Development of Emergency Care Psychiatric Clinical Framework

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The emergency department has become the "portal to the community" and the entry point where patients are introduced to the health care system. According to the literature, persons with serious mental illnesses are more likely than their peers without psychiatric problems to use medical services, most likely the emergency department, primarily due to the high rate of co-morbidities associated with mental illness. Historically, emergency nurses have felt unprepared to provide adequate care for patients with mental illnesses. Our uneasiness is exacerbated by the increasing challenges the disparities in our health care system have brought for persons with substance use and mental health disorders, such as the decline of inpatient psychiatric beds and of community mental health services availability.

Well aware of this context, in summer 2007, ENA formed the Psychiatric Patients Work Team (PPWT). I chaired the PPWT, charged to make recommendations to the board of directors on public policy areas relevant to patients in emergency care with mental illnesses and/or substance use disorders. The board accepted the work team recommendations contained in the report, which summarized the emergency nurse's challenges in this way:

"Silently accepting the current position of EDs as an endpoint in the health care system enables a dysfunctional mental health care system and perpetuates the marginalization of mentally ill patients as 'outcasts.' A consequence of the ED's role as the community's de facto safety net is the costly universal access to care for mentally ill patients, without providing adequate treatment and disposition for patients with mental illnesses. Other unintended consequences of the ED as the safety net for patients with mental illnesses are crowding, recidivism, liability concerns, and displacement of other emergency patients."

Mental illness/chemical dependency is a disease, requiring appropriate, quality, and safe care to all people presenting at an emergency department regardless of diagnoses. Nurses know all too well that the false assumption detaching mental health care from a holistic model of medical/health care only fragments care, relegating people with mental health and/or substance use disorders to a second-class medical system of mental health care. This separation of mental health from medical health is health care politicized, thus demanding our nursing advocacy expertise to transform the larger political context shaping emergency care practice for patients with mental illness and/or addictions. The ED nurse often is the last chance for these wounded, outcast patients to receive care that gives them the dignity and respect they need and we all deserve as human beings.

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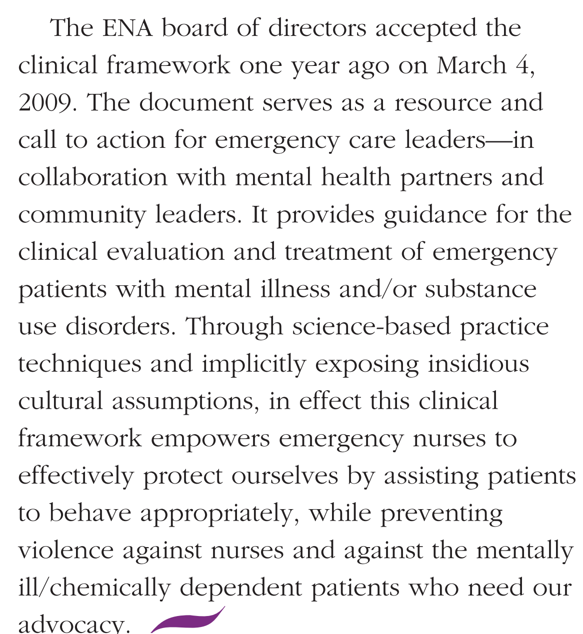
Believing that emergency nurses and health care professionals have a unique opportunity to make unprecedented change in the care of patients with mental illness in the emergency department, the board built on one of the PPWT recommendations to convene a stakeholders meeting in July 2008 on ED-Care of Patients with Mental Illnesses. During the meeting, attended by 15 organizations, it was decided to form a work group to draft a clinical framework, a consensus statement to aid health care workers and, most importantly, to provide the quality care that all our patients ought to have.

Participating with ENA in the work group's clinical framework project were the American Academy of Emergency Medicine, American College of Emergency Physicians, American Nurses Association, American Psychiatric Nurses Association, International Society of Psychiatric-Mental Health Nurses and the National Association of State Mental Health Program Directors. Reviewing the clinical statements extrapolated from the discussion held at the July 2008 stakeholders meeting, the work group completed a draft consensus statement on the Emergency Care Psychiatric Clinical Framework. The document consists of an introductory statement of the problem, principles for practice and emergency care, clinical evaluation guidelines for the assessment and treatment of emergency patients with mental illnesses and/or substance use disorders and includes an addendum of defined terms and cited references.



The ENA board of directors accepted the clinical framework one year ago on March 4, 2009. The document serves as a resource and call to action for emergency care leaders—in collaboration with mental health partners and community leaders. It provides guidance for the clinical evaluation and treatment of emergency patients with mental illness and/or substance use disorders. Through science-based practice techniques and implicitly exposing insidious cultural assumptions, in effect this clinical framework empowers emergency nurses to effectively protect ourselves by assisting patients to behave appropriately, while preventing violence against nurses and against the mentally ill/chemically dependent patients who need our advocacy.

Emergency Care Psychiatric Clinical Framework

Printed below, Emergency Care Psychiatric Clinical Framework also is available as an ENA Position Statement at: **http://www.ena.org/SiteCollectionDocuments/Position%20Statements/ClinicalFramework.pdf**.

The following document is currently being reviewed by other professional organizations for endorsement.

In order to provide competent and accountable emergency psychiatric care, hospitals need to provide a consistent practice model for patient care regardless of facility or time of day. Our collective goal for the provision of psychiatric and substance use disorder treatment in the emergency department is to provide care that meets the Institute of Medicine's Six Quality Aims of safe, effective, timely, efficient, equitable and patient-centered care.[1]

The following principles provide the framework for competent and accountable emergency psychiatric clinical care.

Principles of Practice and Care

1. Implement evidence-based clinical guidelines for emergency patients with mental illnesses and/or substance use disorders.
2. Use a standardized ED triage scale and acuity categorization[2] to ensure the timely and appropriate evaluation and treatment of emergency patients with mental illnesses and/or substance use disorders.[3]
3. Expect emergency care professionals providing evaluation and care to emergency patients with mental illnesses and/or substance use disorders to possess the core competencies necessary to perform the clinical evaluation functions as outlined in the Clinical Evaluation Guidelines section of this document.
4. Support and participate in research, when possible, to further the development and dissemination of best practices models and algorithms for care.
5. Encourage and support efforts to organize and regionalize psychiatric care including adherence to state and community guidelines for emergency medical services. Collaboration will be needed among emergency care, mental health, and law enforcement services in the development of regional transport guidelines.
6. Ensure that patients requiring inpatient treatment are not boarded in the emergency department.

Clinical Evaluation Guidelines

1. Perform a psychiatrically relevant and ***focused medical assessment*** when indicated by triage or medical evaluation – a process by which a medical etiology for the patient's symptoms is excluded and other illnesses and/or injuries in need of acute care are detected and treated.[4] Assessment findings which may indicate a patient has a medical illness for which a symptom-based evaluation is suggested include:[4]
   - Abnormal vital signs
   - Abnormal physical exam relevant to clinical presentation
   - Altered cognition relevant to the clinical presentation
2. Engage in a collaborative psychiatric assessment with each patient individually beginning with a mental status examination that includes appearance, speech, mood, cognitive function, perception, sensorium, insight and judgment.
3. Include the following objectives in an emergency psychiatric evaluation:[5]
   - Assess and have processes in place to enhance the environmental safety of the patient and others.
   - Establish a provisional diagnosis (or diagnoses) of the mental disorder most likely to be responsible for the current emergency, including identification of any general medical condition(s) or substance use that is causing or contributing to the patient's mental condition.
   - Review current medications (prescribed and non-prescribed) and known indications.
   - Review relevant laboratory or radiologic study reports.
   - Identify family or other involved persons who can provide information that will help the mental health provider determine the accuracy of reported history, particularly if the patient is cognitively impaired, agitated or psychotic and has difficulty communicating a history of events.
   - Identify any current treatment providers who can supply information relevant to the evaluation. Community mental health providers should be encouraged to contact and provide clinically relevant information when referring their patients to an emergency care facility.
   - Identify social, environmental and cultural factors relevant to immediate treatment decisions.
   - Determine whether the patient is able and willing to form a therapeutic partnership alliance that will support further assessment and treatment.
   - Identify what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary. Treatment should be delivered in the least restrictive manner to ensure positive clinical outcomes.[6]
   - Determine whether the patient requires treatment in a hospital or other supervised setting and what follow-up will be required if the patient is not placed in a supervised setting.
   - Address family members' or caretaker's ability to care for the patient and their understanding of the patient's needs, if the patient is to be discharged to the care of family members or other caretaking persons.
   - Develop collaborative relationships and policies to facilitate the admission of patients to the most appropriate mental health facility with the least delay after evaluation and disposition by the emergency health care professional.
   - Develop a specific plan for follow-up, including immediate treatment and disposition.
   - Ensure that patients requiring inpatient treatment ***are not boarded*** in the emergency department.[7]

Signed by: American Academy of Emergency Medicine, American Nurses Association, Emergency Nurses Association, International Society of Psychiatric-Mental Health Nurses.

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Assess and have processes in place to enhance the environmental safety of the patient and others.

Definitions

- **Boarding** is the term used to describe the process of holding patients in the ED for extended periods of time who have been directed for admission by a physician with admitting privileges. This process then has certain elements of the admission process and ongoing patient care provided by ED staff members. (***AHRQ ED Performance Measures and Benchmarking Consensus Statement***, 2006)
- **Emergency health care professional** is a licensed health care professional working in an emergency care setting who is providing assessment, planning, diagnosing, and/or interventions to treat an individual with a mental illness.
- **Focused medical assessment** is the process by which a medical etiology for the patient's symptoms is excluded and other illness and/or injury in need of acute care is detected and treated. (***ACEP Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department***, 2006)
- **Mental illness** is the term that refers collectively to all diagnosable mental disorders and generally includes disorders related to substance abuse. ***Mental disorders*** are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) that are all mediated by the brain and associated with distress, or impaired functioning, or both. Mental disorders spawn a host of human problems that may include personal distress, impaired functioning and disability, pain, or death. These disorders can occur in men and women of any age and in all racial and ethnic groups. They can be the result of family history, genetics, or other biological, environmental, social, or behavioral factors that occur alone or in combination. (**SAMSHA**, 2008)
- **Psychiatric emergency** is an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community. 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 the resources available to understand and deal with the situation are not available at the time and place of the occurrence. (***APA Report and Recommendations Regarding Psychiatric Emergency and Crisis Services***, 2002)
- **Six Quality Aims** as defined by the Institute of Medicine are:
  - **Safe:** Avoiding injuries to patients from the care that is intended to help them.
  - **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit thereby avoiding under use and overuse, respectively.
  - **Patient-centered:** Providing care that is respectful of and responsive to individual patients' preferences, needs, and values and ensuring that patient values guide all clinical decisions.
  - **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
  - **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
  - **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. (***Crossing the Quality Chasm, IOM Report***. National Academies Press, 2001)
- **Standardized Triage** is a system to assess and categorize acuity which incorporates all aspects of objective and subjective physical and mental patient assessment data and has demonstrated validity and reliability.