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	Patient-Centered Mental Health Care in Emergency Departments **Maine Department of Health and Human Services, Office of Adult Mental Health Services**
1.	**Welcome** Hi and welcome. I'm your training guide, Kate. This training was developed by the Maine Department of Health and Human Services, Office of Adult Mental Health Services, based on input from mental health care consumers and providers, to offer guidance to Emergency Department staff on providing optimal, patient-centered mental health care. We'll discuss the challenges of providing mental health care in an ED, confront myths, give hopeful statistics on recovery, and more. Plus, we'll examine how to: • Use the latest mental health treatment standards and tools to improve ED care • Engage patients in their own treatment • Enable patients to have a more positive experience in the ED; and • Access community resources that provide and support mental health treatment and help patients to avoid future ED visits and hospitalizations It is our hope that this will be an informative and thought provoking learning experience for you.

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2.	**Getting Around** Before we get into the course, let's review some quick navigational features. To the left is the course outline, listing each of the topics and sub-topics. It's best to run through the program topic by topic. You can advance or return to a topic by selecting it from the Outline. The Notes Tab provides an exact script of the audio portion of the training. This option is helpful for those who are hard-of-hearing and for those who simply prefer to read along as they listen. It will take approximately one and a half hours to complete this training. If you choose to exit this training part way through, you will be given the option upon returning to resume the training where you left off. A certificate of completion, as well as Continuing Medical Education (CME) contact hours and Continuing Nursing Education contact hours (CNE) and Continuing Education (CE) contact hours for licensing psychologists are available upon successful completion (80%+ on quiz) of this training. Please note that contact hours are available to Maine residents only. Throughout the training we refer to a variety of documents that are included as Attachments. A notes symbol on the screen indicates that the source document can be accessed under the Attachments menu. We encourage you to access the Attachments while going through the training and afterwards, should they prove to be a useful resource. Sometimes you'll also see a highlighted **LEARN MORE** button. Click this button to get further information on a particular topic. Below are the control buttons. Use the buttons to play/pause the screen, go the next topic or return to the previous topic. At the end of most screens, the Status Bar is all blue and the Play/Pause button will pulse. When this happens, click this button to advance to the next topic. Some topics will include a Next button inside them. If you see this button, click this instead to advance to the next topic.

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3.	**Course Sections** This course includes five sections. Please note, the artwork and poetry presented here and on each section page were created by Mainers who experience mental health issues and have given their permission to include this very personal work. I. Providing Mental Health Care - looks at some statistics and myths about mental illness and mental health care. II. Adopting a New Lens - presents new ways of thinking about how to interact with and care for mental health patients in crisis. III. Conducting Assessments - reviews some important points about conducting physical and mental health assessments. IV. Providing Treatment – explores what treatment options are available beyond hospitalization. V. Addressing Law Enforcement Cases - reviews the 2009 legislation impacting treatment of those with mental illness and the special circumstances involved when a mental health patient is brought to the ED by law enforcement. Ready to get started? Click the pulsing Play button now.
4.	**SECTION I: PROVIDING MENTAL HEALTH CARE**
5.	**Pivotal Role of the ED** No matter what brings a patient to the ED, the staff must triage all cases, quickly assess patients and determine the type of care needed. In situations where a patient's primary need is mental health care, an assessment can be particularly challenging. She may be in such an acute crisis that hospitalization is required. Or he might have an undiagnosed or untreated mental or medical illness that requires assessment and referral. Then again, family, friends, or the police may have brought the patient to the ED because they were unaware of crisis services and

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	other community-based mental health services available.
6.	**Pivotal Role of the ED (continued)** In these situations, ED staff must decide whether the patient requires inpatient services or can be treated safely in the community. These decisions can have an enormous impact on the lives of people with mental illness, their families, and the community as a whole. Those who work in EDs often report feeling unprepared to make such key decisions. In some cases, especially in rural settings, this is due to limited treatment options in the community. In other cases, ED staff may not be fully informed about resources. They also may not have had access to training in the current standards of mental health treatment that support recovery, such as screening for a history of abuse, avoiding restraint and seclusion, and using crisis plans and advance directives.
7.	**Integrated Mental Health Care** While the community is the preferred setting for providing care, it is essential that ED mental health care—and inpatient care—is available for those times when that level of care is indicated. Mental health recovery is a non-linear process, and occasional setbacks are often part of the process. Although Emergency Departments, and inpatient settings, should be the treatment site of last resort for psychiatric crises, they perform an important function. A key point to keep in mind: If viewed in the context of recovery, treatment in the ED is not seen as a sign of the patient's failures, but rather as a step in the recovery process. Later in this training we provide some examples of how community-based mental health services and crisis services can be of help to ED staff. Better-integrated care can make for a more successful experience for patients and ED staff alike.

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8.	**Imagine if you will...** To explore what we mean by patient-centered care, let's consider a situation you may have experienced before in your ED. The following is a scenario that was developed for this training as a learning tool. We will revisit this scenario periodically throughout this training.
	Imagine if you will... (continued) John is in his in 50's. His brother Sam recently brought him into the ED. As they approached the front desk, Sam explained to the nurse that his brother John had shown up at his wife's workplace (a car dealership) after drinking, was disruptive at the workplace and verbally abusive to his wife. His wife felt threatened, so she called Sam. Sam explained to the nurse that John has bipolar disorder, and had been doing well until recently when he started drinking again. In the past month he has had dramatic mood swings and there were two incidents when he was verbally abusive and physically threatening his wife while he was intoxicated. After the second incident she told him to move out. He is now staying with his brother. He questions whether he is currently taking his psych medications. The nurse talked with the John. She noticed that his speech was rapid, and he was pacing and reciting excerpts from Alcoholics Anonymous literature.
	Imagine if you will... (continued) What are some immediate thoughts that run through your mind about how to properly assess and treat this patient? Click inside the box and share your thoughts.
	Imagine if you will... (feedback) Thank you for sharing your thoughts.

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9.	**Challenges of Mental Health Care in the Emergency Department** Thank you for your thoughts. Throughout this training we will ask you to consider and comment on a situation such as this to support learning. Your comments are not being evaluated. Medical professionals and other advocates recognize that EDs are not the best place to resolve a mental health crisis. Susan Stefan, an attorney with the Center for Public Representation in Massachusetts and a highly regarded expert in mental health disability law explains the challenges of providing emergency mental health care in the ED this way: "Providing crisis care for people with psychiatric disabilities brings an overlay of issues: insufficient time; inadequate space; lack of expertise in assessment or treatment; vanishing dispositional alternatives; increasing numbers of individuals with complex combinations of medical, psychiatric, and substance abuse disorders; misunderstandings of legal requirements mixed with fear of liability; and frustration with frequent visitors demanding help that ED staff seem unable to provide all add to the pressures experienced by ED staff. The inherent tensions between the trust and time necessary to help people in emotional crisis and the scarcity of time in EDs … means that EDs are often not the best place for frightened, psychotic, and suicidal people to get help or weather their crises."
10.	**SAMHSA Practice Guidelines** Does Ms. Stefan's description of the challenges resonate with your experience? While there are no easy answers to the challenges Ms. Stefan articulates, The Substance Abuse and Mental Health Services Administration (SAMHSA) recently gathered a diverse expert panel of leaders within the mental health profession and mental health advocacy to develop crisis services guidelines that promote two goals: 1.) Crisis services that are guided by standards consistent with mental health recovery and resilience and 2.) Interventions that work toward preventing future emergencies and producing better outcomes rather than a reactive, cyclical approach. The panel's work resulted in the 2009 SAMHSA publication, *Practice Guidelines: Core Elements in Responding to Mental Health Crises.* Those guidelines are included in the Attachments.

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	The *Practice Guidelines* articulate ten essential values when responding to a mental health crisis. These include: 1. Avoiding Harm 2. Intervening in Person-Centered Ways 3. Shared Responsibility 4. Addressing Trauma 5. Establishing Feelings of Personal Safety 6. Based on Strengths 7. The Whole Person 8. The Person as Credible Source 9. Recovery, Resilience and Natural Supports 10. Prevention
11.	**Myths about Mental Illness** The ten essential values depicted in SAMHSA's Practice Guidelines provide the foundation for patient-centered mental health care in the ED and throughout the mental health care system. As the system moves toward more patient-centered care we must counteract some enduring myths about mental illness. Some myths about mental illness are well-known-such as the idea that people with mental illness are violent and dangerous. In fact, many studies show that people with a mental illness are more likely to be the *victims* of violence. As new supports and treatment methods are developed, other assumptions are being discredited. Let's explore some of those myths.

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12.	**Myth: People with Mental Illness Cannot Recover** Not so long ago, mental illness, especially in its most severe forms—such as schizophrenia and bipolar disorder—was believed to be a progressively debilitating, lifelong condition. Longitudinal studies from the U.S., Japan, Switzerland, and Germany challenge this idea, demonstrating that as many as two-thirds of people diagnosed with schizophrenia and other severe forms of mental illness improve or recover. Even 20 to 30 years after being diagnosed, studies show, people *can* improve. RECOVERY IS POSSIBLE
	LEARN MORE: Recovery is Possible for People with Mental Illness **One review of such studies concluded that, "In fact, these studies and other shorter ones have shown that the course of severe psychiatric disorder is a complex, dynamic, and heterogeneous process, which is non-linear in its patterns moving toward significant improvement over time and helped along by an active, developing person in interaction with his or her environment."** **Links to the full texts of these studies are in the attachment:** **Research on Recovery—Examples of Human Resilience.**
13.	**Myth: People with Mental Illness Cannot Recover (continued)** William Anthony, Ph.D., executive director of the Boston Center for Psychiatric Rehabilitation, describes it this way: "Recovery is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic events of mental illness."

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14.	**Myth: Hospitalization is the best option for a person experiencing a psychiatric crisis** Do we sometimes hospitalize unnecessarily? Is hospitalization the best option for a person experiencing a psychiatric crisis? The percentage of psychiatric patients admitted for inpatient treatment from the ED far outweighs that of medical patients. While roughly 12% of people who visit the ED for medical treatment are admitted to inpatient beds, the inpatient admission figure for people seen in the ED for psychiatric reasons is more than twice as high, and in some places exceeds 50% of people brought for psychiatric emergency services. What are some potential consequences of this? (Check all that apply.) ☐ This can create delays in disposition. ☐ This can result in overnight and multiple-day "boarding" of patients. ☐ Unnecessary hospitalization is expensive. ☐ Unnecessarily allocating emergency room beds for psychiatric patients is frustrating for both ED staff and psychiatric patients.
	Myth: Hospitalization is the best option for a person experiencing a psychiatric crisis (continued) All of these are potential consequences of unnecessarily hospitalizing a person who is in crisis. How do you prevent these consequences? Let's look at this as we explore the next myth.
15.	**Myth: Patients with mental illness cannot participate meaningfully in treatment decisions.** Quite the contrary: patients with mental illness are indeed aware of their illness. In fact, they are your best resource for determining what type of mental health care would work best for them. We will discuss this in more detail later in this training.

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16.	**Myth: People with Mental Illness Are "Clogging Up" Maine EDs** Take a guess at some health care averages and statistics: In 1999, the use of Maine EDs for overall health care was _____% higher than the national average. (27) In 2008, the use of Maine EDs for overall health care rose to _____ % higher than the national average. (43) True or False? The use of Maine EDs for mental health care has remained stable over the last ten years. (True) What % of the visits to the ED in Maine is for mental health care? (5) And for Mainers who are diagnosed with a mental illness, what % of their visits to the ED are for mental health care? (8)
	Myth: People with Mental Illness Are "Clogging Up" Maine EDs (continued) What conclusions can we draw from these statistics? • People diagnosed with mental illness are NOT clogging up the Maine EDs seeking mental health care. • In the state of Maine, less than one out of ten patients visits the ED seeking mental health care. Nationwide, people with serious mental illness have more chronic medical conditions than the general public. Given that, they may indeed use EDs for overall health care more than the rest of the population.

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17.	**SECTION III: ADOPTING A NEW LENS**
18.	**Adopting a New Lens** We dispel these myths by **adopting a new lens** that focuses on the following: • Providing Patient-Centered Care • Building a Relationship • Creating a Comforting Environment Let's look at each of these more closely.
19.	**Providing Patient-Centered Care** What is Patient-Centered Care? Anna Fitzgerald, M.D., provides psychiatric consultation to the Emergency Department at Boston Medical Center and teaches psychiatry at the Boston University School of Medicine. She advocates a shift toward a more holistic approach to emergency mental health care. In Dr. Fitzgerald's experience, patient-centered care does not necessarily take more time. It *does* require you to use your time—whether you are a physician, nurse, social worker, aide, or security person—in a different way.
20.	**Providing Patient-Centered Care (continued)** Which items in the list below reflect patient-centered care? (Click each item for feedback.) ☐ The primary focus of the assessment is to prevent bad outcomes and minimize liability While these are important considerations during the assessment, the primary focus should be to engage the patient in treatment. ✓ The primary focus of the encounter is to engage patient and family in treatment Yes, this reflects patient-centered care

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	✓ Crisis evaluation is not solely for triage but to begin or to continue treatment Yes, this reflects patient-centered care ☐ Psychiatric hospitalization is the gold standard of care Hospitalization can be regressive and traumatic. While hospitalization is sometimes indicated, a patient should be treated in the least restrictive environment possible. ✓ Hospitalization is more often the treatment of last resort Yes, this reflects patient-centered care Psychiatric crises inherently threaten a patient's capacity to make informed decisions. Patients should be involved in all aspects of decision making as much as possible. Most people in crisis can provide important information regarding what treatment has and has not been useful in the past. Also remember to ask if they have a crisis plan. ✓ Responsibility is shared by patients provided they are not grossly psychotic or cognitively impaired Yes, this reflects patient-centered care ☐ Risk-focused care is the best clinical care and the least risky A treatment plan focused solely on risk prevention could be regressive and runs the risk of psychological harm to the patient ✓ Good clinical care may involve taking risk, and it is the thoroughness and communication of awareness of risk that protects patients and caregivers alike Yes, this reflects patient-centered care Note to reader: These are all the in patient-centered care items: ✓ The primary focus of the encounter is to engage patient and family in treatment ✓ Crisis evaluation is not solely for triage but to begin or to continue treatment ✓ Hospitalization is more often the treatment of last resort ✓ Responsibility is shared by patients provided they are not grossly psychotic or cognitively impaired ✓ Good clinical care may involve taking risk, and it is the thoroughness and communication of awareness of risk that protects patients and caregivers alike

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21.	**Patient-Centered Communication** Patient-centered communication is an essential part of patient-centered care. The American Medical Association (AMA) has developed a Patient-Centered Communication Framework to help medical organizations with their communication policies and practices. **Quality interpersonal communication effectively elicits health needs, beliefs and expectations; builds trust; and conveys information that is understandable and empowering.**
22.	**Equal Communication Access** Your hospital's communication policies must include clear procedures and plans so that staff can communicate meaningfully with patients and/or family members with limited English skills or who are Deaf or hard-of-hearing. You must ensure that qualified foreign language or American Sign Language (ASL) interpreters will be provided at no cost to the patient. This is not only essential to patient-centered communication; it is also the law.
	LEARN MORE: EQUAL COMMUNICATION ACCESS Maine Department of Health and Human Services' Office of Multicultural Affairs website: http://www.maine.gov/dhhs/oma/MulticulturalResource/index.html For information and referrals to organizations in Maine for addressing the needs of ethnic and linguistic minorities. Includes numerous resources, including an up-to-date list of foreign language and American Sign Language (ASL) interpreters as well as information regarding MaineCare reimbursement for interpreters.
23.	**Building a Relationship** We'll explore next some of the steps you can take to help patients feel they are more in control—of themselves and their environment.

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	Building a Relationship: Step 1: Build rapport Building rapport with a patient naturally follows from patient-centered care. Do you know the number-one reason consumers reported going to or being brought to an ED? Select your choice from the list below and then click Submit. ✓ Feeling out of control ☐ Needing medication ☐ Needing a place to stay for the night ☐ Being picked up by a police officer as a result of acting inappropriately in public Note: The full text of the published survey is in the attachments, in the document, "What Do Consumers Say They Want and Need During a Psychiatric Emergency?"
	Building a Relationship: Step 1: Building rapport (continued) The number one reason is: Feeling out of control You can help minimize this feeling and continue to build rapport with a patient by: • Keeping Patients Informed • Setting the Right Tone • Remaining Aware of Your Own Frustrations Let's look at these next.

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	Building a Relationship: Step 2: Keep Patients Informed From the beginning of the visit: ✓ Provide regular updates to patients, even if there is nothing new to relate. Updates can help people to remain calm, especially when they are frightened or feeling out of control. ✓ Ask if there is anyone they want to have with them. ✓ Help patients call family members or friends. ✓ Ask if they have a crisis plan, WRAP (Wellness Recovery Action Plan) or a Mental Health Advance Directive. Use these to contact designated support persons. ✓ Encourage them to more fully participate in treatment ✓ Ask if they have a case manager, therapist, or doctor. If yes, contact them. ✓ Help them understand why a particular treatment plan is being recommended Keep in mind: Clinicians do not give up all decision-making—but an open and honest collaboration between ED staff and patients in all aspects of care can result in more effective treatment.
	Building a Relationship: Step 3: Set the Right Tone In addition to keeping patients informed, consider how you communicate with patients. Recall a time when you visited your own physician and felt good about the visit. What do you think contributed to that positive interaction?

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	Building a Relationship: Step 3: Set the Right Tone (continued) Thanks for your input. Communication has a big impact on how patients perceive the quality of the treatment they receive. ED patients report that being respected, reassured, and treated with dignity and compassion is the most effective approach. An ED patient in psychiatric crisis will respond more positively if you provide: • A calming presence • Active listening • Choices • Information on community resources
	Here is some positive feedback from Maine ED consumers: "They were attentive to my comfort, brought food and drink, blankets and pillows. I was not made to get undressed and put on a gown but allowed to remain in street clothes." "Staff checked on me to see how I was doing and if there was anything I needed." "The nurse who took my vital signs was very nice, talked to me, and asked me if I wanted something to eat." "They were kind to me and they tried to calm me down. I was scared and they tried to help me to relax." "I tried to kill myself. The staff gave me hope to keep on living."
	Building a Relationship: Step 4: Remain Aware of Your Own Frustrations A busy ED is not the ideal setting for resolving a psychiatric crisis. ED staff do the best they can, but lack of time, lack of resources, and lack of space can make a difficult situation worse. As Susan Stefan notes: "Sometimes the memories of past experience may create sensitivities for both the individual and staff, which in turn create their own momentum of escalation, force, and repetition of the original negative experience." Knowing in advance that you and the patients you are treating may have had frightening experiences in the ED can help to keep your frustrations in perspective.

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	Survivors of sexual and physical abuse, in the process of adapting to extreme circumstances, may develop coping methods that are helpful in the short run but harmful over time. They may avoid talking about the abuse, shut down emotionally to suppress the pain, or act in a hostile manner. These behaviors may cause you to feel sceptical, annoyed, or frustrated with the person in crisis.
	Building a Relationship: Step 4: Remain Aware of Your Own Frustrations (continued) That is a common and understandable response. Below are some questions to consider, that could help you dissipate the frustration you may be experiencing. • What **problems** could her behavior be trying to solve? • What might have happened to him, or what past **experiences** might he be re-enacting? • How could I respond differently in light of this new information or **perspective**?
24.	**Creating a Comforting Environment** Let's look at ways to do this: • Remember the Power Differential • Consider the Environment • Reconsider Policies that Could Be Traumatic
	Creating a Comforting Environment: Remember the Power Differential ED staffs have the power to determine whether or not people will be involuntarily hospitalized, and even when they can eat, drink, or go to the bathroom. Remember that this is always in the back of the minds of people with a mental illness, particularly those who have been involuntarily hospitalized in the past.

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	Creating a Comforting Environment: Consider the Environment Waiting in an ED can be difficult for *any* patient. For patients in a psychiatric crisis, waiting can be excruciating. Failure to attend to the ED environment can lead to an escalation of patients' symptoms. For example, Dr. Fitzgerald lists the following as risk factors for potential violence: • Long ED stays • Rigid rules and lack of choices • Disrespectful engagement styles • Re-stimulation of physical or sexual abuse trauma • Lack of recognition of psychosis or intoxication
	Creating a Comforting Environment: Consider the Environment (continued) On the other hand, mental health consumers who have been in EDs say that it helped them when ED staff provided: • A quiet room to wait, and someone to stay with them or check in on them • Access to food, water, bathrooms, and telephones • Blankets and pillows • Magazines, books, TV, soothing music, playing cards, and drawing or writing paper Can you think of other ways to create a comforting environment?
	Creating a Comforting Environment: Story of One Successful Outcome Let's take a moment to hear a true story from another mental health consumer: "One night there was no hospital room available, and I had to spend the night in the ED. ED staff slowly went over things with me, taking time to make sure that I understood what was occurring. They also called crisis and they responded to help me. The ED staff made sure that I was comfortable, gave me a pillow, asked if I was hungry, turned the lights down, and put me in a room away from disturbing noises.

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	They let me keep my clothes on. This was different from past experiences. They also arranged for hospital staff to go outside with me so I could smoke. They treated me like a normal person with human needs, not just a person with mental illness. I was pretty scared and negative when I went in there. They didn't treat me like a special case. They told me step by step what was happening and they kept me updated. They validated my feelings. I felt like they weren't judging me. That had a calming effect on me."
	Creating a Comforting Environment: Reconsider Policies that Could Be Traumatic The consumer in the success story you just heard said she was allowed to keep on her own clothes. Remember that the majority of people with a mental illness are survivors of abuse. Some ED practices, such as forced disrobement, restraints, and isolation can be perceived as a re-enactment of past abuse and make patient's participation in treatment very difficult.
	Creating a Comforting Environment: Reconsider Policies that Could Be Traumatic: Is disrobing necessary? Often people in psychiatric crises are made to disrobe due to "policy" or as a safety issue. Being completely undressed, in only a flimsy Johnny gown, can be traumatic. The patient often feels vulnerable—bad news for someone already in crisis. There *are* alternatives. Patients could be allowed to: • Remove only the clothing that prevents medical treatment • Wear their undergarments • Redress once their clothing has been checked for security
	Creating a Comforting Environment: Reconsider Policies that Could Be Traumatic: Are restraints necessary? Restraints should never be viewed as a means of treatment and should only be used when all other alternatives have been tried. A successful alternative to restraints used by some EDs is to ask someone to sit with the patient, such as the security guard, trusted family member or friend, or trained peer supporter.

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	In those very rare situations when no other less-restrictive intervention will keep the patient safe, restraints *may* become necessary. Being restrained is frightening and can also be a reminder of past traumatic experiences. Having someone sitting with the patient can help reduce fear and anxiety. Be sure that a support individual is someone the patient is willing to have stay with him.
	Creating a Comforting Environment: Reconsider Policies that Could Be Traumatic: Is Isolation Helpful? A number of EDs isolate patients, believing that quiet and solitude may calm someone in psychiatric crisis. This may be true for some people, but be sure to ask the patient first. Certain people experience isolation as being secluded and alone, which can cause anxiety. They may escalate their behavior to have human contact. This is especially true if they are in restraints.
	Assess Your ED's Readiness to Treat Patients Who Have Been Abused The Center for Public Representation's Emergency Department Project has a self-assessment quiz entitled, "Is Your ED Providing Trauma-Informed Care?" The quiz reflects federal requirements and American Psychiatric Association guidelines. The quiz is in the attachments.
25.	**Remember John?** As the ED nurse asked John some initial questions when he arrived in the ED, he seemed to be angry and frustrated. The nurse brought him to the quietest area of the ED, offered him food and asked if he wanted his brother to come sit with him. The ED ran some labs to screen for possible contributing medical conditions, and a tox screen for possible additional substances he may have been using. The labs identified no medical issues other than an elevated blood alcohol level. Over time in the ED John seemed less agitated. He became withdrawn and cried intermittently. Eventually he was willing and able to talk with the ED staff with help from his brother. He talked about recent stressors in his life, and expressed remorse over mistreatment of his wife and starting to drink again. He asked his brother to contact one of his friends from AA, to ask him to come to the ED to talk with him.

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	In what ways do you think ED staff demonstrated patient-centered care?
	Remember John? (continued) Thanks for your thoughts. ED staff demonstrated patient-care in a number of ways, including: • Finding the quietest place available. • Offering him food • Encouraging communication. • Offering choices such as having his brother and AA friend sit with him.
26.	**SECTION III: CONDUCTING ASSESSMENTS**
27.	**Conducting Assessments** We've covered a lot of ground so far as it relates to adopting a new lens for treating patients who are in crisis. Next, let's review some important points about assessments: • Seeing the Whole Person • Screening for a History of Abuse • Conducting Physical and Mental Health Assessments • Checking for Crisis Plans, Mental Health Advance Directives (MHADs) and/or Wellness Recovery Action Plans (WRAPs)

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28.	**Seeing the Whole Person** In the process of conducting an assessment, remember to see the patient as a whole person. ***I Am a Person*** "I am a person. A mother, a hard worker, a Red Sox fan, and a gardener. I am respected at my job. Just because I have a mental illness does not mean that I am incompetent, indecisive, or don't know what will help me. Please talk to me. Please ask me. I know my illness. Please respect me." *I Am* Not *My Mental Illness* I am a person first. I may have a mental illness and I may have diabetes, but I am more than these illnesses. I am talented, complex, and intelligent. I am also not feeling well right now. I am scared, lonely, and confused about what to do. I just don't feel right and I am not sure why. Is it my medication? Is it my diabetes?"
29.	**Screening for a History of Abuse** Violence of any form is a significant factor in later health problems and in psychiatric and emotional difficulties. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) requires an assessment for domestic violence, abuse, and neglect, asking specifically about childhood physical or sexual violence. EDs have become skilled in treating rape victims in a sensitive and respectful manner. ED staff can call on those same skills and abilities when conducting an assessment for childhood abuse or current violence. A note on terminology: Most literature on physical and sexual abuse refers to this as trauma. Because ED staff have a different understanding of the term *trauma*, this training mostly uses the word *abuse* instead. Documents in the attachments, however, refer to trauma-based standards or trauma-based care. Remember that these documents are referring to abuse.

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30.	**Conducting Mental Health Assessments** There are no consistent standards regarding mental health assessments in EDs. And not all EDs have access to experienced mental health professionals able to perform these advanced assessments. One reference that is commonly used for further information is the 2002 American Psychiatric Association Task Force on Psychiatric Emergency Services report (see attachments). As mentioned earlier, even when people are in a crisis they can often respond, interact, and explain what they want or need. During a formal or informal assessment, offering the patient choices lets them know that their input is respected and needed.
	Conducting Mental Health Assessments (continued) Below are some important questions to ask: ✓ Which treatment options have been helpful to you in the past? ✓ Which treatment options do you think will be most effective and safe? ✓ Which medications have helped you before—and which ones have not helped? Which ones do you think might help now? ✓ Have you experienced side effects, adverse or allergic reactions, or medical contraindications from your previous medications? ✓ Do you have a crisis plan or mental health advance directive (MHAD)? (What additional questions have you found to be helpful? Note: Research suggests that clinical impressions based on interviewing the patient alone, the method used by many EDs, tend to err on the side of admission. Checking admission decisions against actuarially based risk assessment instruments and other sources of information can lead to better decisions.

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	Conducting Mental Health Assessments (continued) Thank you for your input on this.
31.	**Checking for Crisis Plans, Mental Health Advance Directives (MHADs) and/or Wellness Recovery Action Plans (WRAPs)** Before continuing with mental health assessment, let's consider the usefulness of consumer-created advance-planning tools. Part of the recovery process for people with a mental illness is to take personal responsibility for their own care. Consumers may develop a written plan specifically for a crisis, or many include crisis planning in a more inclusive recovery plan, such as a WRAP (Wellness Recovery Action Plan). In a crisis plan, consumers indicate the medications and treatments that are helpful to them and which ones to avoid, who they want to help and specific tasks for these people, community-care options, and information for the physician, including lists of symptoms and their importance. During the assessment process, ask patients if they have an advanced planning tool. If they do, ask if it should be included in their ED record.
32.	**Checking for Crisis Plans, Mental Health Advance Directives (MHADs) and/or Wellness Recovery Action Plans (WRAPs) (continued)** Under Maine and federal law, hospital staff is required to ask a patient if he has a MHAD, and must inform him of his right to have one. If a patient is judged by an ED physician to be legally incompetent and the patient has a MHAD, staff should immediately contact the designated agent. The table below illustrates the basic differences between these 3 planning tools. Mental Health Advance Directives are legally enforceable, allow for a health care proxy and include a plan for crisis as well as an optional wellness plan. A Crisis Plan is not legally enforceable, does not permit a health care proxy, does include a plan for crisis as well as

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	an optional wellness plan. A Wellness Recovery Action Plan is not legally enforceable, does not permit a health care proxy, does include a plan for crisis and a wellness plan.

	Mental Health Advance Directive (MHAD)	Crisis Plan	Wellness Recovery Action Plan (WRAP)
Legally enforceable?	Yes	No	No
Option of designating health care proxy?	Yes	No	No
Include plan for crisis?	Yes	Yes	Yes
Include wellness plan?	Optional	Optional	Yes

For more information on MHADs and other planning tools, see the following attachments:

- Comparison of 3 Planning Tools
- Sample Mental Health Advance Directive
- Users Guide for Mental Health Advance Directives
- Sample Crisis Plan
- WRAP (Wellness Recovery Action Plan)
- Wellness and Recovery (for general self-help information)

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33.	**Conducting a Physical Health Assessment** When a person with a psychiatric history seeks treatment, there is a risk of focusing solely on his mental illness. **A physical health assessment should be performed on every patient presenting with a mental illness.** Not only can physical illnesses cause symptoms that mimic mental illness, but people with a mental illness often have undiagnosed and untreated physical illnesses. Nearly 70% of people with serious mental illness have at least one chronic medical condition, 50% have at least two, and 25% have three or more.
	LEARN MORE: Conducting a Physical Health Assessment The statistics regarding the poor health status of people who have mental illness are quite alarming. Compared to the general population, people with major mental illness on average live a life span that is 25 years shorter than those without mental illness. The premature mortality of people with serious illness is predominantly due to chronic conditions such as diabetes and cardiovascular and pulmonary diseases. A 2008 report of the National Association of State Mental Health Program Directors concluded that, "Our mental health system routinely screens for suicide risks and develops suicide response plans, but on the whole, it does relatively little to screen for or respond to more prevalent causes of early death." (The full text of the 2008 report, "Measurement of Health Status for People with Serious Mental Illness," is in the attachments.)
34.	**Get Other Perspectives: Community Mental Health Professionals, Family and Friends** Let's return to the assessment process. Whenever possible, try to contact the mental health professional(s) who are treating this person. And be sure to talk to the people who accompanied the patient to the ED. They can be useful sources of information about the patient and what may have precipitated the crisis. Remain aware, however, that family and friends could have their own agendas. And they could have very different perspectives on what may be helpful. Following are things friends or family members might say.

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	"Jane means well, but she just isn't herself. If you would just listen to me, *I* know what she needs." "My friend is afraid of hospitals, so you should talk to me instead. We don't want her to become even more upset." "Please put her in the hospital. I know it's what she needs. We are afraid for her. *Please*." "Please talk to Jane. She knows what helps and what will probably help her now." How might you respond to any one of these? Enter your thoughts below and then click Submit.
	Get Other Perspectives: Community Mental Health Professionals, Family and Friends Thanks for your input. Considering input and feedback from community mental health professionals and the patient is important, as is input from family and friends. Ultimately you will need to consider a variety of input and exercise your clinical judgement to provide the best patient-centered treatment. Let's look next at some treatment options.
35.	**SECTION IV: PROVIDING TREATMENT**
36.	**Section Overview** You've assessed your patient and determined that treatment is needed. Are you aware of ALL your options? Before we take a look at these, let's revisit John's case.
37.	**John's Case Revisited** ED staff asked John about recent events in his life. He and his wife have been married for 20 years, and were recently estranged due to the two incidents of verbal abuse and physical threatening. John was diagnosed with bipolar disorder while he was in his twenties. In the past ten years he has been hospitalized voluntarily four times;

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	with the last hospitalization occurring two years ago. He has a history of alcohol abuse but quit drinking two years ago around the time of his last hospitalization. He attends 12 step meetings regularly, and gets a lot of support from the AA community. John has suffered two significant losses recently. He lost his sales job six months ago, and his father died unexpectedly one month ago. He started drinking alcohol again recently and is not attending AA meetings. His brother reported that in the "old days" when John drank heavily he would get combative with family members, and he has been combative with police in the past when they were called by the family. The ED Staff contacted Crisis Services to assist with the assessment and consult on the best disposition for the patient. When crisis services arrived, the ED doc briefed them on what the ED staff knew thus far.
38.	**John's Case Revisited (continued)** Crisis staff asked the patient if he had a crisis plan or Advance Directive. He didn't know. Crisis learned from the brother that the patient has been getting outpatient therapy and community integration services from the local community mental health agency for the past several years. Crisis was able to access mental health records from the mental health agency after hours. There was no crisis plan or advance directive on file. Crisis Services also contacted the patient's wife to get additional history. Crisis services' assessment was that the patient was not a danger to himself or others at that time. Crisis staff discussed their assessment and discharge options with the ED doc. The ED and Crisis staff, the patient, his brother and his AA friend all agreed that the patient would stay with his AA friend (who doesn't drink and doesn't keep alcohol in the house) for the next week and go to outpatient therapy the next morning. John also agreed to attend 12 step meeting 2-3 times that week. All parties also agreed that if the patient threatens anyone again the police will be called. Prior to discharge the ED staff also inquired about the patient's access to firearms and requested that any access be restricted during this crisis period.

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39.	**John's Case Revisited (continued): Two Contradictory Treatment Practices** John's case provides an example of how two seemingly contradictory aspects of treatment planning can coexist: • Shared decision making • Risk management
40.	**Shared Decision-Making** Remember, shared decision-making enhances patients' sense of control, helps them to be responsible for their own recovery, decreases the chance that patients will leave the ED against medical advice, and engages patients in a collaborative treatment process. In Dr. Anna Fitzgerald's clinical experience, collaboration and honoring patients' wishes and preferences achieve the most favourable short-term and long-term outcomes.
41.	**Risk Management** According to Dr. Fitzgerald, clear and thorough communication to the patient of the possible risks and benefits of treatment options can improve outcomes and reduce liability. Except when severe psychosis and cognitive impairments make it impossible, patients can share the responsibility for care and avoidance of risk. In the case of a suicidal or at-risk patient, ED staff and the patient can discuss questions like: • Is there is a responsible friend or family member who will stay with him all night and make sure he'll see a therapist in the morning? • Can he be referred to crisis services? • Is there a crisis stabilization unit that will offer safety without hospitalization?

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	Considering alternatives and documenting discussions during the assessment process can lead to better treatment outcomes for patients and reduced liability for ED staff.
42.	**Treatment Options** When providing treatment, options to consider include: • Peer-Support Resources • Crisis Services • Hospitalization
43.	**Peer-Support Services** The Office of Adult Mental Health Services currently funds Peer Support Services in Emergency Departments at Maine Medical Center and Mid-Coast Hospital, with plans to expand peer services in community hospital EDs. The Peer Support Specialist's role in the ED is to support the individual experiencing a mental health crisis in their efforts to resolve the crisis situation; to assist the individual to view the crisis as an opportunity for growth and change; and to consider ways for the individual to manage future crises ideally within the community rather than in a hospital or other crisis setting. The Peer Support Specialist's role is not to perform crisis assessments or to serve as an advocate for a particular clinical disposition, though he or she may be called upon by ED or crisis staff to provide input on disposition options.
	LEARN MORE: Peer-Support Services More information about peer support is in the "Wellness and Recovery" attachment. Also in the attachments: "FAQ for ED Staff," which provides practical information on available resources, protocols, contacts, and requirements.

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44.	**Crisis Services** Crisis services are available across the state on a 24/7 basis. The toll- free number for crisis services is: 1-888-568-1112 Crisis services are provided to *all* persons in crisis requesting help. These services are mobile and are provided in a variety of settings, including an individual's home, mental health agency, social service agency, public locations, and EDs of hospitals. Crisis service providers can assist ED staff by: • Helping to assess the individual in crisis and determining the least restrictive, most effective treatment. • Accessing the individual's mental health records 24/7 if she is receiving community support services. • Coordinating with community mental health providers to ensure continuity of care. • Assisting the ED in locating a bed if the ED determines that hospitalization is required. A list of all crisis services by geographic area and with contact information is in the attachments. See also "FAQ for ED Staff" attachment.
	Crisis Services Toll Free Number Quick check: Do you remember the toll free number for crisis services? Click the correct number then click Submit. ✓ 888-568-1112 □ 888-568-1122 □ 888-568-1222
45.	**Crisis Services Toll Free Number (feedback)** The correct number is: 888-568-1112

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46.	**Hospitalization** Unnecessary hospitalization can slow the recovery process, hamper ability to work, and have a negative impact on a person's self-esteem. Hospitalization should be reserved as the treatment of last resort. However, if hospitalization is unavoidable, explaining that recovery is still possible may ease the transition. If ED staff spends a few minutes reflecting with patients on how they were able to contribute to their own treatment planning, it can help patients—and staff—to see a psychiatric crisis as part of recovery. The Office of Adult Mental Health Services has developed, "Protocol Guidelines for Psychiatric Hospitalization Process." Please see this document in the attachments.
47.	**Preparing for Discharge** If the following protocols have been followed, much of the work for discharge has already been accomplished: • Communication with patients has been clear, consistent, and respectful • Patients have participated in decision making • A range of community resources has been considered, incorporated into the treatment plan as much as possible, and contacted for referrals Consider making printed materials about community resources available to patients upon discharge. Numerous resources and references are available in the attachments.

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48.	**Transporting Patients Who Require Hospitalization** When hospitalization *is* determined to be the best option for an ED patient in crisis, and transfer between hospitals is needed, the medical needs and safety of the patient should be the guiding factors in choosing the most appropriate level of transportation**.** Key points to keep in mind: • Being transported in more restrictive methods (police car, ambulance) can re-stimulate past trauma • If the attending physician decides that a patient can be safely transported by a friend or family member, this is permissible under EMTALA and preferred **Attachment: AG Memo EMTALA Transportation Question**
49.	**SECTION V: ADDRESSING LAW ENFORCEMENT CASES**
50.	**2009 Legislation Regarding Law Enforcement and Individuals with Mental Illness** The 124th Maine Legislature passed LD 1166, "An Act to Implement the Recommendations of the Ad Hoc Task Force on the Use of Deadly Force by Law Enforcement Officers Against Individuals Suffering from Mental Illness." Two specific sections of the law impact discharge planning. They are: **1.** Notification to law enforcement of release after examination: When a person is taken by a law enforcement officer to the hospital for examination and is not admitted but released, the hospital must notify the law enforcement officer or agency of that release. **2.** Firearms and discharge planning: When an individual is involuntarily committed, discharge planning must include inquiries into access by the patient to firearms and notification to the patient, family, and other caregivers that possession of a firearm by a person to be discharged is prohibited. The full text of LD 1166 is included in the attachments.
51.	**John's Case Revisited if Law Enforcement Involved**

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	These two new requirements could create an interesting challenge to providing patient-centered mental health care. Let's return to John's scenario to consider how these two requirements could be addressed: Let's change the scenario to one where John was brought to the ED by local police. The police told the ED staff that the patient showed up at his wife's workplace (a car dealership) after drinking, was disruptive at the workplace and verbally abusive to his wife. His wife felt threatened, so her employer called the police. The wife explained to the police that her husband has bipolar disorder, and had been doing well until recently when he started drinking again. The police officers talked with the man, and convinced him to leave the workplace. While he denied having a mental illness, he did acknowledge that he was feeling very stressed lately, and had started drinking again. He said no one understood what he was going through, and he was just trying to get his wife to understand. His speech was rapid, and he was pacing and reciting excerpts from Alcoholics Anonymous literature. The police determined that the man did not pose a threat requiring arrest, but appeared to be in psychiatric distress and needed a psychiatric evaluation. They took him into protective custody and brought him to the ED.
52.	John's Case Revisited if Law Enforcement Involved (continued) Imagine that John's scenario in the ED unfolds exactly as described previously, with the exception of being brought to the ED by local police. Just as described previously, it was determined that John was not a danger to himself or others. The ED and Crisis staff, the patient, his brother and his AA friend all agreed on the discharge plan. All parties also agreed that if John threatens anyone again the police will be called. They also agreed that the discharge plan would include asking the police, if they are called again, to send a Crisis Intervention Team (CIT) trained officer and also to call Crisis Services. The ED staff explained to John that, since he was brought to the ED by the police, the ED has a legal requirement, if he is not being hospitalized; to contact the law enforcement agency that brought him to the ED and let them know that he is being discharged. The Crisis staff talked about the benefits of keeping the police informed about the patient's discharge plan. Since the police brought him to the ED due to concern about him harming himself or others, the discharge plan must address those concerns in a way that is acceptable to the police. If that isn't done, the police may feel that it is necessary to pick him up again and bring him back to the ED, for his own wellbeing and the wellbeing of others.

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	The ED staff got a release from John so that they could explain the discharge and treatment plan to the police to allay their concerns, and to keep them informed about the plan in case they are called again. The ED staff made the call to the police with John present. Prior to discharge the ED staff also inquired about the patient's access to firearms and requested that any access be restricted during this crisis period.
53.	John's Case Revisited if Law Enforcement Involved (continued) How did the new legislation affect this scenario?: **1.** The ED staff notified law enforcement of John's release **2.** If John had been involuntarily committed, possession of a firearm would be prohibited and discharge planning must include inquiries into access by the patient to firearms and notification to the patient, family, and other caregivers that possession of a firearm is prohibited. Although John was not involuntarily committed it is always good practice to confirm that a patient being discharged from the ED will not have access to firearms in the foreseeable future.
54.	**Patient-Centered Care and Law Enforcement** In John's scenario, what steps did the ED staff take to maintain a patient-centered approach while meeting the requirements of the new legislation? • Communication was open and transparent. • The discharge plan was developed collaboratively, and John understood the police would be called if he threatened anyone • ED staff pre-planned with law enforcement in the event that John interacts with law enforcement again • The discharge plan included requesting a CIT trained office if the police were called (more about CIT later)

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	• ED staff explained the requirements of the new law to John • ED staff explained law enforcement's concerns to John, and the benefits of keeping the police informed • ED staff asked John for a release so that they could explain the discharge and treatment plan to the police, rather than just telling the police John was being released • ED staff called police in John's presence What other steps might the ED staff have taken?
55.	**Crisis Intervention Team (CIT) Training** What is CIT? It is a specialized training for police officers on how to recognize and respond appropriately to individuals experiencing a psychiatric crisis. It reduces officer injuries, and the amount of time officers spend on the disposition of mental health disturbance calls. It also helps to keep people with mental illnesses out of jail, and into treatment. Originally developed in 1988 by the Memphis chapter of the National Alliance on Mental Illness in conjunction with the police and the state university, the training is now widely available. The Office of Adult Mental Health Services provides funding to NAMI Maine to offer CIT training across the state. For information about CIT in Maine, and a list of Maine communities with CIT Teams, go to the NAMI Maine web site at www.namimaine.org Also included in the attachments are two documents regarding CIT: "CIT Facts" and "Criminalization Facts".
56.	**SUMMARY**
57.	**Assessing Your ED** We have included two additional resources for EDs interested in taking additional steps to improve by making a thorough assessment of their policies, procedures, and staff training. The Massachusetts Department of Public Health has issued recommendations incorporating many of the practices in this training. This short document, "Practice Recommendations for the Emergency Department Care of Patients with Psychiatric Disorders and/or Behavioral Issues," is in the attachments. A more detailed set of standards has been developed by a Task Force assembled by the Massachusetts Center for Public Representation as part of its Emergency Department Project. The Task Force—comprised of a national group

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	of experts, including physicians, community service providers, and people with a mental illness—made findings and proposed recommendations specific to the issues addressed in this training. "Standards for Emergency Department Treatment of Individuals with Psychiatric Disabilities" is in the attachments.
58.	**Remembering Their Experiences** These are the words of a patient who spent many years at the Augusta Mental Health Institute and wrote this message on an AMHI wall: "If my heart could speak, I'm sure it would say, I wish I were someplace else today. Among these books a great amount of knowledge there must be, but what good is knowledge where others carry the keys. Through the last ten years many improvements have been made. But the final words seems to say, don't forget my good man, you're still a patient here today. Intelligence, ability, and knowledge surely will never last. Why all we want to look at my good man is your past. I wish that some of these people who write the books and make the rules could spend just a few years walking in our shoes."
59.	**Conclusion** Thank you for taking the time to participate in this training. When you are ready, please take a brief quiz on the topic. Once you have successfully completed the quiz, you will be able to print a certificate. You must also complete the evaluation of the course. You will then e-mail the class evaluation and your notification of successful completion of the class to the Education Department of Riverview Psychiatric Center for continuing-education credit. We invite and welcome your comments and suggestions regarding the topic of this training. Please contact Christine Robinson in the DHHS Office of Adult Mental Health Services at Christine.c.robinson@maine.gov
60.	**FINAL QUIZ**