

ASHRM/AHA Behavioral Health White Paper Series Behavioral Health Care in the Emergency Department Setting

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TABLE OF CONTENTS

INTRODUCTION	4
LOGISTICS, FACILITIES, ENVIRONMENTAL SAFETY AND SUPPORT	4
STARTING TREATMENT EARLY	5
EMTALA AND PSYCHIATRY	5
STAFF COMPETENCY	5
MANAGING AND PROVIDING TREATMENT WHEN RESOURCES MAY NOT BE AVAILABLE	6
WAITING FOR A PLACEMENT OR DISPOSITION	6
ELOPEMENT.....	7
LEAVE WITHOUT BEING SEEN OR AGAINST MEDICAL ADVICE	8
DISCHARGE PLANNING AND KNOWING COMMUNITY RESOURCES	8
USE OF TECHNOLOGY IN THE ED FOR BEHAVIORAL HEALTH.....	9
WORKPLACE VIOLENCE	9
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND PATIENT PRIVACY IN THE ED	9
RELEASE OF INFORMATION AND CONSENTS	10
DOCUMENTATION.....	10
SUICIDE AND HOMICIDE RISK ASSESSMENT	10
SECLUSION AND RESTRAINT	11
SAFETY CONTRACTS/SAFETY PLANS	11
PATIENTS WHO PRESENT TO THE ED WITH SUBSTANCE USE DISORDERS	12
CO-OCCURRING DISORDERS AND DETOXIFICATION PROTOCOLS	13
SAFETY AND SECURITY	13
UTILIZING METRICS FOR ROOT CAUSE ANALYSIS (RCAS)	14
TREATMENT OF SPECIFIC PATIENT POPULATIONS	14
DUTY TO WARN/PROTECT IN THE ED SETTING	18
MEDIA.....	19
CONCLUSION	19
APPENDIX A: RESOURCE LIST FOR BEHAVIORAL HEALTHCARE IN THE EMERGENCY DEPARTMENT SETTING	20
REFERENCES	23
ADDITIONAL REFERENCES.....	30

INTRODUCTION

Patients with behavioral health disorders are being treated in every segment of health care, including the emergency department (ED). Behavioral health disorders include both mental illness and substance use disorders. Mental illnesses are specific, diagnosable disorders characterized by intense alterations in thinking, mood and/or behavior over time. Substance use disorders are conditions resulting from the inappropriate use of alcohol or drugs, including medications. Persons with behavioral health care needs may experience either or both types of conditions as well as physical co-morbidities.

It is important to note, behavioral health issues may present in the ED as behavioral health disorders, but may have underlying medical causations. For example, urinary tract infections may result in a patient being combative and psychotic until treatment is established. In the second of this three-part white paper series, we explore the issues that may be encountered when treating patients with behavioral health disorders in the ED.

Depending on the setting, EDs may not be equipped with sufficient facilities, staff, transfer options or specific resources available for behavioral health patients. Approximately one in eight visits to EDs in the United States (U.S.) involves mental and substance use disorders.¹ Approximately 10% of all patients seen in the ED present with a psychiatric illness; however, many do not have a diagnosed psychiatric illness. Two studies found that 45% of adults and 40% of pediatric patients seen in the ED with non-psychiatric complaints have an undiagnosed mental disorder.² These issues can create challenges in effectively treating patients with behavioral health disorders.

The reality is that patients with behavioral health disorders will continue to be seen in the ED, and there may not be adequate services to care for them either internally within a health system, or externally. As the need continues, hospitals may have to implement creative strategies to provide care and use newer models of delivery such as telebehavioral health or distance treatment. These strategies and changes are only expected to grow and evolve as there are insufficient providers and services available.

As mentioned in the first publication in this series [ASHRM Behavioral Health Care in the Ambulatory Care/Outpatient Setting](#), each health care organization is unique. Therefore, variations may exist in how services are offered, creating differences in potential liability exposures. Hospitals and health systems should seek risk management or legal advice specific to their organization and state.

LOGISTICS, FACILITIES, ENVIRONMENTAL SAFETY AND SUPPORT

Patients with a psychiatric diagnosis, substance use disorder, behavioral disorder, or a co-occurring or dual diagnosis require specialized care to address their complex psychological, medical and social needs. Ideally, patients should be assessed and managed in a safe, quiet and calm setting, uncharacteristic of many emergency care settings.³

For more than two decades, EDs have seen increasing numbers of patients with psychiatric and behavioral health needs. Even though psychiatric and behavioral health patients account for a relatively small portion of an ED's total census, these high-risk patients pose a unique set of challenges for these clinical settings.⁴ Many emergency providers have limited clinical skills to manage the complexities of these patients, which can include the need for emergent interventions of diagnosis, sedation, restraint and care for comorbid medical conditions.⁵ The primary goal of the ED is to keep patients safe until they can be stabilized, discharged or transferred to an inpatient behavioral health unit.⁶

Keeping patients safe significantly depends on their physical environment of care. Although EDs do not have to meet the same standards as inpatient psychiatric facilities, they do need to provide a safe environment and comply with the standard of care. Environmental safeguards in the ED may include dedicated behavioral health rooms or an entire ED behavioral health section where there is excellent visibility, decreased opportunity for elopement, ligature-free environment, low stimulation, tamper proof screws, vents, bedding, etc.⁷ The Centers for Medicare & Medicaid Services (CMS) expanded their ligature risk policy in 2017. The Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) revised its suicide risk standards in 2018. EDs need to pay attention to these enhanced standards.⁸ Screening and assessing patients for suicide risk, performing environment of care rounds and conducting risk assessments that focus on behavioral health standards within the ED can help keep patients safe and educate staff on the importance of environment in caring for patients with behavioral health needs.

STARTING TREATMENT EARLY

Early treatment response is an important consideration when a patient with behavioral health needs presents to the ED. The American Hospital Association (AHA) highlights a proactive strategy when treating patients with behavioral health disorders.⁹ Research shows that if appropriate treatment is started promptly, the majority of behavioral emergencies can be resolved within 24 hours without inpatient hospitalization.¹⁰

Abuse of alcohol and other substances complicates many other medical conditions, and early identification and management is important to improve health outcomes.¹¹ Patients who may be at increased risk of harming themselves or others require early, effective, thorough and potentially continuous monitoring. ED providers should be able to recognize and address early warning signs, as well as changes in condition or behavior that may signal impending issues for patients.¹² When indicated, it is important to involve the psychiatry, social service, risk management, and case management departments to best treat and manage patients.

EMTALA AND PSYCHIATRY

The Emergency Medical Treatment and Labor Act (EMTALA) requires that all patients who present to an ED be given appropriate screening examinations. If an emergency condition is diagnosed, the patient must be stabilized before being transferred or discharged. In the case of a patient with a behavioral health disorder, an emergency is defined as a patient who is a danger to himself or others.¹³

It is within the scope of practice for ED providers to evaluate patients with behavioral health conditions, the same as they would for any other medical or surgical condition. The ED provider may utilize hospital resources to assist with patient examination and treatment or arrange appropriate transfers if additional resources are needed.¹⁴ The goal is to protect and to prevent patients with behavioral health disorders from self-harm or harm to others. CMS provides criteria for ED stabilization which indicate: "Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him, herself or others."¹⁵

STAFF COMPETENCY

If an ED operates without clear policy or guidelines for treatment of patients with behavioral health issues secondary to underlying medical conditions or disorders, it becomes difficult to expeditiously stabilize patients. Consistent staff training in triage, comprehensive behavioral health

assessment, diagnosis, verbal de-escalation techniques, psychopharmacology, and avoidance of coercion, seclusion and restraints is as important as training for any other processes addressed in an ED medical crisis.¹⁶ The most important aspects of staff training for managing patients with behavioral health issues in the ED include: anxiety management, risk assessment for suicidal ideation, substance abuse, agitation management, medical complexity identification, crisis intervention for self-harm or violence and psychoeducation.¹⁷

Health care and para-professionals working in the ED with patients that have behavioral health issues should recognize and appreciate when social problems contribute to a patient seeking care in the ED and when they contribute to the decline of the clinical picture.¹⁸ Ideally, a multidisciplinary team in the ED will provide wraparound services to a patient with behavioral health issues.

MANAGING AND PROVIDING TREATMENT WHEN RESOURCES MAY NOT BE AVAILABLE

Patients with behavioral health issues often present to the ED for crisis care. While EDs are adept at stabilizing and managing medical illness, there has not been great advancement in behavioral health stabilization of this population.¹⁹ Health policy experts have concluded that a minimum of 50 psychiatric beds per 100,000 persons should be available; however, 15 states have only 10 psychiatric beds per 100,000 persons.²⁰ Rationale for not meeting the 50-bed minimum include: a reduction in total state spending on public mental health services, reduction in reimbursement for psychiatric admissions and closure of state and private psychiatric hospitals.²¹ ED providers tend to be more conservative and admit patients for liability risk mitigation rather than for clinical reasons.²² This approach to patient management leads to strain on staff and resources.²³

WAITING FOR A PLACEMENT OR DISPOSITION

Problems can arise when behavioral health patients are unable to be transferred in a timely manner from the ED. This can occur because inpatient beds are not available or insufficient outpatient resources exist to safely discharge patients. This can be experienced with patients who have medical needs as well as patients who have behavioral health issues. Other compounding factors also include, “insufficient funding for lower levels of care from basic community clinics to intensive outpatient programs, community crisis stabilization units, and respite services.”²⁴

The number of inpatient psychiatric beds dropped by 95% from 340 beds/100,000 people in 1955 to 17 beds/100,000 people in 2005.²⁵ As a result, patients with behavioral health disorders may often wait hours or days in the ED without treatment. The average ED duration of stay for patients with behavioral health disorders ranges from seven to 34 hours in the U.S., three times longer than patients with physical illnesses and injuries.²⁶ This contributes to ED overcrowding and wait times for patients with behavioral health disorders, as well as those with other medical issues.

“Boarding” has become a new ED norm. Boarding can be described as the time patients spend waiting in a hospital ED for an inpatient hospital bed or for patients with primary psychiatric conditions to be transferred to another inpatient facility.²⁷ Patients with behavioral health disorders may end up boarding until they can be assessed, a bed is available for transfer or a discharge plan is in place. These patients are four times more likely to be boarded and on average must wait more than two times as long to receive treatment as patients with non-behavioral health needs.²⁸ According to a 2015 Emergency Medicine Practice Research Network poll, 70% of emergency physicians surveyed reported that behavioral patients were boarded on their last shift.²⁹

Boarding can be taxing on ED providers, the patient, and the patient's family. Inadequate staff or staffing issues can exist when ongoing care is provided to the patient in the ED and may limit staff's ability to provide care to other patients. Patients likely are not receiving necessary behavioral health treatment, which can cause agitation, frustration, and worsening of their symptoms.

In the alternative, the patient may stabilize and when re-evaluated, may no longer require additional care. Thus, a transfer to a higher level of care never occurred, the patient stabilized, and was able to be discharged. Finally, with respect to the family, they may have dealt with the patient's behavioral needs for many years and may be stressed or unable to continue to assist with the patient's ongoing needs.

Patients without insurance board significantly longer than Medicare, Medicaid and privately insured patients. In 2012, the average cost for an ED to board a patient with behavioral health issues was estimated at \$2,264 per stay.³⁰ Ironically, patients with private insurance board longer than Medicare or Medicaid patients because privately insured patients require authorization for admission, whereas Medicare and Medicaid patients do not.³¹ In the U.S., serious mental illness (SMI) accounts for \$193.2 billion in lost earnings each year.³²

Some pilot programs currently offer expedited behavioral care upon admission to the ED. Establishing a behavioral health emergency service can "provide assessment and treatment that may stabilize over 75% of the crisis mental health population at this level of care, thus dramatically alleviating the demand for inpatient psychiatric beds".³³ These collaborative programs include stakeholders from hospital organizational leadership and the community ie: crisis centers, mobile crisis services, outpatient mental health clinics, law enforcement, emergency medical services (EMS), group homes, crisis stabilization units, consumer advocates, peer specialists, judges, and local governments. All of these stakeholders have a vested interest in helping the chronically, psychiatrically ill to divert to lower community levels of care and or follow up thereby decreasing boarding time. Thereby, leaving the EDs for emergent care as intended.³⁴

ELOPEMENT

An issue that any ED must be aware of is elopement. This is of particular importance if the patient has behavioral health issues where s/he is a danger to self or others. An elopement occurs when a patient is aware that s/he is not permitted to leave; however, still proceeds to do so.³⁵ An elopement is an unsuccessful attempt to leave whereas an escape is a successful departure. Both are high-risk events with potential for the patient to injure himself/herself or others. Patients who elope or escape often have a plan. It is important that ED staff recognize the potential for patient elopement or escape and put in place proper safeguards to decrease the likelihood of occurrence. The following steps should be taken to minimize the risk of elopement or escape:

- Create standard policies/procedures across the system.
- Implement training for staff and consider mock safety drills.
- Assess elopement/escape risk when a patient presents to the ED.
- Closely monitor at-risk patients.
- Communicate risk to all providers.
- Re-assess risk and communicate risk status at handoffs and shift changes.
- Understand state regulations regarding patients who elope or escape.

If a patient does elope or escape, it may be necessary to breach confidentiality. In these circumstances, immediately involve the relevant departments to inform of the incident. Risk management, legal, security and, media relations staff likely will need to be involved in this communication. If the patient is being held involuntarily, security and local law enforcement should be informed immediately. In addition, health care organizations should provide police with patient photos and identifying information and thoroughly document actions taken to locate the patient.

LEAVE WITHOUT BEING SEEN OR AGAINST MEDICAL ADVICE

Restraints, chemical and/or manual, may be necessary at times to ensure safety. It is important health care professionals be aware of regulations governing when a patient can be forcibly held and seek consultation to determine applicable legal and regulatory considerations when faced with this issue.

Some patients also leave the ED without being seen or against medical advice (AMA). Patients who leave AMA represent 0.1% to 2.7% of all ED patients.³⁶ Patients with behavioral health disorders who leave the ED without being seen or AMA and may be a danger to themselves or others present particular challenges. For example, if a patient leaves without being seen or AMA and an adverse event occurs, there may be liability risk for the hospital and provider. Keeping the patient, other patients and staff safe is critical, especially when a patient presents an imminent risk of danger to self or others. Proper steps and processes should be followed.

Documentation is critical when a patient cannot be held. Hospitals should have proper protocols in place that include having the patient sign a designated form and also should ensure that providers document fully and completely. In the event a patient refuses to sign, the provider should document this thoroughly and objectively in the medical record. If a patient leaves the ED and safety is a concern, staff should determine whether authorities can be contacted and a well-person check can be requested of local law enforcement.

DISCHARGE PLANNING AND KNOWING COMMUNITY RESOURCES

A variety of issues can occur when a patient is discharged from the ED, and providers must ensure that a safe discharge plan is in place. Staff may encounter an elderly person who will be at-risk after discharge, a combative patient transferred from a nursing home that will not allow the resident to return after being seen in the ED, or lack of alternative placement options for a child who may not be safely discharged to a parent. These issues can be taxing on staff and also can impact revenue when the organization is not reimbursed if a payer determines that hospital-level of care was not necessary.

Community resources may not be available to help patients upon discharge or staff may not be aware of them. When the ED provider is faced with a challenging discharge plan, it is important to involve individuals from case management, risk management or social services. Involve providers to assist with discharge planning and who may be aware of additional resources. It is also important to be aware of applicable laws, including a safe discharge law, which could preclude the patient's discharge when the patient does not have a safe plan of care. Further, there may be applicable laws regarding follow-up after the patient is discharged.

USE OF TECHNOLOGY IN THE ED FOR BEHAVIORAL HEALTH

If a psychiatrist or other behavioral health provider is not available onsite at all times, telebehavioral health services may be used for screening and assessing patients in a timely manner and providing services that may not otherwise be available.

Utilizing telebehavioral health in the ED can have a number of positive outcomes, including: reduced wait times, reduced patient elopement, decreased staff burden, and reduced potential for staff injury. Expense reductions also can result from decreased use of patient boarding and sitters (safety assistants), and decreased patient length-of-stay. The potential for decreased or lack of reimbursement for patient care, potential for follow-up, and delayed discharge due to a variety of issues including lack of screening.

Implementing a telebehavioral health program in the ED takes time and resources and involves specific risk management and legal considerations. These include: privacy and security, provider licensure, patient safety, and informed consent. Rules and regulations that pertain to using telebehavioral health vary by state. Prior to engaging in telebehavioral health, it is encouraged to be aware of rules and regulations as well as guidelines. (See Appendix A - Additional Resources).

WORKPLACE VIOLENCE

Aggressive patient behavior has become more prevalent in health care. Violence against nurses is most common in clinical settings, occurring primarily in EDs, inpatient psychiatric settings and nursing homes – usually in dementia units. This occupational health issue is very concerning to nurses and other health care providers.³⁷ Verbal and physical assaults are the main forms of violence encountered by nurses and can have significant psychological and physical side effects, such as post-traumatic stress.³⁸ Organizations are looking at innovative ways to address this under-reported risk for employees by encouraging discussion and training staff to: understand behavior and de-escalation techniques, use of panic buttons within badges, recognize and redirect escalating behaviors, conduct purposeful rounding, and intervene with patients or visitors before behavior escalates and/or violence occurs, ie Crisis Prevention Institute (CPI) training. Through administrative support, creation of behavioral response teams, use of psychiatric liaison nurses, and meaningful disruptive patient and visitor policies, employees feel safer and more able to manage the therapeutic environment while keeping all patients and staff safe.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND PATIENT PRIVACY IN THE ED

Patient privacy can be an ongoing issue in the ED whether it is a family member calling to inquire or lack of patient authorization for the ED staff to communicate with outside providers, etc. It is important that all ED staff, particularly those charged with answering phones, receive training on HIPAA and state privacy rules.³⁹ In addition, they should be educated on what can and cannot be communicated and to whom. There are specific regulations pertaining to behavioral health and substance use treatment. The U.S. Department of Health and Human Services (HHS) offers a number of useful online resources including decision charts.⁴⁰ Hospitals should employ training and education for staff relative to state and federal privacy rules. Health care providers also should implement policies concerning release or communication of protected patient mental health and substance use information as these are afforded a higher level of protection from disclosure.

It is important to note that information concerning substance use treatment is regulated by Federal law under the Confidentiality of Alcohol and Drug Abuse Patient Records – 42 CFR Part 2. Under this regulation, heightened protections exist concerning exchange of information that concerns substance use disorder treatment.⁴¹ HIPAA does not require patient authorization for sharing Patient Health Information (PHI) for purposes of treatment, payment or health care operations, whereas 42 CFR Part 2 does require patient consent to share or use PHI and to identify someone as having a substance use disorder.⁴²

RELEASE OF INFORMATION AND CONSENTS

There are times when information needs to be shared or exchanged in order to best treat a patient. It is also important that providers are aware of the patient's right to privacy, particularly as it relates to mental health and substance use treatment. Patients who present to the ED with behavioral health/substance use disorders may be at risk of hurting themselves or others and, as a result, may not be able to make informed or rational decisions concerning their care or treatment.

It is also important that providers are aware of privacy regulations. Hospitals should use a release of information and consent form with a specific section pertaining to behavioral health and substance use PHI. This document should comply with state and federal regulations. Patients can revoke consent at any time. If the patient has expressed that a provider cannot communicate with someone, this request should be adhered to. There may be times when legal consultation should be sought, particularly if a substitute decision maker is needed or has already been appointed.

DOCUMENTATION

Documentation reflects care delivered, supports billing for services and, should an adverse issue occur, provides information for legal purposes. It is important to know what should and should not be documented when treatment involves behavioral health disorders or issues and to have a process in place concerning access to the records. A patient with behavioral health issues may not be a reliable source of information concerning symptoms or intention. Therefore, providers should document objective findings rather than solely relying upon a patient's statements or account.

SUICIDE AND HOMICIDE RISK ASSESSMENT

ED providers likely will encounter patients who are suicidal or homicidal. These patients create unique, high-risk situations. Suicides are often not long-planned acts. In a 2001 study of people aged 13 to 34 who survived a near-lethal suicide attempt, participants were asked how much time had passed between when they decided to take their lives and when they actually made the attempt. The study found 24% said less than five minutes; 48% said less than 20 minutes; 70% said less than one hour; and 86% said less than eight hours.⁴³ This study reveals how difficult it can be for a provider to determine if a patient is likely to commit suicide. It also shows how important documentation is if a lawsuit results following a patient suicide.

It is vital to ask all ED patients questions about risk of harm to self or others. Language such as: "have you ever had thoughts about hurting yourself" and "have you ever had thoughts about hurting others" can provide useful information and should be asked with each patient who presents to the ED. It is important to pay attention to indicators that may increase risk of harm to self or others.⁴⁴ A few things to keep in mind:

- Look for signs of acute suicide and homicide risk in all patients.
- Using an evidenced-based tool, assess each patient for suicide and homicide risk by incorporating standard questions with each new patient encounter.

- Ask about firearms/weapons access and be aware that there are some states that have regulations concerning whether you can ask about firearm access. Should you have questions, consult with legal counsel.
- Look for warning signs of suicide and/or homicide.

If you or staff suspect a patient is at risk of suicide, additional probing questions should be asked, including:

- Have you ever thought of dying or that life is not worth living?
- Have you ever thought about ending your life?
- Do you have a plan?
- What steps have you taken?

If a patient is assessed to be at risk of harm to self or others, steps should be taken to minimize risk of harm, including:

- Determine if a sitter or 1:1 person is needed.
- Implement checks at five- to 15-minute intervals.
- Implement seclusion and/or restraint.
- Minimize environmental risks.⁴⁵

SECLUSION AND RESTRAINT

When treating patients with behavioral health disorders, the least restrictive treatment method is always preferred. However, patients sometimes are unable to control their behavior; and seclusion or restraint become necessary to assist with de-escalation and to ensure the safety of the patient, staff, and possibly other patients.⁴⁶ There are risks associated with these restrictive interventions, such as further escalation in behavior or exacerbation of a physical condition that may require intervention.⁴⁷

Seclusion and restraint policies need to be written with patient and staff safety in mind. Observation, restriction of rights, physiologic monitoring needs, and release from seclusion or restraint as soon as safely possible should be the standards guiding use of these modalities during a behavioral crisis.⁴⁸ Oversight of seclusion and restraint utilization must be an integral part of an organization's performance improvement effort, and data must be available for inspection by internal and external regulatory agencies.⁴⁹

Due to the seriousness of using restraints and seclusion, CMS regulations and policies as well as The Joint Commission standards apply.^{50,51} Most states also have laws concerning seclusion and restraint. It is important that health care organizations provide proper training on current, applicable regulations and use of seclusion and restraint. Provide routine staff competencies and be aware of any changes to applicable rules and guidelines.

SAFETY CONTRACTS/SAFETY PLANS

Safety contracts and safety plans are used by providers when a patient is perceived to be a risk to self or others. They can provide a false sense of security; however, and are often overvalued and their effectiveness has been shown to be questionable.⁵²

When using a safety contract with a patient, keep in mind:

- Safety contracts are not legal documents.
- Safety contracts cannot be used as exculpatory evidence. In other words, simply because a patient contracts for safety does not mean there is no liability risk. Courts often look at foreseeability if an adverse issue occurs: whether the harm was foreseeable and if the provider could have done something to prevent it.
- Safety contracts should not take the place of an adequate and complete risk assessment and safe discharge plan. The standard of care may vary depending upon jurisdiction and could be court dependent. Be aware of practice area standards regarding safety contracts.

PATIENTS WHO PRESENT TO THE ED WITH SUBSTANCE USE DISORDERS

There is a subset of patients that present to the ED because patients, their families, and friends believe they urgently need psychiatric care based on symptoms that easily mimic psychosis such as anxiety, agitation, delirium, hallucinations, mania, and paranoia, when in reality these patients are experiencing substance-induced psychotic symptoms.⁵³ The Diagnostic and Statistical Manual, 5th edition (DSM-V), defines substance- or medication-induced psychotic disorder (SIPD) as delusions and/or hallucinations related to the physiological effects of a substance or medication, based on evidence from the patient's history, physical examination or laboratory findings.⁵⁴ The toxic effects of substances such as alcohol, caffeine, cannabis, cocaine, amphetamines, opioids, nicotine, and street drugs can mimic mental illness in ways that can be difficult to distinguish from true mental illness.⁵⁵

These patients may have unpredictable presentations which can place other patients and staff at risk. They require careful evaluation and close monitoring in the ED.⁵⁶ Security staff or local law enforcement may be needed to assist with safety. It is important to remember that security staff or local law enforcement are not an extension of ED clinical staff, but rather support safe campus policy with specific skills utilized at the direction of ED providers in crisis situations to keep patients, staff, and visitors safe.⁵⁷

As of January 2020, 10 states (Alaska, California, Colorado, Illinois, Maine, Massachusetts, Michigan, Nevada, Oregon, Vermont and Washington) and the District of Columbia have legalized the use of recreational cannabis. More states are likely to follow. In Colorado, for example, cannabis legalization has resulted in increased ED visits due to cannabis-associated health care utilization.⁵⁸ Emergency physicians noted an increase of visits linked to overuse of cannabis, with conditions or symptoms such as tourist overutilization, butane hash oil burns, cannabinoid hyperemesis, and cannabinoid psychosis.⁵⁹ Unintentional cannabis-infused edibles exposure and their consequential effects via THC (the main psychoactive compound in marijuana), cannabis-infused edibles, and other avenues to the pediatric population, has also driven up ED visits, and calls to the poison control center.⁶⁰

While cannabis may not be the only contributing factor to psychotic type presentations to the ED, cannabis use is known to exacerbate certain psychiatric conditions such as schizophrenia, personality, mood panic, and anxiety disorders.⁶¹ From a risk perspective, it is important to provide standardized training and require a consistent approach that all providers use in caring for patients with these issues, so that objective data can be collected and used to determine an adverse drug reaction versus a true psychotic episode.⁶²

From 1999-2017, 70,237 drug overdose deaths occurred in the U.S. and District of Columbia.⁶³ The rate increased on average by 10% per year from 1999 through 2006, by 3% per year from 2006 through 2014 and by 16% per year from 2014 through 2017, with opioids being the main cause of death.⁶⁴ Every state is mandated to educate health care professionals to manage prescribing and dealing with the opioid crisis in the U.S.⁶⁵ Most states have rules and regulations instituting a formal Prescription Drug Monitoring Program (PDMP).⁶⁶ It is important that prescribers are aware of their responsibilities when they prescribe controlled substances.

Buprenorphine is a medication now being used to treat opioid use disorder in the ED. Previously EDs would treat only the sequelae of overdose and addiction, such as nausea or diarrhea. Now, specifically licensed ED prescribers can initiate opioid addiction treatment when a patient may or may not be experiencing withdrawal at the time of discharge.⁶⁷ There will be years of sustained, coordinated and vigilant efforts required to contain the current opioid epidemic and ameliorate its harmful effects.⁶⁸ Risk managers should stay current with opioid treatment advances and assist with formulating organizational policies that address opioid use and impact.

CO-OCCURRING DISORDERS AND DETOXIFICATION PROTOCOLS

Previously known as dual diagnosis, co-occurring disorders are defined as the presence of a behavioral and substance use disorder occurring at the same time.⁶⁹ Symptoms may vary in severity and can change over time. Patients should receive intensive medical and therapeutic intervention and care for both disorders at the same time. This allows providers to manage the symptoms caused by the patient's behavioral health disorder without abusing drugs and worsening those symptoms, or allowing an untreated behavioral health disorder to increase the urge to drink or get high.⁷⁰ Patients with psychiatric illnesses and substance use disorders visit the ED more frequently, contributing to the 28% of overuse visits to the ED per year.⁷¹ This patient population requires creative intervention strategies both in and outpatient to help reduce the strain on ED overutilization.⁷²

SAFETY AND SECURITY

Checking patients and visitors for contraband, use of metal detectors, and implementation of a code system that helps identify violent patients are steps that hospitals and health systems can take to increase safety and security in the ED and organization.

ED patients should be checked for all contraband, including weapons, medications, sharp articles, ropes, toxic fluids, and strings. It is critical to document the search, confiscate, remove and catalog any items, and be aware of any laws concerning searches. Obtaining an order for routine searches of patients and the environment may be necessary, particularly if visitors are present.⁷³ Providing a locked storage area for visitors' belongings also can help ensure patient and staff safety. Security department staff should be involved where indicated.

A 2018 hospital security survey revealed that only 11% of responding hospitals used walk-through detectors, which can be expensive because they require training, constant staffing, and screening. According to the 2018 survey, hospital use of handheld detectors increased to 50% from 33% in the previous survey.⁷⁴

Hospital code systems should include a code for identifying violent patients. While proper staff training and patient interventions can help avoid the need to announce a code, health care organizations should have a policy in place that staff understand and know how to implement when necessary.⁷⁵

UTILIZING METRICS FOR ROOT CAUSE ANALYSIS (RCAS)

Psychiatric care has always involved higher risk to patients, staff, and visitors than care in any other clinical area. The ED is particularly vulnerable because the high-volume, high-stress nature of the care environment can exacerbate the already fragile state of a person in psychiatric crisis. Clinical risk management for behavioral health addresses concerns that, at times, overlaps medical surgical counterparts, but it also uniquely must address higher-level confidentiality concerns, violence and self-destructive behavior (ie: protecting patients, staff from other patients, and patients from self), treatment errors especially in the process of restrictive interventions, and risks associated with behavioral illnesses (ie: psychosis, substance use, violence, and depression).⁷⁶

It is important to conduct several types of behavioral health risk assessments in the ED, including screening and assessing for suicide risk. Assessments should focus on the environment of care, training and expertise of staff and response to critical situations as well as policy and procedure related to care, security, confidentiality, critical incident response, incident reports, near misses, and if necessary use of RCAs to better understand an untoward event involving ED staff. Such assessments can help reveal opportunities to improve the quality and safety of the care provided to patients with behavioral health issues in the ED.⁷⁷

TREATMENT OF SPECIFIC PATIENT POPULATIONS

ED providers and risk managers should be aware of issues related to the care and treatment of specific patient populations with behavioral health conditions. Some of the issues related to caring for pediatric patients and minors, adults and geriatric patients, victims of domestic violence, and other populations that also have behavioral health disorders are discussed below.

Pediatrics and Minors

■ Child Welfare and Reporting Obligations

Providers must understand their duty to report and regulations related to their obligations as a mandated reporter. It is critical that providers are aware when they are required to report suspected child abuse or neglect to the relevant state agencies. Social service, pediatric, psychiatric, risk management and legal staff should be involved when indicated.

■ Management and Safety

Managing and ensuring the safety of a child in psychiatric crisis in the ED can be challenging, particularly if the child remains in the ED for an extended period of time. Health care organizations should institute policies concerning care and treatment of pediatric behavioral patients, ensure that staff are trained, and follow these policies. Involve the relevant departments as indicated above. To the extent that a sitter is needed, it is important to implement early in the process. Providers should be aware of applicable rules and regulations concerning seclusion or restraint before these methods become necessary and are initiated.

■ Lack of Placement Options

Lack of placement options may be a concern when treating minors with behavioral health issues in the ED. If the minor requires inpatient hospitalization, the wait time may be considerable before a bed becomes available. Thus, the patient may be boarded in the ED for an extended period of time. Providers also may encounter a child in psychiatric crisis who comes from a group home, foster care or a home to which the patient cannot return. Relevant health care organization departments and outside agencies should be involved early in the process. Providers must understand with whom they can and cannot communicate. If a child is in the custody of a state agency and a non-custodial parent is seeking PHI, providers must

know whether or not they can communicate with the parent before doing so. A number of state agencies also may be involved in the child's overall care and treatment. Therefore, it is important to involve the organization's case management or social work department to help coordinate patient care and services.

Adults and Geriatric Patients

Most EDs do not have psychiatrists or behavioral health professionals on staff; however, in most instances, the ED is the direct pathway for involuntary admission to a psychiatric unit.⁷⁸ Occasionally, ED providers hospitalize people against their will, and restraint may be required to keep everyone safe, especially when patients are delusional, disorganized, and agitated. Involuntary treatment initiates a situation in which the treatment team may become adversarial to the patient they are treating.⁷⁹ Voluntary admission is always preferable but when a patient is a threat to self or others, appropriate means must be utilized to keep the patient and potentially others safe from risk of harm.

State certification, informing patients of their restriction of rights, and contemporaneous documentation of a voluntary or involuntary admission is critical. Despite best efforts adult and geriatric patients remain a very volatile, fragile, and an unpredictable population who may consider litigation after hospitalization.

Behavioral health units often have multigenerational patients who have multiple diagnoses. It is important for ED providers to assess for any signs of elder abuse (physical, financial or emotional) that may contribute to a new onset or exacerbation of behavioral distress. If abuse is discovered or suspected, reporting to the state department on aging is mandated. When possible, transfer to a dedicated geriatric behavioral health unit is preferred. While the certification, restriction of rights and documentation criteria are the same, how psychiatric illness manifests and the likelihood of medical comorbidities reinforce the need for specialty geropsychiatric units and staff to care for elderly patients.⁸⁰

■ Decisional Capacity: Substitute Decision Makers, Guardianship and Conservatorship

A person may present to the ED confused, disoriented, combative, and agitated and may be unable to make informed decisions. These issues can result from an emergent behavioral health issue or be symptoms of a medical issue, such as infection. In such cases a person who lacks capacity to make informed decisions may need emergency care. Safety for the patient, staff, and other patients is paramount. It is important to determine when a true emergency exists, so that medication may be administered absent informed consent and when it is necessary to obtain a substitute decision-maker such as a guardian or conservator.

Sometimes a patient has a temporary medical issue that affects the ability to make informed decisions, but later resolves with treatment. For example, an elderly patient presents confused and, upon evaluation, is determined to have a urinary tract infection. The confusion may resolve after treatment with antibiotics. In the interim, it will be important to consult with legal counsel, be aware of the rules concerning behavioral health treatment, and understand what constitutes an emergency and whether the patient can be treated without the temporary capacity to consent.

Each state has its own rules concerning guardianship and conservatorship. Many states model their rules on the Uniform Probate Code (UPC). The UPC defines an incapacitated person as "an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks

the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance.”⁸¹

Further, the patient may have an advance directive appointing a health care proxy or agent for medical issues, if the patient has a SMI, or a psychiatric advance directive. Providers should be aware of the rules concerning advance directives in their state and understand that this is an evolving area. For example, in Colorado, a new psychiatric advance directive process went into effect in August 2019. Colorado House Bill 19-1044 created a new “Behavioral Health Order Form” that allows individuals to communicate their behavioral health history, decisions and preferences. This is only implemented when the person lacks capacity to provide informed consent to, withdraw from or refuse medical treatment.^{82,83}

Special Considerations Concerning Domestic Violence

Patients with behavioral health issues that are seen in the ED also may experience domestic or intimate partner violence. Nearly half of all women and men in the United States (48.4% and 48.8%, respectively) have experienced psychological aggression by an intimate partner in their lifetime.⁸⁴ It is important for providers and risk managers to understand state laws that pertain to reporting domestic violence incidents and penalties for failing to report.⁸⁵ As part of ongoing assessment and treatment, providers should inquire about whether a patient feels safe, should discuss abuse, and ensure thorough documentation in the patient’s medical record. Reporting obligations also may exist if children, elders, or disabled persons live within a home where domestic violence occurs. Providers should be aware of their obligations and remain up to date with changes in regulations.

If abuse is suspected and the patient presents with the suspected abuser, it is important to adequately assess the situation with the patient in a private setting. The patient may not be forthcoming in disclosing the issue, either in front of the suspected abuser or in private. There should be sufficient training to recognize signs and symptoms. Health care organizations should have a policy and procedure in place to adequately assess and determine when consultation is needed with social work, security, risk management, legal, or other appropriate departments. Proper security procedures should be in place to minimize potential risk of harm to a patient or staff. A process also should be in place for notifying law enforcement, when indicated and mandated.

Additional Considerations

Additional populations who are seen in the ED may require heightened attention and care. While detailed analysis exceeds the scope of this publication, providers should be aware of issues particular to the following populations:

■ Pregnant Women

Pregnancy can be a high-risk time for a woman with a history of psychiatric illness. It is important for ED providers to understand the mood and anxiety disorders that occur during pregnancy.⁸⁶ A woman with a history of mental illness may have concerns about the effects of psychotropic medications on her fetus and can suffer a major relapse of stabilized conditions. The decision to restart psychiatric medication has many risk and benefit implications. It is important to seek obstetrical and psychiatric consultation with these complex patients.⁸⁷

■ Post-Partum Women

Women who are post-partum and present to the ED can experience a number of issues. Staff should be mindful of symptoms of post-partum depression, post-partum psychosis, heightened stress, anxiety, depression or a new mother’s inability to cope with her role. Providers should be mindful of how the patient presents and if any concerns exist about lack of care for the baby.

Providers should assess the patient's mental status and coping ability and are encouraged to seek consultation. They also should be aware of potential mandated reporting considerations if safety concerns exist for the infant.

■ **Individuals and Youth at Risk for Violence**

Individuals or youth who are at risk for violence may appear in the ED before an incident occurs.⁸⁸ Signs and symptoms may exist that should not be overlooked. Providers should evaluate and document patterns of behavior and engage in frank communication about issues, including access to firearms and thoughts of suicide or depression, to determine potential indicators of violence. Providers should not take lightly social media posts, passive threats or increased difficulty the patient has had with others or at school. Referral may be necessary.

■ **Human Trafficking Sexual Abuse and Exploitation**

ED staff may encounter individuals who are victims of human trafficking. It is important to be aware of the signs of human trafficking and seek consultation when necessary. Victims of human trafficking are likely to be at increased risk for behavioral health issues, such as post traumatic stress disorder (PTSD), depression and anxiety.⁸⁹

■ **LGBTQ**

Unique considerations exist when treating LGBTQ patients in an ED setting. These individuals may have experienced social discrimination, may have been victims of harassment or abuse, and may have experienced health care discrimination. It is vital that providers avoid insensitivities and treat all patients equally regardless of their sex or gender identity or sexual orientation.⁹⁰ Providers also should fully assess LGBTQ patients for suicidality and potential stressors.⁹¹ LGBTQ youth contemplate suicide at approximately three times the rate of heterosexual youth, and 40% of transgender adults reported having made a suicide attempt with 92% reporting the attempt before the age of 25.^{92,93}

■ **Veterans**

ED staff should be aware of patients who are actively serving or who have a history of serving in the military. "Service members and veterans suffer from high rates of co-occurring health problems that pose significant treatment challenges, including traumatic brain injury, post traumatic stress disorder, depression, and anxiety."⁹⁴ It is important for staff to evaluate the needs of patients who are veterans and military family members who may present for care. Staff should be aware of community services and resources available to assist veterans and their families and caregivers.

■ **Forensic Patients**

Sometimes forensic psychiatric patients need to be accompanied to the ED for higher-level assessment or care. They may come to the ED from a county or city jail that does not have behavioral health services or from a prison due to exacerbation of comorbid medical illness. These patients are afforded the same standard of care as any patient; however, they require a higher level of security that includes guards that accompany them to and remain with them in the ED, arriving and remaining in shackles, and no opportunity for privacy. It is important to have clear policy, procedure and staff training surrounding the safe care of forensic patients. Security personnel need to be present for patient and staff safety, and providers should understand that the guards accompanying the forensic patient are responsible for the patient. Constant communication between clinical staff, security, and guards combined with frequent risk assessments will curtail the possibility of violence, escape or both.⁹⁵

■ Patients with Disabilities

Patients in the ED may have special needs, disabilities, and behavioral health needs. The Americans with Disabilities Act (ADA), a federal civil rights law, provides protection to those with disabilities relating to employment, transportation, state and local services, public accommodations, telecommunication, and health care accessibility. Providers should be aware of applicable laws to ensure effective and competent care.

Title III of the ADA applies to places of “public accommodation,” which includes health care settings.⁹⁶ Providers should be aware of obligations regarding provision of care and communication with patients including: when auxiliary aids, such as translators, are needed to ensure effective communication;⁹⁷ when reasonable accommodations should be given for service animals;⁹⁸ and accessibility requirements for those in wheelchairs or other devices,^{99,100} particularly when seclusion, restraint or both are required.

■ Patients with Service or Comfort Animals

A service animal is defined by the ADA as a dog individually trained to perform work or tasks directly related to the patient’s disability, including a physical, sensory, psychiatric, and intellectual or other mental disability. If trained to perform tasks directly related to the patient’s disability, miniature horses are also considered service animals by the ADA. A hospital should have a policy in place to determine how to provide reasonable accommodations.¹⁰¹

There is some controversy concerning requirements for comfort or emotional support animals (ESAs). The ADA does not protect ESAs or companion animals used primarily for comfort, therapy and support, unless they are used for support in planes and in some residences that do not normally allow pets. Providers should review applicable state and federal rules and regulations to determine what may be required at their facilities.

■ Children at Home and Primary Caregivers

ED providers may encounter behavioral health patients who care for others in their homes. In these circumstances, it may be necessary to involve relevant local authorities and state agencies for reporting or protection of those individuals. Providers and staff from social service, risk management, legal, case management, and discharge planning departments should be involved to ensure that those impacted are safe and not at risk of harm.

■ Homeless Persons

Individuals who have a behavioral illness or substance use disorder and are homeless often may present to the ED. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 20 to 25% of the homeless population in the U.S. suffers from some form of SMI compared with 6% of Americans overall.¹⁰² Discharge planning, access to outpatient resources, and follow through may be challenging when ED providers encounter homeless patients. Social service or discharge planning departments should be involved in overall case management and discharge planning.

DUTY TO WARN/PROTECT IN THE ED SETTING

ASHRM’s Behavioral Health Care in the Ambulatory Care Outpatient Setting mentions that most providers will, at some point, treat a patient who is at risk of harm to self or others. It is therefore important for all providers to understand whether they have a duty to warn and protect. For more information refer to [ASHRM Behavioral Health Care in the Ambulatory Care/Outpatient Setting](#) and also The National Conference of State Legislatures.¹⁰³

MEDIA

Facilities may encounter high-profile behavioral health patients or situations where news media may seek to obtain information. For example, a patient may be involved in an incident such as a mass casualty, death or violence either prior or subsequent to treatment. Staff must be aware not to disclose confidential PHI to the media and, if this occurs, that action should be taken to address the issue, including staff disciplinary action. Providers should have a process in place and designated spokespeople to handle media contacts. ED staff should be informed that at no time should they acknowledge to the media that a patient is or was in their care.

CONCLUSION

Patients with behavioral health disorders who are treated in the ED present unique and challenging considerations. ED providers should ensure that emergency policies and procedures are well-developed and followed and be aware of risks that may place the patient, other patients and providers at risk of harm, including patient elopement/escape. It is important that ED providers are competent to manage patients effectively, comply with the standard of care, take steps to reduce overall risk, and when necessary, obtain consultation from relevant professionals. Involving the appropriate professionals and ancillary staff in the patient's overall care and treatment can decrease risk of an adverse outcome. ED providers also should be aware of relevant regulations such as duty to warn/protect, mandated reporting and seclusion or restraint. As behavioral health care is a specialized area of practice, ED providers are encouraged to obtain consultation from a risk management or legal professional when questions arise.

APPENDIX A: RESOURCE LIST FOR BEHAVIORAL HEALTHCARE IN THE EMERGENCY DEPARTMENT SETTING*

* Note: This is a guide to provide resources for clinicians in the ambulatory care/outpatient setting. It is not intended to be a complete resource, but rather to provide tools to assist providers. Should additional assistance be needed, seek advice from a qualified legal counsel or risk management professional.

Questions	Resources	Y	N
Do you understand EMTALA considerations for treating patients with behavioral health issues?	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-15-EMTALA.pdf		
Do you have a safe environment of ED care for patients with behavioral health issues, staff and visitors?	https://betahg.com/wp-content/uploads/2019/01/Section_1_Safety-_EMC_Toolkit_Final.pdf https://www.ecri.org/components/HRCAlerts/Pages/HRCAlerts103118_How.aspx		
Facility Resource Guide for Behavioral Health.	Hunt, J., Sine, D., McMurray, K., Behavioral Health Design Guide. Behavioral Health Facility Consulting, LLC., Ed. 8.1. June 8, 2019. http://www.bhfcllc.com/wp-content/uploads/2019/06/Design-Guide-8.1-web.pdf		
Patient Triage Toolkit.	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf		
Patient Assessment Toolkit.	https://www.calhospital.org/emergency-department-toolkit		
Ligature and Restraint Guidelines.	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-06.pdf https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-12-Hospitals.pdf https://www.aha.org/system/files/2019-01/2018-dec-hfm-ligature-risk.pdf		
Best practices for treating patients with behavioral health issues in the ED.	https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/mental-health-and-substance-abuse/psychiatric-patient-care-in-the-ed-2014.pdf		
Risk assessment for self-harm or violence in the ED.	https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/risk-assessment-_violence_selfharm_ip_final_110615.pdf		
Safety plans in the ED.	Boudreaux, E. D., Miller, I., Goldstein, A. B., Sullivan, A. F., Allen, M. H., Manton, A. P., Camargo, C. A., Jr. (2013). The Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE): Method and Design Considerations. <i>Contemp Clinical Trials</i> , 36(1), 14–24. https://doi.org/10.1016/j.cct.2013.05.008 http://alert.psychnews.org/2018/07/ed-administered-safety-planning.html		

Questions	Resources	Y	N
Pediatric psychiatric care in the ED.	Chun, T.H., Mace, S.E., Katz, E.R., American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, and American College of Emergency Physicians, Pediatric Emergency Medicine Committee. Evaluation and Management of Children and Adolescents with Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients with Mental Health and/or Behavioral Emergencies. Pediatrics. Sept. 2016, 138 (3) e20161570; https://doi:10.1016/j.pediatrics.2013.05.008		
What is a pediatric psychiatric emergency?	https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/What_is_a_Psychiatric_Emergency_126.aspx		
Improving boarding and flow in the ED for patients with behavioral health issues.	https://www.ena.org/docs/default-source/resource-library/practice-resources/topic-briefs/system-wide-strategies-to-reduce-emergency-department-boarding.pdf?sfvrsn=1eb2b7c5_4 https://www.ahrq.gov/research/findings/final-reports/ptflow/index.html		
ETOH withdrawal management in the ED.	https://www.uptodate.com/contents/management-of-moderate-and-severe-alcohol-withdrawal-syndromes		
Initiating Opioid withdrawal treatment in the ED.	https://www.drugabuse.gov/nidamed-medical-health-professionals/discipline-specific-resources/initiating-buprenorphine-treatment-in-emergency-department		
Recognizing Human Trafficking in the ED.	https://www.drugabuse.gov/nidamed-medical-health-professionals/discipline-specific-resources/initiating-buprenorphine-treatment-in-emergency-department https://www.aha.org/combating-human-trafficking		
American Board of Psychiatry and Neurology Core Competencies.	https://www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf		
Non-violent crisis intervention in the ED.	https://www.crisisprevention.com/		
ED psychiatric emergency assessment skills.	https://fpnotebook.com/psych/Exam/EmrgncyPsychtrcEvltn.htm		
Nursing care of the patient with behavioral health issues in the ED.	https://www.ena.org/docs/default-source/resource-library/practice-resources/white-papers/care-of-psychiatric-patient-in-the-ed.pdf?sfvrsn=3fc		
Mental and Behavioral Health and Opioid Overdose release of information.	https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html		
ETOH and other substance use disorders in pregnancy.	https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html		
Geriatric psychiatric assessment.	https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.6.639		
State by state mandatory child abuse reporting laws.	https://www.childwelfare.gov/pubPDFs/manda.pdf		

Questions	Resources	Y	N
Reporting suspected elder abuse.	https://ncea.acl.gov/Suspect-Abuse/Reporting-Abuse.aspx		
Civil commitment requirements.	https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf		
State-by-state Duty to Warn/Protect Rules.	The National Conference of State Legislatures: http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx		
Suicide Prevention Resources.	https://www.jointcommission.org/standards/national-patient-safety-goals/-/media/83ac7352b9ee42c9bda8d70ac2c00ed4.ashx National Suicide Prevention Lifeline: 1-800-273-8255		
Guidelines and Resources for telebehavioral health.	https://www.integration.samhsa.gov/operations-administration/practice-guidelines-for-video-based-online-mental-health-services_at_5_29_13.pdf American Medical Association, Ethical Practice in Telemedicine, https://www.ama-assn.org/delivering-care/ethics/ethical-practice-telemedicine American Academy of Child and Adolescent Psychiatry. Practice Parameter for Telepsychiatry with Children and Adolescents, http://www.webcentral.uc.edu/surgery/telehealth/documents/Practice%20Parameter%20for%20Telepsychiatry%20With%20Children%20and%20Adolescents.pdf , 2008 American Psychological Association, Guidelines for the Practice of Telepsychology, Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, https://www.apa.org/pubs/journals/features/amp-a0035001.pdf , 2013. American Telemedicine Association, Practical Guidelines for Videoconferencing Based Telemental Health, http://www.ATA.org Center for Telehealth and eHealth Law, http://www.ctel.org . Recupero, P, M.D., J.D., Fisher, C. E., M.D. American Psychiatric Association, Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry http://www.psych.org/Departments/HSF/UnderservedClearinghouse/Linkeddocuments/telepsychiatry.aspx , 2014		
Resources for treating Veterans with behavioral health issues in the ED.	https://www.nursingworld.org/~48e191/globalassets/foundation/the_ptsd_toolkit_for_nurses__assessment.99783.pdf https://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp		

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