

STANDARDS FOR EMERGENCY DEPARTMENT TREATMENT
OF INDIVIDUALS WITH PSYCHIATRIC DISABILITIES

EMERGENCY DEPARTMENT PROJECT
CENTER FOR PUBLIC REPRESENTATION

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Project Director: Susan Stefan, J.D.

Advisory Council Members:

Dr. Robert Factor, Director, Emergency Services Unit, Mental Health Center of Dane County, Veteran's Administration Hospital.

Dr. Robert Glover, Executive Director, National Association of State Mental Health Program Directors

J. Rock Johnson, J.D., Board member, National Association of Protection and Advocacy Systems.

Dr. Edward Knight, Vice President for Recovery, Rehabilitation and Mutual Support, Value Options

Dr. Charles Lidz, Director, Center for Mental Health Services Research, University of Massachusetts Medical School

Mr. Steven Miccio, Director, PEOPLE, Inc., Poughkeepsie, New York.

Dr. Robert Okin, Chief of Psychiatry, San Francisco General Hospital

TABLE OF CONTENTS

- 1. CRISIS PLANS**
- 2. INFORMED CONSENT**
- 3. MANDATORY DISROBEMENT**
- 4. MEDICAL CLEARANCE**
- 5. MEDICAL COMPLAINTS**
- 6. RESTRAINT**
- 7. SECLUSION**
- 8. SECURITY GUARDS**
- 9. TRAUMA**
- 10. ACCOMPANYMENT**
- 11. ADVANCE DIRECTIVES**
- 12. MAXIMUM DETENTION INVOLUNTARY**

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

CRISIS PLANS

Findings:

1. One of the major developments in theory and practice relating to the treatment of people with serious psychiatric disabilities is the focus on recovery, as well as the patient's control over his or her own recovery. This focus is supported by the President's New Freedom Commission Report (2003), the Surgeon General's Report on Mental Health (1999), the National Center on Disability's report "From Privileges to Rights" (2000), and the National Association of State Mental Health Program Directors (1999). The Institute of Medicine also indirectly supports this model in its call for health care in general to become more patient-centered. (Crossing the Quality Chasm 2001)

2. Emergency departments, perhaps because they primarily see people in psychiatric crisis, have generally not adopted either the person-centered Institute of Medicine approach or the strength-based recovery model increasingly accepted in mental health.

3. For many people with psychiatric disabilities, crises are often both predictable and potentially avoidable. Many people have psychiatric crises around anniversaries of traumatic events, as a result of certain predictably stressful events (court appearances, Social Security reviews, family reunions), or as a predictable response to certain environmental triggers. Planning ahead for responses to these crises can help avoid, alleviate or mitigate the crisis.

4. Many different written models and training manuals exist for creating crisis plans. The best known of these is Mary Ellen Copeland's WRAP (Wellness Recovery Action Plan). Mary Ellen Copeland's web site also offers a post-crisis plan for those patients who are discharged from a crisis setting back into the environment that helped cause the crisis in the first place.

Standard:

1. Training for social workers employed in emergency departments should include orientation to wellness maintenance and crisis plans, e.g. the Wellness Recovery Action Plan (WRAP).

Recommendations:

1. Emergency department social workers should make wellness maintenance and crisis plan materials available to patients with psychiatric disabilities upon discharge, along with a referral to any peer operated support groups in their areas.
2. Hospital social workers should maintain a list of peer operated support groups and clubhouses in their area, and work with them to improve emergency department services for people who have psychiatric disabilities. Hospitals which are not aware of the groups in their area can contact their State Department of Mental Health, State Protection and Advocacy agency (list of all State Protection and Advocacy agencies available at www.napas.org).
3. Emergency departments should develop standard forms as part of patient history that includes both specific medications and treatments that have been used in the past, and whether these medications and treatments have proven to be helpful or harmful to the patient's condition. The form should be attached to the chart prominently (first page on medication order section, or inside front cover of chart).
4. Forms exist that permit patients to indicate what helps them in a crisis. These forms are often called "restraint reduction forms." Emergency departments should work with patients who present frequently in psychiatric crisis to ensure that a restraint reduction form is in the file of anyone who visits the emergency department because of psychiatric crisis on a regular basis.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

INFORMED CONSENT

Findings:

1. Legal requirements that patients give informed consent to proposed treatment apply in the emergency department just as they do in other health care settings (Sanders 1991). These requirements may vary in the case of patients under involuntary detention orders. (Stefan 2005).

2. People with psychiatric disabilities rank “being asked about what treatment I want” and “being asked about what treatments were helpful and not helpful to me in the past” as being of primary importance to them in emergency department treatment (Allen, Carpenter, Sheets, Miccio and Ross 2003; Connecticut Protection and Advocacy 1999).

3. Professionals in emergency departments often fail to obtain informed consent from people with psychiatric disabilities. People with psychiatric disabilities report that they are not told the risks and benefits of treatment, including invasive medical treatment, they receive in emergency departments. In one survey, 82% of people with psychiatric disabilities who had received treatment in an emergency department disagreed or disagreed strongly with the statement that the nature of proposed treatment, its risks, benefits and alternative options had been described to them before they were asked to consent to the treatment. (Allen, Carpenter, Sheets, Miccio and Ross 2003).

4. Survey results from people with psychiatric disabilities regarding informed consent include

** Nurses and doctors pumped my stomach but I was not told what they were doing...

** They put me in a separate room with a guard. I had signed a form for tests--I didn't realize one was putting a long pipe down my throat into my stomach and I said no, I didn't want that--they could give me the paper back. I rescinded my consent. The MD told me to shut up--you're a psych patient, you don't know what's good for you. They put me in restraints and did it anyway.

5. Informed consent is a regulatory and licensing requirement for emergency departments (45 C.F.R. 482.13, JCAHO RI-2.30, RI-2.40).The failure

to obtain informed consent from psychiatric patients in emergency department settings has led to substantial damage awards in a number of recent cases.

STANDARDS:

A. Existing Standards

1. No assessment procedure or medical test should be performed upon a conscious, competent patient without describing to the patient ahead of time what will be done, and why, and inviting the patient to ask questions about the procedure.

2. A patient's refusal of a procedure or test should be respected, except if a physician determines and documents that the patient is not competent to make a decision about the procedure or test after being given information in language that he or she can understand about the benefits and drawbacks of the procedure or test. A patient can be informed of the non-medical consequences of refusal (e.g. an inpatient bed in a psychiatric facility may be available only if the patient has undergone a drug screen).

3. No medication should be given to a conscious patient on a non-emergency basis without describing to the patient what the medication is, why it is being given, and inviting the patient to ask questions about the medication.

4. Competent refusals of medications must be respected.

5. Conclusions that a patient is not competent must be made by a physician and the form of examination and basis for the conclusion documented in detail in the patient's chart.

B. Proposed Standards

1. Force, including restraints, may not be used under any circumstances to perform procedures, tests or screens on an unconsenting, unwilling patient without a court order from a court of competent jurisdiction, unless a professional specifically documents that the patient is at risk of death or serious medical injury if the specific test being ordered is not immediately conducted.

2. No procedure should be performed solely at the request of police upon an unconsenting, unwilling patient. The fact that the procedure may be

medically justifiable does not, by itself, suffice to overcome the refusal of a competent patient.

3. The fact that a psychiatric hospital or ward requires a toxicology screening in order to admit a patient is not a sufficient medical justification to overcome the refusal of a competent patient.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

DISROBEMENT

Findings:

1. One of the issues that causes the most complaints by individuals with psychiatric disabilities surveyed about their experiences in emergency department treatment is mandatory disrobing.

- ** "...the ER nurse instructed me to take off my clothes as she put the shackles on the bed. I have been hospitalized numerous times and have long given up any physical fight."
- ** "I was immediately strapped down, given two injections, and my clothes were taken. I was given a hospital gown..."
- ** "There is a practice in the crisis unit which is particularly degrading and humiliating. Once on the unit, before being seen, they demand your shoes and clothes. This of course puts them in control...I refused to give things up and was threatened with the use of physical force and restraint (8 guys showed up)."
- ** "When a patient arrives, you are forced to take all clothes off!!! Not always necessary."

2. Mandatory disrobement of psychiatric patients is common. In one survey of Connecticut patients, 57% of patients presenting with psychiatric complaints were asked to remove their clothes. Individuals with a history of psychiatric treatment presenting with medical complaints were asked to remove their clothing 40% of the time. (State of Connecticut Office of Protection and Advocacy for Persons with Disabilities, Protection and Advocacy for Individuals with Mental Illness, Emergency Room Survey, 1999).

3. Hospital policies vary considerably. Some hospitals require all psychiatric patients under involuntary detention orders to disrobe; others require all psychiatric patients to disrobe; still others require all patients to disrobe. Still others permit patients to keep their clothing after a pat down, or leave requests for disrobing up to the discretion of emergency department staff (Policies on file at Center for Public Representation).

4. Both courts and state licensing agencies have disapproved blanket policies regarding mandatory disrobement without individualized assessments of dangerousness. There is no safety justification for discrepant treatment of psychiatric and medical patients with regard to disrobement policies, and no

justification for uniform treatment of psychiatric patients based on flight concerns. There is no policy justification for blanket assumptions about psychiatric patients. Moreover, such blanket assumptions contradict the requirements of the Americans with Disabilities Act. (Stefan 2001).

5. Being forced to remove street clothing can be extremely disturbing and feel very unsafe for individuals who have a history of sexual abuse and trauma. These individuals may refuse to remove their clothing and ultimately engage in physical struggles as security guards attempt to strip them, reenacting their former abuse and greatly exacerbating the emotional crisis that brought them to the emergency department in the first place.

STANDARDS

1. Care and treatment in emergency departments should not be conditioned on disrobing, except in extremely limited circumstances where professionally documented assessments specifically weigh the emotional and physical risk to the individual of enforced clothing removal against the immediate medical necessity for such removal to provide treatment, and conclude that the requirement of disrobing is essential.

2. If the professional assessment is made that disrobing is necessary to provide treatments, voluntary patients may leave in lieu of disrobing. No patient may be converted from voluntary to involuntary status on the basis of refusing to disrobe.

3. A hospital policy requiring automatic disrobement solely on the basis that a patient has a psychiatric diagnosis or is seeking psychiatric treatment is clinically unjustified, discriminatory and illegal.

4. Flight risk is not a sufficient justification for removal of clothing.

Implementation:

1. Hospitals should rescind any blanket policies regarding mandatory disrobement or patdowns that apply solely to patients seeking psychiatric treatment or who have psychiatric histories.

2. If a hospital's policy on disrobement applies to all patients, medical or psychiatric, the hospital should modify the policy in ways that make disrobement as minimally intrusive as possible. Hospitals whose policy or practice is to give the patient a choice about disrobing should ensure that the patient is aware that she has this choice.

3. Safety concerns are only a sufficient justification for forcible removal of clothing if an individualized assessment of dangerousness has been made that weighs the safety risk against the risk of emotional and physical harm attendant upon forced disrobing.

4. If a medical examination requires a patient to disrobe, he or she should be required to disrobe only to the extent necessary to conduct the examination, and should not be asked to disrobe until such time as the doctor can reasonably be expected to conduct the examination within one half hour of disrobing. Clothing should be returned as soon as possible.

5. An order of involuntary detention by itself does not constitute an individualized assessment of dangerousness for purposes of requiring patients to disrobe. If the hospital's policy on disrobing applies solely to individuals under involuntary detention orders, disrobing should not be mandatory without an individualized assessment of dangerousness and flight risk that weighs the risk against the risk of emotional and physical harm attendant upon forced disrobing.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

MEDICAL CLEARANCE

Findings:

1. Emergency department professionals and mental health professionals greatly disagree about what constitutes appropriate medical clearance of a person presenting with psychiatric condition. There is also division among emergency department professionals about what constitutes appropriate medical clearance. (Stefan 2005).

2. It is undisputed that many medical conditions present with symptoms that may lead to a mistaken psychiatric diagnosis. Thus, ruling out medical causes of behavioral problems is crucial. In addition, many people with psychiatric problems have co-occurring medical problems which may contribute to or appear to exacerbate the psychiatric condition.

3. Many emergency department professionals believe that medical clearance simply means identifying and treating emergency medical conditions, and believe that unreasonably extensive medical clearance requests represent an attempt to shift costs to emergency departments and result in unreasonably lengthy emergency department stays for people with known psychiatric conditions. On the other hand, psychiatric professionals on inpatient units believe that they do not have the expertise or the testing equipment to rule out a variety of medical syndromes that may be causing or contributing to symptomatology that appears to be behaviorally related.

4. These differences of opinion and approach may also implicate legal rights. For example, the need to do toxicology tests including blood tests and urine tests has led to forced catheterizations of psychiatric patients and patients being restrained to draw blood. (*Straub v. Kilgore* 2004; *Sullivan v. Bornemann* 2004; *Tinius v. Carroll County Sherriff Dept.* 2004).

Recommendations:

1. Uniform medical clearance standards applicable to all patients presenting with psychiatric conditions are inappropriate. For example, individuals presenting with first-time psychiatric crises, elderly people, and children, should receive more thorough medical clearance procedures than individuals who are well known in the emergency department and have been seen recently. People who

present with symptoms of psychosis and confusion may need more thorough medical clearance evaluations than people who present with depression.

2. Standard minimum medical clearance procedures for all patients include vital signs, medical history and visual examination (Expert Consensus Guidelines Series 2001). Toxicology screenings should be considered and the professional's decision relating to the screening should be documented.

3. The National Institute of Mental Health should convene an expert panel, which should include representatives of people receiving psychiatric evaluations in emergency department settings, to recommend a nation-wide minimum set of tests, or algorithm, to be followed by emergency departments in their medical clearance procedures.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

INAPPROPRIATE ASSESSMENT AND TREATMENT OF MEDICAL COMPLAINTS

Findings:

1. Medical reports, treatises, testimony to Congress and patient surveys all concur that people with known psychiatric histories or diagnoses are frequently not given appropriate assessments for medical complaints because it is assumed that their reported problems are psychiatric in nature. (Stefan 2005).

2. Testimony before Congress when it was considering the Americans with Disabilities Act included an account of a woman with a psychiatric disability miscarrying and hemorrhaging in the street after an emergency room assumed her report that she was pregnant was a delusion.(A&P Comm.Print 1990 28B *1251)
Among the complaints of survey respondents:

- ** [patient went in] “for stomach pains, which they kept saying was all in my mind. So they sent me over to the Crisis where they didn’t believe me either when all this time it was a bleeding ulcer which I just found out now”
- ** [patient went in for] “severe back numbness...9 ½ hours nobody ever looked at my back instead did psych eval.”
- ** “I am a 36 year old, divorced Mom working full time and raising 2 children. I felt like I was treated like a ‘hysterical female’, the way doctors hooked women on valium in the 60’s...”
- ** “It seemed that my symptoms of a possible heart attack were ignored by the doctors, especially my own, since I had a bipolar diagnosis, even though my blood pressure was high. I was treated as though I had an anxiety attack which I did not. I was stigmatized as soon as they heard my diagnosis.”
- ** “Had a cut cornea and was crying. Intake took down my psychiatric meds. The doctor came in to treat me for emotional upset. I’m crying because my eye needs to be fixed.”

Recommendations:

1. Hospital risk management and/or quality assurance committees should investigate how the hospital’s emergency department treats medical complaints made by patients with known psychiatric histories.

2. Hospitals should conduct trainings of all emergency department staff, including physicians and nurses, which emphasize that minimizing medical complaints of psychiatric patients is poor medical practice, may endanger lives, and may also constitute both medical malpractice and a violation of the Americans with Disabilities Act. An important component of the trainings should be addressing the doctor's own stereotypes about people with psychiatric disabilities, and how those stereotypes interfere with good medical practice. At least some of these trainings should be led by people with psychiatric disabilities.

3. Teaching hospitals should ensure that the principles of these trainings are incorporated into every day teaching rounds.

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RESTRAINT

Findings:

1. Few data are available on the extent of restraint and seclusion in emergency departments. The data that are available suggests great variation in restraint use between emergency departments. Rationale for restraint includes danger to the patient or others, but patients are also restrained to prevent them from leaving the emergency department. Some hospital policies or forms list “flight risk” among the reasons for restraint, despite the fact that expert consensus considers this a clinically inappropriate rationale for restraint.

2. For decades, research has underscored the detrimental effect that restraint has on most psychiatric patients, both emotional and physical. The federal government, the National Association of State Mental Health Program Directors, and the National Council on Disability all have recommended working toward the abolition of the use of restraint on individuals with psychiatric disabilities. (National Association of State Mental Health Program Directors, 1999; United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration 2003). The Joint Commission on Accreditation of Health Care Organizations has noted that seclusion and restraint constitute “an aversive experience with potential for serious physical and emotional consequences including death. Organizations are required to continually explore ways to decrease and eliminate use through training, leadership commitment, and performance improvement.” (JCAHO 2002).

3. People responding to surveys about emergency department experience frequently mentioned restraints as among the most harrowing and painful parts of their experience. A substantial number state that after experiencing restraints, they were unwilling to seek psychiatric care voluntarily. Often these complaints reflect the isolation and retraumatization of the restraint process. Although regulations require a person in restraints to be continually observed, in many cases the observer was either not present or refused to speak to the patient:

- ** “I woke up in restraints soaking wet and no one talked to me for hours.”
- ** “I was strapped down despite my protests- it was so humiliating and degrading.”
- ** “...I was restrained for hours and left with a guard with a gun who refused to say one word to me or even look at me when I tried to talk

with her. I was not dangerous or in any way threatening anybody- the restraints were because I tried to move the thing I was laying on out from under a drip holder that I was hallucinating was coming at me.”

4. Emergency departments that have made an effort to reduce use of restraints have succeeded in doing so through a wide variety of techniques. The most helpful one appears to be the use of sitters/companions/psychiatric advocates, who stay with the person in psychiatric crisis. One hospital, Bay State in Springfield, Massachusetts, introduced such a program, with 24/7 coverage, for approximately \$22,000 a year.

Standards:

1. The use of restraints should be considered a sentinel event, requiring root cause analysis and reporting to the Joint Commission on Accreditation of Health Care Organizations.

2. The use of restraint to prevent a voluntary patient from leaving the hospital prior to assessment is not justified and should not be permitted. The use of restraints for the purpose of completing a medical evaluation or to hold a patient while completing a competence evaluation is not justified and should not be permitted.

3. The reduction of seclusion and restraint in emergency departments should be a core indicator of performance for purposes of quality assurance and risk assessment.

a. Hospitals should supplement staff if necessary to comply with JCAHO and CMS requirements regarding in-person monitoring of seclusion and restraint. Models exist such as the one at Bay State Hospital in Springfield that are low cost and effective.

b. Chart audits of all restrained patients should be conducted to identify compliance with standards, as well as to identify both staff and patients who are repeat users of restraint or seclusion. Individual staff should receive prompt feedback on compliance with standards after a restraint episode.

c. Forms exist that permit patients to indicate what helps them in a crisis. These forms are often called “restraint reduction forms.” Emergency departments should work with patients

who present frequently in psychiatric crisis to ensure that a restraint reduction form is in the file of anyone who visits the emergency department because of psychiatric crisis on a regular basis.

- d. Emergency departments should collect data on frequency of seclusion/restraint by sex, race, shift, day of the week, type of restraint, and duration of seclusion/restraint. Emergency departments should follow the protocol of the National Association of State Mental Health Program Directors, which is in the process of being adopted by private hospitals, in order to ensure uniformity of data for comparison purposes. This data should be published internally and compared to known rates at similar facilities.
- e. Emergency departments should debrief staff, and if possible, the patient, after every episode of restraint, especially when the restraint involves an individual who is known to the emergency department staff. “Debriefing” means an analysis of 1) triggers, 2) antecedent behaviors, 3) alternative behaviors, 4) least restrictive or alternative interventions attempted, 5) deescalation preferences or safety planning measures identified.

4. The use of restraint should be as humane and non-traumatizing as possible under the circumstances.

- a. Staff who are assigned to observe and support an individual in restraints should be trained to communicate with individuals in restraints in a supportive and reassuring way, and should do so.
- b. Clocks should be securely affixed to the walls of any room used to restraint patients and should be visible to the patient.
- c. Patients who need to use the bathroom should be escorted to toilet facilities. Bedpans should not be used.
- d. If security guards take any part in restraining patients, they should receive the same training as all ED staff involved in restraint procedures, including non-violent crisis management, deescalation, and training in interactions with people with psychiatric disabilities. At least some of this

training should be conducted by people with psychiatric disabilities.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

SECLUSION

Findings:

1. The Center for Medicare and Medicaid Services defines “seclusion” as “the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.” (CMS Interpretive Guidance 482.13(f)(1). The Joint Commission on the Accreditation of Health Care Organizations defines seclusion as involuntary confinement of a person alone in a locked room.

2. For years, research has underscored the detrimental effect that seclusion has on most psychiatric patients. The federal government, the National Association of State Mental Health Program Directors, and the National Council on Disability all have recommended working toward the abolition of the use of seclusion and restraint on individuals with psychiatric disabilities. (National Association of State Mental Health Program Directors, 1999; United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration 2003). The Joint Commission on the Accreditation of Health Care Organizations finds that seclusion and restraint as “an aversive experience with potential for serious physical and emotional consequences including death. Organizations are required to continually explore ways to decrease and eliminate use through training, leadership commitment, and performance improvement.” (JCAHO 2002)

3. Patients report that seclusion is one of the worst aspects of their experience in emergency departments. Their comments underscore the adverse emotional consequences of isolation:

** I arrived at Bridgeport Hospital in bad emotional condition but calm and compliant, was not combative or hysterical and still sent to the isolation room...

** I felt very isolated in that little room...

** The most scary thing for me was being told how lucky I was that my social worker came with me otherwise I would have had to stay in an “isolation room” because they did not have enough staff to watch me.

** All psychiatric patient’s rights as human being not as animals should be respected and not violated by being cooped up in isolation in a filthy urine smelling room...

- ** Don't lock patients in an observation room for many hours without talking to someone professional.
- ** I was often left alone for hours in a cubicle and terrified, thinking I was in all kinds of evil places
- ** Try to avoid putting patients in the little locked room and ignoring them...

4. Hospital emergency departments often lock psychiatric patients into assessment rooms while waiting for evaluation. This is particularly true for patients who are subject to involuntary detention petitions, but is also true even for voluntary patients. Some hospitals acknowledge a policy of locking patients in rooms because they do not have sufficient staff to watch them. Although hospitals often do not consider a patient in seclusion unless he or she is in a room denominated as a seclusion room, the practice of locking assessment rooms, or prohibiting patients from leaving assessment rooms, is equally frightening and isolating to patients. Furthermore, because the patient cannot leave the room, this practice legally constitutes seclusion of the patient.

STANDARDS:

1. Under federal regulations, locked assessment rooms constitute seclusion, and patients may not be prevented from leaving rooms in which they are alone unless the conditions for seclusion have been met.

- a. A patient who is not permitted to leave a room in which he or she is alone must be continuously observed in person for the first hour, with continuous audio-visual monitoring permissible after the first hour, and fifteen minute well-being checks through out this period.

2. The use of seclusion to prevent a voluntary patient from leaving the hospital prior to assessment is not justified and should not be permitted. The use of seclusion for a brief period of time to permit a medical evaluation for the purpose of determining if the individual has a life-threatening condition or is competent is permissible if the period of time is as short as possible under the circumstances, and in no case over one hour.

3. The reduction of seclusion and restraint in emergency departments should be a core indicator of performance for purposes of quality assurance and risk assessment.

- a. Hospitals should supplement staff if necessary to comply with JCAHO and CMS requirements regarding in-person monitoring of seclusion and restraint. Models exist such as the one at Bay State Hospital in Springfield that are low cost and effective.
- b. Utilize additional staff as sitters/companions/psychiatric advocates. Many hospitals have hired “sitters” or “psychiatric advocates” or use light duty staff or available staff as “sitters.” Although the names vary, the function is to sit with a person in psychiatric crisis, to provide comfort and attention and awareness of the individual’s needs. This obviates the need for seclusion and often for restraints as well. Hospital personnel monitoring a person in seclusion should be instructed to speak to the patient and attempt to comfort them and discern their needs.
- c. Chart audits of all restrained and secluded patients should be conducted to identify compliance with standards, as well as to identify both staff and patients who are repeat users of restraint or seclusion. Individual staff should receive prompt feedback on compliance with standards after a restraint episode.
- d. Emergency departments should collect data on frequency of seclusion/restraint by sex, race, shift, day of the week, type of restraint, and duration of seclusion/restraint. Emergency departments should follow the protocol of the National Association of State Mental Health Program Directors, which is in the process of being adopted by private hospitals, in order to ensure uniformity of data for comparison purposes. This data should be published internally and compared to known rates at similar facilities.

4. The use of seclusion should be as humane and non-traumatizing as possible under the circumstances.

- a. Staff who are assigned to observe and support an individual in seclusion should be trained to communicate with individuals in seclusion in a supportive and reassuring way, and should do so.
- b. Clocks should be securely affixed to the walls of any room used for seclusion purposes. Magazines should be available, as well as material on relaxation techniques.
- c. Patients who need to use the bathroom should be escorted to toilet facilities. Bedpans should not be used.
- d. If security guards take any part in observing patients in seclusion, they should receive the same training as all ED staff involved in restraint procedures, including non-violent crisis management, deescalation, and training in interactions with people with psychiatric disabilities. At least some of this training should be conducted by people with psychiatric disabilities.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

SECURITY GUARDS

Findings:

1. About 15-20% of hospital security guards carry guns. About 20-30% carry pepper spray. The proportion of armed security guards has been steadily decreasing over the past two decades due to increased training of health care security in deescalation techniques and increasing concern over the health and safety issues involved when hospital security personnel carry weapons. (Colling 2004).

2. While the presence of armed security guards may make some medical patients feel safer, many patients with a history of psychiatric disability, and of unpleasant encounters with the police, are made uncomfortable and frightened by the presence of uniformed security guards, especially when armed. For some people with psychiatric disabilities, police uniforms can be extremely intimidating and threatening, increasing the chances of escalation on the part of the individual (Stefan 2005, Miccio 2005, Colling 2005).

3. The Center for Medicare and Medicaid Services (“CMS”) has investigated and disciplined hospitals for using pepper spray on patients, including psychiatric patients. CMS has issued interpretive guidance to its regulations regarding patient’s rights that “pepper spray, mace, nightsticks, Tazers, cattle prods, stun guns, pistols and other such devices” are considered weapons, and that “CMS does not consider the use of weapons in the application of restraint as safe appropriate health care interventions... CMS does not approve the use of weapons by an hospital staff as a means of subduing a patient to place that patient in patient restraint/seclusion.” (Center for Medicare and Medicaid Services, State Operations Manual, Interpretive Guidance to 45 C.F.R. 482.13(f), available at www.cms.hhs.gov/manuals/107_som/som107ap_a_hospitals.pdf.)

STANDARDS:

1. Hospital security guards in emergency departments should not carry guns, pepper spray or tasers.

2. Security guards should wear distinctive clothing but not full police uniforms.

3. Hospital security guards should receive training in interacting with people with psychiatric disabilities, including training on deescalation and redirection. At least one segment or module of the training should be conducted by an individual with a psychiatric disability, and at least one segment or module of the training should relate to the effect of stereotypes and stigma on perceptions of likely violence and unpredictability of persons with psychiatric disabilities.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

TRAUMA

Findings:

1. There is a clear relationship between an individual's experience of severe trauma, such as childhood physical or sexual abuse, and later psychiatric and emotional difficulties, including self-injury. Over 60% of people with serious psychiatric disabilities report a history of childhood sexual or physical abuse. Over 80% of adolescents and children in continuing care inpatient and intensive residential treatment programs in Massachusetts were found to have trauma histories (LeBel and Stromberg 2004).

2. People with trauma histories are frequently the highest users of costly mental health crisis and emergency services (SAMHSA 2004). These patients' trauma histories may greatly affect their presentation to the emergency department, their reactions to various treatment interventions in the emergency department, and appropriate recommendations for treatment. For example, emergency department policies on restraint or removal of clothing may cause serious emotional damage to people with histories of rape or sexual abuse, whether they experience such practices or witness others being restrained or having their clothing removed. In addition, there is evidence that in some cases dissociation or PTSD flashbacks related to trauma may be inappropriately diagnosed as psychosis or schizophrenia (Harris 1994). There is also evidence that people with schizophrenia and longer term psychoses have a high incidence of trauma co-morbidity (Kessler, R.C., Sonnega, A., Bromet, E. et al 1995).

3. State Departments of Mental Health have paid increasing attention to the impact of trauma on individuals in state systems (SAMHSA 2004; National Association of State Mental Health Program Directors 2004). However, emergency department and crisis services have not been as attuned to this issue. Emergency departments have, however, been sensitized to the treatment of rape victims, and many of these policies could be usefully and positively applied to individuals with psychiatric disabilities who have suffered trauma.

4. A number of emergency department policies specifically impact negatively on people with trauma histories: the requirement that patients disrobe, the use of seclusion and restraints, the utilization of armed and uniformed security guards, and the equation of cutting with suicidality, resulting in seclusion, restraint, or involuntary detention. Patients with trauma histories are particularly

prone vulnerable to harm from these policies, although they also have a negative impact on all patients with psychiatric diagnoses.

Recommendations:

1. **Universal screening** is recommended for history of trauma. These questions should be brief and simple, asked in private, and are extensions of assessments already currently required by the Joint Commission on the Accreditation of Health Care Organizations for domestic violence, abuse and neglect (PC 3.10). A number of different models exist for these questions, and are attached.
2. **Universal precautions.** Because not all patients feel comfortable reporting a history of trauma, and because practices that benefit patients with trauma histories benefit all patients, ED staff should adopt trauma-informed practices toward all patients. These practices often involve replicating treatment of rape victims, and include maximizing information given to the patient, maximizing choice wherever possible, assuming a collaborative and respectful stance, and minimizing coercion. Examples of these practices include asking a patient's permission before taking blood or vital signs, or before touching a patient (except in an emergency); addressing a patient by her last name rather than her first, explaining why certain procedures are being followed, and being sensitive to gender preferences in staff-patient interactions.
3. **Requirements for clothing removal.** If a patient refuses to comply with a hospital requirement of clothing removal, and the person in fact has a history of trauma, an individualized determination should be made and documented by a physician that the medical and psychiatric risk involved in forcibly removing the clothing from an individual with a trauma history is outweighed by the benefit of forcibly removing the clothing.
4. **Treatment.** It is important to identify trauma victims, because it highlights the importance of differentiating between hallucinations and post-traumatic flashbacks or dissociation. The medications of individuals diagnosed with a severe mental illness who are the survivors of sexual abuse should be reevaluated in light of the impact of the trauma on the symptoms and behavior of the individual. In addition, self-injury, a common practice in individuals with trauma histories, requires informed treatment, and treaters should distinguish this from suicidal behavior in their treatment planning.
5. **Disposition.** Emergency Departments should make particular efforts to avoid inpatient admission for people with histories of trauma unless absolutely necessary. Because control is so important for people with trauma histories,

inpatient admissions rarely have long-term benefits and should only be used when there is no other means to assure safety in the short-term.

6. **Referrals.** If a patient has a trauma history, it is helpful to have information about available resources and books, as well as knowing whether any local agency offers trauma-specific treatment. “Evolution of Trauma-Informed and Trauma-Specific Services in State Mental Health Systems” is available from the Substance Abuse and Mental Health Services Administration in Washington D.C. or from the Center for Public Representation.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

ACCOMPANIMENT

Findings:

1. About one third of people with psychiatric disabilities who visit emergency departments are accompanied by family members or friends. The American College of Emergency Physicians encourages patients to bring a family member or friend to “be at the bedside.” (“The Emergency Department: What to Expect,” www.acep.org/1,241,0.html).
2. However, many hospital emergency departments refuse to permit friends, relatives or advocates to accompany people with psychiatric disabilities when they are sent back to the assessment room or area. This is true even if the individual requests accompaniment, and even when the hospital permits such accompaniment for medical patients. In some hospitals, this refusal is articulated in a hospital policy prohibiting such accompaniment for psychiatric patients, or patients under orders of involuntary detention. In others it is left to staff discretion, and accompaniment becomes a matter of which staff are on duty. (Stefan 2005).
3. Surveys of individuals with psychiatric disabilities indicate that waiting alone in an assessment room often exacerbates anxiety, depression or panic which created the psychiatric emergency in the first place. The presence of a *desired* other--friend, advocate, or family member--is seen as extremely important. At the same time, if there is any element of involuntariness to the ER visit, they may not want to be accompanied or assessed in the presence of a relative or other individual whom they view as being responsible for bringing them or causing them to be brought to the emergency department. (Office of Protection and Advocacy of the State of Connecticut 1999).
4. Among the reasons cited by emergency departments for the policy or practice of prohibiting accompaniment of patients with psychiatric disabilities to assessing areas are concerns for the safety of the accompanying individual and/or the patient’s safety; clinical concerns regarding the exacerbation of the patient’s condition; discomfort with the presence of a peer advocate, and the fact that if

psychiatric patients are locked in rooms, the emergency department does not want to lock a non-patient in the room. (Stefan 2005).

5. Although neither the Center for Medicare and Medicaid Services nor the Joint Commission on Accreditation of Health Care Organizations have standards directly addressing this issue, both underscore the importance of respecting the individual's requests, involving the individual in decisions regarding care, as well as involving family members when appropriate. (RI 1.2, 42 C.F.R. 482.13(b)).

STANDARD:

Individuals with psychiatric disabilities are entitled to accompaniment in emergency departments, if desired by the patient, unless doing so would create a documented risk of immediate danger to the patient or others.

Implementation:

1. Hospital emergency departments should adopt policies that accompaniment by a family member, friend, or advocate while the individual awaits assessment is presumptively permitted, if desired by the patient, unless doing so would create a risk of immediate danger.
2. The desires of the individual as to accompaniment should be ascertained privately. This can be accomplished at triage or in any other way appropriate to the individual emergency department setting.
3. The assessment that accompaniment would create a risk of immediate danger must be made by a qualified professional, be specific and be documented in the individual's chart.
4. The hospital may limit the number of persons accompanying the individual to one.
5. Emergency departments should comply with federal and JCAHO standards prohibiting the utilization of individuals accompanying patients as a substitute for the presence of hospital staff when required by law (e.g. observation of a patient in restraints) or other persons required by law (e.g. interpreters for patients who are deaf or do not speak English).

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

ADVANCE DIRECTIVES

Findings:

1. All states have statutes permitting individuals to create advance directives, which must be honored by emergency departments. A substantial number of those states have statutes specifically recognizing psychiatric advance directives. A number of web sites exist which contain sample advance directive forms specifically oriented to the needs of individuals with psychiatric disabilities (see, e.g. Bazelon Center for Mental Health Law website, www.bazelon.org).

2. Few individuals with psychiatric disabilities have advance directives. This is true of people who visit emergency departments in general. Although the American College of Emergency Medicine recommends that patients bring advance directives to the emergency department, even people who already have advance directives often do not bring them to emergency departments. Emergency departments are more familiar with the concept of “DNR”s (“do not resuscitate”) orders or patient “codes” than they are with advance directives, and it is probable that most emergency department staff will be completely unfamiliar with psychiatric advance directives (Stefan 2005).

3. Some individuals with psychiatric disabilities who have advance directives report that the emergency departments would not honor their advance directives (State of Connecticut Office of Protection and Advocacy for Individuals with Mental Illness Emergency Room Survey 1999).

4. Both the Joint Commission on the Accreditation of Health Care Organizations and the Center for Medicare and Medicaid Services require emergency departments to document the existence of advance directives in patient charts and to honor advance directives. (42 C.F.R. 482.13(b)(2) and (b)(3), State Operations Manual, Hospital Interpretive Guidelines; JCAHO Standards RI-1.2.4, IM 7.2).

Recommendation:

1. Hospitals should ensure that emergency department staff are aware of and respect the advance directives of people with psychiatric disabilities. A psychiatric disability does not preclude an individual from executing an advance directive, and the advance directive may contain directions regarding psychiatric treatment. (*Hargrave v. Vermont* 2003).

2. The Joint Commission on the Accreditation of Health Care Organizations and the Center for Medicare and Medicaid Services should enforce their requirements regarding advance directives with respect to psychiatric advance directives in emergency departments.

Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements

Maximum Hours of Involuntary Detention in Emergency Departments Prior to Assessment

Involuntary Patients

Findings:

1. A number of patients are brought to emergency departments for assessments on legally executed certificates permitting their involuntary detention.
2. Research on the proportion of psychiatric patients brought to emergency departments under orders of involuntary detention varies from location to location, and ranges from 17% to over 50% of patients.
3. The fact that people arrive at emergency departments with certificates indicating probable cause to believe that they are mentally ill and dangerous to themselves or others should indicate a high level of urgency in assessment, placement and treatment.
4. Some states have statutes which regulate the maximum time a person who is already under a legal order of involuntary detention because of dangerousness findings (e.g., by the police) may be forced to wait for an evaluation in an emergency department. The most common statutory maximum is six hours, N.Y. Mental Hygiene Law 9.40; Md Health Gen. Code Ann. 10-624(b)(2).
5. Often a patient who arrives with an involuntary certificate is placed in seclusion or restraint upon arrival at the hospital emergency room.

Proposed Standards:

1. **No person under an order of involuntary detention should wait more than three hours to be assessed and evaluated, resulting in a disposition decision or treatment plan.**
2. **No person in seclusion or restraints should wait more than one hour for assessment and evaluation resulting in a decision regarding disposition or treatment plan.**
 - a. If a person is secluded or restrained, the Center for Medicare and Medicaid Services one-hour rule requires that a physician assess the individual in person

within one hour. This assessment should include the required evaluation, so that no person in restraints should wait more than one hour for an evaluation.