

“Patients in Crisis in the Emergency Department: Clearance, Boarding, and Future Interventions”

23rd Annual Wisconsin Crisis Intervention Conference

September 20th, 0830-1030 (Session #27)

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Disclosures

- **Source of Research Support** – NONE
- **Stock Equity (>\$10,000) / Speaker's Bureau** – NONE
- **QA/QI involvement** – Precedence and Greeley

National Position:

President Elect for the American Association for Emergency Psychiatry (AAEP)

State Position:

- Milwaukee Chapter President for the Wisconsin Psychiatric Association (WPA)

Consulting Relationships:

- NHSC and member of MCW Dept. of Psych

Specific Disclosure for today's discussion....

▶ **Co-Chair of a State Task Force:**

- ▶ Consisting of leaders of both the Wisconsin Psychiatric Association (WPA) and the Wisconsin Chapter of the American College of Emergency Physicians (WACEP)

▶ **Focusing on.....**

- ▶ 1) Topics pertaining to the interface of ERs and mental illness
- ▶ 2) Collaborations to help guide policy, legislation, and best practice guidelines

Contact Information

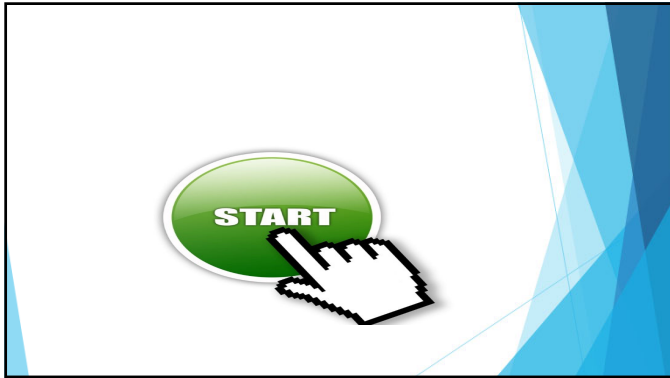
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Objectives (as per your handout)

- ▶ 1) Note the complication of treating crises in medical emergency settings.
- ▶ 2) Process how patients in crisis also have medical needs requiring assessments.
- ▶ 3) Discuss how future state solutions can address both up-stream intervention and modification of medical emergency settings.

Agenda for our next two hours!

- ▶ 1) Introduction to the task force (10 minutes)
- ▶ 2) Focus on the topic of medical clearance (45 minutes)
- ▶ 3) BREAK (10-15 minutes)
- ▶ 4) Discussion of the treatment of agitation in medical emergency rooms for those with mental illness (30 minutes)
- ▶ 5) Process future directions (20 minutes)



WPA / WACEP task force (formed 2017)

- ▶ Members of two professional state organizations
 - ▶ Wisconsin Psychiatric Association (WPA)
 - ▶ Wisconsin Chapter of the American College of Emergency Physicians (WACEP)
- ▶ Similar goals and aims.....
 - ▶ Enhance patient safety and experience
 - ▶ Improve the process for the medical systems/providers
 - ▶ Address variability in process and look to standardize care
- ▶ Began meeting several times a year to address the interface of our two fields..... and how it affects the patients under our care!

Task Force (cont.)

- Membership:
 - Dr. Bobby Redwood (Divine Savior, WHA)
 - Dr. Michael Replinger (UW Madison)
 - Dr. Michael Peterson (UW Madison)
 - Dr. John Schneider (Milwaukee County)
 - Dr. Martha Rolli (DHS state system)

Items being considered

- ▶ 1) Medical Clearance (first project)
- ▶ 2) Education of ER personnel on topics pertaining to mental health
- ▶ 3) Standardization of parity in care for inpatient hospitals/health systems
- ▶ 4) Clarifying what outpatient/inpatient options are available at any point in time
- ▶ 5) Serving as a panel of subject matter experts for any policy or law makers to consult

Future collaborators and stakeholders?

- ▶ DHS
- ▶ Counties and their Associations
- ▶ WHA
- ▶ Individual health systems
- ▶ Patient groups and/or advocacy gatherings
- ▶ Oversight boards
- ▶ CMS



Topic of "Medical Clearance"

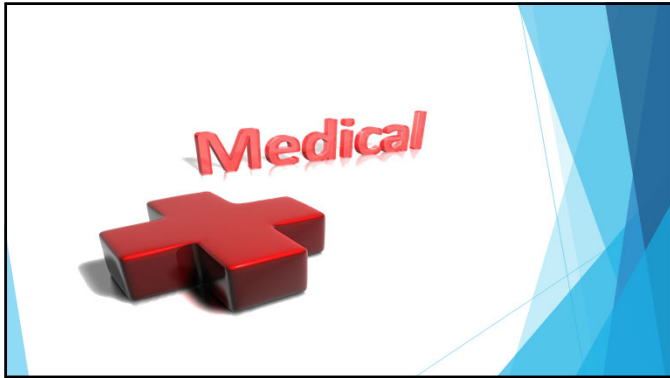
- ▶ **Current issues (locally):**
 - ▶ Outside of Milwaukee County, ALL Emergency Detention patients are being taken to medical Ers
 - ▶ Not only is this costly, but it is not evidence based.....
 - ▶ Hence, it leads to boarding issues (culpability here also to access issues).....
 - ▶ Dissatisfaction follows for:
 - ▶ Patients
 - ▶ ER providers
 - ▶ Transport companies
 - ▶ Sheriff deputies

Patients needing Emergency Room assistance.....

- ▶ Incidence of mental illness is INCREASING while services are decreasing (or not keeping up with the increase).....
 - ▶ Curtin SC, Warner M, Hodegaard H. Increase in Suicide in the United States, 1999-2014. NCHS Data Brief 2016;(241):1-8.
- ▶ Inherent in this is lack of parity, deinstitutionalization, and stigma....
- ▶ As such, more patients with crisis symptoms (due to mental illness) are presenting to local medical Emergency Departments!
 - ▶ Scott J. 2010. Treatment of Psychiatric Patients in Emergency Settings (Internet). From: Psychiatry. [cited 2018 Dec 10];Available from: <http://primarypsychiatry.com/treatment-of-psychiatric-patients-in-emergency-settings/>

Even in Wisconsin??

- ▶ **Recent Wisconsin Medical Society Briefing, 2018:**
 - ▶ State already has a shortage of 215-262 psychiatrists
 - ▶ 50% of all psychiatrists in WI are over 55 years old
 - ▶ Mental Health America (MHA) rates our state:
 - ▶ 34th out of 50 for workforce availability
 - ▶ 30th out of 50 for physician availability
- ▶ *****Hence, while the shortages are difficult now, they are most likely due to worsen prior to improvement.....**



Medical misperceptions with Mental Illness

- ▶ Those with chronic mental illness actually have MORE medical issues, not less.....
 - ▶ James GK, Macdon C, Sarriso PJ, Fisher BR, Hargreaves WA, Harding CM. Prevalence, severity, and co-occurrence of chronic physical health problems of patients with serious mental illness. *Psychiatr Serv Wash DC* 2004;55(1):1250-7
- ▶ Stigma towards those with mental illness OFTEN affects the amount and quality of care they receive.....
 - ▶ Alan A, Rachal J, Tucci VT, Mouskaddam N. Emergency Department Medical Clearance of Patients with Psychiatric or Behavioral Emergencies, Part 2: Special Psychiatric Populations and Considerations. *Psychiatr Clin North Am* 2017;40(3):425-33.
- ▶ Patients presenting with medical issues (but with psychiatric illness) often have ALL their symptoms attributed to mental health etiologies!
 - ▶ Wilson MP, Nordstrom K, Anderson EL, et al. American Association for Emergency Psychiatry Task Force on Medical Clearance of Adult Psychiatric Patients. Part II: Controversies over Medical Assessment, and Consensus Recommendations. *West J Emerg Med* 2017;18(4):940-6.

Concerns over GLOBAL medical clearance

- ▶ While we do not want to overlook any medical issues, the idea of LARGE "one size fits all" medical panels do not improve outcomes!
 - ▶ Weisberg MP. Emergency room medical clearance: an educational problem. *Am J Psychiatry* 1979;136(5):787-90.
- ▶ In fact, most issues can be readily uncovered by quality physical exams with a focus on all possible issues (not anchoring towards a mental illness)
 - ▶ Anderson EL, Nordstrom K, Wilson MP, et al. American Association for Emergency Psychiatry Task Force on Medical Clearance of Adults Part I: Introduction, Review and Evidence-Based Guidelines. *West J Emerg Med* 2017;18(2):229-42.
- ▶ A key component of this is making sure that all providers in emergency rooms are providing best practices and not treating those with mental illness in a different fashion (i.e. "turking" to non-medical individuals)
 - ▶ Tucci VT, Mouskaddam N, Alan A, Rachal J. Emergency Department Medical Clearance of Patients with Psychiatric or Behavioral Emergencies, Part 1. *Psychiatr Clin North Am* 2017;40(3):411-23

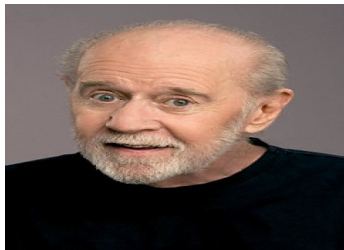
Medical Clearance contributing to "Boarding issues"

- ▶ This is a national issue affecting many Emergency Rooms
- ▶ Tied to lack of access in many venues:
 - ▶ **Outpatient services** - needing the ER in that moment....
 - ▶ **Inpatient services** - waiting in the ER for an inpatient bed....
 - ▶ **Crisis services** - finding a way to bridge the two.....ER staff feeling forced to choose the inpatient option because we "have no other options".....
- ▶ Many legal outcomes but with little actual change.....
 - ▶ Reference State of Washington Supreme Court finding in 2016-2017
- ▶ Also affects risk management and assessment
 - ▶ Most crises resolve (WITH TREATMENT) quite quickly.....but ER staff still feel that the "episode" must end in an hospital based unit!

Boarding concerns (cont.)

- ▶ Boarding is not only unsatisfactory, it can actually contribute to mortality and increased length of stays!
 - ▶ Singer AJ, Thode HC, Viccalito P, Pines JM. The association between length of emergency department boarding and mortality. Acad Emerg Med Off J Soc Acad Emerg Med 2011;18(12):1324-9.
- ▶ Patients presenting with mental health symptoms often have LONGER length of stays, regardless of symptom/acuity (4X as long).
 - ▶ Conrad HL, Holzerbach KA, Gelbach DL, Ferran N, Barham TA, Cantaris KL. The Impact of Behavioral Health Patients on a Pediatric Emergency Department's Length of Stay and Left Without Being Seen. Pediatr Emerg Care 2018;34(8):544-7.
- ▶ Furthermore, those with Medicaid or lack of insurance, have that time increased.....and are twice as likely to be in the ER for more than 24 hours (when compared to privately insured patients)!
 - ▶ Pearlmaster MD, Dwyer RH, Burke LG, Rattlev N, Maranda L, Yotaro G. Analysis of Emergency Department Length of Stay for Mental Health Patients at Ten Massachusetts Emergency Departments. Ann Emerg Med 2017;70(2):193-202.e16

"The Power of Words"



Medical Clearance vs. that of MEDICAL STABILIZATION

- ▶ The term "medical clearance" is misleading
 - ▶ Wilson MP, Nordstrom K, Anderson EL, et al. American Association for Emergency Psychiatry Task Force on Medical Clearance of Adult Psychiatric Patients. Part II: Controversies over Medical Assessment, and Consensus Recommendations. *West J Emerg Med* 2017;18(4):640-6.
- ▶ Using a "clearance term" can actually hinder the flow of information between psychiatric and non-psychiatric personnel
 - ▶ Weisberg MP. Emergency room medical clearance: an educational problem. *Am J Psychiatry* 1979;136(5):787-90
- ▶ Clearance for.....
 - ▶ 1) ALL medical conditions?
 - ▶ 2) Acute medical conditions (delirium)?
 - ▶ 3) Chronic medical conditions?
 - ▶ 4) Admission to a private psych unit?
 - ▶ Anderson EL, Nordstrom K, Wilson MP, et al. American Association for Emergency Psychiatry Task Force on Medical Clearance of Adults: Part I: Introduction, Review and Evidence-Based Guidelines. *West J Emerg Med* 2017;18(2):235-42

1963



Institutes of Mental Disease (IMD)

- ▶ Developed back in the 60s
- ▶ CMS terminology noting those units that are "free standing" and not located within a medical hospital
- ▶ CMS refuses to pay for these individuals:
 - ▶ 1) Back in the 60s it was meant to "incentivize" the closure of institutions
 - ▶ 2) But.....it still continues TODAY!
- ▶ Important to note that these hospitals do not have medical functions, supplies, or staffing
 - ▶ It can affect who is hospitalized there, even if the medical issue is chronic
 - ▶ Think dialysis, feeding tubes, inability to eat/clothe/care for oneself, etc...

IMDs (cont.)

- ▶ Special section in our white paper
- ▶ SIGNIFICANT reduction in what types of medical issues can be treated
 - ▶ As opposed to psychiatric units within a medical hospital
 - ▶ Tucci V, Liu J, Materin A, Shah A, Hussaini N. Like the Eye of the Tiger: Urgent Psychiatric Facility Exclusionary Criteria and Its "Prevalence" of the Emergency Psychiatric Patients. *J Emerg Trauma Shock*. 2017;10(4):189-91.
- ▶ Focusing on the high amount of IMDs in Wisconsin
 - ▶ Aurora Psych
 - ▶ Rogers Behavioral Health
 - ▶ Milwaukee County and Waukesha County BHD
 - ▶ UHS (incoming)
 - ▶ Winnebago
 - ▶ Mendota

Improving Care in the medical stabilization process?

- ▶ Improvement is needed as history has shown that the average ER exam is not very thorough (missing many elements) when it comes to a psychiatric patient!
 - ▶ Riba M, Hale N. Medical clearance: fact or fiction in the hospital emergency room. *Psychosomatics* 1990;31(4):400-4.
- ▶ While the ER providers may feel that delirium is an area of skill, evidence shows this diagnosis being missed frequently.....
 - ▶ Han JH, Zimmerman EE, Carter M, et al. Delirium in older emergency department patients: recognition, risk factors, and psychomotor subtypes. *Acad Emerg Med* 2011;16(10):1191-1200.
- ▶ IN particular, focusing on certain special populations as being higher risk for medical complications and/or delirium:
 - ▶ 1) New onset illness
 - ▶ 2) Those younger than 12
 - ▶ 3) Absence of personal or family history
 - ▶ 4) Pregnancy
 - ▶ Reeves RS, Perry CL, Burke RS. What does "medical clearance" for psychiatry really mean? *J Psychosoc Nurs Ment Health Serv* 2010;48(8):2-4.

The image shows a series of black silhouettes of human figures in various walking or running poses, arranged in a line from left to right. The background is white with a blue geometric pattern on the right side.

Systemic Tension.....

▶ Between inpatient psychiatrists.....

- ▶ 1) Feel they have been "burned" by accepting cases with bad medical outcomes
- ▶ 2) Worried that ER staff are minimizing medical issues of their patients
 - ▶ Mackey KE, Qu C. Can Mobile Integrated Health Care Paramedics Safely Conduct Medical Clearance of Behavioral Health Patients in a Pilot Project? A Report of the First 1000 Consecutive Encounters. Prehospital Emerg Care Off J Natl Assoc EMS Physicians Natl Assoc State EMS Dir 2018;1:10
- ▶ 3) Given shortages, are in a larger position of leverage amongst the health systems

▶ And emergency medicine physicians.....

- ▶ 1) Feel as if their medical skill set is being ignored
 - ▶ Trivedi TK, Glano M, Heim G, Schriger DL, Sporer KA. Emergency Medical Services Use Among Patients Receiving Involuntary Psychiatric Holds and the Safety of an Out-of-Hospital Screening Protocol to "Medically Clear" Psychiatric Emergencies in the Field, 2011 to 2016. Ann Emerg Med 2018.
- ▶ 2) Frustrated at not talking to their peers about said issues
- ▶ 3) Displacing emotions about lack of access from their own internal systems to the inpatient systems currently providing care!

Pending article in the Wisconsin Medical Journal (WMJ)



Task force summaries in a broad white paper / article

▶ "Medical Clearance" of Patients with Acute Mental Health Needs in the Emergency Department"

- ▶ A Literature Review and Practice Recommendations by the Wisconsin Chapter of the American College of Emergency Physicians and the Wisconsin Psychiatric Association
- ▶ Tony W. Thrasher, D.O.; Martha Rolli, MD; Robert S. Redwood, MD, MPH; Michael J. Peterson, MD, PhD; John Schneider, MD; Lisa Maurer, MD; Michael D. Repplinger, MD, PhD

Take home points of the Medical Clearance Recommendations

- ▶ 1) A detailed History and Physical Exam should constitute the minimum necessary information required for most assessments.
- ▶ 2) Clinical information should guide further diagnostic testing.....NOT blanket requirements for all patients (or receiving facilities).
- ▶ 3) Emergency Physicians should understand the limited medical capabilities of Institutes of Mental Disease.....and that these inpatient facilities may have need for differing levels of testing.
- ▶ 4) Structured medical algorithms should be used to enhance these practices.
 - ▶ This Task Force recommends the Wisconsin SMART form
- ▶ 5) Emergency Physicians and Psychiatrists should be communicating on these issues DIRECTLY and without intermediaries.

Wisconsin SMART form

- ▶ 1) SMART form first produced by the Sierra Sacramento Valley Medical Society
 - ▶ A Project of the Sierra Sacramento Valley Medical Society | SMART Medical Clearance [Internet]. [cited 2018 Oct 29]. Available from: <http://smartmedicalclearance.org/>
- ▶ 2) Details an evidence based, efficient way to screen for conditions that might need MORE than purely a history and physical
 - ▶ Shah SJ, Fiorito M, McNamara RW. A screening tool to medically clear psychiatric patients in the emergency department. *J Emerg Med*. 2015;45(5):877-8.
- ▶ 3) Sacramento was very useful in sharing their data and journey!
- ▶ 4) Copies are in the back.....

Wisconsin SMART form

- ▶ **SUSPECT** New Onset Psychiatric Condition?
- ▶ Other **MEDICAL** Conditions that Require Screening?
 - ▶ Diabetes (sugars outside of 60 or 250), Possibility of pregnancy, Other non-psychiatric medical complaints)
- ▶ **ABNORMAL?**
 - ▶ Vital signs, Mental Status, Physical Exam (unclothed)
- ▶ **RISKY** Presentation?
 - ▶ Age outside of 12-55, ingestions, eating disorder, "found down", withdrawals, trauma involved in presentation (cutting, ligatures, MVAs, etc.....)
- ▶ **THERAPEUTIC** Levels Needed?

Scoring??

- ▶ If the answer to all five categories is NO, then the patient can be considered medically stabilized with no further testing be mandated!
 - ▶ More patients are in this category than many may think.....
 - ▶ This is the category where more discussions are expected with IMD facilities
- ▶ If any section is answered with YES, then further testing should proceed around THAT concern.....
 - ▶ NOT blanket testing.....or "admission criteria"
- ▶ ***If there is any lack of agreement between the ER doc and the Psychiatrist, then an immediate phone conversation is expected to occur between the two to come to consensus!

How do you grade intoxication?

- ▶ The level of intoxication in any patient can be a complicated matter depending on many factors:
 - ▶ Tolerance
 - ▶ Withdrawal history
 - ▶ Co-morbid medical issues
- ▶ The choice was made to use the H-Impairment Index (HII Score):
 - ▶ On the back of the SMART form
 - ▶ Scored 0-4
 - ▶ Some similarities to sobriety field testing

Medical Stabilization Conclusions

- ▶ 1) Patients with mental illness often have as many health issues (if not more) as those without mental illness.
- ▶ 2) When presenting to an Emergency Department for crisis care, this is often at risk of being overlooked.
- ▶ 3) That being said, global (over inclusive) testing for all patients with mental illnesses are not evidence based, trauma informed, and they contribute to the boarding epidemic!
- ▶ 4) Education of Emergency Department staff can lead to better physical examinations and notification of any issues.
- ▶ 5) Education of Psychiatry staff can help make the overall process of transitioning out of the ER to be more fruitful and less laborious!
- ▶ 6) To guide these examinations, the WPA/WACEP task force suggest the usage of the Wisconsin SMART form

Break time!!!



Next Section.....

▶ Treatment of **Agitation** in the Patient presenting to the Emergency Department

What is AGITATION?

- > It is a behavioral and medical emergency!
 - > 1.7 million medical ER visits per year in US involve agitated patients (Sachs, GS, J Clin Psych, 2006)
 - > "Excessive verbal and/or motor behavior" when the pt displays:
 - Psychomotor activation
 - Mood Lability
 - Verbal Abuse
 - Aggression
 - Potential to harm self/property/etc..
- Citrome, L. Post grad Med, 2002

Why is this an issue in Emergency Departments for our patients?

*JCAHO reviews restraint related incidents as a **main marker of functionality**

*Most patient-to-staff assaults **lead to missed days of work**, not to mention the psychological sequelae (Allen, Currier, Hughes et al, Postgraduate Medicine, 2001)

*Almost 2/3 of these assaults occur during containment procedures (Carmel, Hunter, Hospital and Community Psychiatry, 1989)



Often heard in these settings.....

▶ "We aren't used to handling *those types* of patients"

- ▶ This is:
 - ▶ Unethical
 - ▶ Uninformed
 - ▶ Improper
 - ▶ Liable
 - ▶ UNACCEPTABLE!

Ethical Issues in the Treatment of Agitation

- ▶ Patients have a right to not be agitated
- ▶ This should be treated as a symptom like any other medical symptom.....
- ▶ Physicians treat:
 - ▶ 1) Pain
 - ▶ 2) Fever
 - ▶ 3) Insomnia
 - ▶ 4) WHY NOT AGITATION?

UT-SW: Journal of Emergency Psychiatry (Sept. 2016)

- ▶ "Characteristics of Violent Behavior in County Hospital Emergency Departments"
- ▶ Violence in ED continues to be present with assaults not uncommon
- ▶ Noted interventions of "successful" programs:
 - ▶ **Recognizing high risk**
 - ▶ **Improving security**
 - ▶ **Designating rooms for patients with agitation**
 - ▶ *****Shortening the time for de-escalation processes**
 - ▶ *****Shortening the time for either chemical or physical restraints**
 - ▶ **Training ED staff on agitation protocols**



Causes of Agitation?

- Medical issues.....delirium
- Involuntary detainment
- Paranoia
- Fear of legal repercussions
- Mania/irritable depression
- AODA
- Past experiences
- Feeling scared
- History of trauma (Trauma Informed Care)
- Feeling like "things are out of control"
 - NOT ALWAYS PATHOLOGICAL

Take a brief step back.....

- ▶ Please note that on that list.....
- ▶ **Agitation can happen to any patient for a myriad of issues!**
- ▶ **While agitation can go hand in hand with a treatable mental illness, it can also occur in the absence of any such diagnosis**

Staff Safety

- ▶ Having the whole team understand the process assists in morale
 - ▶ Decreases helplessness
 - ▶ Increases feelings of knowledge/skill
 - ▶ **Assists the patient in feeling SAFE**
 - ▶ When we are anxious/agitated.....it has clear affect on our patients
 - ▶ *Something to consider when patient is arriving agitated at your door for reasons tied to WHO BROUGHT THEM IN.....*

Measurements?

- > Broset Violence Checklist (BVC)
- > A) Confusion
- > B) Irritability
- > C) Boisterousness
- > D) Physically Threatening
- > E) Verbally Threatening
- > F) Attacking Objects
 - > 1-2, consider moderate risk with meds indicated



Congratulations, You Made it!
Now what?

Diagnosis is made.....what are our Priorities?

- > 1) Ruling out life threatening causes
- > 2) Verbal options / de-escalation by staff
- > 3) Pharmacological Options
- > 4) Physical plant Options
 - > Seclusion
 - > Restraint

Project BETA

- “Best Practices in Evaluation and Treatment of Agitation”
- W. Journal of Emergency Medicine (2/12)
- Six related articles
 - Most downloaded in the history of the journal
 - Can be obtained for free reading or download at the WJEM website:
 - http://escholarship.org/uc/uciem_westjem?volume=13:issue=1



The six Project BETA articles are the most downloaded and most cited articles in the history of the *Western Journal Of Emergency Medicine*.

Stories about Project BETA have appeared in *Emergency Medicine News*, *Psychiatric Times*, *Psychiatric News*, and many other publications.

Project BETA Articles (6)

- 1) Overview of the Project
- 2) Medical Evaluation and Triage
- 3) Psychiatric Evaluation of the Agitated Patient
- 4) Verbal De-escalation of the Agitated Patient
- 5) Psychopharmacology of Agitation
- 6) Use and Avoidance of Seclusion and Restraint

Verbal De-escalation



Topics to keep in mind!

- ▶ 1) Trauma Informed Care
- ▶ 2) Psychological First Aid
- ▶ 3) Autonomy of Patients with Mental Illness
- ▶ 4) Autonomy of Patients with Mental Illness who are on a Civil Hold
 - ▶ What does a Chapter 51 allow you to do?
 - ▶ **Hint: most of what people think.....it doesn't allow for (think Capacity and Ch. 55)**

Hints for De-escalation

- > 1) "I feel".....not "you should"
- > 2) Watch posture
- > 3) Keep proper space
- > 4) Be aware of your position in the ER
- > 5) Avoid "circling the wagon"
- > 6) Have one voice at a time
- > 7) Speak low and slow
- > 8) **IF YOU ARE UNEASY THE PATIENT LIKELY WILL BE TOO.....so pick your words accordingly**

“Seek First to Understand.....”

-Stephen Covey

Can we talk?

-safety, distance, security

What do you want?

-find positive items....be honest about *what you can and cannot help with*

I want to help you get that!

-this does not rule out therapeutic LIMIT SETTING

“....then to be Understood”

-Stephen Covey

➤ Identify automatic feelings:

- Fight or Flight.....even “freezing”
- “What can I do”.....hopelessness
- “Not my job”.....often systemic in nature

➤ Psychological First Aid (PFA):

- Seek to meet the patient where they are...
- It’s about what they need.....not what I want!

➤ Trauma Informed Care (TIC)

- Recognize how past history affects not only our patients but also our STAFF



Take Home Point #1

- ▶ Most providers drastically overemphasize the risks of psychiatric medication.....
- ▶ AND.....
- ▶ Most providers immensely underemphasize the risks of untreated mental illness!

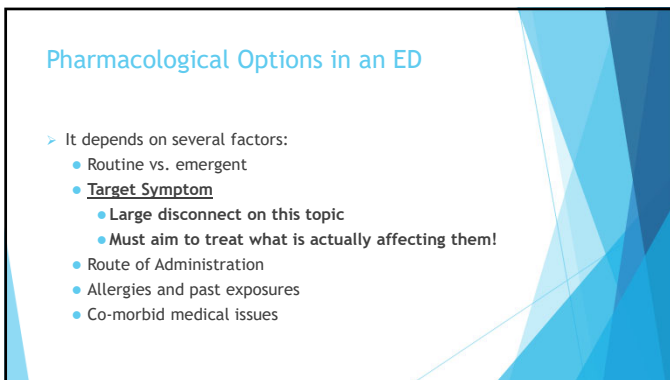
Take Home Point #2

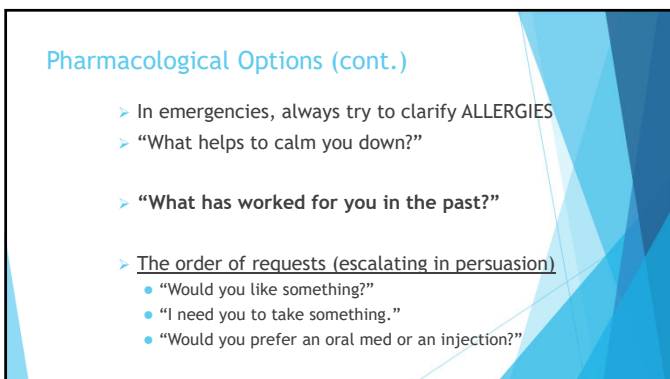
- ▶ Most providers do not intervene EARLY enough
- ▶ Treating agitation is an ONGOING issue
 - ▶ Not “one PRN” and then stop monitoring.....
- ▶ Physicians have a duty to lead this charge; however, they are often not involved at the beginning
 - ▶ Some of this is due to the physical structure
 - ▶ Some of this is due to institutional ignorance

Take Home Point #3

- ▶ While restraints may be clinically necessary, it is ethically inappropriate to:
- ▶ 1) Place patients in restraints without any psychotropic intervention
- ▶ 2) Leave patients in restraints waiting for a resolution of agitation
- ▶ 3) Using untreated restraint episodes as punitive behaviors to be held against the patient
- ▶ 4) Assuming, systemically, *that all restraints should / must be avoided*







Other Pharmacological general comments

- ▶ Remember that not all usage of medication must result in complete sedation

- ▶ The skilled provider will know to tailor their choice in med to fit the need of the patient
 - ▶ Sedation -Facilitating an interview
 - ▶ Calming -Establishing rapport/trust!
 - ▶ Alleviating psychosis

Project BETA recommendations

- ▶ Reviewed:
 - ▶ First Generation Antipsychotics
 - ▶ Second Generation Antipsychotic
 - ▶ Benzodiazepines

- ▶ Lead Editor:
 - ▶ Dr. Zun, Chicago Sinai, Current AAEP President

- ▶ Delirium:
 - ▶ Given special attention to ensure that the CAUSE is being sought prior to medication

Project BETA recs (cont.)

- ▶ Intoxication:
 - ▶ BZDs first line.....SGAs added if needed
 - ▶ Alcohol depending on w/d vs. intoxication
 - ▶ Haloperidol somewhat preferred in EtOH situations due to lack of studies with SGAs

- ▶ Psychiatric Illness:
 - ▶ Antipsychotics first line (SGAs preferred)
 - ▶ Risperidone has most evidence, OLZ "some" (low n)
 - ▶ Adding BZDs is second line

- ▶ Delirium:
 - ▶ SGAs or low dosage haloperidol



What about children and adolescents?

- ▶ “Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the ED: Consensus Statement of the AAEP”
 - ▶ -Western Journal of Emergency Medicine
 - ▶ -February 2019
 - ▶ -Acknowledges that these cases are:
 - ▶ Multimodal, needing ETIOLOGY to drive treatment
 - ▶ Non-pharm options should precede.....but not replace pharmacological options



Debriefing with staff

- ▶ While **Psychological First Aid (PFA)** is now more clinically indicated than “debriefing”, it is still important to:
 - ▶ Check on your staff afterwards
 - ▶ Consider quality improvement
 - ▶ Contemplate how this can trigger history in your staff as well
 - ▶ Attempt to mitigate any labeling or anchoring that can occur in repeat cases.....

Debriefing with patient

- ▶ 1) Speaking with those involved afterward
 - Patient is “using your frontal lobe”
 - Modeling alternative ways of handling stress
- ▶ 2) Checking on them after treatment given
- ▶ 3) Maladaptive coping often gives RESULTS
 - ▶ Need to show that we care even when stable.....

More patient debriefing

- ▶ 4) Can we contact anyone for you?
- ▶ 5) Information is power.....keeping clients informed decreases further agitation
 - ▶ i.e., not saying “we’re just waiting.....”
 - ▶ i.e., not propagating your own staff’s helplessness
- ▶ 6) Relapsing/recurring illnesses
 - ▶ *These symptoms could return again..*
 - ▶ *How do we handle it differently?*

Conclusions on Agitation Treatment in the Emergency Setting

- ▶ 1) Recognize agitation at an EARLY stage
- ▶ 2) It is a **patient's right** to have this agitation treated to alleviate their suffering
- ▶ 3) The most dangerous thing is to do nothing, give minimal effort, or just restrain
- ▶ 4) Excellent evidence base in Project BETA
- ▶ 5) All interactions with patients can be therapeutic



Future Topics to consider.....

- ▶ 1) Funding of mental health services in a COUNTY fashion.....sustainability?
- ▶ 2) Predominant inpatient stays at one state institute.....sustainability?
- ▶ 3) Viewing the Emergency Detention as "one stop" to inpatient care?
- ▶ 4) Saving the Emergency Detention for ONLY involuntary patients.....NOT to access care!
- ▶ 5) **Considering the Psychiatric Emergency Room as an option to assist in all four items above!!**

1) County based model

- ▶ Many peer states have transitioned to a REGIONAL model to deliver mental health care
 - ▶ Better sharing of risk and financial elements
 - ▶ Ex: IA, MN, MO, parts of IL
 - ▶ Also aids with the provider shortage
 - ▶ Allows smaller counties to pool resources
 - ▶ Assists with the provider shortage (now and future.....)
 - ▶ Requires some state investment/oversight

2) Predominance of involuntary care to a state institute

- ▶ Currently, Winnebago handles the predominance of involuntary holds for 70 counties!
 - ▶ Concerns over work force and sustainability?
 - ▶ How therapeutic is it to have someone be hospitalized HOURS away from loved ones and support systems?
 - ▶ Does this force smaller counties to hold on to funds to cover WMHI expenses?
- ▶ Having other inpatient options can improve the patient experience!
 - ▶ Is this patient centered?
 - ▶ Is this trauma informed?
- ▶ Having other options for Emergently Detained clients can improve the patient experience (more on this later)!

3) 51.15 patients being thought predominantly of inpatient?

- ▶ It is well known that the majority of psychiatric crises can resolve in 24-72 hours
 - ▶ Treveth TK, Glenn M, Horn G, Schriger DL, Sporer KA. Emergency Medical Services Use Among Patients Receiving Involuntary Psychiatric Holds and the Safety of an Out-of-Hospital Screening Protocol to "Medically Clear" Psychiatric Emergencies in the Field, 2013 to 2016. Ann Emerg Med 2018
- ▶ An Emergency Detention is sometime used not as much for its legal stature but **as a "means to an end" and/or "there was nothing else available".....**
- ▶ Viewing the crisis moment as an option for intervention.....not to have them moved elsewhere per se!
 - ▶ **Does it make sense to take our most acute individuals.....at their toughest times.....and move them hours away?**
- ▶ Viewing the 51.15 as meaning that the patient is now involuntary, but that does not have to be longitudinal

4) Emergency Detentions only for INVOLUNTARY CARE

- ▶ Chapter 51 is quite clear that this detention procedure should only be used for those that are INVOLUNTARY and dangerous.....not just dangerous
 - ▶ Act 158 of Chapter 51
- ▶ Chapter 51 is similarly clear that this detention process should only be used in concordance with the Least Restrictive Option
 - ▶ Lake v. Cameron (Supreme Court, 1965)
 - ▶ O'Connor v. Donaldson (Supreme Court, 1975)
- ▶ Staff are transparently documenting that they are placing a Chapter 51 to "access care"
 - ▶ Illegal
 - ▶ Unethical
 - ▶ Liable

5) State Psychiatric ERs

- ▶ Several of these placed in regions across the state could ameliorate current issues.....and improve the patient/stakeholder experience!
- ▶ A) **Reduce numbers going to Winnebago** by treating 51.15s at the ER/Observation level before considering Inpatient care
- ▶ B) **Reduce ER numbers** by not requiring global medical clearance
- ▶ C) **Reduce Law enforcement wait time** by having convenient entry and not having to wait
- ▶ D) **Improve patient experience** by keeping those in crisis closer to their families, communities, and outpatient resources

State Psych Ers (cont.)

- ▶ E) **Alleviate workforce shortages** by concentrating skilled providers in one location to serve many counties
- ▶ F) **Assist counties by reducing overall costs** and having less need to arrange transports to and from WMHI
- ▶ G) **Increase adherence to best practices** for those in crisis by intervening quickly with county resources so that the least restrictive venue is found
- ▶ H) **Manifest respect for patient rights** and civil statutes in a way that only utilizes involuntary procedures when absolutely necessary (not for convenience).....

Questions.....discussion items?



▶ Thank you for your time and attention!!
