Emergency Departments for the Psychiatric Population(s)

Introduction

The Agency for Healthcare Research and Quality's report on cost and utilization (H-CUP)[3] states that among adults in 2007, 12.0 million ED visits involved a diagnosis related to mental health and/or substance abuse, which accounted for 12.5% of all ED visits in the US (one out of every eight) and the percentages of mental health and substance abuse-related ED visits were:

- 42.7 % Mood disorders
- 26.1% anxiety disorders
- 22.9% alcohol-related conditions.
- 8.3% Mix of drug-related conditions, schizophrenia and other psychoses, and intentional self-harm.

A few more statistics from the study quoted above are important to be understood when considering the need for special EDs for psychiatric and substance-abuse issues:

- These patients were 2 ½ times more likely to result in a hospital admission (nearly 41% were hospitalized, although ED visits billed as uninsured were 2-4 times LESS LIKELY to result in a hospital admission, depending on the type of presenting condition.
- Medicare was billed the most frequently for psychiatric and substance-abuse related visits (30.1%), followed by private insurance (25.7%), uninsured (20.6%) and Medicaid (19.8%).

Bellevue Hospital Center in New York City is the oldest public hospital in the US. Opening in 1736 with a 6-bed infirmary to serve the underserved, it has been an almshouse, a penal institution, and an asylum. It also claims the world's first ambulance service, maternity ward, pediatric clinic, and emergency room. As such, it has a long history of addressing the psychiatric population with incredibly extensive and specialized services described below[4]:

Emergency Psychiatry: Our Comprehensive Psychiatric Emergency Program (CPEP) is a state of the art emergency psychiatric service. CPEP provides a spectrum of services designed to meet the needs of our diverse clientele, in the most effective and least restrictive manner possible. Our clinical program is one of the most respected of its kind, and is the destination of choice for many private and public agencies seeking help for someone requiring emergency psychiatric care. Our service is fully integrated with the entire spectrum of psychiatric services available at Bellevue Hospital.

- The Extended Observation Unit (EOU) is a six-bed inpatient unit physically located in the CPEP. Patients can be admitted to the Extended Observation Unit for up to 72 hours for high intensity evaluation and management of unclear and difficult clinical situations and for cases which may not require a full inpatient admission.
- The Mobile Crisis Unit consists of clinicians who can respond to persons in need of emergency psychiatric care who are unable or unwilling to present on their own. The Mobile Crisis Unit receives referrals from the community, goes to the person's home, performs assessments, delivers care, and removes individuals to an emergency department when necessary.
- The Interim Crisis Services Clinic assists patients transitioning to community mental health resources who may require resolution of acute crises. This service is located near CPEP, on the ground floor of Bellevue Hospital. It provides high-intensity, easy access to care of limited duration, to patients who otherwise might require inpatient hospitalization to stabilize and resolve a time-limited crisis.
- Crisis Residence Beds provide short term community housing for patients in acute psychiatric need who lack adequate supportive housing for safe community maintenance.

Forensic: The Forensic Psychiatry Inpatient Unit consists of 68 beds on two units, in a maximum-security mental health unit jointly operated by the New York City Health and Hospitals Corporation and the Department of Correction of the City of New York.

Substance Abuse: The Chemical Dependency Crisis/Detoxification Unit is a 20-bed service providing short-term detoxification and referral for longer-term treatment. The three goals of this treatment are safe detoxification, provision of a humane environment, and preparation for aftercare.

The Dual Diagnosis Unit, part of the adult inpatient service, is a 30-bed unit developed specifically for the rehabilitation of patients diagnosed with both general psychiatric and addictive disorders. It employs a behavioral treatment model combined with peer management techniques and psycho-educational programs tailored to this population.

Consultation-Liaison Service: The Consultation Liaison Service provides high quality, readily accessible, psychiatric consultations to all patients in the hospital on non-psychiatric units in need of psychiatric evaluation and/or treatment. Consultations are requested for a wide range of indications including but not limited to evaluation for capacity, mental status evaluation, treatment of depression, anxiety, agitation, psychosis, assessment of suicidal/homicidal ideation, management of substance abuse

intoxication/withdrawal, inappropriate or disruptive behavior, and issues of death and dying.

Adult Inpatient Services are comprised of 220 beds distributed among seven general units for patients ages 18 and older. A full range of in-patient psychiatric treatment is provided, including particular attention to those with psychotic, affective, and other major psychiatric illness, often with co-occurring substance abuse. One of the units is devoted to the treatment of Latino patients, one to Chinese-speaking patients, and one to patients with both major psychiatric and substance abuse illness.

In her fascinating and graphic book, Weekends at Bellevue, Julie Holland, MD, the weekend physician in charge of the psychiatric emergency room for nine years, states: "It's not until I start working at Bellevue that I finally appreciate what sets psychiatry apart from the rest of medicine. Medical illness has an endpoint: death. Psychosis is boundless; the degree to which someone can lose their mind is infinite. Most nights at CPEP, I'll think I've just seen the craziest person ever, and then inevitably, a week later, a new patient will best the last."[5]

While Bellevue Hospital is very committed to the psychiatric population, other hospitals and health systems are not. For example, the total number of state psychiatric beds has decreased by 14% (between 2005-2010), plunging to levels of beds/capita not seen since 1850! As a result, EDs often "board" psychiatric patients in holding rooms or hallways while they await placement or treatment, or both. "Health systems recognize that they need to address the psychiatric boarding problem because EDs bring in a lot of paying patients. Delays in serving them because of the boarding of psychiatric patients can hurt revenue. Hospitals also are hoping that more mentally ill patients will gain insurance coverage for behavioral care through the federal healthcare reform law and the new federal mental health parity rule. In addition, many states are more closely integrating behavioral healthcare and substance-abuse treatment with physical healthcare in their revamped Medicaid managed-care programs, recognizing that better and more coordinated care for these expensive patients is key to reducing Medicaid costs."[6]

Responding to the Population with Mental Health Needs

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Learning Objectives

1. Identify the spectrum of levels of care for patients with psychiatric illness
2. Name various aspects of the role of the psychiatric case manager in the emergency department (ED)

3. Identify strategies to promote positive relationships with hospitals and agencies and clinicians in the community

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In the early hours of a Sunday morning an ambulance arrives at the ED with a 16-year-old male. He is alert and oriented and presents with an injured right hand. The EMTs report that during an altercation with his step-father tempers flared, both threatened to hurt the other and then the teenager said he "may as well die" and put his hand through a glass window. His mother arrived home from work, came upon the scene, and called 911. The police arrived and calmed the situation, but upon hearing about the suicide threat, they called the EMTs to take the boy to the local community hospital for further evaluation.

The role of the ED Case Manager in the care of the patient with a need for mental health assessment and possibly services— like the young man described above— is ever changing and challenging. Meanwhile the role of the ED itself has been changing. Shrinking services for the mentally ill, especially since the recession of 2008, has played out in increases in this population seeking help in the Emergency Department. Across the country ED beds are occupied by patients awaiting placement on psychiatric units. An insufficient number of inpatient psychiatric beds to meet these needs has resulted in clogged ED's and enormous strain on both the ED and the internal or external case management and other staff working to find the right services and obtain insurance authorization for the services.

Health insurance protocols require a level of care assessment before any services can be assigned and these assessments have been taking place in EDs where licensed mental health professionals, either hospital employees or a consulting team from another service are available around the clock. They gather the data needed for the next step of case management for these patients. There are a number of possible scenarios that determine who does the insurance review and who finds the services. Figure #1 indicates possible assignment of tasks in the care of the person presenting to the ED with a need for mental health services.

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Task	**Hospitals with Psychiatric Services**	**Hospitals without Psychiatric Services**	**For patients in all hospitals with insurance that outsources management of psychiatric care**

Task	Hospitals with Psychiatric Services	Hospitals without Psychiatric Services	For patients in all hospitals with insurance that outsources management of psychiatric care
Psychiatric level of care (LOC) assessment	Psychiatrist or resident	Hospital based licensed professional: APRN, LICSW, LMHC, PHD	Designated outsourced (often community mental health) team
Insurance authorization for level of care	Possibly resident, especially after hours; otherwise ED case manager	Most likely licensed clinicians if they do LOC assessment	Most likely team that does evaluation; they may be only ones authorized by insurance to do this
Bed search or outpatient referral/appointment	Possibly resident; more likely ED case manager	Commonly done by clinician; possibly assisted by ED case manager	Most likely team that does evaluation; may have help from insurance company

Note: The problem of uninsured patients in every hospital is not limited to psychiatric patients alone, although psychiatric patients presenting in EDs without insurance is a special concern because of the extended time required to identify funding. Some hopitals which have consult/liaison services that may manage these patients every day while they are in the ED. Other hospitals may put them in medical beds with 24 hour sitters if needed. Yet others may hold off until "the waiting list cure"—time has gone by, the crises if over, and the patient can be discharged safely from the ED.

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In the case of the young man described above, after medical clearance (cuts, swelling to his right hand, no broken bones or deep lacerations), a psychiatric nurse evaluator is called in to do an evaluation. In this hospital, a team of Advanced Practice Registered Nurses have been employed by the hospital to meet the needs of patients requiring a mental health assessment. Unless the patient's insurance requires another evaluation team, this nurse will do the psychiatric level of care assessment (evaluation), the insurance authorization and the referral for services or the "bed search" should inpatient care be needed.

Even though this patient has been registered in the ED and his face sheet has insurance information included, one of the first steps in his assessment is to begin the disposition process and establish the mental health benefits available to him. The evaluator asks to see his insurance card. He is covered by his step-father's insurance plan, and so, after letting the patient know the next step, the nurse must explain this situation to the step-father. If the patient were older than 16, or considered an emancipated minor, the nurse might need the patient's consent to speak with the stepfather about anything related to the patient's medical information. If the step-father was not the legal guardian, the nurse might need his mother's consent to speak about the boys' clinical situation. The state statutes regarding minors as applied to federal patient privacy law, HIPPA, are provided to the nurse by the hospital legal staff and guide how these situations are managed.

"Even before I speak with you about what happened tonight and how I can best help you," she tells the weary stepfather, "I have to ask to see your insurance card to determine who will actually do the evaluation." Many insurers over the past twenty-five years have "carved out" or outsourced the management of benefits for mental health care. As indicated in the right column of table #1, these arrangements can determine who can evaluate a patient and what treatment services are available to the covered consumer. Sometimes these cost containment measures can affect mental health benefit consumers in a negative way such as requiring long waits for traveling evaluation teams to arrive at the ED and limiting the choice of psychiatric units.

Recent changes in federal health care laws such as the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and the 2013 Affordable Care Act as well as the implementation of Accountable Care Organizations, (ACOs) may result in changes in this process. But as of this writing, determining the scope of the mental health benefits and who is authorized to access the benefits for the patient is essential. After checking the card, the nurse spends a few minutes answering the father's questions, reassuring him that he will not be forced to return home with his out-of-control step-son. She then finds a quiet place to review the card information, and she may need to check with the insurance mental health benefits line by calling the 800 number on the insurance card to determine:

Whether the benefits for this patient are current

Which evaluators can activate the mental health benefits

What providers are in-network for this patient

Managing patients in need of mental health service requires a number of skills, including the ability to properly navigate this complicated initial part of the process. The reality of so

many and various processes required by insurance companies means that a case manager managing a psychiatric crisis in the ED must "dance" (balance priorities) between managing a patient and/or family in acute distress and carefully following specific protocol to insure the access of the benefits and services critical to the patients.

First step: Determining roles and responsibilities

If the case manager is not authorized to do the assessment, he or she must return to the patient and family and explains that another team has been called in and that the team's members will determine the services based on their evaluation. This APRN case manager is also using her clinical skills to assist the ED staff in the management of the patients: i.e. deciding if medication is indicated to reduce an altered mental status such severe anxiety or agitation, or in some cases, florid psychosis. Perhaps with the staff nurse assigned to the patient she will decide if it is better for the patient and family to wait together or in separate spaces, as would be indicated if there were ongoing hostile feelings between them. The case manager or staff nurse might provide a source of distraction like a magazine and something for the patient and/or family to eat or drink if the wait is extended. The ED staff nurse assigned to the patient often has to move on to the next patients' medical crises, leaving this patient who, unless having severe behavior management problems, may not appear to need much immediate care. If the patient and anxious family are waiting for the consulting clinician to arrive there is a good opportunity for the case manager to provide support, education and reassurance to them. If, however, the ED clinician is authorized to evaluate and plan treatment for the patient, the process can begin immediately. Seasoned ED clinicians often start with a hunch about an evaluation but stay open-minded until the assessment is complete.

Next step: Psychiatric Evaluation

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CASE SCENARIO

1. Troubled family dynamics

One hunch would be that the current crisis is the result of troublesome family dynamics in an otherwise healthy family where the patient and his parents have the emotional resources to find solutions to the precipitating factors in this crisis. For example:

The patient: The troubled boy may be the mother's first-born or only child, or in some other way a special son who has felt displaced by his stepfather.

His **mother:** She may feel guilty about her remarriage. She may consider her son abandoned, at least emotionally, by his biological father and overcompensate for this by failing to set appropriate limits on this teenager.

His step-father: might be a new husband who wants to help raise this son but cannot, for example, tolerate the rude way he speaks to his mother, a behavior that predated his arrival in the family.

Unconsciously, the two men compete for the mother's support and acceptance, forming an unstable family triangle that escalates to talk of the men hurting themselves or each other.

After clinical interview in the ED during which the nurse elicits the patient and family narrative of the events leading up to the patient's display of symptoms — often causing the eruption or venting of some anger by any of the parties —and she assesses the mental status of the patient, she shares the problems identified and provides a formulation. In this case the dangerous behavior— punching the window— and the symptomatic suicidal statements may be redefined as the boy's unsuccessful attempt to adjust to a newly combined family. If the tension is clearly diffused during a family meeting, the assessment itself can be the intervention which shifts the situation from crisis to a beginning of a resolution and the family may be able to return home with a referral for family therapy.

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CASE SCENARIO

2. Depression and A Risk for Suicide

Another possibility is that the troubled boy is suffering from a clinically significant depression. It may be that taking the patient's history reveals a year long struggle with sadness, a drop in grades, increasing sleep disturbance, disinterest in friends and activities and increased isolation. When the young man's suicidal ideation is further carefully assessed, his description of his wish to die indicate long simmering feeling of worthlessness, despondency, and depression.

It cannot be stated too emphatically that patients who present with suicidal ideation are not safe for discharge from the ED *unless the factors that precipitated their crisis have changed*. In cases where there are active, caring parents who possess the economic means to provide outpatient care for the boy and there seems to be a reduction in the family tension that precipitated the outburst, it is tempting to send the patient and family back home with an outpatient referral. But when the pre-existing or precipitating circumstances have not significantly changed, or the evaluator determines that the young man has a very realistic plan for suicide such as hanging himself with a clothesline or poisoning himself

with car fumes— methods that require tools he can easily acquire— this is the clinical situation of a patient who continues to be at risk and must be hospitalized to provide safety. The task of the nurse evaluator is to share this assessment and recommendation with the family. In cases of a patient being a danger to himself or others, the plan for hospitalization for safety must be implemented even against patient or family wishes.

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These two scenarios suggest two possible outcomes of the patient's psychiatric evaluation. In either case, the ED evaluator/case manager's sound evaluation includes an assessment of the following factors in a patient's case:

- Patient's assets and liabilities
- Patient's family and social history
- Past psychiatric and medical history, including hospitalizations
- Suicidal intent, possible plan, ability to carry out the plan, past attempts, and family history of suicide
- Patient and family substance abuse history including, for the patient, the number of detoxes, longest period of sobriety, and usual consumption per day, week, or month of substances
- Current and past medications, effectiveness and compliance, as well as previous treatments, compliance, and effectiveness

When the assessment is completed using the five-axis Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition[7] (DSM-5), the clinician makes a level of care recommendation. Possible levels of care listed in increasing levels of intensity of treatment include:

- No treatment
- Support groups
- Outpatient therapy
- Multiple outpatient therapies (individual, family, psychopharmacology)
- IOP (intensive outpatient therapy that meets two to four times a week)
- Partial or day hospitalization (if available)
- Residential treatment
- Crisis stabilization unit

Inpatient hospitalization

Guidelines for these levels are founded in good clinical care but often formalized and specified by the insurer or the mental health benefit management company. The level of care that is recommended should take into account the patient's previous experiences with treatment, the presence or absence and location of specific supportive people and therapists in the patient's life , the patients' ability to make a contract for safety, and, most importantly, the reliability of this contract.

It is possible that patients with severe depression, psychosis, anxiety, or delusions do not present a safety risk or require hospitalization. Medication, a referral for a medication consult in the near future, or a family intervention may be an adequate ED intervention that can prevent a hospitalization. However, a remorseful patient who has made a serious attempt and promises not to try again may in fact need the safety and further evaluation that a hospitalization— possibly one the patient or family resists— can offer, especially if none of the precipitants (causes or triggers)to his suicidal ideation have changed since his attempt.

Living conditions and the presence or absence of safety and support must always be considered. A depressed, chronically suicidal teenager with a family who is knowledgeable about her illness, supportive, and vigilant might be able to be discharged home, but a patient without those supports but the same clinical presentation could not safely be discharged to a marginal living situation or a shelter. Likewise an impulsive teenager who has made a serious first suicide attempt and who lives in a wealthy, resource rich but chaotic home with inconsistent support will continue to be at risk if not hospitalized or offered a crisis bed in a safe setting.

Final Step: Case management

Once a patient has been assessed and treatment options are determined, insurance plans with 'round-the-clock' case management of mental health benefits will require that the case be presented to a clinician to supply the information outlined above.

EDs need to move patients along quickly. An ED will treasure a case manager with skills to find safe dispositions for psychiatric patients. The three-P philosophy of case management—patients, patience, and partnerships—emphasizes the basic data and skills a case manager needs.

PATIENTS

The ED case manager must efficiently and effectively get to know the patient. Whether the psychiatric case manager or another evaluator does the assessment, it is best to have as much data as possible. When an assessment without the specifics of past psychiatric history, details of a substance abuse problem, or collateral information is submitted to a program, the case manager can be sent back again and again for more data. Does the patient smoke? Does the patient know there is no smoking at this psychiatric unit? Does the patient have family who can drive him to this partial hospital program? Does a patient in detox have a history of seizures? Can an elderly patient complete his or her own activities of daily living? Does the patient want help, or will she need to be committed to treatment? Is the family available for support, and will they participate in treatment? These are all questions considered by accepting programs therefore essential to a complete patient evaluation.

Information from collateral sources is invaluable. Although it can be difficult to gather the names of others who may know the patient well, obtain permission to speak with them and finally to actually reach them, it is worth the effort. Early in my career as a psychiatric nurse clinician and case manager in the ED of a community hospital, I made an egregious error in the evaluation and disposition of a patient—an error that I hope never to repeat. A tiny, frail, timid, and quiet woman presented in the ED. Her large husband and three adult sons brought her in and began to describe her as "totally changed," losing touch with reality, unwilling to eat or sleep at normal times, if at all, and "talking nonsense." As I proceeded with my evaluation, she denied the symptoms they described. All the while we spoke she managed to hold a nice, logical conversation. As a small person myself, I found the menfolk in this family quite intimidating and had trouble being open to their description of the problem, if in fact there was a problem. I felt bullied by them and thought the patient might feel that way as well. She said she *did* eat, and she *was* sleeping, but they rushed her too much, that no one would give her the time she needed. I asked her who understood her needs the best, and she named one of her daughters-in-law.

My mistake was in not contacting the daughter-in-law for her view of the problem. It was late, and I thought she might feel bothered. Now I realize that this daughter-in-law more than likely was aware of the problem and that her husband and mother-in-law were seeking help in an ED that night. The size, bluster, aggressive and demanding style of the sons and their father, who no doubt were upset and anxious about the patient's condition, made it hard for me to get a history that made sense and that I could believe. This dear sweet woman described everyone as against her. But as is often the case, it turned out that she was not a reliable reporter of her own situation and the daughter-in-law's data might

have helped me piece together the discrepancy between the patient's story and the family's worry.

I absolutely missed the seriousness of her condition and sent her home with referrals for family therapy. Luckily, the family went to another ED where the patient's psychotic depression was recognized and appropriate treatment instituted. She was safely hospitalized, I learned from the family. They took the trouble to call me back and let me know how unhappy they were with my eval and the outcome of their long night of seeking care. I remain grateful that they did.

Family and other providers can round out the story of a patient's problem and the previous efforts at treatment. They have a good perspective on what has helped and what has not worked for the patient. They can tell you if there is enough family or friend support to avoid a stay in a crisis bed or an inpatient unit. These sources are not always available, but as my sad tale indicates, it is worth the effort to try to reach them. When they are not the clinician must determine as well as possible the most appropriate level of care, and use her case manager skills to find it.

PATIENCE

But how does a psychiatric case manager in the ED transition a person who is resistant, confused, desperate, angry, despondent, or in denial to a useful treatment experience? This is the *patience* part of the practice.

Using the good data collected, the psychiatric case manager makes a request for approval from the insurance company for the least restrictive but safest level of care for the patient. The case manager sometimes must work strategically to have the insurance reviewer work collaboratively to determine a plan. The seriousness of the patient's illness and current situation cannot be understated or minimized. The patient's strengths should always be noted, but the acuity and need for safety must be presented as well to justify the care, especially with a request for inpatient hospitalization—the most expensive option.

Sometimes the process takes so long that the crisis has passed and all the patient and their family want to do is go home! But a good evaluation should already have determined if the situation is too serious to be resolved so quickly, and abandoning a plan for treatment is not an option.

Case managers in the ED are responsible for getting insurance authorization for as little as one night. After that step, the accepting hospital or agency's utilization review staff will pick up the job and continue working with the insurance company for the continued stay. But to get that one night, there may be hours on the phone or waiting for a call back and a delicate negotiation process with an insurance reviewer. All this time, there is a patient to be managed, and the ED staff may not see this patient as their responsibility, but that of the case manager. These generally are not patients with the coping skills needed to manage long waits for dispositions. The case manager may be juggling patient care needs with the need to wait and wait and wait for a hospital intake or insurance reviewers' call.

Helping a patient learn to self soothe during this time is both patient education and nursing care. Severe emotional distress can often be relieved by grounding or distracting with physical sensations.[8] To that end, items on a sensory cart used with consideration for safety can provide patients with some relief. Carts include items that can distract from psychic pain by stimulating any of the senses: stress balls, wireless headphones with a built in source of music, a small sachet of relaxing scents like lavender, hard candies that are sweet, sour or hot. If there is a built-in TV in the room, a relaxing screen saver on an in-house channel is far better than the news or some action movie for an upset or labile patient.

The case manager may need to arrange for a meal for a patient who has missed their last few, some quiet space for sleeping, and for the administration of the medications that the patient is or was normally scheduled to take, meds he may have been missing. The medication reconciliation form that is required by The Joint Commission[9] (TJC) as of January 1, 2014, once completed with validation by a pharmacy, is helpful in situations when an ED physician is reluctant to prescribe psychiatric medications. Re-instituting any aspect of what is perceived as "normal" to the patient while they are enduring long ED waits helps the patient to feel better and therefore manage their own behavior. The case manager may have to take an active role and assertive stance to encourage ED physicians to write orders for typical psychiatric medications.

As the Recovery Movement—by which recovered patients work in an advocacy role in ED and psychiatric settings— gains hold, these patient advocates will be an asset to the care and management of the patient in the ED with mental health needs.

PARTNERSHIPS

The case manager must have enormous patience for the process, and finally, work in partnerships with the ED staff, the insurance reviewers, and the many providers, agencies, and hospitals in the area. For an ED psychiatric case manager in a new position and not familiar with the agencies and inpatient units in the area, it is ideal to take the time to visit the local psychiatric programs, outpatient agencies, and clinicians—all of whom want referrals. They also want trustworthy data and a good medical and psychiatric work-up on the patients they receive. A case manager who has visited a hospital, met the staff, seen the layout, even tasted the food at the facility, is in a much better position to reassure the frightened people sent off in an ambulance that the place they are heading to is safe and the care they will receive is good care, provided by known people. In addition, if the system knows and trusts the data from an ED, patients sent off from that ED are in a much better position to be accepted and well received.

Once a referring ED case manager develops a reputation for skimping on the medical evaluation or under-reporting physical limits or medical problems, or if an ED sends patients with inaccurate payment information or an under-reported behavioral problem, a bridge is burned. Going forward, if an agency or inpatient unit feels it has been tricked or treated badly it is difficult to achieve that "Yes, we can take the patient" answer a case manager is always seeking. Partnerships with accepting agencies are built over time with communication and collaboration. A face-to-face meeting is worth the investment of the time and travel such meetings may require.

Sometimes patients come through the ED frequently and are known to a number of treating agencies, many of which do not feel they should be involved in repeated unsuccessful attempts to assist or treat the patient. A clinical conference including partners from other agencies, with the goal of a strictly enforced and mutually agreed upon treatment plan, is a good option for future successful encounters for the patient and successful referrals for the case manager.

Sometimes patients come to EDs because they are sure they will receive some kindness, a meal, and a nice nap in some clean sheets. They may not know how to access care or services any other way. A care plan designed to intervene by first meeting some imminent emotional and biological needs— that is a warm, short chat and a cafeteria voucher— when safe and appropriate, has been shown to avoid a costly, unnecessary ED stay and medical workup.

Sometimes a person consciously seeks mental health services in the ED to avoid her regular therapists because she has been noncompliant with the agreed-upon treatment plan. Communication between all parties can save a good deal of misdirected clinical effort.

For patients who suffer from severe, episodic trauma-related symptoms or people with long standing personality disorders, repeated, extensive ED evaluations followed by restrictive inpatient hospitalizations are contraindicated. If the patent is optimally involved in a Dialectical Behavioral Therapy[10] (DBT) program, the DBT team may set up protocols with the ED to provide an alternative, safe space for the patient, avoiding the unnecessary medical evaluation and psych disposition.

Time and space in the ED are expensive commodities, especially when what they provide is not what the patient needs at the time. When a case manager has the experience of spending hours seeking a disposition for someone with psychiatric problems who, it turns out, has been everywhere and tried everything, without he desired improvement in their health or situation, it is time to call a systems-level meeting. A better understanding of the patient's needs and experiences will help the professionals involved devise a more realistic, creative (if not radical), and effective plan that can avoid trips to and through the ED. These plans involve getting any available collateral people-- from probation officers to distant aunts, from local ministers to GED instructors, from guardians to community service workers-- on board with a realistic and appropriate plan. This is a ton of case management work up front that has the potential to save hours and dollars in fruitless work down the road.

In summary, a sensitive, comprehensive, and accurate evaluation is only the beginning of care for the psychiatric patient in the ED. The goal of all psychiatric case managers in the ED is an accurate patient (and patient-focused) assessment and disposition. This is possible if the case manager has set up highly functional partnerships with the ED staff, the outside agencies and psychiatric hospital units, and the insurance reviewers and has all the patience needed to stay focused on the patient.

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