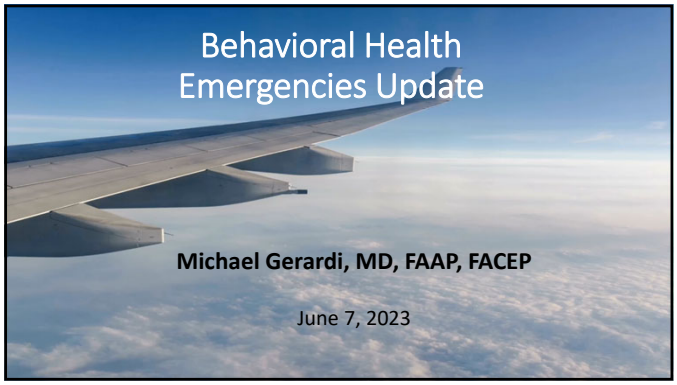
"Earn Your CME in Your Sandals"

1



Disclosures

- BioExcel
  - Medical Advisor (Emergency Medicine)
  - Speaker's Bureau
- American Association of Emergency Psychiatry
  - Board of Directors
  - President Elect (How did that happen?) ☺
- Coalition on Psychiatric Emergencies
  - Inaugural Steering Committee

COVID-19 and Pediatric Mental Health Hospitalizations

Jahidur Rahman Khan, PhD,[a,*] Nan Hu, PhD,[b,*] Pingyi Lin, PhD,[b,c,d,e] Valsamma Eapen, PhD,[b,c,d] Natasha Nassar, PhD,[f] James John, PhD,[b,c] Jackie Curtis, MBBS,[g] Maugan Rimmer, MBChB,[h] Fenton O'Leary, MBBS,[i] Barb Vernon, PhD,[i] Raghu Lingam, PhD[a]

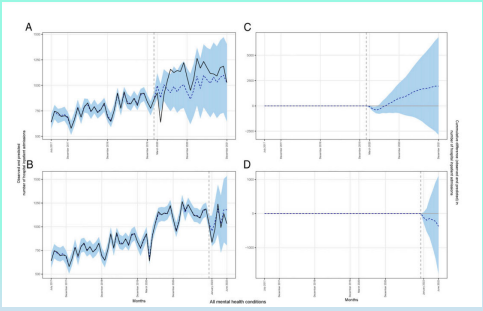
abstract

OBJECTIVES: To analyze Australian national data to examine the impact of the coronavirus disease 2019 (COVID-19) pandemic on mental health-related hospital presentations among children and adolescents during the pandemic period with restrictions, and the period after the restrictions eased.

METHODS: We analyzed the monthly mental health-related inpatient admissions and emergency department (ED) attendances data from 6 large pediatric hospitals across Australia, using the Bayesian structural time series models. The COVID-19 restriction period was from March 2020 to December 2021 and the COVID-19 restriction-eased period from January to June 2022.

RESULTS: A total of 130 801 mental health-related hospital admissions (54 907) and ED attendances (75 894) were analyzed. During the COVID-19 restriction period, there was a significant increase in inpatient admissions related to deliberate self-harm behaviors (82%, 95% credible interval [CrI], 7%–160%) and ED attendances related to overall mental health disorders (15%, 95% CrI, 1.1%–30%) and eating disorders (76%, 95% CrI, 36%–115%). The increase was higher among females and those living in the least socioeconomically disadvantaged areas, suggesting a widening gap between mental health-related presentations by sex and socioeconomic status. After the restrictions eased, there were slight declines in mental health-related hospital presentations; however, the numbers remained higher than the pre–COVID-19 levels.

Observed and Predicted Hospital Admissions



Observed and Predicted ED Visits

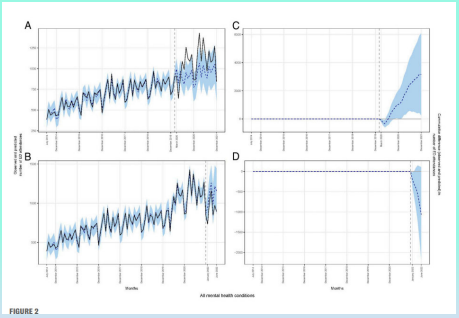


FIGURE 2

CONCLUSIONS

- During the COVID-19 pandemic period with restrictions, there was significant increase in pediatric hospital presentations related to **eating disorders and deliberate self-harm** behaviors
- Highest increase among **female adolescents** and those living in the less disadvantaged areas. Additional support should be provided to these populations.
- As **restrictions** started to **ease**, slight decrease in mental health-related hospital presentations, but the #'s remained at high levels.

ACEP *NOW* May 2023

Thoughts from ACEP President Christopher S. Kang, MD, FACEP

The COVID-19 pandemic has indelibly disrupted our individual lives, local and national communities, and clinical practices. Throughout it all, emergency departments, staffed by you and your teams, remained open and steadfast. However, emergency medicine cannot continue to shoulder most of the health care system as various inadequacies persist and grow. Mental health patients have increasingly complex needs, fewer places for support, and board longer in the ED than medical patients. Left unaddressed, mental health care for patients and ourselves will challenge, even threaten, our security and humanity as well

ACEP Update on Behavioral Health: President Christopher Kang; email May 30, 2023

1. EPs can and should do more than simple medical screening/clearance;
   - Educational content is being curated by ACEP staff: ? available Fall 2023.
   - Scientific Assembly 2023: 4-5 presentations on behavioral health
   - If attendance & feedback is (+) , a dedicated course tract at SA24 possible

2. Behavioral health should encompass a wide range of patients - from depressed to personality disorders to substance use to pediatric/adolescent to geriatric.

3. Collaboration is being fostered - with CPE, AAEP, APA, and others.

4. LAC highlighted several legislative priorities - ED boarding (including psych) and funding for social work services in addition to **988 Crisis Line**.

ACEP Award Honors *Innovations in Suicide Prevention* May 2023

- Every year, ACEP partners with the **American Foundation for Suicide Prevention** to bestow the Innovation in Suicide Prevention Award.
- This honor recognizes promising and innovative acute care activities in the area of suicide prevention, that improve patient outcomes and lives of patients and/or clinicians.

Winners of ACEP Suicide Prevention Award 2022

- **Michael P. Wilson, MD, PhD**, Angie Waliski, PhD, and Ronald G. Thompson, Jr., PhD, LCSW
  - led the first pilot of a peer-delivered suicide safety planning program in the ED.
  - EDs are many patients' 1st access point to care
  - 31 % of people who die by suicide visit an ED in the year prior to their death.
  - A safety plan empowers the patient to design and utilize a personalized list of coping skills, activities and supports for patients to cope with suicidal thoughts.

Tested the feasibility of safety planning initiated in the ED:

- Led by **peers**, people in the community who provide support through compassion, empathy, and lived experience with suicidal thoughts or behaviors, but lack formal medical training.
- The results revealed that participants were **equally likely** to embrace peer-delivered safety plans
- **More likely to complete** the programs led by peers, than those led by professionals.

ACEP *NOW* May 2023

Emergency Departments and the Growing Mental Health Crisis

MAY IS MENTAL HEALTH AWARENESS MONTH, A RECOGNITION THAT SHINES A MUCH-NEEDED SPOTLIGHT ON AN ISSUE CONFRONTED IN EMERGENCY DEPARTMENTS EVERY DAY OF THE YEAR.

by GREGG MILLER, MD, FACEP, AND ENRIQUE ENGUIDANOS, MD, FACEP

While the COVID-19 pandemic certainly impacted Americans' mental health, ED visits for psychiatric needs had been steadily climbing for years beforehand. In 2007, mental health visits comprised 6.6 percent of all ED visits. By 2016, that number almost doubled to 11 percent.[1,2] In a 2015 poll, 70 percent of emergency physicians reported that psychiatric patients were boarding on their last shift, with more than half reporting average boarding times of up to two days.[3]

During the pandemic, mental health issues remained disproportionately high.[4,5]

Now that ED visits have stabilized closer to pre-pandemic volumes, it is too soon to have a precise understanding of the current state of ED visits for mental health issues. One large review suggests that population-level mental health has rebounded close to pre-pandemic baselines, with only a slight increase in depression.[6] This is not necessarily good news; if we're right back where we started prior to the pandemic, we are still not in a good place.

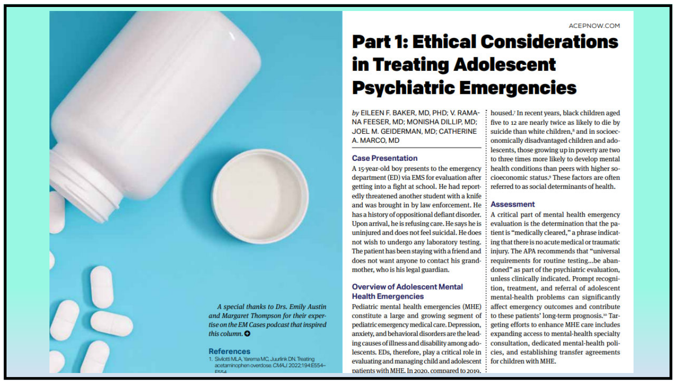
It is clear to practicing EM physicians that caring for patients with mental health issues remains a pressing concern. Too many patients wait far too long in our EDs to receive necessary mental health care, causing need-

Awareness Month is by making sure you know about the helpful tools and resources available to assist with emergent behavioral health:

- ACEP's Mental Health & Substance Abuse Information Papers web page is a very useful collection of articles offering insight into several pertinent ED practices, including:[7]
  - Recent reviews of ED psychiatric care
  - Advice on medication therapy during psychiatric emergencies
  - Assessment of psychiatric safety in suicidal patients
  - Practical solutions to boarding of psychiatric patients
- ACEP has relevant clinical policies and
- ACEP's advocacy efforts related to behavioral health care are documented on its website and will be recapped in person at the 2023 Leadership & Advocacy Conference.[8]
- The Coalition on Psychiatric Emergencies (CPE) is made up of a group of leaders in emergency medicine, psychiatry and patient advocacy who are focused on improving the treatment of psychiatric emergencies for patients and emergency providers.[9]
- ICARuS is a point of care tool for managing suicidal patients in the ED.[10] Behavioral Health is among the top priorities for ACEP President Chris Kang, MD,

Community information exchanges *FindHelp & UniteUs*

- Provide lists of available community resources such as:
  - homeless shelters, behavioral health treatment centers, sobering centers and substance use disorder organizations
- Access to relevant information on these platforms
  - free of any charge
  - easily available to the general public
  - targeted by zip codes,
  - wealth of information on available resources such as hours of operation, contact information, and resource website access.



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Part 1: Ethical Considerations in Treating Adolescent Psychiatric Emergencies

by EILEEN F. BAKER, MD, PHD; V. RAMANA FEESER, MD; MONISHA DILLIP, MD; JOEL M. GEIDERMAN, MD; CATHERINE A. MARCO, MD

Case Presentation

A 15-year-old boy presents to the emergency department (ED) via EMS for evaluation after getting into a fight at school. He had reportedly threatened another student with a knife and was brought in by law enforcement. He has a history of oppositional defiant disorder. Upon arrival, he is refusing care. He says he is uninjured and does not feel suicidal. He does not wish to undergo any laboratory testing. The patient has been staying with a friend and does not want anyone to contact his grandmother, who is his legal guardian.

Overview of Adolescent Mental Health Emergencies

Pediatric mental health emergencies (MHE) constitute a large and growing segment of pediatric emergency medical care. Depression, anxiety, and behavioral disorders are the leading causes of illness and disability among adolescents. EDs, therefore, play a critical role in evaluating and managing child and adolescent patients with MHE. In 2020, compared to 2019, ... housed.[7] In recent years, black children aged five to 12 are nearly twice as likely to die by suicide than white children,[8] and in socioeconomically disadvantaged children and adolescents, those growing up in poverty are two to three times more likely to develop mental health conditions than peers with higher socioeconomic status.[9] These factors are often referred to as social determinants of health.

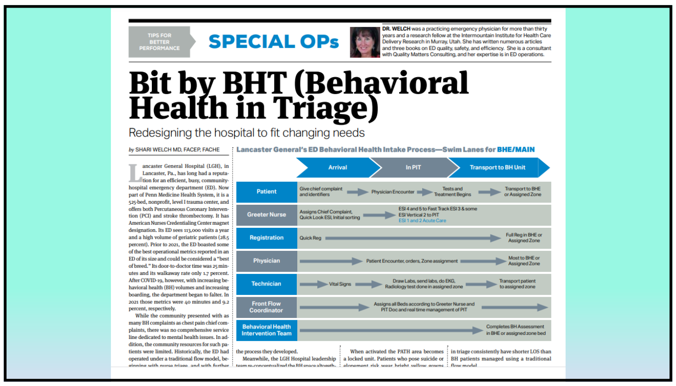
Assessment

A critical part of mental health emergency evaluation is the determination that the patient is "medically cleared," a phrase indicating that there is no acute medical or traumatic injury. The APA recommends that "universal requirements for routine testing...be abandoned" as part of the psychiatric evaluation, unless clinically indicated. Prompt recognition, treatment, and referral of adolescent mental-health problems can significantly affect emergency outcomes and contribute to these patients' long-term prognosis.[10] Targeting efforts to enhance MHE care includes expanding access to mental-health specialty consultation, dedicated mental-health policies, and establishing transfer agreements for children with MHE.

A special thanks to Drs. Emily Austin and Margaret Thompson for their expertise on the EM Cases podcast that inspired this column.

References

1. Sivilotti MLA, Yarema MC, Juurlink DN. Treating acetaminophen overdose. *CMAJ*. 2022;194:E554–E554.



TIPS FOR BETTER PERFORMANCE

SPECIAL OPs

DR. WELCH was a practicing emergency physician for more than thirty years and a research fellow at the Intermountain Institute for Health Care Delivery Research in Murray, Utah. She has written numerous articles and three books on ED quality, safety, and efficiency. She is a consultant with Quality Matters Consulting, and her expertise is in ED operations.

Bit by BHT (Behavioral Health in Triage)

Redesigning the hospital to fit changing needs

by SHARI WELCH MD, FACEP, FACHE

Lancaster General Hospital (LGH), in Lancaster, Pa., has long had a reputation for an efficient, busy, community-hospital emergency department (ED). Now part of Penn Medicine Health System, it is a 525-bed, nonprofit, level I trauma center, and offers both Percutaneous Coronary Intervention (PCI) and stroke thrombectomy. It has American Nurses Credentialing Center magnet designation. Its ED sees 113,000 visits a year and a high volume of geriatric patients (28.5 percent). Prior to 2021, the ED boasted some of the best operational metrics reported in an ED of its size and could be considered a "best of breed." Its door-to-doctor time was 25 minutes and its walkaway rate only 1.7 percent. After COVID-19, however, with increasing behavioral health (BH) volumes and increasing boarding, the department began to falter. In 2021 those metrics were 40 minutes and 9.2 percent, respectively.

While the community presented with as many BH complaints as chest pain chief complaints, there was no comprehensive service line dedicated to mental health issues. In addition, the community resources for such patients were limited. Historically, the ED had operated under a traditional flow model, beginning with nurse triage, and with further ...

Lancaster General's ED Behavioral Health Intake Process—Swim Lanes for BHE/MAIN

	Arrival	In PIT	Transport to BH Unit
Patient	Give chief complaint and identifiers → Physician Encounter	→ Tests and Treatment Begins	→ Transport to BHE or Assigned Zone
Greeter Nurse	Assigns Chief Complaint, Quick Look ESI, Initial sorting →	ESI 4 and 5 to Fast Track ESI 3 & some ESI Vertical 2 to PIT; ESI 1 and 2 Acute Care	
Registration	Quick Reg →	→	Full Reg in BHE or Assigned Zone
Physician	→	Patient Encounter, orders, Zone assignment →	Most to BHE or Assigned Zone
Technician	→ Vital Signs →	Draw Labs, send labs, do EKG, Radiology test done in assigned zone →	Transport patient to assigned zone
Front Flow Coordinator	→	Assigns all Beds according to Greeter Nurse and PIT Doc and real time management of PIT	→
Behavioral Health Intervention Team	→	→	Completes BH Assessment in BHE or assigned zone bed

... the process they developed.

Meanwhile, the LGH Hospital leadership ...

When activated the PATH area becomes a locked unit. Patients who pose suicide or ...

... in triage consistently have shorter LOS than BH patients managed using a traditional flow model.

Psychiatric assessment, treatment and healing (PATH) model

- Ligature-free rooms and common hallway spaces
- Lockers to store patient belongings safely and privately
- Medication-reconciliation specialist in ED
- Security stationed in unit
- Duress buttons provided for every staff member
- Care team: ED r e g i s t e r e d nurse, BH intervention team (BHIT) member, psychiatry consults when applicable
- Laundry area in unit, overflow rooms with garage doors

Clinical Policy: Critical Issues in the Evaluation and Management of Adult Prehospital or Emergency Department Patients Presenting With Severe Agitation
This DRAFT is EMBARGOED – Not for Distribution

From the American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on Severe Agitation:

Molly E. W. Thiessen, MD (Subcommittee Chair)
Steven A. Godwin, MD
Benjamin W. Hatten, MD, MPH (Domain Lead)
Jessica A. Whittle, MD
Jason S. Haukoos, MD, MSc (Methodologist)
Deborah B. Diercks, MD (Committee Chair)

Members of the American College of Emergency Physicians Clinical Policies Committee (Oversight Committee):

Deborah B. Diercks, MD, MSc (Chair 2022-2023)
John D. Anderson, MD
Richard Byyny, MD, MSc (Methodologist)
Christopher R. Carpenter, MD, MSc
Seth R. Gemme, MD
Charles J. Gerardo, MD, MHS
Steven A. Godwin, MD
Sigrid A. Hahn, MD, MPH

- **Level A recommendations**. Generally accepted principles for patient care that reflect a high degree of scientific certainty (eg, based on evidence from one or more Class of Evidence I, or multiple Class of Evidence II studies that demonstrate consistent effects or estimates).
- **Level B recommendations.** Recommendations for patient care that may identify a particular strategy or range of strategies that reflect moderate scientific certainty (eg, based on evidence from one or more Class of Evidence II studies, or multiple Class of Evidence III
- **Level C recommendations**. Recommendations for patient care that are based on evidence from Class of Evidence III studies or, in the absence of adequate published literature, based on expert consensus. In instances where consensus recommendations are made, **"consensus"**

5 1. Is there a superior medication or combination of medications for the acute management of adult prehospital or ED patients with severe agitation?

- Patient Management Recommendations
- Level A recommendations. None specified.
- Level B recommendations.: combination of **droperidol and midazolam**; or an atypical antipsychotic in combination with midazolam.
- Single: use **droperidol** or an atypical antipsychotic, due to the adverse effect profile of midazolam alone.
- **Severe agitation**, use the above agents as described or haloperidol, alone or in combination with lorazepam.

- Level C recommendations. In situations where **safety** of the patient, bystanders, or staff is a concern, consider **ketamine (IV or IM)** to rapidly treat severe agitation in the emergency department (Consensus recommendation).
- **No recommendations** for or against the use of specific agents in the **prehospital setting** can be made at this time (Consensus recommendation).
- **No recommendation** for or against the use of specific agents in patients **over the age of 65** can be made at this time (Consensus recommendation).

Ketamine

- Ketamine was thought to be an ideal agent for this purpose given a rapid time to effective sedation: <2 minutes following IV administration and 2 to 10 minutes following IM administration
- Compared to antipsychotic or benzodiazepine-based regimens, ketamine appears to provide faster and more reliable management of agitation following a single dose of medication, particularly in cases of IM administration.
- However, as use increased, safety concerns became more widespread. Ketamine itself is a respiratory depressant in a dose dependent fashion and is employed as a general anesthetic in operating room settings.

Ketamine Class III

- Unfortunately, the body of literature informing the use of ketamine to treat severe agitation is uniformly flawed.
- No studies of sufficient quality were identified to inform a recommendation for or against the use of ketamine for this purpose in the prehospital or emergency department setting.

Ketamine Class III

- Rapid time to effective treatment and reliable degree of sedation following IM administration
- Ketamine remains an option in situations where the safety of the patient, bystanders, and staff necessitate a more rapid and reliable treatment of agitation than provided by other therapeutic options.

Potential Benefit of Implementing the Recommendations:

- Safe, adequate sedation facilitates medical evaluation of the acutely agitated patient.
- Adequate sedation allows avoidance of prolonged physical restraint and/or isolation, both of which are associated with increased morbidity and mortality.
- Safe, adequate sedation improves the safety of staff caring for the patient.
- A combination of droperidol and midazolam maximizes the balance of adequate sedation while minimizing side effects.

Potential Harm of Implementing the Recommendations:

- Use of anti-psychotics always carries the inherent risk of extrapyramidal side effects such as a dystonic reaction.
- Use of anti-psychotics carries the risk of **QTc prolongation** and torsades de pointes.
- Use of benzodiazepines carries the risk of over-sedation.

Name	Class	Dosing	Mean Time to Sedation (Minutes)	Median Time to Sedation (Minutes)	Proportion of Patients Sedated at a Time Interval
Droperidol	Antipsychotic	5 mg IM (Cole 2021)[17] 10 mg IV (Taylor*)[9] 10 mg IM (Isbister)[13] 5 mg IV (Knott)[15] 5 mg IM (Martel 2021)[18]		16 (Cole 2021)[17] 11 (Taylor*)[9] 20 (Isbister)[13] 8 (Knott)[15]	27% (5 minutes) 55% (10 minutes) (Taylor*)[9] 16.5% (5 minutes) (10 minutes not reported as not significant) (Knott)[15] 64% (15 minutes) (Martel 2021)[18]
Haloperidol	Antipsychotic	5 mg IM (Chan 2021)[10] 5 mg IM (Nobay)[19]	28.3 (Nobay)[19]	23 (Chan 2021)[10]	

Table 1. Summary of Medications (Continued).*

Name	Class	Dosing	Mean Time to Sedation (Minutes)	Median Time to Sedation (Minutes)	Proportion of Patients Sedated at a Time Interval
Single Agents					
Olanzapine	Atypical Antipsychotic	5 mg IM (Chan 2021)[10] 10 mg IV (Taylor*)[9] 10 mg IM (Cole 2021)[17]		11.5 (Chan 2021)[10] 11 (Taylor*)[9] 17.5 (Cole 2021)[17]	35% (5 minutes) 59% (10 minutes) (Taylor*)[9]
Ziprasidone	Atypical Antipsychotic	10 mg IM (Martel 2021)[18] 20 mg IM (Martel 2021)[18]			25% (Martel 2021)[18] 35% (Martel 2021)[18]
Lorazepam	Benzodiazepine	2 mg IM (Martel 2021)[18] 2 mg IM (Nobay*)[19]	32.2 (Nobay*)[19]		29% (Martel 2021)[18]

Table 1. Summary of Medications (Continued).*

Name	Class	Dosing	Mean Time to Sedation (Minutes)	Median Time to Sedation (Minutes)	Proportion of Patients Sedated at a Time Interval
Midazolam	Benzodiazepine	2.5 to 5 mg IV (Chan 2013*)[8] 5 mg IM (Chan 2021)[10] 10 mg IM (Isbister)[13] 5 mg IV (Knott)[15] 5 mg IM (Nobay)[19]	67.8 (Chan 2013)[8] 18.3 (Nobay)[19]	10 (Chan 2013)[8] 8.5 (Chan 2021)[10] 24 (Isbister)[13] 6.5 (Knott)[15]	44.6% (5 minutes) (Knott)[15]

Table 1. Summary of Medications (Continued).*

Name	Class	Dosing	Mean Time to Sedation (Minutes)	Median Time to Sedation (Minutes)	Proportion of Patients Sedated at a Time Interval
Combinations					
Droperidol + Midazolam	Antipsychotic + Benzodiazepine	5 mg IV droperidol + 2.5 to 5 mg IV midazolam boluses (Chan 2013*)[8] 5 mg IV droperidol + 5 mg IV midazolam (Taylor)[9] 5 mg IM droperidol + 5 mg IM midazolam (Isbister)[13]	21.3 (Chan 2013)[8]	6 (Chan 2013)[8] 5 (Taylor)[9] 25 (Isbister)[13]	 66% (5 minutes) 88% (10 minutes) (Taylor*)[9]
Olanzapine + Midazolam	Atypical Antipsychotic + Benzodiazepine	5 mg IV olanzapine + 2.5 to 5 mg midazolam boluses (Chan 2013*)[8]	14 (Chan 2013)[8]	5 (Chan 2013)[8]	

*Ketamine dosing is not included in this table, as none of the ketamine papers assessed for this policy met the quality

Summary

- For patients with acute agitation in the ED, a combination of droperidol and midazolam is preferred given the improved time to sedation and side effect profile.
- If a single agent must be given, **droperidol is preferred**.
- If droperidol is not available, use an atypical antipsychotic.
- In cases where **safety calls for the use of ketamine**, it must be done in a setting where staff can institute immediate hemodynamic monitoring and advanced airway management when needed.

High quality research should focus on

- Examining the effectiveness of non-pharmaceutical interventions.
- Determining the efficacy, safety, ideal dosing regimen, and most appropriate situations for the use of ketamine to treat severe agitation.
- Directly comparing the efficacy and safety of leading options for treatment of severe agitation such as droperidol (particularly compared directly to haloperidol), atypical antipsychotics, midazolam, and ketamine (and combinations thereof).
- Identifying **prehospital treatments** for severe agitation.
- Identifying the safest and most efficacious treatment for acute agitation in **older patients.**
- Exploring disparities related to race, ethnicity, and language that impact the treatment of severe agitation.

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Back to table of contents | Previous Article | Next Article

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Updates in the Assessment and Management of Agitation

Ashley Curry, M.D., Nasuh Malas, M.D., M.P.H., Megan Mroczkowski, M.D., Victor Hong, M.D., Kimberly Nordstrom, M.D., J.D., Christina Terrell, M.D.

Published Online: 16 Jan 2023 | https://doi.org/10.1176/appi.focus.20220064

AMERICAN PSYCHIATRIC ASSOCIATION
Medical leadership for mind, brain and body.

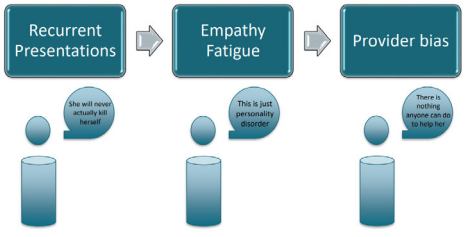
WHEN PROVIDER BIAS BECOMES LETHAL, HIGH UTILIZERS IN THE HEALTHCARE SYSTEM

Kelley-Anne Klein, MD
Raunak Khisty, MD, MPH, FAPA
Sahil Munjal, MD
James Kimball, MD

APA Annual Meeting 2023, San Francisco, CA
May 20, 2023

LOOKING IN THE MIRROR

AMERICAN PSYCHIATRIC ASSOCIATION



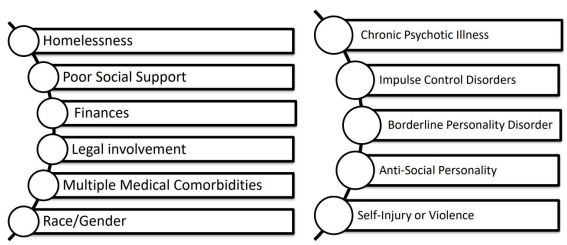
INSTANT COUNTER-TRANSFERENCE

"…instant, spontaneous set of feelings that form towards patients, even in the shortest of interactions" (Moukaddam et al, 2019)

WHO IS AT RISK FOR INSTANT COUNTER-TRANSFERENCE?

- Those at highest risk:
  - Personality disordered patients
  - High level of suicidality
  - Repetitive self-harm
  - Violent, hostile, demeaning, or threatening behavior

GENERAL AND PSYCHIATRIC RISK FACTORS FOR PROVIDER BIAS



RISKS TO THE PATIENT ASSOCIATED WITH PROVIDER BIAS

- Minimizing patient risk level
- Premature discharge
- Inappropriate level of care recommendations
- Lack of linkage to outpatient care/resources
- Serious self harm or violence→ outcomes can be lethal

LEGAL CONSIDERATIONS

- "Reasonable physician"– malpractice exists is another reasonable physician in the same situation would handle the situation differently
- EMTALA-
  - Who needs to evaluate the patient before they are discharged?
    - If there is a specialist available and a consult is placed they must provide the consultation
  - What kind of dispositions are considered to meet EMTALA requirements?
    - They must be able to be discharged with reasonable certainty that their condition will not deteriorate

LEGAL CONSIDERATIONS IN DOCUMENTATION

- Assess and document CURRENT suicide risk
- Document protective factors
- Document reasons that treatment in an acute care setting is not indicated
  - Specifically note presence or absence of acute processes that could cloud patient's judgement (psychosis, intoxication, etc)
- Document all conversations around discharge
  - Did the patient participate in a meaningful way?
  - What are the options for disposition?
  - Was a safety plan attempted/completed?
- Consult with another physician
  - Document consultation

HOW TO AVOID THE ICT TRAP

AMERICAN PSYCHIATRIC ASSOCIATION

- **The one where you walk away:** recognize feelings of anger, frustration and remove yourself from the situation for a breather
- **The one where you follow standard of care:** remove the patient's name from your plan, determine what you would do for a patient who walked through the door with the same issue→ make that the plan for this patient
- **The one where you realize you don't care:** feelings of apathy are more difficult to face and more difficult to admit to ourselves. First step→ get a second opinion. Second step→ talk to a mentor, start asking the difficult question of why.

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REVIEW ARTICLE

OPEN ACCESS Check for updates

Evaluating threats of mass shootings in the psychiatric setting

Amy Barnhorst[a] and John S. Rozel[b]

[a]Vice Chair for Community and Hospital-based Services, University of California Firearm Violence Research Center, Department of Psychiatry and Behavioral Sciences, Department of Emergency Medicine, University of California, Davis, CA, USA; [b]Resolve Crisis Services of UPMC Western Psychiatric Hospital, Psychiatrist, UPMC Systemwide Threat Assessment and Response Team, Associate Professor of Psychiatry and Adjunct Professor of Law, University of Pittsburgh, Pittsburgh, PA, USA

ABSTRACT

Psychiatrists may encounter patients at risk of perpetrating mass shootings or other mass violence in various settings. Most people who threaten or perpetrate mass violence are not driven by psychiatric symptoms; however, psychiatrists may be called upon to evaluate the role of mental illness plays in the risk or threat, and to treat psychiatric symptoms when present. Regardless of whether psychiatric treatment is likely to reduce symptoms or the potential for violence, the psychiatrist should collaborate closely with law enforcement, potential targets, and other agencies involved to mitigate risk. Such communications are governed by various privacy laws and duties to third parties. Additional measures, like protective orders, may be a means of restricting the subject's access to firearms.

ARTICLE HISTORY
Received 24 March 2021
Accepted 22 June 2021

KEYWORDS
Mass shootings; firearms; mental illness; red flag laws; violence; forensic psychiatry; gun violence

Table 1. Investigate all THREATS[3].

T	Threats, leakage, or other statements of intent to harm made currently or recently
H	History of violence, especially with the identified target or in an escalating pattern
R	Recent stressors (relationships, finances, housing, employment, health, victimization)
E	Ethanol / other drug intoxication, current or frequently present
A	Agitated / annoyed easily (Hostile Attributional Style)
T	Takes no responsibility (External Attributional Style)
S	Suicidality, increasing hopelessness
S	Symptomatic psychiatric illness currently or frequently present
S	Specific target / access / means identified

Table 2. Threat assessment professional organisations.

Association of Threat Assessment Professionals (USA)	https://www.atapworldwide.org
Canadian association of threat assessment professionals	https://catap.ca/
Asia Pacific Association of Threat Assessment Professionals	https://www.apatap.org/
African Association of Threat Assessment Professionals	https://afatap.africa/
Association of European Threat Assessment Professionals	https://www.aetap.eu/

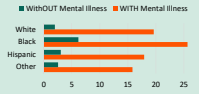
- Awareness of potential aggression and violence is crucial when treating patients experiencing mental health crises in psychiatric emergency and inpatient settings.
- Clinical contexts of violence in these settings, possible impact on patients and staff, and approaches to mitigating risk are reviewed.
- Considerations for early identification of at-risk patients and situations, and nonpharmacological and pharmacological interventions, are highlighted.

Every day in America…

911: What happens after the call?

Police-Involved Deaths

- **One Quarter** of police involved shooting deaths involve mental illness
- Half occur in the person's home
- Black Americans with Mental Illness have the highest rates of death
- …and are less likely to call 911 for help with a mental health emergency



Jails: The New Asylums

- **The "Divert to What?" Question**
- Prevalence of mental illness in our jails & prisons is 3-4x that of the US population
- Inmates with mental illness
  - Often do not get needed treatment
  - Incarcerated 2x as long at 2x the cost
  - 3x more likely to be sexually assaulted in jail
  - More likely to be homeless, unemployed, re-arrested upon release

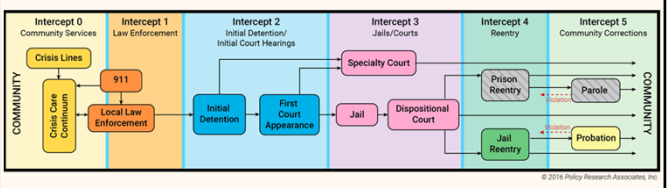
ED Boarding

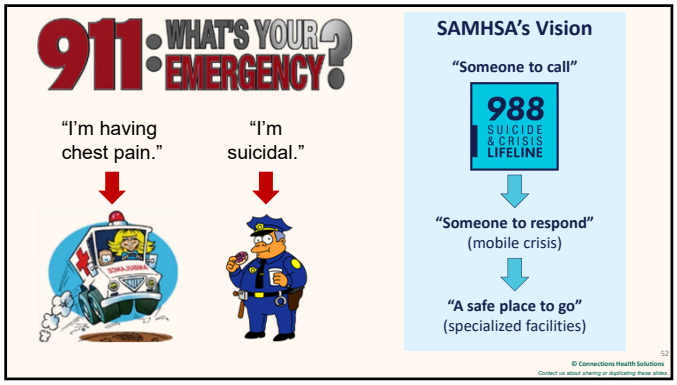
- 62% of EDs report they have no psychiatric services available
- Without treatment, inpatient is the default disposition, and people wait for hours for transfer to a psych hospital
  - Increased risk: Assaults, injuries, self-harm
  - Increased cost: $2300/day
  - Poor patient experience: Nontherapeutic environment with untrained staff

Saleh AZ, Appelbaum PS, Liu X, Scott Stroup T, Wall M (2018) Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry* 58:110–6
Steadman HJ et al. (2009) Prevalence of serious mental illness among jail inmates. *Psychiatric Services* 60(6):761-5.
Glaze LE, James DJ. (2006) Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics.
Nordstrom K et al., Wred J Emergency Med. 2019 Jul 22;20(5):690-695.
Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int.* 2012;2012:360308.

The Sequential Intercept Model

Intercepts 0 and 1 focus on *preventing police interactions & arrest*




911 WHAT'S YOUR EMERGENCY?
"I'm having chest pain."
"I'm suicidal."
SAMHSA's Vision
"Someone to call"
988 SUICIDE & CRISIS LIFELINE
"Someone to respond" (mobile crisis)
"A safe place to go" (specialized facilities)
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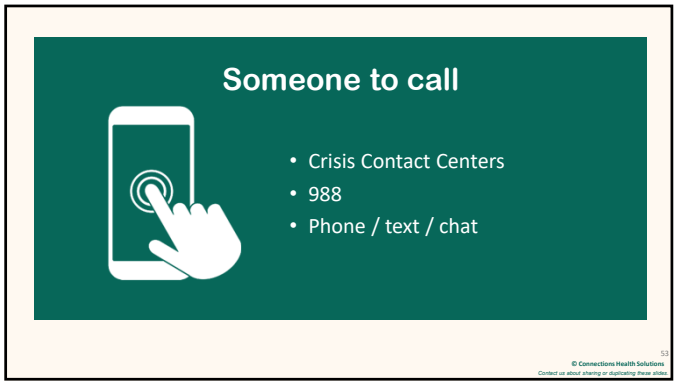
Contact us about sharing or duplicating these slides.


Someone to call
• Crisis Contact Centers
• 988
• Phone / text / chat
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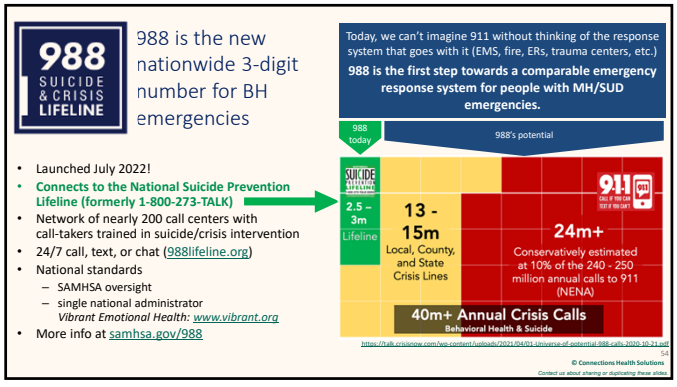
988 SUICIDE & CRISIS LIFELINE
988 is the new nationwide 3-digit number for BH emergencies
• Launched July 2022!
• Connects to the National Suicide Prevention Lifeline (formerly 1-800-273-TALK)
• Network of nearly 200 call centers with call-takers trained in suicide/crisis intervention
• 24/7 call, text, or chat (988lifeline.org)
• National standards
– SAMHSA oversight
– single national administrator
Vibrant Emotional Health: www.vibrant.org
• More info at samhsa.gov/988
Today, we can't imagine 911 without thinking of the response system that goes with it (EMS, fire, ERs, trauma centers, etc.)
988 is the first step towards a comparable emergency response system for people with MH/SUD emergencies.
988 today
988's potential
2.5 – 3m
Lifeline
13 - 15m
Local, County, and State Crisis Lines
24m+
Conservatively estimated at 10% of the 240 - 250 million annual calls to 911 (NENA)
40m+ Annual Crisis Calls
Behavioral Health & Suicide
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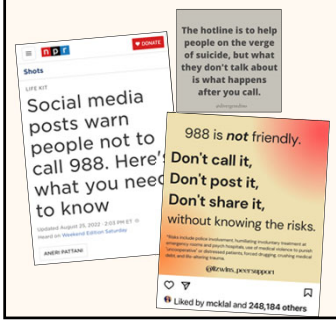
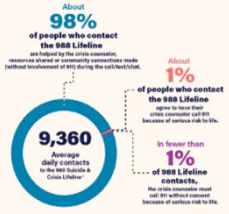
What happens after the 988 call?



- *988 activates 911 in a small number of calls (about 2%) when there is an immediate threat to life.*
- ***The more alternatives a community has (like mobile crisis), the less need to involve law enforcement.***

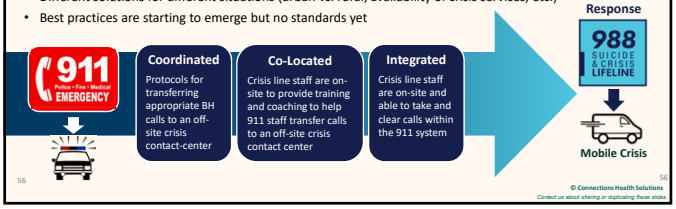


Source: 988lifeline.org

911 Integration:
Routing BH calls to a "health-first" response

No One-Size-Fits-All Approach

- Over 9000 Public Safety Answering Points (PSAPs) across the US
- Local crisis lines & PSAPs are experimenting on ways to identify & re-route BH calls
- Different solutions for different situations (urban vs. rural, availability of crisis services, etc.)
- Best practices are starting to emerge but no standards yet



What happens after the 988 call? It depends on where you live.

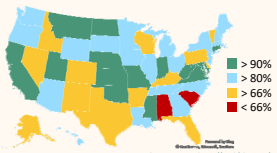
For the ideal outcome, 988 callers need to

- Be routed to a **local call center**
- Connect to **local crisis services** *(someone to respond, a safe place to go)*

Challenges:

- Calls are routed based on the area code of the caller's phone, not their geolocation
- Variable call center performance across states
- Inconsistent access to crisis services across communities

988 In-State Answer Rate

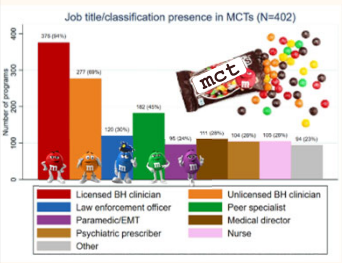


April 2023. Source: https://988lifeline.org/our-network/

Someone to respond

- Mobile Crisis Teams
- Co-responders
- Multi-disciplinary Response Teams

Mobile Crisis Teams (MCTs) come in many combinations



Preliminary results from a survey of over 400 mobile crisis teams in the US.
Courtesy Preston Looper & Matt Goldman. http://doi.org/10.1176/appi.ps.20220449

Clinician-only MCTs (most common)

- Licensed BH clinician + unlicensed clinician or peer

Rural areas: 1 person teams +/- telemed backup

Co-Responder Teams

- Law enforcement + BH clinician or peer

- Civilian only: EMT + BH clinician
  CAHOOTS (Eugene, OR); STAR (Denver)

Multi-Disciplinary Response Teams (MDRT)

- BH Clinician + Paramedic + Officer
  RIGHT Care (Dallas)

The Crisis Response Center

- Built with Pima County bond funds in 2011
  - County owns the building, services funded by the RBHA
  - Alternative to jail, ED, hospitals
  - Serving 12,000 **adults** + 2,400 **youth** per year
- Services include
  - 24/7 walk-in **urgent care**
  - **23-hour observation**
  - Short-term adult **subacute inpatient**
- Police drop-offs with **NO WRONG DOOR that TAKES EVERYONE**
- Space for co-located community programs
- Unique Campus: CRC is adjacent to
  - Crisis Line Call Center
  - Banner University of Arizona Medical Center
    - Emergency Department
    - 66-bed inpatient psychiatric unit that performs most of Pima County's civil commitment evals
  - Mental health court

A Solution to the "Divert to What?" Question
Connections Culture of Treating LE as a "preferred customer"

CIT Recommendations for Mental Health Receiving Facilities[1]

1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Police Turnaround Time**
5. Wide Range of Disposition Options
6. Community Collaboration

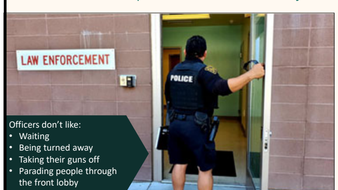
Studies show this model:
- Critical for pre-arrest diversion[2]
- Reduces ED boarding[3,4]
- Reduces hospitalization[3,4]

These two are the hardest to do well.
It means
- **Be easier to use than jail.**
- Drop off time less than 10 min
- Never turn police away.
- Take everyone:
  - High acuity: No such thing as "too agitated" or violent
  - Can be highly intoxicated
  - Involuntary or voluntary
  - Without using security guards

1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
2. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22
3. Little-Upah P et al. (2013). The Banner psychiatric center: a model for providing psychiatric crisis care to the community while easing behavioral health holds in emergency departments. Perm J 17(1): 45-49.
4. Zeller S et al. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15(1): 1-6.

61

Quick and Easy Access for Law Enforcement
so that we're the preferred alternative to jail or the emergency room



Officers don't like:
- Waiting
- Being turned away
- Taking their guns off
- Parading people through the front lobby

Dedicated police entrance with secure gated sally port & workspace
Crisis Response Center - Tucson AZ

Studies show this model is critical for pre-arrest diversion,[2] reduces ED boarding,[3,4] and reduces hospitalization.[3,4]

In Tucson…

"For both officer-initiated events and 911 calls, the odds of arrest were lower for mental health/medical incidents than for violent crimes. This finding may be partly due to the role of Tucson's Crisis Response Center, which provides an alternative to arrest and jail booking… the odds of arrest for mental health/medical versus violent crimes were far lower concerning officer-initiated events than 911 calls."

Vera

Figure 6.2.6: Tucson, AZ. Predictors of arrest: Officer-initiated events / …n, AZ. Predictors of arrest: 911 calls

	OFFICER-INITIATED EVENTS				911 CALLS			
	Adjusted odds ratio	p-value	N	Percentage	Adjusted odds ratio	p-value	N	Percentage
PREDICTORS OF INTEREST								
Incident type								
Violent crime	Reference	Reference	729	0.3	Reference	Reference	8,268	1.4
Domestic violence	0.75	.059	625	0.3	2.02	<.001	39,259	6.7
Property crime	0.85	.146	4,298	1.9	0.62	<.001	48,030	8.2
Other crimes	2.21	<.001	5,102	2.3	0.92	.034	75,972	12.9
Proactive	0.34	<.001	44,564	19.9	0.21	<.001	1,233	0.2
Police operations	11.87	<.001	2,593	1.2	2.34	<.001	1,409	0.2
Traffic-related	0.31	<.001	124,063	55.4	0.54	<.001	31,572	5.4
Service assignments	0.93	.492	3,657	1.6	[illegible]	<.001	15,537	2.6
Mental health/medical emergency	0.13	<.001	5,673	2.5	0.61	<.001	67,030	11.4

Neusteter RS et al. (2020) Understanding Police Enforcement: Multicity 911 Analysis. Vera Institute of Justice.
https://www.vera.org/downloads/publications/understanding-police-enforcement-911-analysis.pdf

1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
2. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22
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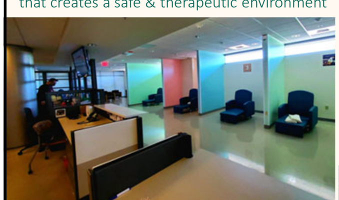
4. Zeller S et al. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15(1): 1-6.

62

23-Hour Observation: Open design that creates a safe & therapeutic environment



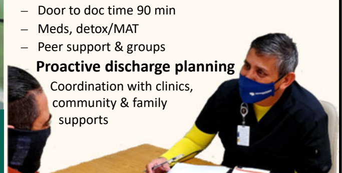
The open design facilitates:
- Safety: Continuous observation
- Therapeutic milieu: Open area for therapeutic interactions with others
- Flexibility: Ability to accommodate surges in volume

Interdisciplinary care starting with the *assumption that the crisis CAN BE resolved*

Interdisciplinary Teamwork
- 24/7 psychiatric provider coverage (MD, NP, PAs)
- Peers, nurses, techs, case managers

Early Intervention
- Door to doc time 90 min
- Meds, detox/MAT
- Peer support & groups

Proactive discharge planning
Coordination with clinics, community & family supports

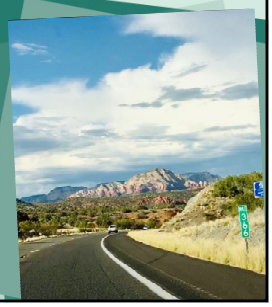


~60% discharged to community-based care
~70% converted to voluntary status

63

Early Intervention, Deflection, & Diversion
Intercept 0 (Community Services) &
Intercept 1 (Law Enforcement Collaboration)

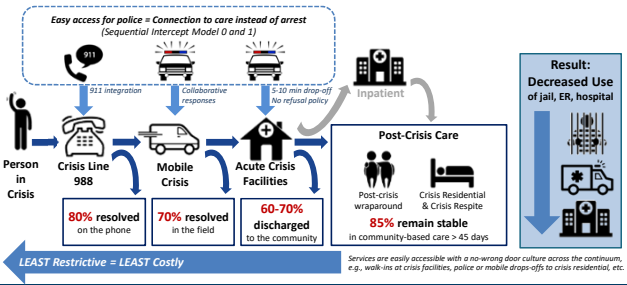
Roadmap to the Ideal Crisis System: Lessons from Arizona



Margie Balfour, MD, PhD
Connections Health Solutions
Chief of Quality & Clinical Innovation
Associate Professor of Psychiatry, University of Arizona
margie.balfour@connectionshs.com

CONNECTIONS

Crisis continuum with services aligned towards a common goal: care in the least-restrictive setting

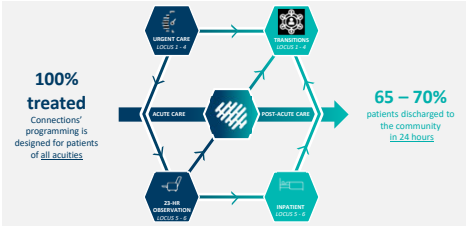


connections HEALTH SOLUTIONS

Adapted from: Balfour ME, Hahn Stephenson A, Delaney Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. Epub ahead of print Oct 20, 2021. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000721.
(Community stabilization rates are based on FY2019 data from the Southern Arizona region and were provided courtesy of Johnnie Gasper at Arizona Complete Health/Centene)

Model Creates an Open, Accessible Door for Those in Crisis

Connections Health Solutions has operated for 30 years, continuously innovating its services to meet community needs. Our continuum treats, stabilizes and connects patients of all acuities.



connections HEALTH SOLUTIONS

Youth Services at the Crisis Response Center (Tucson, AZ)

23-hour observation unit:
starts with the assumption that the crisis *can* be resolved

- **Interdisciplinary team** of psychiatric providers, nurses, therapists & case managers, behavioral health technicians, and peers
- **Treatment** includes medications, groups, peer & family support
- **Proactive discharge planning** and care coordination
- **Community partnerships** including daily calls with DCS, "familiar faces" staffings with RBHA and other health plans
- **Therapeutic milieu** with open design to facilitate social interaction and continuous observation

2,200 youth visits *in 2022*

25% arrived via police

80% discharged to community-based care *(instead of the hospital, ED, or jail)*

1.72% readmission rate *within 72 hours*

98% families report they would recommend the CRC to others

Age Trends

	2016	2022
0-7	2%	3%
8-12	20%	26%
13-17	78%	71%

SUD Trends

28% have an SUD diagnosis or positive tox.

Most common:
- **Cannabis** (66%)
- **Alcohol** (12%)
- **Opiates** (11%)

connections HEALTH SOLUTIONS

Read more about our youth crisis services here:
https://www.psychiatrictimes.com/view/how-to-support-youth-in-crisis-with-behavioral-health-services

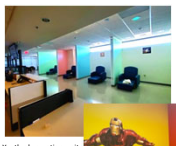
Safe and Comfortable Space Designed for Youth and Families

Connections is known for prioritizing the safety of both the individuals served and the staff.

The youth unit was thoughtfully designed to make youth and families feel at ease and supported while ensuring safety.

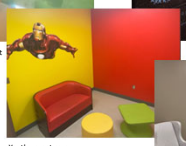
Youth-Centered Design

- **Dedicated lobby and sally port waiting areas**
- **Superhero-themed urgent care rooms**
- **Separate space for vitals and assessment**
- **Bright colors used in urgent care**
- **Soft, calming colors used in observation**
- **Calming activities and outdoor time used in observation**

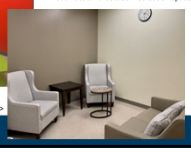


Youth observation unit

Youth obs unit: outdoor recreation space



Youth urgent care



Family meeting room >

connections HEALTH SOLUTIONS

EmPATH

Emergency **P**sychiatric **A**ssessment **T**reatment **H**ealing

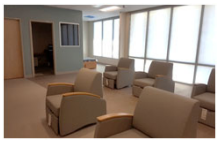
Research shows that **75% or more** of severe psychiatric emergencies can be **stabilized within 24 hours**

What makes the EmPATH Approach Different?

- Designated destination for all medically-cleared patients in crisis prior to determination of disposition or IP admission; not viewed as an alternative destination but *THE* destination; is outpatient observation
- Designed and staffed to treat all emergency psychiatric patients – philosophy of "no exclusion"
- Immediate patient evaluation and treatment by a psychiatrist, constant observation and re-evaluation
- Provides a calming, healing, comfortable setting completely distinct from the Medical ED
- Wellness and Recovery-oriented approach in an open-room milieu, where
  patients are free to move about and choose their own recliner
  and can sit up for treatment, or fold flat to nap or relax

A Calming, Comfortable Environment-
Sample EmPATH units from across the USA:

Scalable model can fit any size or shape hospital…
Urban, Rural, Academic or Community hospital settings



Patient Benefits

Trauma-informed Unit, a home-like care setting different from a chaotic, confined ED
relaxation, movement, recreation encouraged

Multi-disciplinary Treatment Team involved from arrival to disposition

Rapid Evaluation by Psychiatrists, ensuring prompt meds, care integration with comprehensive treatment plan

Calming Environment that best meets patients' needs, can serve themselves snacks, beverages, linens

Constant Observation & Re-evaluation leads to much higher diversion from hospitalization, mitigates ligature risk issues

Restraint Elimination
Typically far less than 1%
In same patient population that 20% or more would be in restraints in the ED

Hospital Benefits

EMTALA-Compliant
for both voluntary and involuntary behavioral health emergencies

ED Capacity Creation
Alleviate volume pressure in the ED and eliminate boarding, reduce sitter costs

Reimbursement Options
Among Medicaid, Medicare and private payers

Eliminate Unnecessary Admissions
While reducing payer denials for inpatient psychiatric units

Cost-Effective Implementation
by remodeling available, underutilized hospital spaces

Up to
80%
Reduction in Admission Rates
Keeps inpatient beds available for those who truly have no alternative

Academic Emergency Medicine
A GLOBAL JOURNAL OF EMERGENCY CARE

Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) Unit Decreases Hospital Admission

Published: 17 August 2021

- Reduced ED length of stay from an average of 16.2 hours to just 4.9 hours (70% reduction!)
- Reduced inpatient psychiatric admissions by 53%! (*from 57% of patients to just 27% of patients)*
- Improved the outpatient follow-up of patients from 39.4% to 63.2% (60% improvement!)
- Reduced 30-day psych patient return to ED (recidivism) by 25%
- Added $861,000 to ED bottom line in first year by moving BH patients out of the ED to more targeted, timely, better care!
- Reduced inpatient lengths of stay for patients admitted from EmPATH

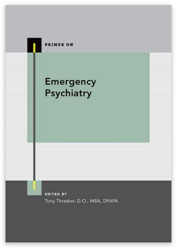
Hey Mike! What about ACEP and that EP Focused Practice Designation thing?

- **Conversation has morphed from FPD to creating Emergency Psychiatry Subspecialty!**
- **Who's on Board?**
  - **ACEP**
  - **AAEP**
  - **ABEM**
  - **(?) APA – May 2023 Annual Mtg: no noticeable objections**
  - **ABPN – meeting with us**

Coalition on Psychiatric Emergencies

AAEP – NUBE December 6-8, 2023

Hot Off the Presses!



Emergency Psychiatry (PRIMER ON SERIES)

by Tony Thrasher (Editor)

#1 New Release in Psychiatry

See all formats and editions

Kindle	Paperback
$78.99	$80.73 - $89.95
Read with Our Free App	2 Used from $80.73 4 New from $85.95

Psychiatric emergencies are encountered throughout the practice of medicine, in many clinical settings. They may range from a patient expressing suicidal thoughts in an outpatient medical visit to an agitated, threatening patient with psychosis who is acutely intoxicated brought to the Emergency Department by ambulance. Decisions regarding admission, discharge, treatment, and referral are time-sensitive in the emergency setting or when acute safety issues are at stake. A broad knowledge of

Questions?

Comments?