

Best Practice Guidelines for the Treatment of Individuals with Behavioral Health Problems in Emergency Departments.

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Even hospitals committed to considerate, client-centered practices are sometimes challenged by individuals presenting with behavioral problems that involve both psychiatric and substance abuse difficulties. Hospital staff may find themselves in demanding situations with little guidance for appropriate and effective treatment. Areas of conflict and unfortunate human rights violations can occur when ED (emergency department) staff engage in the following:

- ✚ Forced disrobing
- ✚ Coercion and use of excessive force
- ✚ Disrespectful treatment and
- ✚ Violation of patient privacy.

Many of the complaints of individuals with behavioral health difficulties have been found to violate Center of Medicaid and Medicare Services (CMS)¹, as well as ethical standards of the Emergency Nursing Association and the College of Emergency Physicians². Additionally, since so many of the individuals treated in ED settings have current or past experiences of traumatic abuse (for example, rape, domestic violence, childhood sexual or physical abuse), it is imperative that principles of (psychiatric) trauma-informed care are implemented and that inadvertent re-traumatization does not occur. The specific care required should be respectful, collaborative and ensure that the patient's dignity is preserved.

Fortunately, a number of best practices, including approaches that mitigate interpersonal conflict and support the rapid development of a therapeutic alliance, have been elaborated and applied to emergency departments in the last few years.

It is important to note that the ED is one of the most important settings for individuals with psychiatric difficulties. It is often the "entry point" - the place where people receive care when they are in the greatest distress and often before admission to a psychiatric inpatient unit. The experience in an ED may have long-lasting positive or negative effects depending on the kind of interactions that occurred and treatment received. This is likely to affect a future relationship and sense of trust with the psychiatric care system. In an

¹ 42 Code of Federal Regulations 482.13

² The Emergency Nursing Association's standards provide "the emergency nurse acts with compassion and respect for human dignity and the unique individual" and "protects the individual when health care and safety are threatened by incompetent (or) unethical practice". Similarly, the College of Emergency Physicians states that the ED physician will "respond...expertly, without prejudice or partiality, to the need for medical care" and "respect the rights and strive to protect the best interests of their patients...(and) patients most vulnerable" as well as "secure ...informed consent for treatment" and "respect patient privacy".

attempt to consider a range of efforts that would be helpful in improving the care of individuals with behavioral health problems, the following set of recommendations have been developed to assist ED staff. Many EDs have already made significant progress in developing policies and practices that help to ensure that individuals with behavioral problems receive safe, appropriate and dignified care. The following practice guidelines were developed in order to support and continue to improve practice in this important area of care.

RECOMMENDATIONS

- Training ED staff (including Security) should receive training in the following:
 - The signs and symptoms of mental illness and substance abuse disorders and effective stabilization of persons in acute distress suffering from such disorders
 - Best practice approaches for people with histories of Physical and Sexual Abuse
 - Include impact of coercive practices on individuals with abuse histories and/or Post Traumatic Stress Disorder (PTSD)
 - Addressing triggers and soothing strategies to help patients regain sense of control (similar to rape victims)
 - Inclusion of patients in self-directed care including treatment choices and medication preferences
 - Therapeutic interventions with individuals presenting challenging behaviors including how to avoid power struggles between staff and patients that could potentially lead to negative outcomes
 - Training on the role of environments and staff attitudes in preventing or triggering aggression, violence, self-injury or elopement
 - Level of risk evaluation when patients with psychiatric difficulties have medical needs
 - Alternative de-escalation strategies
 - CMS and JCAHO standards for prevention of restraint and seclusion and requirements if used

- Practice Considerations:
 - Consideration of involvement by psychiatric staff at triage level or the earliest possible time to decrease waiting time and resulting anxiety, a known risk factor for frustration and increased likelihood of conflict
 - Inquire if the patient has an advance directive or crisis prevention plan and utilize this information during the ED stay
 - Ensure appropriate medical care is provided to patients with behavioral problems and that medical concerns do not get overlooked
 - Always provide information about both the ED process and suggested treatments for the patient's condition, including choices of treatment as appropriate
 - Respect patient's treatment refusal unless patient is clinically determined and documented to be incompetent or unless there is an emergency creating imminent risk of serious physical injury

- No procedure should be performed on an unconsenting, unwilling patient solely at the request of police
 - Emergency department security guards should not be armed with or use pepper spray or mace
 - Involvement by psychiatric staff if indicated during medical evaluation and clearance
 - Involvement of significant others to provide support, including accompaniment if appropriate
 - Revise and rewrite any blanket policies and procedures, such as forced disrobing for medical evaluation or personal searches, that do not take into consideration the individual needs of the patient and potential for re-traumatization (see example of best practice disrobing policy below).
 - Since ED staff will not necessarily always know a person's trauma history, consider adopting a "universal precautions" approach in avoiding coercion and minimizing forcible interventions
 - Ensure that forced interventions are used as a last resort only when there is clear imminent psychiatric or medical risk that rises to a level of danger that is objective and quantifiable
 - If a restraint or seclusion is necessary, ensure the earliest possible release
 - Use of advocates or human rights personnel or other individuals with the skill to mediate when patients don't conform to ED rules
 - Early referral to crisis team with expectation that the designated local team will fulfill its contractual obligation to provide evaluation and referral in a timely fashion
- Environmental Considerations
 - Moving "voluntary" patients with behavioral disorders to alternative sites within the hospital or into the community in order to decrease the ED census and provide a less activating environment.
 - Consideration of how to best ensure privacy needs in the ED by designating a couple of rooms, if the physical plant allows, for people with primary mental health or substance abuse problems.
 - Physical plant improvements to the psychiatric area that might include soft colors, comfortable seating, an area to make private calls and distracting and soothing items such as: wall murals, secure fish tank, etc.
 - Use of sensory approaches such as quiet music or gliding rocking chairs or 'sensory carts' that could offer sensory specific interventions for calming and soothing purposes

Example Policy: *Emergency Department Disrobing Policy issued by the Massachusetts Department of Public Health, July 8, 2008 (Circular Letter: DHCQ 08-07-495)*

1. Policies regarding clothing removal should apply equally to all patients seeking treatment in the emergency department. Hospitals should rescind any policies regarding clothing removal or pat downs that apply solely to patients seeking psychiatric treatment or who have psychiatric histories.
2. All hospital policies regarding clothing removal should recognize the right of patients to refuse to remove their clothing as well as the need by the clinician to request the removal of clothing if appropriate to conduct a medical screening examination. This right should be included in any materials or communications presented to patients that enumerate their rights. Patients need not be verbally informed of this right prior to a request for the removal of clothing, but must be informed of this right in the event of a refusal by the patient. All clothing should be returned to the patient as soon as is reasonable.
3. It is well recognized that removal of clothing may be necessary to enable a medical screening examination for the identification of an emergency medical condition. Another reason to request the removal of clothing is to protect self or others against potentially harmful substances or weapons that might be hidden on a patient's person. Forced removal of clothing is a form of physical restraint, and as such, all appropriate alternatives to this action should be used before restraint is applied. Therefore, compelling clinical information indicating imminent risk to self or others is necessary to support forced removal of clothing.

The above policy reflects consensus reached by a variety of stakeholders including Department of Public Health and Department of Mental Health staff, hospital ED professionals, consumers of mental health and mental health advocates from throughout the Commonwealth of Massachusetts. This policy is enforced by the Department of Public Health, the state agency regulating hospital ED's. Hospital surveyors will reference the hospital policy when reviewing complaints alleging the violation of patients' rights arising from forced removal of clothing. The surveyors may also refer to the policy during routine hospital surveys.