the patient on each shift and who is responsible for providing the patient with active treatment including psychoeducation, crisis psychotherapy, substance abuse treatment, developing a plan for returning to the community that addresses potential obstacles to a successful return.

### ***Assessment***

Nursing care plans are developed for all patients. [72]

A social work assessment and discharge plan is developed for all patients. [72]

### ***Treatment***

Patients are involved in active treatment that includes: psychiatric assessment and treatment (with at least daily visits with a psychiatrist), crisis psychotherapy, psychoeducation, family intervention, substance abuse treatment and relapse prevention [72].

## **Psychiatric Urgent Care Facility**

### **Definition**

Psychiatric Urgent Care Services and Clinics are an essential component of most mental health systems of care. They serve two purposes: ready access to psychiatric assessment and treatment for new patients with urgent needs, and access to same day psychiatric assessment

and treatment for existing patients within the system. In the latter role, they essentially substitute for the treatment team, either because the team does not have enough time to see the patient urgently, or because the patient's need occurs after hours. While this may not be an ideal way of providing care, it is far better than having no immediate access or after hours access at all.

Psychiatric Urgent Care Services and Clinics are generally much less expensive than Psychiatric Emergency Services. They are often more "patient friendly" since the need for control of behavioral emergencies is much smaller and therefore the physical layout can be more open.

They provide care for patients who do not currently have a behavioral emergency (e.g., are not currently likely to hurt themselves or others) but who might develop an emergency if they are not provided with same day assessment and treatment.

## **Level of Care**

Because they have the capacity to provide immediate treatment, they may be able to take patients with fairly severe needs, if there is reason to believe that a brief, moderately intensive, intervention might reduce the need for care to the moderate level. For instance, Urgent Services can often treat patients with a serious risk of harm, if the individual appears to have some ability to control the impulses to harm him or herself. Similarly, some patients with serious impairment in their level of functioning can be treated here, as long as there is reason to believe that treatment of the psychiatric symptoms may reduce this impairment to the moderate level. These services are generally more limited in their ability to manage medically complex patients, or patients with significant substance related co-morbidity and generally are not appropriate places to refer patients with major co-morbidity. They are also generally not appropriate places to provide treatment for patients with highly stressful living situations, patients with poor response to previous treatment and patients with minimal engagement in treatment and recognition of the need for treatment.

## **Description**

Facilities should be available during extended hours, particularly evenings and weekends.

## **Assessments**

### ***Telephone Assessments and Triage***

There should be a written procedure for handling emergency calls.

### ***Screening Assessments and Processes***

Patients should receive a screening assessment within 15 minutes of presentation. Until the patient receives that assessment they should wait in a location with constant staff observation and monitoring.

A screening assessment should include an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and an evaluation of the need for an immediate medical screening assessment by a nurse or psychiatrist.

There should be a written description of the process for performing this screening assessment. This description must address the criteria for request an immediate medical screening assessment. Where emergency medical services are not available on site there must be staff on site at all times who are prepared to provide first-responder health care (Basic Life Support, First Aid, etcetera).

Staff who perform this assessment should be Licensed Independent Mental Health Practitioners (LIMHP) or nursing staff who have training in triage and screening assessment.

There should be a log of all patients who present for services. There must be documentation of the screening assessment of all such patients that includes the patient name, date of birth, Social Security Number (if available), address, telephone number and the names and contact information for any significant other who is contacted.

There must be written criteria for determining which individuals presenting for care are referred to another health care facility or provider. These criteria should outline a process of assessment that ensures that those referred for care elsewhere are at low risk of harm to themselves or others, have no more than mild functional impairment, do not have significant medical, psychiatric or substance abuse comorbidity and have adequate understanding and acceptance of the need for treatment (if such need exists) that they will comply with the referral. There should be a written procedure for ensuring continuity of care and successful linkage with the referral facility or provider. There should be a continuous process of monitoring the outcomes of such referrals.

### ***Full Assessment***

Patients who are not referred for care elsewhere after a screening assessment should receive a full psychiatric assessment. This assessment should be initiated within three hours of the patient's presentation to the service. All individuals who receive a psychiatric assessment must see a psychiatrist within 8 hours of presentation to the service. There must be a written process and procedure that ensures that those who require such an evaluation more urgently can be seen and assessed within fifteen minutes of initial presentation.

The assessment process includes:

1. Patient interviews by a LIMHP's including board eligible psychiatrists;
2. Review of records of past treatment;
3. History gathering from collateral sources (see section on confidentiality);
4. Contact with the current mental health providers wherever possible;
5. A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
6. Identification of social, environmental and cultural factors that may be contributing to the urgent need for care;
7. An assessment of the patient's ability and willingness to cooperate with treatment;
8. A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescriber;

9. A general medical history that addresses medical illnesses that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
10. An assessment of substance use, abuse and misuse;
11. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

### ***Physical Health Assessment***

An initial evaluation for physical health should generally include:

1. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
2. A medical history and review of symptoms;
3. A pregnancy test in all fertile women;
4. Blood levels of psychiatric medications that have established therapeutic or toxic ranges;
5. Other tests and examinations as appropriate and indicated.

There should be at all times the capability to perform the routine aspects of a physical exam, including vital signs monitoring, on all patients who require it.

There should at all times be the capacity to have urgent phlebotomy with stat lab results on the same day.

### ***Assessment for Possible Abuse or Neglect***

Every patient will be assessed for sexual or physical abuse or neglect by a LIMHP with training in this assessment.

### ***Child Assessments***

Every patient less than 18 years of age shall have an assessment (including a developmental assessment) performed by a LIMHP with appropriate training and experience in the assessment and treatment of children in a crisis setting.

### ***Laboratories***

There should at all times be the capacity to have urgent phlebotomy with stat lab results on the same day. Laboratory studies that should be available include:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;

6. Psychiatric medication levels;
7. Other studies as appropriate, based on the patterns of illness in the patients served.

### ***Staff Scope of Practice***

The scope of practice for all staff involved in the assessment or treatment of patients will be defined in writing by the clinical director and, where the clinical director is different from the medical director, will also be approved by the medical director. The scope of practice will be appropriate to staff training and experience.

### ***Coordination of Care***

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the patient's assessment in the service.

## **Treatment and Treatment Planning**

### ***Stabilizing Care***

There is access to immediate care to reduce the risk from a behavioral emergency (e.g., quiet room, voluntary medications, adequate staff to perform interventions other than seclusion and restraint).

There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service that is approved by the clinical director and updated at least annually.

### ***Definitive Care***

An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. This is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.

Patients receive appropriate education that is relevant to their condition. This should include information about the most effective treatment for the patient's psychiatric disorder.

### ***Referrals***

There is a mechanism for ensuring that all patients have access to appropriate referrals to public guardians or conservators, legal services, self help organizations, patient advocacy, social services, etcetera.

## **Medication Use and Safety**

### ***Access to Appropriate Medications***

There is immediate access to oral medications commonly used to treat acute psychiatric disorders. This includes medications that are not on the facility's formulary but are commonly used in the community.

### ***Dispensing and Storage of Medications***

All medications are securely stored and dispensed by appropriate staff. Patient medications are not used to provide treatment in the facility except in an emergency situation.

### ***Medication Administration***

Qualified staff administer medications.

Qualified staff assess the response to medications continuously during the first half an hour after administration.

Patients may or may not have medications administered while in the clinic. Where clinically appropriate they may be given a small supply of medication to take home or a prescription for medication.

## **Seclusion and Restraint**

### ***Staffing***

There are adequate numbers of staff available to ensure that when patients show signs of agitation there is immediate verbal intervention. Also, patients are not required to wait for food, water, or other necessities.

### ***Space***

There is adequate space to ensure that every individual who needs space to be alone has access to such space.

### ***Quiet Rooms***

There is at least one quiet room, a single room that allows constant observation.

### ***Staff Training***

All staff are continuously trained in alternatives to seclusion and restraint. At least yearly, each staff member receives a full day training in managing behavioral emergencies in the least restrictive, most effective, way.

### ***Facilities that Perform Seclusion and Restraint***

See the section above entitled "Psychiatric Emergency Services – Facility Based" for the appropriate models.

## **Aftercare**

### ***Plan for Aftercare***

For each patient seen there is a plan for ongoing care that is derived from the initial psychiatric assessment. The plan for ongoing treatment is documented in the chart.

### ***Models for Aftercare***

There are written models to assist in the development of appropriate plans for ongoing treatment. These models assist the clinical staff in developing plans that incorporate the least restrictive alternatives that are consistent with the optimum improvement of the patient's condition.

Unless the plan for ongoing treatment involves involuntary treatment, staff develops plans for ongoing treatment that are the most likely to be implemented after discharge, and that are consistent with the patient's understanding of the nature of their problem, their needs, and the community resources and natural support system that they have access to.

There is a clear process outlined for referrals to other types and levels of care:

1. Medical emergency rooms;
2. Substance abuse facilities and providers;
3. Inpatient and outpatient mental health services.

There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

### ***Continuing Care***

The discharge process ensures continuing care for patients with ongoing problems.

There is a clear procedure to ensure the transfer of appropriate records to the facility or provider who is going to be providing ongoing care.

The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for continued outpatient mental health treatment within one week of discharge.

The service has developed a means of ensuring access to a psychiatrist by phone or in person until the patient's outpatient appointment.

Subsequent contact to ascertain the patient's status is a routine part of care. The service has a provision for such contact with most patients by phone or in person after they are discharged from the emergency service.

The service routinely monitors its success with making aftercare plans that are most likely to be effective.

## **Space and Equipment**

### ***Security and Safety***

Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.

The space is continuously supervised and monitored by staff.

### ***Waiting and Reception Areas***

Waiting and reception areas are comfortable and large enough to accommodate the patients and visitors.

There is a room for family members to wait in and to visit with the patient. While awaiting a screening assessment or full assessment, patients can sit in a comfortable and secure area.

### ***Screening Assessment Area***

The area where patients wait for a screening assessment is secure and is monitored continuously by staff, but is otherwise private.

### ***Restrooms and Showers***

There is one toilet per 6 patients.

### ***Patient Privacy***

A telephone is available to all patients with a reasonable degree of privacy balanced with security. There is no use of hallways for patients waiting for or receiving care. Patient assessments take place in private rooms unless there is a clinical reason not to do so. There is adequate room for meetings with family and for conjoint meetings with mental health clinicians and case managers.

### ***Other***

Ventilation is adequate for a patient population that is at increased risk for poor hygiene, poor health care, and tuberculosis.

## **Staffing**

### ***Staff Competence***

The competence of all staff is continuously evaluated, monitored and enhanced.

There is a written procedure for ensuring the ongoing assessment of staff competence in core clinical areas. This procedure is developed and approved by the clinical director, and where there is a separate medical director, the medical director. Individual plans for the development and improvement of clinical skills are part of the yearly performance evaluation process.

### ***Qualifications of Staff***

The clinical director has developed explicit written criteria for the qualifications of staff regarding training, experience and competence. The criteria specifically address the training in crisis or emergency settings. In general, those staff who work without ongoing supervision should have had supervised experience in an acute psychiatric setting.

These criteria for qualifications of staff are reviewed and approved by the medical director, where the medical director is not the clinical director.

### ***There is Adequate Staffing***

The Medical Staff credentialing process ensures that all medical staff that work without supervision have adequate experience in medical screening and the assessment and treatment of psychiatric emergencies.

There is a social worker available days and evenings.

There is always one staff member on site who is able to do an assessment of substance abuse and to do treatment planning and intervention. Staff who assess substance abuse have competence in history gathering, the natural history of substance related disorders, evidence based treatment, and available community resources.

Staff who assess children have competence in developmental assessment, evidence based treatment and community resources.

A psychiatrist should at all times be available by phone and to perform a face-to-face evaluation on site.

There should be a medical director who is board certified in Psychiatry.

### ***Staffing Adjustment***

There is a process for assessing and anticipating staffing needs. There is an on-call roster of clinical staff.

### ***Staff Orientation and In-Service Training***

There is an ongoing educational program to update staff regarding best practices in urgent psychiatric services.

There is adequate training to ensure that staff are competent to provide services to patients from all of the cultural backgrounds represented in the catchment area of the program.

The ongoing educational program incorporates findings from the Quality Improvement process.

### ***Multi-Disciplinary Team***

The role of each member of the multi-disciplinary team is defined in writing. These standards are developed and approved by the clinical director, and where there is a separate medical director, the medical director.

Staff who are not independent practitioners are supervised on an ongoing basis. There is a licensed clinical staff member who directly supervises all trainees.

Security (police) roles are clearly specified. Where a contractor provides security for the facility there is a clear written agreement that specifies the role of security in the process of care.

There is a process for reviewing the performance of security services and their role in managing assaultive behavior. There is a written protocol that specifies these roles.

### ***Consultation and Continuous Learning***

Staff performance evaluation and review processes encourage all staff to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

### ***Individual Assessments of Staff***

Every staff member has an assessment completed at least yearly. The clinical director, and, where there is a separate medical director, the medical director, participates in the process of staff assessment for all clinical staff.

### **Medical Records**

Medical records are stored in a confidential and secure manner. There is provision for emergency access (within one hour) to records of previous treatment.

There is an individual record for each patient and that record includes: identifying information, marital status, legal status, a description of the emergency care provided before admission to the facility, a record of patient preferences regarding involuntary treatment (if such a document was previously provided to the facility), the assessments, treatment plans, level of care determination and aftercare plan for each patient.

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

### **Quality Improvement**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation. . At a minimum, the service should capture information about the patients served including culture and ethnicity, the type and number of emergencies, and the treatment provided.

### ***Key Measures***

Linkage with aftercare is continuously measured.

### ***Patient Satisfaction***

There is a process for evaluating patient satisfaction. This process includes an opportunity to obtain detailed information about patient concerns that is gathered in such a way that patients do not experience concern about being honest (e.g., interviews done by former mental health patients, anonymous surveys that are mailed back).

### ***Grievance Process***

Every patient is provided information about how to file a grievance on entry and exit from the service.

There is a written process for handling grievances or complaints that ensures that there is no adverse consequence (retaliation) for filing a grievance, that grievances are responded to within 30 days and that includes a means for appealing decisions to someone outside the service.

### ***Critical Events***

Every patient death within 30 days of discharge from the service is reviewed as part of a critical event review.

There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff who were involved in the assessment and care of the patient.

Findings from critical event reviews lead to changes in the way that care is provided.

## **Leadership**

### ***Leadership Roles***

There must be a clinical or medical director who is a board eligible psychiatrist with adequate training and experience in acute psychiatry. Where the roles of clinical, medical and administrative director are separated, there is a written description of the roles and their relationship.

### ***Competence and Role of Staff***

Leadership reviews and ensures the competence of all staff.

### ***Community Liaison***

Leadership ensures ongoing relationships with community services, particularly those involved in providing emergency care and community mental health services.

Leadership ensures that there is consumer and community input in service planning and outreach.

Leadership ensures that there is an up to date and complete list of resources that patients receiving services commonly need.

## **Disaster Plan**

The role of the service in disasters is defined in a written document. Staff are adequately trained to fulfill this role.

## **Ethics and Patient's Rights**

Treatment is not denied or delayed because of an inability to pay.

As much as possible patients are involved in all aspects of making decisions.

Patients are given complete information about their diagnosis and the options for treatment unless there is a clinical contraindication for this.

All staff carry identification that indicates their name, title and affiliation.

### ***Consent***

All patients give informed consent for treatment except those who are not competent to make these decisions.

There is a written procedure that describes the evaluation of patients to determine if they are competent to give consent and that deals with the procedures for providing emergency care to such patients.

### ***Confidentiality and Privacy***

Confidentiality of all patients is maintained except:

1. As permitted by law and as specified in written procedures in order to ensure the safety of the patient or others.
2. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
3. To the extent that the patient consents to the release of information to others, especially significant others and health care providers.

### ***Communication with Significant Others***

As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.

To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.

Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

### ***Restrictions on Patient Rights***

The circumstances under which patient rights may be curtailed are specified in a written policy and procedure. That policy and procedure includes the requirements for documentation and the limitations on such restrictions.

### ***Information on Patient Rights***

All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights. There is immediate access to an advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

### ***Diversity and Communication with Patients and Families***

There is acceptance of and respect for differences that is manifested in a variety of ways including efforts to expand cultural knowledge and resources through consultation with minority stakeholders, continuous assessment and service adaptation and enhancement to meet the diverse needs of the population served.

There is a provision for communication with patients who are speech or hearing impaired.

There are staff available who can communicate with patients who do not speak English, and whose primary language is spoken by 5% or more of individuals in the catchment area of the service.

There is provision for translation in all other languages.

### ***Grievance Process***

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.

## **Mobile Psychiatric Emergency Service**

### **Definition and Description**

Mobile services that provide psychiatric emergency care have the capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility. They are available 24 hours a day. They have access to the full continuum of care and have a psychiatrist available by phone or for in-person assessment as needed and clinically indicated.

Mobile services provide care in the patient's natural environment, and this makes it easier to get a full sense of the environmental and social sources of an emergency. They also allow outreach to individuals who do not meet criteria for involuntary detention, but clearly need psychiatric treatment.

In areas that are not densely populated, they may be the ideal way of delivering high quality psychiatric emergency care.

### **Level of Care Criteria**

These services must be prepared to manage patients who, as the result of a psychiatric disorder, are at extreme risk of harm to themselves or others. They must also be prepared to manage patients with extreme impairments in functioning and with severe medical, psychiatric and substance abuse co-morbidities.

### **Models**

The proposed models for the services derive from the essential functions of the services: immediate access to assessment and treatment and the ability to manage the most severely ill psychiatric patients at all times. Facilities should be available at all times. There should be some ability to provide mobile services (either through an agreement with another service or using existing staffing). There must be immediate access at all times to emergency medical care.

### **Assessments**

#### ***Telephone Assessments and Triage***

There should be 24-hour access to licensed independent mental health practitioners (LIMHP) who are trained in the assessment and management of crisis phone calls and who are able to assess the priority of the call and provide interventions that are appropriate to level of acuity of the caller.

Telephone calls should be answered within two minutes. If this is not possible there should be the opportunity to leave a message, or to have the call handled outside the routine system if it is an emergency.

A screening telephone assessment should include an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and a medical screening assessment.

There should be written procedures for handling phone calls that include prioritization and coordination with available means of performing outreach to callers. There should be a large easily visible map to assist in the dispatching process.

There should be the capacity for caller identification electronically and call tracing.

There should be a process for obtaining immediate assistance from other staff when such assistance is needed to safely manage the call (e.g., threats of harm to self or others).

There should be a set of written models and procedures for evaluating the level of risk to staff of the patient.

There should be a protocol for ensuring that police and the mobile response team both meet the patient at the site.

There should always be two staff on every outreach. There should always be a psychiatrist, a nurse or mid-level practitioner on each team where the outreach is to a non-medical facility or into the community.

Urgent calls should lead to an in-person response within one hour, and where this level of response will not be possible, there should be a mechanism for ensuring that the patient receives timely care via the emergency response system.

There should be a log of all calls. There must be documentation of the screening assessment of all such patients that includes the patient name, date of birth, Social Security Number (if available), address, telephone number and the names and contact information for any significant other who is contacted.

### ***Full Assessment***

Patients who are not referred for care elsewhere after a screening assessment should receive a full psychiatric assessment. This assessment should be initiated within two hours of the call (except in urgent cases).

The assessment process includes:

1. Patient interview(s) by LIMHP's (including a psychiatrist, nurse or mid-level practitioner);
2. Review of records of past treatment;
3. History gathering from collateral sources (see also section on confidentiality);
4. Contact with the current mental health providers wherever possible;
5. An assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
6. Identification of social, environmental and cultural factors that may be contributing to the emergency;

7. An assessment of the patient's ability and willingness to cooperate with treatment;
8. A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescriber;
9. A general medical history that addresses conditions that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
10. An appropriate physical health assessment (see below);
11. A detailed assessment of substance use, abuse and misuse conducted by an individual trained in assessing substance related disorders;
12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

### ***Physical Health Assessment***

An initial evaluation for physical health should generally include:

1. Vital signs;
2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
3. A screening neurologic examination that is adequate to rule out significant acute pathology;
4. A medical history and review of symptoms;
5. A pregnancy test in all fertile women;
6. Other tests and examinations as appropriate and indicated.

There should be a procedure for ensuring immediate access to urgent and emergent non-psychiatric medical assessment and treatment.

Due to the high medical and substance abuse comorbidity in this population there should generally be capability for such routine assessments as pulse oximetry, glucometry (or stat blood glucose testing), blood pressure, and temperature with the outreach team.

### ***Assessment for Possible Abuse or Neglect***

Every patient will be assessed for sexual or physical abuse or neglect by a LIMHP with training in this assessment.

### ***Child Assessments***

Every patient less than 18 years of age shall have an assessment (including a developmental assessment) performed by a LIMHP with appropriate training and experience in the assessment and treatment of children in a crisis setting.

### ***Laboratories***

There will be a process for obtaining same day laboratory studies including:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels;
7. Other studies as appropriate, based on the patterns of illness in the patients served.

### ***Staff Scope of Practice***

The scope of practice for all staff involved in the assessment or treatment of patients will be defined in writing by the clinical director and will be appropriate to staff training and experience.

### ***Coordination of Care***

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the patient's assessment in the service.

## **Treatment and Treatment Planning**

### ***Stabilizing Care***

There is access to immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others).

There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service that is approved by the clinical director and updated at least annually.

### ***Definitive Care***

An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. This is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.

Patients receive appropriate education that is relevant to their condition. This should include information about the most effective treatment for the patient's psychiatric disorder.

### ***Reassessment and Response to Treatment***

For those patients who require crisis stabilization, there should be a protocol and procedure for transporting the patient (if necessary) to a safe environment where they can receive treatment and have their response to treatment assessed.

Response to treatment is assessed at least every four hours by nursing staff trained in the assessment of acute psychiatric patients or by a board eligible psychiatrist.

Whenever it appears necessary, the treatment plan is adjusted to incorporate the patient's response to previous treatment.

### ***Referrals***

There is a mechanism for ensuring that all patients have access to appropriate referrals to public guardians or conservators, legal services, self help organizations, patient advocacy, social services, etcetera.

## **Medication Use and Safety**

### ***Access to Appropriate Medications***

There is a secure medication kit that includes the medications most likely to be necessary to manage behavioral emergencies.

There is a process for obtaining other psychiatric medications within four hours of initial assessment.

### ***Dispensing and Storage of Medications***

All medications are securely stored and dispensed by appropriate staff.

### ***Medication Administration***

Qualified staff administer medications.

Qualified staff assess the response to medications continuously during the first half an hour after administration and at least every two hours thereafter until the behavioral emergency is stabilized.

## **Behavioral Emergencies**

There is a written procedure for managing behavioral emergencies in the field and this procedure describes the means of ensuring safe transportation to a secure facility, if necessary.

### ***Staff Training***

All staff are continuously trained in alternatives to seclusion and restraint. This training is adjusted to reflect current quality improvement information about the use of seclusion and restraint. At least yearly each staff member receives a full day training in managing behavioral emergencies in the least restrictive, most effective, way.

### ***Debriefing***

After every on site visit that leads to emergency intervention in order to managed patient behavior there is a debriefing with the other emergency personnel at the site. Recommendations that are made in those meetings are incorporated into the Quality Improvement process.

### ***Data Collection and Review***

Data regarding behavioral emergencies in the field are collected. Outcomes, staff and patient injuries, and other relevant information is reviewed at least quarterly.

## **Aftercare**

### ***Plan for Aftercare***

For each patient seen there is a plan for ongoing care that is derived from the initial psychiatric assessment and from the results of treatment and the reassessments performed by the clinical staff.

There is a written procedure for determining which patients must be seen by a psychiatrist prior to the end of an episode of care. This procedure is approved by the clinical director.

### ***Models for Aftercare***

There are written models to assist in the development of appropriate plans for ongoing treatment. These models assist the clinical staff in developing plans that incorporate the least restrictive alternatives that are consistent with the optimum improvement of the patient's condition.

Unless the plan for ongoing treatment involves involuntary treatment, staff develops plans for ongoing treatment that are the most likely to be implemented after discharge, and that are consistent with the patient's understanding of the nature of their problem, their needs, and the community resources and natural support system that they have access to.

There is a clear process outlined for referrals to other types and levels of care:

1. Medical emergency rooms;
2. Substance abuse facilities and providers;
3. Inpatient and outpatient mental health services.

There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

### ***Continuing Care***

The discharge process ensures continuing care for patients with ongoing problems.

There is a clear procedure to ensure the transfer of appropriate records to the facility or provider who is going to be providing ongoing care.

The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for continued outpatient mental health treatment within one week of discharge.

The service has developed a means of ensuring access to a psychiatrist by phone or in person until the patient's outpatient appointment.

Subsequent contact to ascertain the patient's status is a routine part of care. The service has a provision for such contact with most patients by phone or in person after they are discharged from the emergency service.

The service routinely monitors its success with making aftercare plans that are most likely to be effective.

## **Space and Equipment**

### ***Security and Safety***

Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.

Each team member on an outreach carries a cellular phone and pager, or some other mechanism of immediately accessing emergency services if needed.

Each team has basic medical equipment such as blood pressure cuff, thermometers, glucometer, pulse oximeter, a portable automatic defibrillator, and first aid supplies.

### ***Transportation***

The service provides staff with appropriate transportation for outreach into the community.

## **Staffing**

### ***Staff Competence***

The competence of all staff is continuously evaluated, monitored and enhanced.

There is a written procedure for ensuring the ongoing assessment of staff competence in core clinical areas. This procedure is developed and approved by the clinical director. Individual plans for the development and improvement of clinical skills are part of the yearly performance evaluation process.

### ***Qualifications of Staff***

The clinical director has developed explicit written criteria for the qualifications of staff regarding training, experience and competence. The criteria specifically address the training in crisis or emergency settings. In general, those staff who work without ongoing supervision should have had supervised experience in an acute psychiatric setting.

### ***There is Adequate Staffing***

All medical staff (including nurses and mid-level practitioners) who work without supervision have adequate experience in medical screening and the assessment and treatment of psychiatric emergencies. All medical staff as defined in this section are trained in basic life support, first aid, and the use of an automatic defibrillator.

Staff who assess substance abuse have competence in history gathering, the natural history of substance related disorders, evidence based treatment, and available community resources.

Staff who assess children have competence in developmental assessment, evidence based treatment and community resources.

A psychiatrist should at all times be available by phone and to perform a face-to-face evaluation on site as needed.

There should be a clinical director who is a board certified psychiatrist with appropriate training and experience in emergency and acute psychiatry.

### ***Staffing Adjustment***

There is a process for assessing and anticipating staffing needs. There is an on-call roster of clinical and nursing staff.

### ***Staff Orientation and In-Service Training***

There is an ongoing educational program to update staff regarding best practices in emergency and acute psychiatric services.

There is adequate training to ensure that staff are competent to provide services to patients from all of the cultural backgrounds represented in the catchment area of the program.

The ongoing educational program incorporates findings from the Quality Improvement process.

### ***Multi-Disciplinary Team***

The role of each member of the multi-disciplinary team is defined in writing. These standards are developed and approved by the clinical director.

Staff who are not independent practitioners are supervised on an ongoing basis.

There is a memorandum of understanding with all local emergency services (including police) that specifies the role of each responder in managing medical, psychiatric and other emergencies.

There is a process for reviewing the effectiveness of these agreements and for meeting with leadership of emergency service providers to enhance the effectiveness of outreach.

### ***Consultation and Continuous Learning***

Staff performance evaluation and review processes encourage all staff to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

### ***Individual Assessments of Staff***

Every staff member has an assessment completed at least yearly. The clinical director participates in the process of staff assessment for all clinical staff.

## **Medical Records**

Medical records are stored in a confidential and secure manner. There is provision for emergency access (within one hour) to records of previous treatment from the mobile service (via phone or on site fax, if necessary)

There is an individual record for each patient and that record includes: identifying information, marital status, legal status, a description of the emergency care provided before admission to the facility, a record of patient preferences regarding involuntary treatment (if such a document was previously provided to the facility), the assessments, treatment plans, level of care determination and aftercare plan for each patient.

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

## **Quality Improvement**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation. At a minimum, the service should capture information about the patients served including culture and ethnicity, the type and number of emergencies, and the treatment provided.

### ***Key Measures***

Performance on key measures is compared to the performance of comparable services elsewhere. This includes: linkage to aftercare and the management of behavioral emergencies.

### ***Patient Satisfaction***

There is a process for evaluating patient satisfaction. This process includes an opportunity to obtain detailed information about patient concerns that is gathered in such a way that patients do not experience concern about being honest (e.g., interviews done by former mental health patients, anonymous surveys that are mailed back).

### ***Grievance Process***

Every patient is provided information about how to file a grievance on entry and exit from the service.

There is a written process for handling grievances or complaints that ensures that there is no adverse consequence (retaliation) for filing a grievance, that grievances are responded to within 30 days and that includes a means for appealing decisions to someone outside the service.

### ***Critical Events***

Every patient death within 30 days of discharge from the service is reviewed as part of a critical event review.

There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff who were involved in the assessment and care of the patient.

Findings from critical event reviews lead to changes in the way that care is provided.

## **Leadership**

### ***Leadership Roles***

The clinical director should be a board certified psychiatrist with appropriate training and experience in emergency and acute psychiatry. Where the roles of clinical and administrative director are separated, there is a written description of the two roles and their relationship. The clinical director is responsible for ensuring the overall quality of care in the service.

### ***Competence and Role of Staff***

Leadership reviews and ensures the competence of all staff. The clinical director approves the definition of the role of each care providing staff member.

### ***Community Liaison***

Leadership ensures ongoing relationships with community services, particularly those involved in providing emergency care and community mental health services.

Leadership ensures that there is consumer and community input in service planning and outreach.

Leadership ensures that there is an up to date and complete list of resources that patients receiving services commonly need.

### **Disaster Plan**

The role of the service in disasters is defined in a written document. Staff are adequately trained to fulfill this role.

### **Ethics and Patient's Rights**

Treatment is not denied or delayed because of an inability to pay.

As much as possible patients are involved in all aspects of making decisions.

Patients are given complete information about their diagnosis and the options for treatment unless there is a clinical contraindication for this.

All staff carry identification that indicates their name, title and affiliation.

### ***Consent***

All patients give informed consent for treatment except those who are not competent to make these decisions.

There is a written procedure that describes the evaluation of patients to determine if they are competent to give consent and that deals with the procedures for providing emergency care to such patients.

### ***Confidentiality and Privacy***

Confidentiality of all patients is maintained except:

1. As permitted by law and as specified in written procedures in order to ensure the safety of the patient or others.
2. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
3. To the extent that the patient consents to the release of information to others, especially significant others and health care providers.

### ***Communication with Significant Others***

As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.

To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.

Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

#### ***Restrictions on Patient Rights***

The circumstances under which patient rights may be curtailed are specified in a written policy and procedure. That policy and procedure includes the requirements for documentation and the limitations on such restrictions.

#### ***Information on Patient Rights***

All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights. There is immediate access to an advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

#### ***Diversity and Communication with Patients and Families***

There is acceptance of and respect for differences that is manifested in a variety of ways including efforts to expand cultural knowledge and resources through consultation with minority stakeholders, continuous assessment and service adaptation and enhancement to meet the diverse needs of the population served.

There is a provision for communication with patients who are speech or hearing impaired.

There are staff available who can communicate with patients who do not speak English, and whose primary language is spoken by 5% or more of individuals in the catchment area of the service.

There is provision for translation in all other languages.

#### ***Grievance Process***

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.

## **Mobile Psychiatric Urgent Care Service**

### **Definition and Description**

Mobile services that provide urgent psychiatric care have the capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility. They are available 12 to 16 hours a day, especially in the evening hours and on weekends. They have access to the full continuum of care and have a psychiatrist available by phone or for in-person assessment as needed and clinically indicated.

Urgent care services do not substitute for a means of delivering emergency psychiatric care, but they are able to provide same day treatment in order to prevent individuals at risk from developing psychiatric emergency conditions.

Some form of mobile psychiatric urgent care is often provided by comprehensive psychiatric emergency services in urban settings.

## **Level of Care Criteria**

Patients with fairly severe needs can be managed by mobile urgent care services. For instance, patients at serious risk of harm may be served by these services if a careful telephone screening determines that the individual can contract for safety, has adequate impulse control and does not have access to means of carrying out the behavior. Patients with severe impairment in social function are often assessed by urgent care services. Severe medical and substance abuse co-morbidity may be problematic, but many patients with major co-morbidity can be safely served, if their conditions are relatively stable. Patients with severely stressful environments and no support will often have to be referred to residential services for aftercare, but may be assessed by a mobile team. Patients who are at high risk of harm and are extremely frightened or avoidant of treatment may be beyond the capacity of these services, but otherwise minimal engagement in treatment and poor response to prior treatment need not be a barrier to an effective first assessment or intervention by a mobile urgent care service.

## **Models**

The service should be available at least twelve hours a day, six days a week. The schedule should preferentially cover afternoon, evening and weekend days when other resources are hard to access.

## **Assessments**

### ***Telephone Assessments and Triage***

There should be access to licensed independent mental health practitioners (LIMHP) who are trained in the assessment and management of crisis phone calls and who are able to assess the priority of the call and provide interventions that are appropriate to level of acuity of the caller at all times that the service is available.

At times that the service is not available phones should be answered by a service that is able to connect callers with emergency personnel.

Telephone calls should be answered within two minutes. If this is not possible there should be the opportunity to leave a message, or to have the call handled outside the routine system if it is an emergency.

A screening telephone assessment should include an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and a medical screening assessment.

There should be written procedures for handling phone calls that include prioritization and coordination with available means of performing outreach to callers. There should be a large easily visible map to assist in the dispatching process.

There should be the capacity for caller identification electronically and call tracing.

There should be a process for obtaining immediate assistance from other staff when such assistance is needed to safely manage the call (e.g., threats of harm to self or others).

There should be a set of written models and procedures for evaluating the level of risk to staff of the patient.

There should be a protocol for ensuring that police and the mobile response team both meet the patient at the site.

There should always be two staff on every outreach. There should be a procedure for determining in which circumstances a psychiatrist, a nurse, or mid-level practitioner should be on a team. Where a psychiatrist, nurse or mid-level practitioner is not on a team, there should be a written procedure for managing psychiatric or medical emergencies.

Urgent calls should lead to an in-person response within four hours.

There should be a process for ensuring that emergency calls are handled by other emergency response systems.

There should be a log of all calls. There must be documentation of the screening assessment of all such patients that includes the patient name, date of birth, Social Security Number (if available), address, telephone number and the names and contact information for any significant other who is contacted.

### ***Full Assessment***

Patients who are not referred for care elsewhere after a screening assessment should receive a full psychiatric assessment. This assessment should be initiated within four hours of the call.

The assessment process includes:

1. Patient interview(s) by LIMHP's;
2. Review of records of past treatment;
3. History gathering from collateral sources (see also section on confidentiality);
4. Contact with the current mental health providers wherever possible;
5. Identification of social, environmental and cultural factors that may be contributing to the emergency;
6. An assessment of the patient's ability and willingness to cooperate with treatment;
7. A history of previous treatment and the response to treatment;
8. A detailed assessment of substance use, abuse and misuse conducted by an individual trained in assessing substance related disorders;
9. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

There is a process for ensuring that appropriate patients are seen by a psychiatrist on the same day as the initial call. This procedure is defined in writing and is approved by the medical director.

### ***Physical Health Assessment***

There should be a written procedure for assessing the need for referral for a physical health assessment for all patients seen. This procedure is approved by the medical director.

There should be a procedure for ensuring immediate access to urgent and emergent non-psychiatric medical assessment and treatment. This procedure is approved by the medical director.

### ***Assessment for Possible Abuse or Neglect***

Every patient will be assessed for sexual or physical abuse or neglect by a LIMHP with training in this assessment.

### ***Child Assessments***

Every patient less than 18 years of age shall have an assessment (including a developmental assessment) performed by a LIMHP with appropriate training and experience in the assessment and treatment of children in a crisis setting.

### ***Laboratories***

There will be a process for obtaining same day laboratory studies including:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels;
7. Other studies as appropriate, based on the patterns of illness in the patients served.

### ***Staff Scope of Practice***

The scope of practice for all staff involved in the assessment or treatment of patients will be defined in writing by the clinical director and, where that individual is not a physician, by the medical director, and will be appropriate to staff training and experience.

### ***Coordination of Care***

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the patient's assessment in the service.

## **Treatment and Treatment Planning**

### ***Stabilizing Care***

There is process for obtaining access to care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others).

There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service that is approved by the clinical director and, where that individual is not a physician, by the medical director, and updated at least annually.

### ***Definitive Care***

An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. This is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.

Patients receive appropriate education that is relevant to their condition. This should include information about the most effective treatment for the patient's psychiatric disorder.

### ***Referrals***

There is a mechanism for ensuring that all patients have access to appropriate referrals to public guardians or conservators, legal services, self help organizations, patient advocacy, social services, etcetera.

## **Medication Use and Safety**

### ***Access to Appropriate Medications***

There is a process for obtaining psychiatric medications for patients within six hours of initial assessment.

## **Behavioral Emergencies**

There is a written procedure for managing behavioral emergencies in the field and this procedure describes the means of arranging for transportation to a secure facility, if necessary.

### ***Staff Training***

All staff are continuously trained in field safety.

### ***Debriefing***

After every on site visit that leads to emergency intervention in order to managed patient behavior there is a debriefing with the other emergency personnel at the site. Recommendations that are made in those meetings are incorporated into the Quality Improvement process.

### ***Data Collection and Review***

Data regarding behavioral emergencies in the field are collected. Outcomes, staff and patient injuries, and other relevant information is reviewed at least quarterly.

## **Aftercare**

### ***Plan for Aftercare***

For each patient seen there is a plan for ongoing care that is derived from the initial psychiatric assessment and from the results of treatment and the reassessments performed by the clinical staff.

There is a written procedure for determining which patients must be seen by a psychiatrist prior to the end of an episode of care. The clinical director approves this procedure, and where that individual is not a physician, the medical director does also.

### ***Models for Aftercare***

There are written models to assist in the development of appropriate plans for ongoing treatment. These models assist the clinical staff in developing plans that incorporate the least restrictive alternatives that are consistent with the optimum improvement of the patient's condition.

Unless the plan for ongoing treatment involves involuntary treatment, staff develops plans for ongoing treatment that are the most likely to be implemented after discharge, and that are consistent with the patient's understanding of the nature of their problem, their needs, and the community resources and natural support system that they have access to.

There is a clear process outlined for referrals to other types and levels of care:

1. Medical emergency rooms;
2. Substance abuse facilities and providers;
3. Inpatient and outpatient mental health services.

There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

### ***Continuing Care***

The discharge process ensures continuing care for patients with ongoing problems.

There is a clear procedure to ensure the transfer of appropriate records to the facility or provider who is going to be providing ongoing care.

The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for continued outpatient mental health treatment within one week of discharge.

The service has developed a means of ensuring access to a psychiatrist by phone or in person until the patient's outpatient appointment.

Subsequent contact to ascertain the patient's status is a routine part of care. The service has a provision for such contact with most patients by phone or in person after they are discharged from the emergency service.

The service routinely monitors its success with making aftercare plans that are most likely to be effective.

## **Space and Equipment**

### ***Security and Safety***

Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.

Each team member on an outreach carries a cellular phone and pager, or some other mechanism of immediately accessing emergency services if needed.

### ***Transportation***

The service provides staff with appropriate transportation for outreach into the community.

## **Staffing**

### ***Staff Competence***

The competence of all staff is continuously evaluated, monitored and enhanced.

There is a written procedure for ensuring the ongoing assessment of staff competence in core clinical areas. This procedure is developed and approved by the clinical director, and, where that individual is not a physician, the medical director. Individual plans for the development and improvement of clinical skills are part of the yearly performance evaluation process.

### ***Qualifications of Staff***

The clinical director, and where that individual is not a physician, the medical director have developed explicit written criteria for the qualifications of staff regarding training, experience and competence. The criteria specifically address the training in crisis or emergency settings. In general, those staff who work without ongoing supervision should have had supervised experience in an acute psychiatric setting.

### ***There is Adequate Staffing***

Staff who assess substance abuse have competence in history gathering, the natural history of substance related disorders, evidence based treatment, and available community resources. Staff who assess children have competence in developmental assessment, evidence based treatment and community resources.

A psychiatrist should at all times that the service is open, be available by phone and to perform a face-to-face evaluation within four hours, as needed.

There is a medical director who is a board certified psychiatrist with adequate training and experience in emergency and acute psychiatry.

### ***Staff Orientation and In-Service Training***

There is an ongoing educational program to update staff regarding best practices in emergency and acute psychiatric services.

There is adequate training to ensure that staff are competent to provide services to patients from all of the cultural backgrounds represented in the catchment area of the program.

The ongoing educational program incorporates findings from the Quality Improvement process.

### ***Multi-Disciplinary Team***

The role of each member of the multi-disciplinary team is defined in writing. These standards are developed and approved by the clinical director, and, where that individual is not a physician, the medical director.

Staff who are not independent practitioners are supervised on an ongoing basis.

There is a memorandum of understanding with all local emergency services (including police) that specifies the role of each responder in managing medical, psychiatric and other emergencies. There is a process for reviewing the effectiveness of these agreements and for meeting with leadership of emergency service providers to enhance the effectiveness of outreach.

### ***Consultation and Continuous Learning***

Staff performance evaluation and review processes encourage all staff to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

### ***Individual Assessments of Staff***

Every staff member has an assessment completed at least yearly. The clinical director and medical director participates in the process of staff assessment for all clinical staff.

## **Medical Records**

Medical records are stored in a confidential and secure manner. There is provision for urgent access (within two hours) to records of previous treatment from the mobile service (via phone or on site fax, if necessary)

There is an individual record for each patient and that record includes: identifying information, marital status, legal status, a description of the emergency care provided before admission to the facility, a record of patient preferences regarding involuntary treatment (if such a document was previously provided to the facility), the assessments, treatment plans, level of care determination and aftercare plan for each patient.

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

## **Quality Improvement**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation. At a minimum, the service should capture information about the patients served including culture and ethnicity, the type and number of emergencies, and the treatment provided.

### ***Key Measures***

Performance on key measures is compared to the performance of comparable services elsewhere. This includes linkage to aftercare.

### ***Patient Satisfaction***

There is a process for evaluating patient satisfaction. This process includes an opportunity to obtain detailed information about patient concerns that is gathered in such a way that patients do

not experience concern about being honest (e.g., interviews done by former mental health patients, anonymous surveys that are mailed back).

### ***Grievance Process***

Every patient is provided information about how to file a grievance on entry and exit from the service.

There is a written process for handling grievances or complaints that ensures that there is no adverse consequence (retaliation) for filing a grievance, that grievances are responded to within 30 days and that includes a means for appealing decisions to someone outside the service.

### ***Critical Events***

Every patient death within 30 days of discharge from the service is reviewed as part of a critical event review.

There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff who were involved in the assessment and care of the patient.

Findings from critical event reviews lead to changes in the way that care is provided.

## **Leadership**

### ***Leadership Roles***

There is a medical director who is a board certified psychiatrist with adequate training and experience in emergency and acute psychiatry. Where the roles of clinical, medical, and administrative directors are separated, there is a written description of the roles and their relationship.

### ***Competence and Role of Staff***

Leadership reviews and ensures the competence of all staff. The medical director approves the definition of the role of each care providing staff member.

### ***Community Liaison***

Leadership ensures ongoing relationships with community services, particularly those involved in providing emergency care and community mental health services.

Leadership ensures that there is consumer and community input in service planning and outreach.

Leadership ensures that there is an up to date and complete list of resources that patients receiving services commonly need.

## **Disaster Plan**

The role of the service in disasters is defined in a written document. Staff are adequately trained to fulfill this role.

## **Ethics and Patient's Rights**

Treatment is not denied or delayed because of an inability to pay.

As much as possible patients are involved in all aspects of making decisions.

Patients are given complete information about their diagnosis and the options for treatment unless there is a clinical contraindication for this.

All staff carry identification that indicates their name, title and affiliation.

### ***Consent***

All patients give informed consent for treatment except those who are not competent to make these decisions.

### ***Confidentiality and Privacy***

Confidentiality of all patients is maintained except:

1. As permitted by law and as specified in written procedures in order to ensure the safety of the patient or others.
2. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
3. To the extent that the patient consents to the release of information to others, especially significant others and health care providers.

### ***Communication with Significant Others***

As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.

To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.

Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

### ***Information on Patient Rights***

All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights. There is immediate access to an advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

### ***Diversity and Communication with Patients and Families***

There is acceptance of and respect for differences that is manifested in a variety of ways including efforts to expand cultural knowledge and resources through consultation with minority stakeholders, continuous assessment and service adaptation and enhancement to meet the diverse needs of the population served.

There is a provision for communication with patients who are speech or hearing impaired. There are staff available who can communicate with patients who do not speak English, and whose primary language is spoken by 5% or more of individuals in the catchment area of the service.

There is provision for translation in all other languages.

### ***Grievance Process***

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.

## **Psychiatric Emergency Residential Facility**

### **Definition and Description**

Residential services providing psychiatric emergency care treat patients with psychiatric conditions that require the highest level of care in a non-hospital environment. They are not the first services to assess patients, that function is generally performed by a mobile or facility based emergency service. These services can do much to reduce the negative responses to acute care that many patients experience. They are generally limited in their ability to manage severe and acute co-morbid medical conditions.

### **Level of Care**

These services are able to handle patients with high risk of harm, severe functional impairment and the most severe psychiatric and substance abuse co-morbidity. Most services are voluntary, and they are not able to provide care for patients who do not recognize their need for treatment and are not able to consent to treatment. They are usually limited in their ability to handle severe or acute medical co-morbidity. They are able to manage patients with the most stressful and least supportive recovery environments and to manage patients who have had negligible response to prior treatment.

### **Description**

#### **Assessments**

##### ***Screening Assessments and Processes***

There must be written criteria for determining which individuals referred for care are accepted for admission to the program. There must be a process for ensuring that these criteria are applied

consistently. There must be telephone access to the medical director or clinical director (if the clinical director is not a physician) at all times for consultation regarding the appropriateness of a patient for acceptance.

### ***Full Assessment***

Patients should receive a full psychiatric assessment. This assessment should be initiated within two hours of the patient's presentation to the service. All individuals who receive a psychiatric assessment should see a psychiatrist within 24 hours of presentation to the service. There must be a written process and procedure that ensures that those who require such an evaluation more urgently can be seen and assessed within two hours of initial presentation.

The assessment process includes:

1. Patient interviews by LIMHP's including board eligible psychiatrists trained in emergency psychiatric assessment and treatment);
2. Review of records of past treatment;
3. History gathering from collateral sources (see also section on confidentiality);
4. Contact with the current mental health providers wherever possible;
5. A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
6. Identification of social, environmental and cultural factors that may be contributing to the emergency;
7. An assessment of the patient's ability and willingness to cooperate with treatment;
8. A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescriber;
9. A general medical history that addresses conditions that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
10. An appropriate physical health assessment (see below);
11. A detailed assessment of substance use, abuse and misuse conducted by an individual trained in assessing substance related disorders;
12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

### ***Physical Health Assessment***

All patients must have received a physical health assessment (as defined below) within the 24 hours prior to admission, or within 4 hours of admission. This initial evaluation for physical health should generally include:

1. Vital signs;

2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
3. A screening neurologic examination that is adequate to rule out significant acute pathology;
4. A medical history and review of symptoms;
5. A pregnancy test in all fertile women;
6. A urine toxicology evaluation (unless there is a protocol that specifies another means of adequately assessing for substance use, misuse, and abuse);
7. Blood levels of psychiatric medications that have established therapeutic or toxic ranges;
8. Other tests and examinations as appropriate and indicated.

There should be immediate access to urgent and emergent non-psychiatric medical assessment and treatment.

There must be a non-psychiatric medical provider who evaluates all patients and provides for their non-psychiatric medical needs while they are in the facility. There must be telephone access to a non-psychiatric medical provider at all times.

#### ***Assessment for Possible Abuse or Neglect***

Every patient will be assessed for sexual or physical abuse or neglect by a LIMHP with training in this assessment.

#### ***Laboratories***

There will be daily access on-site to phlebotomy and laboratory studies including:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels;
7. Other studies as appropriate, based on the patterns of illness in the patients served.

#### ***Staff Scope of Practice***

The scope of practice for all staff involved in the assessment or treatment of patients will be defined in writing by the clinical director (and will be approved by the medical director, where the clinical director is not a physician) and will be appropriate to staff training and experience.

### ***Coordination of Care***

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the patient's assessment in the service.

## **Treatment and Treatment Planning**

### ***Stabilizing Care***

There is access to immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others).

There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service that is approved by the clinical director and updated at least annually.

### ***Definitive Care***

An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. This is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences. Patients receive appropriate education that is relevant to their condition. This should include information about the most effective treatment for the patient's psychiatric disorder.

### ***Reassessment and Response to Treatment***

Response to treatment is assessed at least every eight hours by nursing staff trained in the assessment of acute psychiatric patients or by a board eligible psychiatrist.

Whenever it appears necessary, the treatment plan is adjusted to incorporate the patient's response to previous treatment.

### ***Treatment***

Within twenty-four hours of admission every patient receives an orientation that explains facility rules and expectations, explains patients rights and the grievance policy, and describes the schedule of activities.

Every patient is seen at least six days a week by a board eligible psychiatrist.

There is at least 4 hours a day of treatment that consists of: individual or group psychotherapy or psychoeducation, vocational rehabilitation or training, crisis intervention and crisis psychotherapy, family therapy, advocacy, help with obtaining community supports and housing, help developing social skills and a social support network, substance abuse treatment and relapse prevention.

Patients who have significant substance abuse co-morbidity receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.

There is access to social, community, recreational and religious activities that are consistent with the individual's cultural and spiritual background.

There is a stable therapeutic environment that includes consistently assigned personnel and consistently scheduled activities.

## **Medication Use and Safety**

### ***Access to Appropriate Medications***

There is immediate access to medications commonly used to treat acute psychiatric disorders and behavioral emergencies. There is same day access to medications that are not on the facility's formulary but are commonly used in the community.

### ***Dispensing and Storage of Medications***

All medications are securely stored and dispensed by appropriate staff. Patient medications are not used to provide treatment in the facility except in an emergency situation.

### ***Availability of Emergency Medications***

Emergency psychiatric medications are immediately available.

### ***Medication Administration***

Qualified staff administer medications.

Qualified staff assess the response to medications continuously during the first half an hour after administration and at least every two hours thereafter.

## **Management of Behavioral Emergencies**

### ***Staffing***

There are adequate numbers of staff available to ensure that when patients show signs of agitation there is immediate verbal intervention.

### ***Space***

There is adequate space to ensure that every individual who needs space to be alone has access to such space. Also, group sleeping rooms are not the only options for individuals who may need private space.

Rooms used for seclusion and restraint have adequate air flow, access to a bathroom, adequate lighting that can (whenever possible) be dimmed or brightened at the patient's request, and capacity for continuous observation from outside the room.

### ***Quiet Rooms***

There are enough quiet rooms (single rooms that may be safely used when patients are not in restraints) that every patient who would benefit from such a room has access to one.

### ***Staff Training***

All staff are continuously trained in alternatives to seclusion and restraint. This training is adjusted to reflect current quality improvement information about the use of seclusion and restraint. At

least yearly each staff member receives a full day training in managing behavioral emergencies in the least restrictive, most effective, way.

***Where Seclusion and Restraint is Performed as Part of the Process of Care***

Every time locked seclusion or seclusion and restraint is performed it is based on the order of a psychiatrist or appropriate licensed independent practitioner. Verbal orders for seclusion and restraint are signed within one hour and a psychiatrist or appropriate LIP performs an in-person assessment of each patient within one hour of seclusion or seclusion and restraint. All patients in seclusion or seclusion and restraint are continuously observed by nursing staff.

After every episode of seclusion and restraint there is a meeting of the staff who participated in the episode, including the psychiatrist or licensed independent practitioner who ordered it, to review the procedure, and to identify opportunities that might have existed to prevent the need for seclusion and restraint. Recommendations that are made in those meetings are incorporated into the Quality Improvement process.

Data regarding the use of seclusion and seclusion and restraint are collected and reviewed at least monthly to identify opportunities for improvement in the management of behavioral emergencies. At least yearly the facility's use of seclusion and restraint is compared to the use in at least two comparable facilities and the results of this review are incorporated into staff training and the Quality Improvement process.

***Where Seclusion and Restraint is not Performed as Part of the Process of Care***

There is a written procedure that specifies how behavioral emergencies should be managed. This procedure must ensure that patients do not leave the facility without an assessment by a psychiatrist when they appear to be at risk of harm to themselves or others.

**Aftercare**

***Plan for Aftercare***

For each patient seen there is a plan for ongoing care that is derived from the initial psychiatric assessment and from the results of treatment and the reassessments performed by the clinical staff. Prior to discharge each patient has an assessment performed by a board eligible psychiatrist with training and/or experience in assessing patients in a psychiatric emergency. The results of this assessment and the plan for ongoing treatment are documented in the chart.

***Models for Aftercare***

There are written models to assist in the development of appropriate plans for ongoing treatment. These models assist the clinical staff in developing plans that incorporate the least restrictive alternatives that are consistent with the optimum improvement of the patient's condition.

Unless the plan for ongoing treatment involves involuntary treatment, staff develops plans for ongoing treatment that are the most likely to be implemented after discharge, and that are consistent with the patient's understanding of the nature of their problem, their needs, and the community resources and natural support system that they have access to.

There is a clear process outlined for referrals to other types and levels of care:

1. Medical emergency rooms;
2. Substance abuse facilities and providers;

### 3. Inpatient and outpatient mental health services.

There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

#### ***Continuing Care***

The discharge process ensures continuing care for patients with ongoing problems.

There is a clear procedure to ensure the transfer of appropriate records to the facility or provider who is going to be providing ongoing care.

The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for continued outpatient mental health treatment within one week of discharge.

The service has developed a means of ensuring access to a psychiatrist by phone or in person until the patient's outpatient appointment.

The service routinely monitors its success with making aftercare plans that are most likely to be effective.

#### **Space and Equipment**

Sleeping rooms have doors or other means of ensuring privacy. There is partitioning to provide privacy in rooms of 2-4 patients. There are no more than 4 patients in a room.

Single rooms have at least 80 square feet of usable space, rooms with multiple beds have at least 60 square feet of usable space per patient.

There is a minimum of 35 square feet of living and dining space per resident.

The residence and grounds are furnished in a manner similar to a normal home living environment.

There is access to natural light.

There is access to reading material and other recreational activities that are usually available in a home.

#### ***Security and Safety***

Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.

Provision is made for ensuring that there are no dangerous materials accessible to patients, including: sharp objects, weapons, materials that can be used for hanging, patient medications, etcetera. The space is continuously supervised and monitored by staff. There is controlled access to the space and a process of preventing elopement.

There is a room for family members to wait in and to visit with the patient.

***Restrooms and Showers***

There is one toilet per 6 patients and one shower per 8 patients. Families have access to clean restrooms.

***Patient Privacy***

There are quiet areas that are accessible to all patients. A telephone is available to all patients with a reasonable degree of privacy balanced with security. Patient assessments take place in private rooms unless there is a clinical reason not to do so. There is adequate room for meetings with family and for conjoint meetings with mental health clinicians and case managers.

There is a well-equipped room for physical examinations that is private.

There is provision for resident decoration of their personnel space and access to personnel belongings, to the extent consistent with the rights of others and program rules and the maintenance of the therapeutic environment.

***Storage and Security of Property***

There is a written procedure for ensuring the storage and security of patient property. When valuables or money are to be stored, more than one staff member signs the receipt. When items are misplaced the service replaces them. There is an ongoing review of this process to identify opportunities for improvement.

***Other***

Articles for grooming are readily available.

Meals and snacks are provided at appropriate times and on entry into the service for patients who are hungry or thirsty.

***Staffing******Staff Competence***

The competence of all staff is continuously evaluated, monitored and enhanced.

There is a written procedure for ensuring the ongoing assessment of staff competence in core clinical areas. This procedure is developed and approved by the clinical director (and where the clinical director is not a physician, the medical director). Individual plans for the development and improvement of clinical skills are part of the yearly performance evaluation process.

***Qualifications of Staff***

The clinical director (and where the clinical director is not a physician, the medical director) has developed explicit written criteria for the qualifications of staff regarding training, experience and competence. The criteria specifically address the training in crisis or emergency settings. In general, those staff who work without ongoing supervision should have had supervised experience in an acute psychiatric setting.

### ***There is Adequate Staffing***

There is adequate staff to allow reassessment at least every 8 hours and to provide active therapeutic intervention to the extent that such intervention is consistent with the patient's clinical state.

There is at all times a staff to patient ratio of no more than 1:4. There is at all times at least one staff member on site and there is the capability to increase the number of staff based on the needs of particular patients. Staff on duty remain awake at all times.

There is a LIMHP who is assigned to the patient on each shift and who is responsible for providing the patient with active treatment including psychoeducation, crisis psychotherapy, substance abuse treatment, developing a plan for returning to the community that addresses potential obstacles to a successful return.

There is at least one psychiatric nurse on site days and evenings (defined as a registered nurse who has a Master's degree or a Doctorate in Psychiatric Nursing and two years of post Master's level clinical experience in psychiatric nursing). There is a registered nurse on site at all times. A psychiatrist should at all times be available by phone and to perform a face-to-face evaluation on site.

There is a medical director who is a board certified psychiatrist with adequate training and experience in emergency and acute psychiatry.

### ***Staffing Adjustment***

There is a process for assessing and anticipating staffing needs. There is an on-call roster of clinical and nursing staff.

### ***Staff Orientation and In-Service Training***

There is an ongoing educational program to update staff regarding best practices in emergency and acute psychiatric services.

There is adequate training to ensure that staff are competent to provide services to patients from all of the cultural backgrounds represented in the catchment area of the program.

The ongoing educational program incorporates findings from the Quality Improvement process.

### ***Multi-Disciplinary Team***

The role of each member of the multi-disciplinary team is defined in writing. Every patient is assigned to a psychiatrist who is responsible for the overall care of the patient. These standards are developed and approved by the clinical director (and where the clinical director is not a physician, the medical director).

Staff who are not independent practitioners are supervised on an ongoing basis. There is a licensed clinical staff member who directly supervises all trainees.

Security (police) roles are clearly specified. Where a contractor provides security for the facility there is a clear written agreement that specifies the role of security in the process of care.

There is a process for reviewing the performance of security services and their role in managing assaultive behavior. There is a written protocol that specifies these roles.

### ***Consultation and Continuous Learning***

Staff performance evaluation and review processes encourage all staff to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

### ***Individual Assessments of Staff***

Every staff member has an assessment completed at least yearly. The clinical director participates in the process of staff assessment for all clinical staff.

### **Medical Records**

Medical records are stored in a confidential and secure manner. There is provision for emergency access (within one hour) to records of previous treatment.

There is an individual record for each patient and that record includes: identifying information, marital status, legal status, a description of the emergency care provided before admission to the facility, a record of patient preferences regarding involuntary treatment (if such a document was previously provided to the facility), the assessments, treatment plans, level of care determination and aftercare plan for each patient.

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

### **Quality Improvement**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation. At a minimum, the service should capture information about the patients served including culture and ethnicity, the type and number of emergencies, and the treatment provided.

### ***Key Measures***

Performance on key measures is compared to the performance of comparable services elsewhere. This includes: linkage to aftercare and use of seclusion and restraint.

Linkage with aftercare is continuously measured.

### ***Patient Satisfaction***

There is a process for evaluating patient satisfaction. This process includes an opportunity to obtain detailed information about patient concerns that is gathered in such a way that patients do not experience concern about being honest (e.g., interviews done by former mental health patients, anonymous surveys that are mailed back).

### ***Grievance Process***

Every patient is provided information about how to file a grievance on entry and exit from the service.

There is a written process for handling grievances or complaints that ensures that there is no adverse consequence (retaliation) for filing a grievance, that grievances are responded to within 30 days and that includes a means for appealing decisions to someone outside the service.

### ***Critical Events***

Every patient death within 30 days of discharge from the service is reviewed as part of a critical event review.

There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff who were involved in the assessment and care of the patient.

Findings from critical event reviews lead to changes in the way that care is provided.

## **Leadership**

### ***Leadership Roles***

There is a medical director who is a board certified psychiatrist with adequate training and experience in emergency and acute psychiatry. Where the roles of clinical, medical and administrative director are separated, there is a written description of the roles and their relationship

### ***Competence and Role of Staff***

Leadership reviews and ensures the competence of all staff. The clinical director (and the medical director where the clinical director is not a physician) approves the definition of the role of each care providing staff member.

### ***Community Liaison***

Leadership ensures ongoing relationships with community services, particularly those involved in providing emergency care and community mental health services.

Leadership ensures that there is consumer and community input in service planning and outreach.

Leadership ensures that there is an up to date and complete list of resources that patients receiving services commonly need.

## **Disaster Plan**

The role of the service in disasters is defined in a written document. Staff are adequately trained to fulfill this role.

## **Ethics and Patient's Rights**

Treatment is not denied or delayed because of an inability to pay.

As much as possible patients are involved in all aspects of making decisions.

Patients are given complete information about their diagnosis and the options for treatment unless there is a clinical contraindication for this.

All staff carry identification that indicates their name, title and affiliation.

### **Consent**

All patients give informed consent for treatment except those who are not competent to make these decisions.

There is a written procedure that describes the evaluation of patients to determine if they are competent to give consent and that deals with the procedures for providing emergency care to such patients.

Confidentiality and Privacy.

Confidentiality of all patients is maintained except:

1. As permitted by law and as specified in written procedures in order to ensure the safety of the patient or others.
2. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
3. To the extent that the patient consents to the release of information to others, especially significant others and health care providers.

### **Communication with Significant Others**

As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.

To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.

Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

### **Restrictions on Patient Rights**

The circumstances under which patient rights may be curtailed are specified in a written policy and procedure. That policy and procedure includes the requirements for documentation and the limitations on such restrictions.

### **Information on Patient Rights**

All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights. There is immediate access to an advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

### **Diversity and Communication with Patients and Families**

There is acceptance of and respect for differences that is manifested in a variety of ways including efforts to expand cultural knowledge and resources through consultation with minority stakeholders, continuous assessment and service adaptation and enhancement to meet the diverse needs of the population served.

There is a provision for communication with patients who are speech or hearing impaired.

There are staff available who can communicate with patients who do not speak English, and whose primary language is spoken by 5% or more of individuals in the catchment area of the service.

There is provision for translation in all other languages.

### ***Grievance Process***

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.

## **Psychiatric Urgent Care Resident Facility**

### **Definition and Description**

Most residential crisis facilities fall into this category. The facilities provide a safe environment with clinical staff on site at all times, but there is usually not continuous monitoring and reassessment of patients to ensure safety and to provide them with the most vigorous treatment.

### **Level of Care**

Patients can have some risk of harm, but must be able to identify for themselves the need for support from staff in order to ensure safety. Patients may have fairly severe impairments in functioning. Patients may have severe psychiatric co-morbidity, but should not have severe medical or substance abuse co-morbidity. Patient's home environments can be very high stress and with minimal support. Patients who have had minimal response to treatment in the past will generally not receive adequately intensive treatment in these environments. Patients must have at least minimal engagement; they must have some limited desire to change and to accept responsibility for recovery.

### **Models**

### **Assessments**

#### ***Screening Assessments and Processes***

There must be written criteria for determining which individuals referred for care are accepted for admission to the program. There must be a process for ensuring that these criteria are applied consistently. There must be telephone access to the medical director or clinical director (if the clinical director is not a physician) at all times for consultation regarding the appropriateness of a patient for acceptance.

#### ***Full Assessment***

Patients should receive a full psychiatric assessment. This assessment should be initiated within eight hours of the patient's presentation to the service. All individuals who receive a psychiatric assessment must see a psychiatrist within 24 hours of presentation to the service.

The assessment process includes:

1. Patient interview(s) by LIMHP's (including a board certified psychiatrist trained in emergency psychiatric assessment and treatment);
2. Review of records of past treatment;
3. History gathering from collateral sources (see also section on confidentiality);
4. Contact with the current mental health providers wherever possible;
5. A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
6. Identification of social, environmental and cultural factors that may be contributing to the emergency;
7. An assessment of the patient's ability and willingness to cooperate with treatment;
8. A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescriber;
9. A general medical history that addresses conditions that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
10. An appropriate physical health assessment (see below);
11. A detailed assessment of substance use, abuse and misuse conducted by an individual trained in assessing substance related disorders;
12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

### ***Physical Health Assessment***

All patients must have received a physical health assessment prior to admission to the service. This assessment must have been performed within the week prior to admission. This initial evaluation for physical health should generally include:

1. Vital signs;
2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
3. A screening neurologic examination that is adequate to rule out significant acute pathology;
4. A medical history and review of symptoms;
5. A pregnancy test in all fertile women;

6. A urine toxicology evaluation (unless there is a protocol that specifies another means of adequately assessing for substance use, misuse, and abuse);
7. Blood levels of psychiatric medications that have established therapeutic or toxic ranges;
8. Other tests and examinations as appropriate and indicated.

There should be immediate access to urgent and emergent non-psychiatric medical assessment and treatment.

There must be a non-psychiatric medical provider who evaluates all patients and provides for their non-psychiatric medical needs while they are in the facility. There must be telephone access to a non-psychiatric medical provider at all times.

### ***Assessment for Possible Abuse or Neglect***

Every patient will be assessed for sexual or physical abuse or neglect by a LIMHP with training in this assessment.

### ***Laboratories***

There will be weekly access on-site to phlebotomy and laboratory studies including:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels;
7. Other studies as appropriate, based on the patterns of illness in the patients served.

### ***Staff Scope of Practice***

The scope of practice for all staff involved in the assessment or treatment of patients will be defined in writing by the clinical director and will be appropriate to staff training and experience.

### ***Coordination of Care***

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the patient's assessment in the service.

## **Treatment and Treatment Planning**

### ***Stabilizing Care***

There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service that is approved by the clinical director and updated at least annually.

### ***Definitive Care***

An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. This is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.

Patients receive appropriate education that is relevant to their condition. This should include information about the most effective treatment for the patient's psychiatric disorder.

### ***Treatment***

Within twenty-four hours of admission every patient receives an orientation that explains facility rules and expectation, explains patients rights and the grievance policy, and describes the schedule of activities.

Every patient is seen at least two days a week by a board certified psychiatrist.

There is at least 2 hours a day of treatment that consists of: individual or group psychotherapy or psychoeducation, vocational rehabilitation or training, crisis intervention and crisis psychotherapy, family therapy, advocacy, help with obtaining community supports and housing, help developing social skills and a social support network, substance abuse treatment and relapse prevention.

Patients who have significant substance abuse co-morbidity receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.

There is access to social, community, recreational and religious activities that are consistent with the individual's cultural and spiritual background.

There is a stable therapeutic environment that includes consistently assigned personnel and consistently scheduled activities.

## **Medication Use and Safety**

### ***Access to Appropriate Medications***

There is same day access to medications that are commonly used in the community to treat psychiatric disorders.

### ***Dispensing and Storage of Medications***

Most facilities do not dispense medications. Patients administer their own medications.

These medications must be securely stored.

## **Management of Behavioral Emergencies**

### ***Staffing***

There are adequate numbers of staff available to ensure that when patients show signs of agitation there is immediate verbal intervention.

**Space**

There is adequate space to ensure that every individual who needs space to be alone has access to such space.

**Staff Training**

All staff are trained in managing assaultive behavior.

**Other**

There is a written procedure that specifies how behavioral emergencies should be managed.

**Aftercare****Plan for Aftercare**

For each patient seen there is a plan for ongoing care that is derived from the initial psychiatric assessment and from the results of treatment and the reassessments performed by the clinical staff.

**Models for Aftercare**

There are written models to assist in the development of appropriate plans for ongoing treatment. These models assist the clinical staff in developing plans that incorporate the least restrictive alternatives that are consistent with the optimum improvement of the patient's condition.

Staff develops plans for ongoing treatment that are the most likely to be implemented after discharge, and that are consistent with the patient's understanding of the nature of their problem, their needs, and the community resources and natural support system that they have access to. There is a clear process outlined for referrals to other types and levels of care:

1. Medical emergency departments;
2. Substance abuse facilities and providers;
3. Inpatient and outpatient mental health services.

There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

**Continuing Care**

The discharge process ensures continuing care for patients with ongoing problems.

There is a clear procedure to ensure the transfer of appropriate records to the facility or provider who is going to be providing ongoing care.

The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for continued outpatient mental health treatment within one week of discharge.

The service has developed a means of ensuring access to a psychiatrist by phone or in person until the patient's outpatient appointment.

The service routinely monitors its success with making aftercare plans that are most likely to be effective.

### **Space and Equipment**

Sleeping rooms have doors or other means of ensuring privacy. There is partitioning to provide privacy in rooms of 2-4 patients. There are no more than 4 patients in a room.

Single rooms have at least 80 square feet of usable space, rooms with multiple beds have at least 60 square feet of usable space per patient.

There is a minimum of 35 square feet of living and dining space per resident.

The residence and grounds are furnished in a manner similar to a normal home living environment.

There is access to natural light.

There is access to reading material and other recreational activities that are usually available in a home.

### **Security and Safety**

Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.

Provision is made for ensuring that there are no dangerous materials accessible to patients, including: sharp objects, weapons, materials that can be used for hanging, patient medications, etcetera.

There is a room for family members to wait in and to visit with the patient.

### **Restrooms and Showers**

There is one toilet per 6 patients and one shower per 8 patients. Families have access to clean restrooms.

### **Patient Privacy**

There are quiet areas that are accessible to all patients.

A telephone is available to all patients with a reasonable degree of privacy balanced with security. Patient assessments take place in private rooms unless there is a clinical reason not to do so. There is adequate room for meetings with family and for conjoint meetings with mental health clinicians and case managers.

There is a well-equipped room for physical examinations that is private.

There is provision for resident decoration of their personal space and access to personal belongings, to the extent consistent with the rights of others and program rules and the maintenance of the therapeutic environment.

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There is a written procedure for ensuring the storage and security of patient property. When valuables or money are to be stored, more than one staff member signs the receipt. When items are misplaced the service replaces them. There is an ongoing review of this process to identify opportunities for improvement.

### ***Other***

Articles for grooming are readily available.

Meals and snacks are provided at appropriate times and on entry into the service for patients who are hungry or thirsty.

## **Staffing**

### ***Staff Competence***

The competence of all staff is continuously evaluated, monitored and enhanced.

There is a written procedure for ensuring the ongoing assessment of staff competence in core clinical areas. This procedure is developed and approved by the clinical director. Individual plans for the development and improvement of clinical skills are part of the yearly performance evaluation process.

### ***Qualifications of Staff***

The clinical director has developed explicit written criteria for the qualifications of staff regarding training, experience and competence. The criteria specifically address the training in crisis or emergency settings. In general, those staff who work without ongoing supervision should have had supervised experience in an acute psychiatric setting.

### ***There is Adequate Staffing***

There is at all times a staff to patient ratio of no more than 1:5. There is at all times at least one staff member on site. Staff on duty remain awake at all times.

There is at all times at least one LIMHP on site during the day.

Supervisory staff are available by phone and, as needed, on site, at all times.

There is a LIMHP who is assigned to the patient at least daily and who is responsible for providing the patient with active treatment including psychoeducation, crisis psychotherapy, substance abuse treatment, developing a plan for returning to the community that addresses potential obstacles to a successful return.

A psychiatrist should at all times be available by phone and to perform a face-to-face evaluation on site.

There is a medical director who is a board certified psychiatrist with adequate training and experience in emergency and acute psychiatry.

### ***Staffing Adjustment***

There is a process for assessing and anticipating staffing needs. There is an on-call roster of clinical and nursing staff.

### ***Staff Orientation and In-Service Training***

There is an ongoing educational program to update staff regarding best practices in emergency and acute psychiatric services.

There is adequate training to ensure that staff is competent to provide services to patients from all of the cultural backgrounds represented in the catchment area of the program.

The ongoing educational program incorporates findings from the Quality Improvement process.

### ***Multi-Disciplinary Team***

The role of each member of the multi-disciplinary team is defined in writing. Every patient is assigned to a psychiatrist who is responsible for the overall care of the patient. These standards are developed and approved by the clinical director.

Staff who are not independent practitioners are supervised on an ongoing basis. There is a licensed clinical staff member who directly supervises all trainees.

Security (police) roles are clearly specified. Where a contractor provides security for the facility there is a clear written agreement that specifies the role of security in the process of care. There is a process for reviewing the performance of security services and their role in managing assaultive behavior. There is a written protocol that specifies these roles.

### ***Consultation and Continuous Learning***

Staff performance evaluation and review processes encourage all staff to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

### ***Individual Assessments of Staff***

Every staff member has an assessment completed at least yearly. The clinical director participates in the process of staff assessment for all clinical staff.

## **Medical Records**

Medical records are stored in a confidential and secure manner.

There is an individual record for each patient and that record includes: identifying information, marital status, legal status, a description of the emergency care provided before admission to the facility, a record of patient preferences regarding involuntary treatment (if such a document was previously provided to the facility), the assessments, treatment plans, level of care determination and aftercare plan for each patient.

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

## **Quality Improvement**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation. At a minimum, the service should capture information about the patients served including culture and ethnicity, the type and number of emergencies, and the treatment provided.

### ***Key Measures***

Performance on key measures is compared to the performance of comparable services elsewhere. This includes: linkage to aftercare.

Linkage with aftercare is continuously measured.

### ***Patient Satisfaction***

There is a process for evaluating patient satisfaction. This process includes an opportunity to obtain detailed information about patient concerns that is gathered in such a way that patients do not experience concern about being honest (e.g., interviews done by former mental health patients, anonymous surveys that are mailed back).

### ***Grievance Process***

Every patient is provided information about how to file a grievance on entry and exit from the service.

There is a written process for handling grievances or complaints that ensures that there is no adverse consequence (retaliation) for filing a grievance, that grievances are responded to within 30 days and that includes a means for appealing decisions to someone outside the service.

### ***Critical Events***

Every patient death within 30 days of discharge from the service is reviewed as part of a critical event review.

There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff who were involved in the assessment and care of the patient.

Findings from critical event reviews lead to changes in the way that care is provided.

## **Leadership**

### ***Leadership Roles***

There is a medical director who is a board certified psychiatrist with adequate training and experience in emergency and acute psychiatry. Where the roles of clinical, medical and administrative director are separated, there is a written description of the roles and their relationship.

### ***Competence and Role of Staff***

Leadership reviews and ensures the competence of all staff. The clinical director approves the definition of the role of each care providing staff member.

### ***Community Liaison***

Leadership ensures that there is an up to date and complete list of resources that patients receiving services commonly need.

### **Ethics and Patient's Rights**

Treatment is not denied or delayed because of an inability to pay.

As much as possible patients are involved in all aspects of making decisions.

Patients are given complete information about their diagnosis and the options for treatment unless there is a clinical contraindication for this.

### ***Consent***

All patients give informed consent for treatment except those who are not competent to make these decisions.

There is a written procedure that describes the evaluation of patients to determine if they are competent to give consent.

### ***Confidentiality and Privacy***

Confidentiality of all patients is maintained except:

1. As permitted by law and as specified in written procedures in order to ensure the safety of the patient or others.
2. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
3. To the extent that the patient consents to the release of information to others, especially significant others and health care providers.

### ***Communication with Significant Others***

As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.

To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.

Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

### ***Restrictions on Patient Rights***

The circumstances under which patient rights may be curtailed are specified in a written policy and procedure. That policy and procedure includes the requirements for documentation and the limitations on such restrictions.

***Information on Patient Rights***

All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights. There is immediate access to an advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

***Diversity and Communication with Patients and Families***

There is acceptance of and respect for differences that is manifested in a variety of ways including efforts to expand cultural knowledge and resources through consultation with minority stakeholders, continuous assessment and service adaptation and enhancement to meet the diverse needs of the population served.

There is a provision for communication with patients who are speech or hearing impaired.

There are staff available who can communicate with patients who do not speak English, and whose primary language is spoken by 5% or more of individuals in the catchment area of the service.

There is provision for translation in all other languages.

***Grievance Process***

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.



Section  
**3**

## Report and Recommendations Regarding **Emergency and Crisis Psychiatric Services**

### Conclusions

As noted there is significant variation in emergency service products. This related in some way to the more complex system of funding emergency care. Emergency services have generally functioned as loss leaders and have not attracted investment. Four categories of recommendation are envisioned. The first involves proposing voluntary models, a draft of which are included with this report, for the operation of different categories of emergency service. These models do not have a deep evidence base but represent an expert consensus derived from government and professional sources as well as research. It is recommended that CPS review and refer these to the Council on Quality for their consideration and further development as an APA product. Simultaneously, the draft models will be submitted to other allied organizations such as AAEP and AACP for their input and potential endorsement.

Meanwhile, it is also recommended that the Council on Funding consider investigating the funding of emergency services in more detail. This might ultimately provide technical assistance to agencies attempting to implement APA models for PES's. The need for this is exemplified by the recent efforts of the DC Crisis Services to reorganize and the uncertainty about the funding needed to support the project.

The third set of recommendations relates to the recent authorization by Congress of funding of up to \$25M for "emergency mental health centers". Prospects for funding of this provision are reported by both the congressional sponsors and APA CGR to be good. If appropriated, these funds will be disbursed by the Center for Mental Health Services. It is recommended that APA support funding by publicizing the debate surrounding the appropriations bill and using staff to lobby for passage. Efforts should be taken to prevent an outcome similar to the Community Mental Health Centers Act. APA may play a role in the CMHS RFP development process.

Finally, a permanent liaison for emergency psychiatry should be established within APA. Currently the sitting president of AAEP or her designee occupies a seat on SDS. While providing representation, this approach has disadvantages for APA.

Section  
**4**

## Report and Recommendations Regarding **Emergency and Crisis Psychiatric Services**

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