



Brigham and Women's Hospital
Founding Member, Mass General Brigham

Acute Psychiatric Management and ED Boarding

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Outline

- Emergency Psychiatric Care
- Emergency Department (ED) Boarding Crisis
- Treatment in the ED Setting
- Models of Emergency Psychiatric Care
- Therapeutic Discharge



Emergency Psychiatric Care

- Problem Scope and Etiology
- Prevalence
- Ongoing Stigma and Separation of Care

Common Psychiatric Emergencies

- Psychiatric Safety Risk Assessment
- Undifferentiated Agitation
- Substance Intoxication/Withdrawal
- Medication Adverse/Side Effects
- Capacity Assessments
- Psychosis
- Mood Symptoms (Depression/Mania)
- Delirium



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



A LITERATURE REVIEW:

PSYCHIATRIC BOARDING

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Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document

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**Emergency Psychiatry: Updates, Future
Directions, and Core Concepts**

Guest Editor: Tony Thrasher, D.O., M.B.A.



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INFLUENTIAL PUBLICATION

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Emergency Department “Boarding”

- Variable Definitions
- Patient Characteristics
- Monetary Cost
- Non-Monetary Cost



Sources of ED Boarding



Shortage of Inpatient Psychiatric Beds



Insufficient Funding for Lower Levels of Care



Un/Under-Insured



Managed Care Hurdles



Severe Psychiatric Illness Burden



Bed Reduction of State-Funded Psychiatric Beds

ED Boarding: **Potential Solutions**



Psychiatric care in the emergency department: Converting boarding time to treatment time

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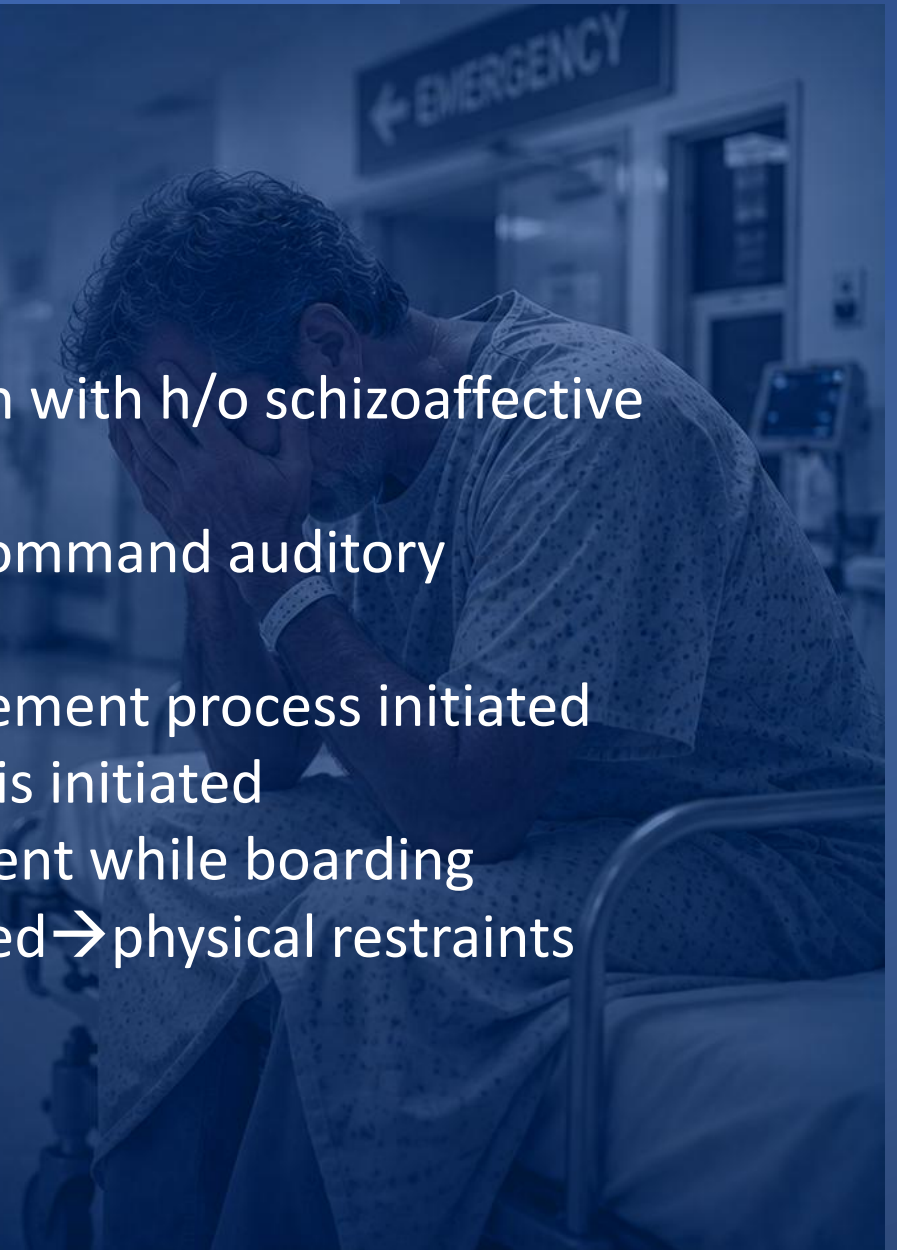
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Patient Example

- 30-year-old man with h/o schizoaffective disorder
- Presents with command auditory hallucinations
- Psychiatric placement process initiated
- Oral lorazepam is initiated
- Begs for treatment while boarding
- Becomes agitated → physical restraints



Converting Boarding Time into Treatment Time



Multimodal Treatment



Rapid Reinitiation of Home Medications



Monitoring of Side Effects,
Up-Titration of Medication



Reassessment of Symptoms



Social Work Assessment



Family Involvement



Referral to Outpatient Care

Models of Emergency Psychiatric Care



Designated Psychiatric
Emergency Department



Emergency Psychiatric
Assessment, Treatment,
and Healing (EmPATH) Units



Psychiatric
Consultation Model



Behavioral Health
Section of Medical
Emergency Department



Telepsychiatry





Brigham and Women's Hospital

Founding Member, Mass General Brigham

Building a 'More Humane' ED

*Expanding the Brigham's Emergency
Department will provide safer and
more private care for patients in crisis.*





Behavioral Health Pamphlet



Behavioral Health Care in the Emergency Department

Our Emergency Department (ED) team works with experts from Psychiatry and Social Work to listen to you. Our goal is to keep you safe and address your concerns while we determine what level of care is best for your needs.



Waiting in the Emergency Department

We understand that waiting in the ED can be frustrating. If you need a hospital stay (inpatient treatment), that process can take some time as well. Please be assured that your care team will meet with you daily to review your treatment plan and provide updates.



Safety

Your safety comes first. Please note these comfort items may not be offered to all patients if safety is a concern.



Cell phone guidelines

This is a healing environment, and we need to protect everyone's privacy. Use of cell phone will be at the discretion of the staff. If you would like to use your cell phone, please follow these rules:

- Cameras, video and/or recording (including FaceTime) are not allowed due to state and federal law.
- Use your phone at a low volume and speak softly, especially after 9 p.m. so others may rest and sleep.
- Staff will charge your phone in a secured area. We recommend having your phone charged overnight (9 p.m. – 7 a.m.) so that you get solid rest time.



Access to Belongings

We will secure your personal belongings. You may be allowed access to items that your care team determines are appropriate.

Self-care, coping and recovery in the Emergency Department

Your safety comes first. Please note these comfort items may not be offered to all patients if safety is a concern.

Feeling anxious?

It is common to experience anxiety while waiting in the ED.



Medication: Please let us know if you would like medication to improve your comfort.



Nicotine Replacement Therapy: Smoking is not allowed in the ED. Patients cannot leave the ED to smoke. Smoking is not permitted anywhere on hospital grounds. Please let us know if you would like nicotine patches.



Sensory Processing Aids: Please ask your care team if you would like earplugs, stress balls, or similar items.

Try these relaxation exercises!

- 1 4-7-8 Breathing Exercise
- 2 Find a comfortable sitting position.
- 3 Place the tip of your tongue behind your top front teeth.
- 4 Empty your lungs of air.
- 5 Breathe in quietly through your nose for 4 seconds.
- 6 Hold your breath for 7 seconds.
- 7 Purse your lips and breathe out through your mouth, making a whoosh sound, for 8 seconds.



Repeat up to 4 times.

Psychiatric Occupational Therapy



**Novel
Intervention**



**Focus: Symptom
Management, Coping Skills**



**Patient
Empowerment**



**Patient
Advocacy**



**Data
Gathering**

Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) Unit



Goal:

Reduce Time in Traditional ED



Open Unit Concept



Evaluation:

Nursing, Social Work, Psychiatry



Treatment Modalities

- Individual and Family Therapy
 - Medication Management
 - Substance Use Treatment Referrals
 - Financial and Housing Assistance
-



Kim AK, Vakkalanka JP, Van Heukelom P, Tate J, Lee S. Emergency psychiatric assessment, treatment, and healing (EmPATH) unit decreases hospital admission for patients presenting with suicidal ideation in rural Americas. *Acad Emerg Med.* 2022 Feb;29(2):142-149.

EmPATH Unit: Outcomes



Primary Outcome—Proportion of
Hospital Admissions: ↓



Return to the ED within 30 Days: ↓



Mental Health Follow Up Appointments: ↑



Overall ED Boarding Time: ↓

THE
NEW YORKER

ANNALS OF MEDICINE

REINVENTING THE E.R. FOR AMERICA'S MENTAL-HEALTH CRISIS

*EmpATH units are advancing a radically new approach to
psychiatric emergencies. It seems to be working.*

By Dhruv Khullar

July 12, 2023





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Roadmap for Behavioral Health Reform

Helping residents access mental health and substance use treatment

Therapeutic Discharge



- Deceptive Behaviors



- Ethics of Hospitalization

EMERGENCY



Therapeutic Discharge Process



Data Gathering



Safety Risk Assessment



Preparation for Discharge



Informing the Patient



Debrief with Staff



Countertransference Awareness



Patient Formulation

- “Notably, the patient’s reported symptoms of low mood, hopelessness and suicidality are incongruent with objective findings on mental status examination including smiling affect, joking demeanor with nursing staff, and demanding behaviors surrounding specific foods.”
- “The patient’s report of the death of his mother 2 weeks ago is inconsistent with available assessment 10 days ago at an outside emergency department where he did not report this information and a visit 3 years ago where he reported her recent death.”
- “When discussing the plan for potential discharge, the patient’s reported suicidality worsened with low-risk/high-rescue threats of self-harm in the ED.”
- “The patient declined to discuss all offers of other modalities of psychiatric treatment, including same-day referral to an outpatient clinic with provision of transportation.”

Patient Risk Assessment

- “The patient’s chronic psychiatric safety risk remains elevated above the general population due to ongoing substance use and its associated risk for impulsive behaviors, previous (albeit remote) self-harm, and unstable housing situation. These risk factors have been chronic and therefore his imminent risk appears to be low.”
- “Acute psychiatric hospitalization, as evidenced by numerous admissions in the past, has not been shown to alter the course of the patient’s reported symptoms or course of his illness.”
- “The current presentation appears to be consistent with previous ED visits during which there has been significant concern that the patient’s reported suicidality has been a means to gain other needs met, namely housing, rather than a decompensation of an underlying psychiatric illness and/or a true desire to die.”
- “Future ED visits may allow for ongoing encouragement for longitudinal outpatient care where the patient may focus on development of productive coping strategies in the face of chronic psychosocial distress.”



Therapeutic Discharge Debrief

- Essential!
- 5-10 Minutes
- Reflections
- Offer Individual Check-Ins

A large, stylized graphic of a human brain in shades of blue, positioned on the left side of the slide. The brain is semi-transparent, showing internal structures. The word "Summary" is written in white, bold, sans-serif font, underlined with a blue horizontal line, and is positioned over the brain graphic.

Summary

- The Emergency Department has Become the Default for Crisis Care
- Longstanding Crisis of ED Boarding
- Boarding Time = Treatment Time
- Many Models of Emergency Psychiatric Care
- We Can All Be Good Stewards of Mental Health Resources