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ACEP poll underscores safety and security concerns with psychiatric patients

More than 90% of respondents say psych patients cause harm in the ED

Few have questioned the impact that a deteriorating mental health system has had on hospital EDs. But even fewer have found legitimate solutions to the problem.

A new poll released in April by the American College of Emergency Physicians (ACEP) provides a snapshot of trends in emergency medicine, based on responses from more than 1,800 ACEP members. The survey addresses issues ranging from the volume of emergency patients since the beginning of the year to the impact that CMS' 2-midnight rule has had on hospital admissions. Some notable statistics include:

- 46% of respondents say they have seen an increase in the volume of emergency patients since January 1, 2014 (although 73% say they anticipated that increase).
- 86% of respondents anticipate an increase of emergency visits over the next three years, and 77% of respondents said their ED is not prepared to manage an increased volume.
- 51% of respondents believe that payment for emergency services will be reduced as a result of the Affordable Care Act (ACA). Additionally, 34% believe the ACA will improve access to emergency care, but 40% believe it will have a negative impact on quality and patient safety.

Although these statistics provide a glimpse into emergency medicine, a portion of the survey that addressed the increase of psychiatric patients in the ED may be of particular interest to hospital security directors who are tasked to provide security oversight for these patients, sometimes for days, in the ED. The survey found that:

- Since January 1, 52% of respondents say the amount of time the ED expends to transfer psychiatric patients has increased, but 43% say it has remained the same
- 84% of respondents report that their ED "boards" psychiatric patients
- 91% of respondents say that boarding psychiatric patients results in harm to other patients or emergency staff

"People having a mental health crisis seek care in emergency departments because other parts of the healthcare system have failed them," **Alex Rosenau, DO, FACEP,** president of ACEP, said in a press release. "Because of the critical shortage of mental health resources, some of these vulnerable patients wait for days in emergency departments. It is simply inhumane."

These responses are reflective of what many EDs are experiencing anecdotally across the country, says **Hans R. House, MD, FACEP,** associate professor of emergency medicine and associate chair for

education at the University of Iowa in Iowa City, residency program director at the University of Iowa Emergency Medicine Residency, and a member of the ACEP board of directors.

"This poll just confirms that everyone is having a problem with this," he says. "It's not just a problem in Iowa, where I work, or New York City, where there are a lot of patients needing care; it's a problem across the board."

It's also an issue that has reached a boiling point in healthcare, House adds. Years of state budget cuts have forced many mental health hospitals to close. When psychiatric patients come to the ED, there are few places to transfer them. As a result, psychiatric patients often spend days on a gurney in the ED waiting for a bed in a mental health facility

"I'm not talking about a couple hours, I'm talking about days," House says. "They are on a gurney in the ED with a curtain around them and nothing else for days. That's not a great place to hang out."

For security departments this problem has created a significant catch-22. The onslaught of psychiatric patients requires an increased security presence in the ER. At the same time, security departments are also facing pressure to reduce their budgets, which usually means reducing the number of security officers, says **John M. White, CPP, CHPA,** president and CEO of Protection Management, LLC, in Canton, Ohio. In some cases, White says he has seen one security officer assigned to monitor as many as 10 psychiatric patients in an ED.

"I don't know how hospitals can maintain these patients in the emergency room," he says. "I know they will, but it puts a lot of people at risk, including the patient, when you have a person who has some serious mental health issues in a place that isn't properly set up for that."

A lack of mental health resources

For many EDs, the problems surrounding psychiatric patients is quite simple: There are too many patients and not enough mental health beds to accommodate them. Adding to the problem, EDs are ill-equipped to evaluate psychiatric patients and, in some cases, mental health professionals need to come in from across state lines just to evaluate that patient.

"We have a challenge in getting mental health professionals to see our patient in the ED, especially in some of the rural hospitals and critical access hospitals," House says. "In some of the rural hospitals, there are teams that take care of the patient. You might have two nurses and a volunteer that cares for the patient until someone can drive in from across the state to see your patient there."

But EDs are not set up for this type of care, White says. EDs are designed to be a temporary transition where the emergency medical staff can take care of any imperative medical conditions. Boarding a mental health patient for days, amid the stress and stimulation of an ED, can be particularly problematic.

"When you place someone that has a mental health crisis going on in that type of environment, it can overstimulate them, which can lead to violence," White says. "So the hospital can't properly board these people because they aren't designed to do that."

One promising development, particularly for small, rural facilities, has been the use of telemedicine for psychiatric patients. Hospitals can contract with larger university hospitals that have more psychiatrists on

staff and use video monitoring to interview the patient and make decisions about the patient's care plan moving forward.

"Sometimes with just that intervention you can determine that the patient isn't at risk and doesn't need to be admitted; they can go to an outpatient clinic instead," House says.

Temporary solutions

Although this issue has been well documented and discussed among healthcare security and emergency medicine experts, to date there haven't been many solutions.

"I know people are talking about it and it has everyone's attention to some degree, but I haven't seen anyone start the process of trying to fix this and mitigate this violence and this influx of patients that some people predicted would happen," White says. "Not everyone was on board, but I think now everyone is starting to understand it."

White adds that this issue has become so pervasive in healthcare that it can't be fixed by one hospital or healthcare organization. Instead it will take comprehensive change from healthcare organizations, government officials, and lawmakers to ensure there is a better system for mental health patients.

But the problem isn't going away, and until there is some kind of reform, hospital EDs will remain the primary dumping grounds for psychiatric patients. For that reason, many hospitals have begun redesigning their ED to allow space for a temporary psychiatric unit within the ED that can be utilized when there is an influx of psychiatric patients. House says the University of Iowa Medical Center has expanded the

Improving psychiatric healthcare through legislation

Politicians are well aware of the problems that hospitals face in caring for psychiatric patients. But so far that awareness hasn't translated to actionable reform.

Hans R. House, MD, FACEP, associate professor of emergency medicine and associate chair for education at the University of Iowa in Iowa City, residency program director at the University of Iowa Emergency Medicine Residency, and a member of the American College of Emergency Physicians (ACEP) board of directors, says that he and other members of the ACEP have talked with lawmakers about the need to find a solution to this problem, part of which includes restructuring Medicare and Medicaid regulations to make it more financially viable to care for mental health patients.

There are a few bills that attempt to address mental health resources, but the ACEP has thrown its support behind one bill in particular: H.R.3717—Helping Families in Mental Health Crisis Act of 2013. The bill was introduced to the House of Representatives in December 2013, and includes:

- Training grants to promote the use of telepsychiatry to identify, diagnose, mitigate, and treat mental health disorders
- Requiring the Assistant Secretary to certify federally qualified community behavioral health clinics that meet specified criteria
- Providing public safety and community policing grants for specialized training for law enforcement officers
- Amending Medicaid requirements to "prohibit a state medical assistance plan from prohibiting payment for a same-day qualifying mental health service or primary care service furnished to an individual at a federally qualified community behavioral health center or a federally qualified health center on the same day as the other kind of service"

The bill would serve as a building block to help hospitals invest in more mental health resources and additional security to protect both staff and patients.

"There are some details being negotiated, but the basic idea is the same, which is changing Medicaid rules and different aspects within the payment structure that would make caring for mental illness more financially viable for hospitals and encouraging them to do more for patients," House says.

ED to include a "fast-track" area to quickly evaluate ED patients. But if they are inundated with psychiatric patients, that area can be sealed off and turned into a psychiatric overflow area, staffed with security personnel.

But House acknowledges that this isn't as simple for small rural facilities or critical access hospitals that may be facing the same overflow.

"We've got the resources and the people to do that, but small hospitals don't always have that same ability," he says.

In its 2012 Security Design Guidelines for Healthcare Facilities, the International Association for Healthcare Security and Safety provides guidelines for "Behavioral/Mental Health Areas" that helps provide a template for hospitals that are planning to redesign their ED to accommodate more psychiatric patients.

Straining security

The influx of psychiatric patients has put a significant strain on hospital security departments during a time when administrators are often looking to trim security budgets. Security directors and ED medical staff both want more of a security presence, which is at odds with budget cuts that have led to downsizing security departments.

"They are getting pulled from one side saying, 'We need more security,' and then pulled from the other side saying, 'You need to trim your costs,' " White says.

Adding to that problem is the fact that security officers are devoting more time and energy to the ER, which can lead to security gaps throughout the rest of the facility.

"The average hospital might have two to three security officers at a given time on their entire property, but during peak times—usually late afternoon throughout the evening and into the night—all of those officers may be in the emergency department and not doing any other type of patrols or preventive security measures on the campus," White says.

House adds that most mental health patients are not outwardly violent, but even if they are deemed a suicide risk, that requires someone to watch over them. In many cases, that is a security officer. Furthermore, security officers are still required to respond to patients that aren't physically violent, but loud and disruptive. "Sometimes there just aren't enough people to go around," House says.

Fast facts on mental health in the ED

- According to the Treatment Advocacy Center (TAC), state psychiatric beds decreased 14% from 2005 to 2010. In 2010, there were 14.1 psychiatric beds per 100,000 people, virtually identical to the ratio that was reported in 1850.
- The TAC also reports that from 2005–2010, 13 states closed 25% of their total state hospital beds, and some states, like New Mexico and Minnesota, closed more than 50% of their beds.
- A July 2010 report released by the Agency for Healthcare Research and Quality (AHRQ) found that in 2007, 12 million ED visits involved a diagnosis related to mental health and/or substance abuse, accounting for one out of every eight ED visits.
- A *Morbidity and Mortality Weekly Report* released by the CDC in June 2013 reviewed ED visits by patients with mental health disorders in North Carolina from 2008 to 2010. Ten percent of ED visits in the state had had one or more mental health disorder diagnosis code. The rate of patients with a mental health disorder diagnosis code increased seven times more than the overall rate of ED visits during that time period.
- According to a July 2013 report by *Bloomberg,* a psychiatric patient at AnMed Health Medical Center in Anderson, South Carolina, spent 38 days in the ED, accumulating $56,392 in extra nursing, security, and physician care.