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Models of Psychiatric Emergency Care

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Abstract As the numbers of patients seeking emergency department care for urgent psychiatric symptoms have dramatically increased across the USA, a variety of different treatment approaches have emerged to best serve this population. This article discusses the most prominent models of psychiatric crisis care and compares the pros and cons of each, with additional focus on the newest and most innovative approaches.

Keywords Psychiatric emergency · Crisis stabilization · Emergency medicine · Emergency department · Throughput · Boarding

The numbers of Emergency department (ED) patient visits continue to rise in the United States, and 60 % of ED physicians report that they believe this is due to an increase in psychiatric emergencies [1]. In 2007 alone, one in eight (approximately 12 million) of all ED contacts was due to either a psychiatric crisis (another term for a psychiatric emergency), substance use disorder, or both, with psychiatric crises comprising 64 % of that total [2].

According to the USA Federal Emergency Medical Treatment and Labor Act (EMTALA), patients with acute psychiatric conditions making them either a danger to themselves, or a danger to others, are considered to have Emergency medical conditions (EMCs), legally equivalent to serious physical ailments—and as such they cannot be discharged until they are stable and safe, with no further emergent dangerousness [3]. Thus, all psychiatric emergencies at hospital EDs must be fully assessed and treated as necessary, with appropriate and secure dispositions; the question is how best to meet these obligations within the limited resources and time constraints of the ED?

Goals of Psychiatric Emergency Treatment

The main objectives of the evaluation and treatment of mental health crises can be summed up in what are known as the "Six Goals of Emergency Psychiatry" [4•]:

(1) Exclude medical etiologies of symptoms and ensure medical stability.
(2) Rapidly stabilize the acute crisis.
(3) Avoid coercion.
(4) Treat in the least restrictive setting.
(5) Form a therapeutic alliance.
(6) Formulate an appropriate disposition and aftercare plan.

Simply put, the main goals are to ensure medical stability, relieve the patient's distress as quickly as possible in a non-coercive, supportive, collaborative manner, and get the patient to the least restrictive environment (e.g., outside of the hospital, preferably home if possible) with a safe and

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well-communicated discharge plan, which will help individuals avoid a return to crisis-level symptoms (and with instructions on what to do should they recur).

How the thousands of EDs and care systems nationwide attempt to meet these goals relies upon varied factors, such as census, availability of psychiatric resources and professionals, local laws, and, of course, financial considerations. Not surprisingly, health care systems across the country have adopted idiosyncratic designs to fit their particular situations best; however, upon scrutiny, most tend to be variations of several distinct models. This article will review these most prominent models of psychiatric emergency care, evaluating the plusses and minuses of each, and will include a discussion of several innovative and alternative methods currently in use around the nation.

Mental Health Consultants in Medical Emergency Department

The use of a mental health professional to consult on patients within the general ED population is likely the most prevalent emergency psychiatry care approach in the United States [5]. In this model, psychiatric patients entering the ED are triaged alongside patients with medical complaints; all receive a medical screening examination (MSE) by the attending provider. If a psychiatric intervention is deemed necessary, a request will be made for a mental health consultant to assess the patient. Most commonly, the consultant is not on duty within the ED, but arrives from a different location, typically either from another area of the hospital, on-call from the community, or, in some cases, via a municipal or regional mobile crisis team.

The preferred professional level for consultation is a psychiatrist, but often may be a psychologist, social worker, or other mental health clinician. Some facilities even employ psychiatric technicians or other practitioners with less than Master's level training to perform consultations, although this use of less clinically qualified personnel has been described as an "insufficient" level of care for those in psychiatric crisis [6].

The requested consultant will typically perform an assessment and may recommend a course of treatment, but most commonly his or her role is to make a determination as to the need for psychiatric hospitalization (as opposed to discharge). The attending ED physician will still be the clinician ultimately responsible for the patient's care in this model, however, and in most systems is also the one who will make the final decision as to disposition—in some cases even over-ruling the mental health consultant's recommendations.

This design can be useful in EDs that encounter relatively few psychiatric crises, especially in smaller community or rural hospitals, where the census is insufficient to justify round-the-clock onsite mental health personnel or a separate site for psychiatric patients. One benefit is that comorbid medical issues may also be addressed while the patient is in the ED, which allows patients to be seen there who might otherwise exceed the capability of a psychiatric-only program. This model is also typically the least expensive option for many hospitals.

However, because the consultant is often coming from another area of the hospital (or may be located off campus), patients may wait hours before the consultant arrives, which takes up space in the ED and impacts throughput, and during this time there is frequently no treatment being provided [7]. Furthermore, patients who are in the midst of a severe psychiatric emergency may further decompensate in the chaos of the ED, especially when untreated, and this may lead to an increase in the level of care required for them [8].

One of the most noteworthy shortcomings of this model is that disposition decisions are typically made at the time of the initial consultation. This will not allow, for example, the opportunity to see if the patient might soon show a good response to medications, or detoxify, or have a change in perspective, or otherwise improve enough for clinicians to consider changing the disposition plans. The ability to 'observe and re-evaluate later' is present in several of the other models, and those using this strategy for appropriate patients will often have better diversion rates from hospitalization as a result [8].

Another major issue in this model can be that if the consultant is not a psychiatrist or licensed prescriber, he or she will not be able to make medication or other physical care recommendations, and then the burden falls upon the ED physician to determine that course of treatment—often with little guidance or expertise to prescribe challenging psychopharmacologic regimens. As a result, too often a patient might receive little more than sedation as part of their ED stay. Also, non-psychiatrist consultants may also lack the expertise to rule out organically caused symptoms that mimic psychiatric emergencies, such as delirium [9]. An additional concern about using non-physicians for psychiatric consultations is that such consultants might be viewed as 'lesser authorities' by some emergency medicine physicians, who may thus feel justified in exerting undue influence on the consultant toward certain dispositions. This can even happen with the common practice of using psychiatry residents to do ED psychiatric consultations, because the physicians in training may be understandably anxious about countermanding an ED attending-level physician's opinion.

There are EDs where the mental health consultation is provided by a visiting "intake" team from an area inpatient psychiatric facility. The impartiality of decisions by such

teams may come into question, as there are perverse financial incentives for their employers regarding admissions, especially for those patients with attractive private insurance reimbursement potential.

One more compelling drawback of this model is that medical ED staff frequently may not be sufficiently trained to intervene with psychiatric emergencies and may actually exacerbate patients' symptoms by being excessively coercive, or by misunderstanding the needs of a person in crisis. Further, there have been instances where staff can be disdainful, condescending or even derisive to these patients, apparently from a mindset that the psychiatric afflictions are not "real" emergencies or perhaps should be the lowest priority for care. This phenomenon has been referred to as part of the "stigma" of psychiatric illness that patients have referred to in their complaints about treatment in medical EDs [10].

Telepsychiatry

The newest version of the consultant model is accessing a psychiatrist via telemedicine. Most commonly, this service is provided via an 'on-demand' format, so the ED only requests a consultation when necessary, and then will access a mental health professional consultant from a remote site via video teleconferencing [11]. Online consultants are able to do face-to-face assessments and make recommendations on treatment and disposition; efficacy, safety, and patient satisfaction have been shown to be roughly equivalent to interactions with a psychiatrist in the same room [12]. The use of telepsychiatry consultants has been rapidly expanding, being used both as a complementary service when onsite clinicians are unavailable, or as the sole source of ED psychiatric consultations; it has now been successfully utilized in EDs statewide in South Carolina for several years [13•]. Studies to date demonstrate that ED telepsychiatry can substantially reduce ED crowding and delays in care while improving access and timeliness for psychiatric interventions [14, 15]. Shortcomings of ED telepsychiatry consultation can be the significant dollar cost per consult, the need to purchase and maintain functioning, up-to-date video conferencing equipment, and the difficulties in credentialing large groups of providers in each individual hospital when the service is provided by a large outside telepsychiatry team.

Dedicated Mental Health Wing of Medical Emergency Department

In this model, the ED has a separate area or room specifically for patients experiencing psychiatric emergencies. Typically, this area is less chaotic than the main ED and there are staff who are knowledgeable in psychiatric care, especially psychiatric nurses, and possibly including social workers, therapists, and even onsite psychiatrists. As the patient is still considered to be within the ED proper, the patients will remain under the supervision of the emergency medicine attending physician, and involved professional staff in this wing may have simultaneous responsibilities in other areas of the ED or hospital.

These specialized sections for psychiatric emergencies tend to be more therapeutically appropriate for individuals in crisis, particularly when the staff is well trained to manage such patients; there may be dimmed lighting, soothing music, and artwork or color schemes conducive to calming. Patients commonly will have the opportunity for longer stays than in the consultant model, because they are not taking up beds allocated for traditional medical patients in the primary ED—and the longer stays may allow for time for healing, detoxification, and for medications to become effective, each of which might improve the chances for a patient to avoid inpatient hospitalization. Also, since this area is part of the ED, medical emergency personnel are nearby and any medical concerns can be dealt with quickly and efficiently. This arrangement thus also permits psychiatric treatment to commence on patients with serious medical co-morbidities, who might otherwise be considered medically unsuitable for stand-alone psychiatric programs.

However, while this separate area of the ED has its benefits, it certainly also has its potential drawbacks. For one, despite its focus and adaptation for psychiatric care, it is still in the midst of the bustling ED, with its cacophony of loud noises, hectic personnel activity, sirens, and enigmatic machinery, which can interfere with healing and increase anxiety. For the crisis patient, being separated from the main areas of the ED may lead to further marginalization or ostracization, along with lack of confidentiality, as other medical and nursing staff (and even other patients) might quickly identify the separated individuals as 'the psych patients.' Some EDs even dress their psychiatric patients in distinctive, different-colored gowns from the general population, with the idea being that this will assist the staff in recognizing 'where patients belong' and help prevent elopements; however, this has often resulted in serious stigma, as others in the ED quickly recognize 'that color means a psych patient'—and it may be completely unnecessary, because of more modern options such as video monitoring or electronic wristbands [16]. Finally, on occasion, due to a high census in the general ED population, these psychiatric wings of the ED might be turned into "float" areas where non-psychiatric emergency patients will be housed, which may interfere or lead to less-specialized care for the psychiatric patients.

Crisis Stabilization Units (CSU)

The concept of a 'crisis stabilization unit' (CSU) has garnered varied meanings in different parts of the USA; depending on location, it could be considered anything from a hospital-based outpatient department, to a community counseling 'drop-in' center, to a 30-day 'halfway house'-style residential program [17, 18]. For the purposes of this article and its focus on programs related to hospital EDs, we shall use the California Medicaid definition, which is an outpatient "…service lasting less than 24 h, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy." [19]. Sometimes, a CSU aligned with this description is referred to as a "23-h program."

Hospital-based crisis stabilization units differ from the "dedicated mental health wing of the ED" in that CSUs typically are distinct programs, separate from the ED, operating in an alternate location of the hospital (or even on a different campus). Whereas the ED wing will usually be staffed by ED team members, and the patients remain under the jurisdiction of the ED emergency medicine attending, a CSU is a completely separate operation, with its own personnel, who are responsible for all the assessment, treatment, and disposition of patients. However, a CSU typically will not have a physician on duty onsite at all times (though a psychiatrist will be available around the clock via telepsychiatry or on-call), and thus a CSU will be unable in most cases to accept direct admissions from the community or police; the most common model has patients initially screened at a medical ED and then referred or transferred to the CSU if deemed stable and appropriate.

Where the 'dedicated mental health wing' is often more of an observation unit, or even simply a 'boarding' section where psychiatric patients await transfer to an inpatient hospital bed or other disposition, the CSU is engaged in active treatment, with a goal of stabilizing individuals to the point that they no longer need an acute or hospital-based level of care. Along these lines, CSUs tend to break down into one of two paradigms. In one, the program will take all psychiatric emergency patients as soon as they have been medically stabilized and referred by the affiliated ED, and all further treatment and disposition decisions are then made as part of the interventions in the CSU. In the second and more commonly seen paradigm, CSU staff will screen referred patients while they are still in the ED to determine the next destination, which may be an inpatient psychiatric hospital bed, the CSU, or discharge. In the latter case, the CSU is seen more as an 'alternative to hospitalization' location, rather than as an active emergency service in which evaluations and interventions lead to disposition decisions.

CSU programs can be very effective in reducing their affiliated ED's overcrowding and shortening its throughput times, especially in those that follow the model of 'accepting all the ED's medically-clear psychiatric patients promptly.' However, a common complaint of many CSUs is that they can be 'overly selective' about the patients they will accept, and will decline seemingly stable individuals due to concerns over very minor medical issues, or any history of violence, or concurrent substance abuse, or perceived high acuity—thus leaving these patients still languishing in the ED, prolonging boarding and throughput problems. And because psychiatrists are usually only 'on-call' or round at specific hours, there may be substantial delays in commencement of pharmacologic treatment, which will reduce the possibility of successful stabilization in less than 24 h.

Psychiatric Emergency Services (PES)

As opposed to a CSU, which pre-screens its patients and medical clearance is done prior to referral, a psychiatric emergency services program (PES) is a distinct operation that is solely dedicated to managing and treating psychiatric emergencies, which can accept patients directly from the field, or via police, ambulance, or self-presentation [20]. A PES is "EMTALA-compliant," meaning that it is a receiving facility with a physician or other licensed independent professional on duty at all times, that is open for emergency care. In this regard, a PES can even be considered a mental health ED roughly analogous to a Level-One medical ED [21].

Like a CSU, under the most common definitions a PES is considered an emergency outpatient program that is permitted to treat patients up to a maximum of 23 h, 59 min; any patients needing care beyond 24 h should be admitted to an inpatient psychiatric hospital.

PES programs typically can provide psychiatric evaluations and treatment for both voluntary patients and those individuals under involuntary psychiatric legal detentions. The designs can span from fully locked, partially locked, or completely unlocked facilities, depending on each unit's policies and obligations. Psychiatric emergency services may vary greatly depending on scope of practice and exit resources, with some sites also offering such services as detox centers, crisis counseling, drop-in medication clinics, long-term or short-term housing referrals, site-based mobile crisis units, partial hospitalization, day treatment, and intensive outpatient case management [22]. With so many idiosyncrasies at each individual program, it is not

unusual to hear experts say that "When you've seen one PES, you've seen one PES."

Yet despite this, there can be many commonalities. PES programs usually consist of full-time staff dedicated to and trained for psychiatric emergencies, including psychiatrists, psychiatric nurses, therapists, social workers, and mental health technicians. Evaluation, medical screening, diagnosis, and treatment can all be initiated quickly onsite; the more prompt the interventions, the greater the possibility of stabilization within 24 h and avoidance of hospitalization [8].

One of the chief advantages of a PES, since it can accept individuals directly from the community, is that patients can bypass the entire process of going to another medical ED first. This subjects patients to less stress, stigma, confusion, and redundancy, while allowing for prompt initiation of psychiatric care with knowledgeable personnel and in the appropriate setting. This paradigm also can mean substantial cost savings to the overall system, by reducing expensive visits to multiple locations and avoiding costly and time-consuming interfacility transfers; and it significantly reduces medical ED crowding and improves throughput, in that most psychiatric patients in such systems will be at the appropriate site from the beginning rather than adding to medical ED censuses.

PES programs can be located near hospital ERs, elsewhere on hospital campuses, or even as stand-alone operations outside of hospital grounds. Many PES programs are directly affiliated with medical EDs or inpatient psychiatric hospitals, but neither of these is a requirement [6].

It is likely true that the great majority of emergency psychiatric patients can be stabilized, to the point of no longer requiring an acute or hospital level of care, in <1 day [23•]. With a focus on prompt interventions, and with a philosophy of attempting stabilization for up to 24 h prior to making a decision on hospitalization, it is not uncommon for PES programs to divert patients from hospital stays in 70 % of more of their cases [24•]. This not only can lead to better outcomes for patients, but can help preserve the limited numbers of available inpatient psychiatric beds for those individuals for whom there is truly no alternative.

The main drawback of PES programs is, given their 24/7 operational demands, that they can be much more expensive to operate than the other treatment modalities; the expenditures required will usually mean that a PES should only be considered in systems with a volume of psychiatric emergencies in excess of 3000 contacts per year [25]. Constructing a de novo PES facility can also be a costly undertaking, even if just remodeling an already existing physical plant—as there is a need for adequate space for patient care, along with enough room for staff, administration, registration, and billing personnel; even once constructed, there are still all the ongoing budgetary issues associated with operations of a distinct program [26]. Another issue is the difficulty in recruiting and maintaining adequate and proper staffing around the clock. This can be challenging for these facilities, as it is not uncommon for busy and demanding crisis programs to experience a high degree of employee turnover [26].

Furthermore, because PES programs are EMTALA-compliant, patients must receive a Medical Screening Examination and be stabilized to the point that they are no longer a danger to themselves or others before a discharge can occur, or they must be admitted to an inpatient hospital. As noted before, psychiatric emergencies involving dangerousness qualify as Emergency Medical Conditions under EMTALA. But it is important to note that although a PES must do a screening examination for medical concerns, it is not required to provide such services as advanced life support; EMTALA recognizes the existence of specialty emergency centers with limited capabilities and permits transports from such sites to higher-level-of-care EDs [3]. Thus, despite having 24-h physicians on duty, PES programs that are not co-located with a medical ED will typically not have the capability to stabilize serious medical conditions. A PES such as this will thus necessitate acute medical conditions be stabilized elsewhere prior to arrival and will need to rapidly transport out patients with medical emergencies arising onsite to a medical ED, even calling 911 in urgent situations.

Regional Dedicated PES Programs

Presently, most PES programs in the USA have a limited catchment area or are part of a specific medical center. However, there are a number of "Regional Dedicated Psychiatric Emergency Services" programs—which accept all emergency psychiatric patients from a defined widespread geographic area, directly from the field, and also have a collaborative relationship with a number of otherwise-unaffiliated EDs, as the higher-level-of-care ED transfer destination for all their psychiatric emergency patients [27].

This regional design allows for a shorter duration of 'boarding times' of psychiatric patients in medical EDs. One regional PES showed more than an 80 % improvement over comparable boarding time state averages—remarkably, for an overall 'cost per patient' less expensive than the average price tag of that same patient languishing those same hours in a medical ED, merely waiting for a disposition, when little or no psychiatric care is occurring [24•]. And the number of psychiatric emergencies evaluated in the area medical EDs is a much smaller percentage of the total that would be seen in systems without a regional PES [24•]. As such, it not only allows for patients to receive treatment in an appropriate setting much more quickly, but also reduces

ED crowding and overall expenditures that are incurred by areas with high censuses and lengthy boarding times.

Alternative Models of Care

In addition to the primary treatment modalities outlined above, there are several other alternative models that those in psychiatric crisis may access, which are typically off hospital grounds: psychiatric urgent care or voluntary crisis centers, mobile crisis teams, and acute diversion units.

Psychiatric Urgent Care/Voluntary Crisis Centers

These walk-in care centers can be beneficial for several reasons, especially from the patient point of view. They are usually voluntary only and focus on empathetic crisis counseling more than acute medical interventions, so patients may feel that they are in a more comfortable and supportive situation, and without the stigma they may experience at a larger ED. The personnel tend to be therapists and social workers rather than nurses and doctors, although many of these programs also have access to prescribers to help their clients obtain medications or medication refills. Some of the most successful of these programs employ "peers"—former psychiatric patients themselves, who can be invaluable in navigator or encouragement roles for people in crisis.

However, most crisis centers will exclude individuals who are presently dangerous, or have a history of dangerous behavior, or who are acutely hallucinating, medically compromised, intoxicated, or in substance withdrawal. Patients in those circumstances, which tend to be a substantial percentage of the overall crisis patients in a region, will still need to go to an ED or a PES for a higher level of care. This can limit the overall effectiveness of these programs in reducing ED utilization for psychiatric conditions.

Mobile Crisis Teams

Mobile crisis teams usually comprise mental health professionals who travel via car or van to the site of a patient in crisis, instead of having police or emergency providers bring the patient to a fixed site. Mobile teams are found in many communities around the United States and can provide a wide range of onsite crisis intervention, de-escalation, and conflict resolution services, as well as assistance with housing and access to more permanent care [28]. Some systems have police summon mobile teams as a consultation for possible involuntary psychiatric detentions, while others may ride along with specially trained police units known as Crisis Intervention Teams (CIT). Because mobile crisis teams are more focused on intervening in emerging situations in the field, they are not a replacement for ED or PES services, but they can often help resolve a patient's crisis without having to transport to a hospital, which can be invaluable assistance in the prevention of unnecessary ED presentations.

Acute Diversion Units (ADUs)/Crisis Residential

Crisis Residential programs (sometimes called Acute Diversion Units or ADUs) are community-based facilities which are often in actual houses, allowing the care to take place in a setting that is comfortable and home like. These can be ideal for patients who would normally be thought to require inpatient psychiatric care, but are eager to engage in treatment, willing to participate in groups and activities, and have not reached a level of acuity or dangerousness that would necessitate only hospitalization. Given the non-clinical setting, much of the stigma and difficulties some patients associate with hospitalization can be mitigated. Most commonly, these programs will take in 10–20 patients at a time for up to a maximum of 2 weeks [29]. Most ADUs require a pre-screening from an ED or PES, but some may also accept patients from mobile crisis units or other community providers.

Discussion

With the number of psychiatric emergencies on the rise, EDs often find themselves inundated with people in psychiatric crises. The needs of this population can often surpass most general medical ED personnel's expertise and capability and will thus require more specialized interventions. While psychiatric consultation, including that done via telemedicine, can work well in EDs with a low volume of psychiatric crises, areas with a higher census of psychiatric emergencies will need to develop urgent care alternatives such as Crisis Stabilization Units and Psychiatric Emergency Services facilities. Surprisingly enough, although these programs can be expensive when viewed in isolation, they can actually provide targeted, immediate, and appropriate care which will actually save systems substantial dollars in other ways, by reducing ED utilization, eliminating boarding, and improving throughput times, all while successfully diverting patients away from unnecessary and costly hospital inpatient admissions.

Compliance with Ethics Guidelines

Conflicts of interest Dr. Zeller and Dr. Rieger both have nothing to disclose.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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