



Emergency Psychiatry: Clinical and Training Approaches

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Introduction

The emergency department (ED) continues to be the portal of entry for the most acutely ill of the patients we treat.¹ Despite an ever-expanding repertoire of psychotropic agents, and increasing numbers of graduate psychiatrists, many people with psychiatric illness present to EDs across the country in need of both treatment and psychiatric care. There is recognition that our training programs need to prepare our future psychiatrists to safely and effectively assess, diagnose and manage this particular patient population.

Since the publication of the Canadian Psychiatric Association's (CPA's) 2004 position paper on emergency psychiatry,² the Royal College of Physicians and Surgeons of Canada (RCPSC) has elucidated more specific training requirements in this area.³ Concurrently, models of care for the psychiatric patient in the ED have evolved, both systemically and therapeutically. This paper will present an emergency psychiatry update, with emphasis on training and education.

Emergency Psychiatry Training— The Canadian Experience

In June 2013, the authors distributed a survey of all psychiatry residency programs to establish an accurate understanding of how training in emergency psychiatry is currently provided. The survey was sent to all psychiatry residents, program directors and self-identified emergency psychiatrists asking for information about the emergency psychiatry training at their university. There were 194 psychiatry residency positions available in Canada per year,⁴ resulting in about 970 residents across the country at the time. Responses were received from 13 of the 17 psychiatry programs in Canada, with a total of 105 surveys completed across all of the programs. The survey was voluntary, and no identifying information was collected other than the name of the respondent's university and their role within the residency program (for example, resident and program director).

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Note: It is the policy of the Canadian Psychiatric Association to review each position paper, policy statement and clinical practice guideline every five years after publication or last review. Any such document that has been published more than five years ago and does not explicitly state it has been reviewed and retained as an official document of the CPA, either with revisions or as originally published, should be considered as a historical reference document only.

The survey indicated that there was considerable variability across and within programs. As a result, the structure of the rotation, supervision provided and collaboration with other health care providers differed greatly. Regarding emergency psychiatry clinical exposure, programs provided between one and five weeks of training, but there were inconsistencies in responses from the same university, indicating that even the concept of dedicated training was unclear. Training sites varied as well; most programs offered a designated psychiatric emergency unit within a general hospital ED. Additional sites were available at many programs, which provided residents with exposure to emergency psychiatry in psychiatric hospitals, crisis follow-up clinics and within general hospital EDs without the use of a designated psychiatric area. Residents were working with a wide range of health care professionals during their emergency psychiatry training, but occasionally there were teams consisting of only psychiatrists (with or without specific emergency psychiatry training) and crisis or social workers. University-affiliated health centres with additional resources had interdisciplinary teams including nurses with or without specific mental health training, psychologists, patient attendants, security guards and translators. Most respondents indicated that their program provided specific safety training and comprehensive security features.

In addition to clinical exposure, all programs reportedly offered teaching in emergency psychiatry. The delivery, duration and content of this teaching varied widely. Didactic lectures, small group sessions and workshops were the most common method of educating residents. Few programs were using online modules and standardized patient interviews. Two programs provided sessions where local police were involved; another provided specific weekly complex case reviews in a fun and educational milieu involving medical students. Respondents varied in their estimations of the amount of teaching they received, with most having indicated that their program provided less than 10 hours. Given the few hours of teaching residents received, the number of topics covered was significant. Common topics included suicide, aggression, chemical restraint, medical clearance and comorbidity, interviewing techniques, medico-legal issues, substances and common ED presentations. All programs included teaching about their provincial mental health legislation.

Training in emergency psychiatry also took place while on call. The structure of the on-call experience showed significant variability across the country. Call duties varied from being at home to in-hospital, and at some programs included a blended structure where residents were expected to be in-hospital until a particular time, after which they could go home. The frequency of call varied, but most programs required residents to be on call about once per week. Handover, after an on-call

shift, occurred at most sites, but did not always involve the residents. Teaching commonly occurred at handover, but this was inconsistent, both across and within programs. While most programs had handover that involved the interdisciplinary team, several programs indicated that handover only occurred between residents, and in some cases only on weekends.

The variability in survey responses indicates a need for improved standardization of both clinical training and didactic teaching programs across Canada to address the needs of the emergency population.

Systems and Settings

Emergency psychiatry is practiced in various treatment settings from the hospital—general or psychiatric—to the community, in crisis clinics or with mobile teams.

There is increasing recognition that the assessment of the psychiatric patient in crisis must take place in thoughtfully designed environments, with attention to the safety of both patients and staff. The ideal location for emergency assessments would occur in the general hospital in a designated space for patients with mental health concerns as noted at triage.⁵ Advantages of the general hospital include having the emergency physician as first line to initially screen for acute medical problems. As well, laboratory facilities are on site, and investigations and consultants are easily accessible. The emergency physician may triage less urgent patients, without the need for the involvement of the psychiatry team.

General hospital EDs have the advantage of medical support, as described above, but the psychiatric hospital has the expertise of trained emergency staff who are specialists in the care of psychiatric patients. The patient will be seen by those trained to empathically and knowledgeably assess and treat psychiatric illness. Regardless of the setting, the emergency psychiatry team should be composed of psychiatrists, psychiatric nurses, clinicians (for example, in social work and psychology) and psychiatric assistants with access to security.⁵

Extended observation beds continue to be ideal for patients not requiring a full hospital admission but who require a longer time for assessment or only a short stay to reconstitute from a crisis.⁵ Patients in substance-induced states also benefit from such a hold, as their symptoms improve with the resolution of the toxidrome.

It is essential that the setting for the emergency assessment be equipped with full safety features, whether in the general or psychiatric hospital environment. Designated interview rooms, with features such as alarm buzzers, video monitoring, sight lines to nursing stations, thoughtfully designed furniture (weighted or bolted), and non-barricadeable doors, are recommended in designing a psychiatric ED.⁶

In addition to the traditional model of hospital-based emergency assessments, there are numerous alternatives that should be considered. Many people with psychiatric illness cannot access family physicians or reliably follow up with appointments in the community. In smaller urban and rural hospitals, financial and staffing pressures have made it impossible to set up a dedicated psychiatric emergency service. Other options include community crisis teams, community crisis beds and specialized mental health units within police forces to deal with emergency mental health situations.^{7,8} Residents' exposure to these additional models of care will vary, depending on the location of the particular program and the region it services. An understanding of these components can be introduced in core teaching and followed up with elective experiences as permitted.

Common Emergency Presentations

Agitation

Acute agitation is a common reason for referral to a psychiatric service. In a US study, 50 per cent of psychiatric presentations to the ED involved agitation.⁹ Assessing the agitated patient can be an anxiety-provoking experience for the psychiatry resident. Resident training programs must provide education to address both the assessment and the management of the agitated patient in the ED. Agitation can be caused by various etiologies including medical, substance and psychiatric. It is optimal that medical causes for agitation be ruled out prior to psychiatric referral, but this is not always the case when the patient arrives in the ED in a state of agitation. At a minimum, the triage of the agitated patient should include vital signs, with oxygenation level and blood glucose level, when possible.¹⁰

The psychiatrist or trainee working in the ED assessing the agitated patient needs to be assured of a safe environment prior to initiating the assessment. Working in a team is essential, and the emergency psychiatrist must determine when extra staff will be required for additional support. Speaking to the referring physician and reviewing past charts can be helpful in determining current and past history of violence. Visualizing the patient in the waiting room to observe the mental status is recommended. Prior to interviewing the patient, the level of agitation needs to be determined to best prepare the interview approach. Recognizing the state of agitation, from anxiety to verbal threats, to overt aggression, is essential, as the interview approach and intervention will need to be paired to match the type of agitation and de-escalation will follow accordingly.

The American Association of Emergency Psychiatry (AAEP) has recently published consensus guidelines on agitation that are not only effective and safety-minded but also patient-centred.¹¹ Previous guidelines

have tended to focus on environmental systems and medication strategies^{12,13}; but, for the first time, a comprehensive document has been created addressing all aspects of intervention, from medical triage, to assessment, verbal de-escalation and, ultimately, pharmacologic management.

Minimal restraint to achieve calmness is the goal, and the means include both mechanical and chemical. Over-sedation to the end point of sleep would preclude the ability to interview and assess. Two broad classes of medications are most commonly used in managing the agitated patient—benzodiazepines (BZDs) and antipsychotics (APs). The APs are divided into the first- and second-generation (FGAs and SGAs, respectively) options. There are multiple routes available for delivery of these medications including oral, sublingual (SL), fast-dissolving, intramuscular (IM) and intravenous. Choice of medication or medication combination, as well as route of delivery, will be influenced by diagnostic impression and severity of the agitation.

Currently, there is no rationale to support the former practices of rapid neuroleptization, and possibly even rapid tranquilization, whereby large cumulative doses of medications are given in a short period of time to induce sedation. At this time it is recommended to work towards a goal of calmness by administering the medication based on the knowledge of specific pharmacokinetics. When at all possible oral medications should be offered prior to IM injections if the patient is cooperative and there are no medical contraindications. The more agitated patients will require routes with quicker onset, such as SL or IM. The most important determinant of medication choice is the working diagnosis. APs, with or without a BZD, are indicated as first-line management with psychosis of psychiatric origin. Typically, the high-potency APs, both FGA and SGA (for example, haloperidol and risperidone), will require a BZD for sedation. For agitation due to intoxication, BZDs will be the preferred agents. The BZD of choice in the ED is lorazepam, for its safety profile and multiple options of route. With the delirious patient, BZDs should be avoided, and the preference would be to use high-potency APs to minimize the possible anticholinergic side effects, and, of course, treating the underlying cause would be essential. Important distinctions between the American guidelines and Canadian approaches include the availability of loxapine in Canada, a mid-potency FGA that is available as an IM injection, and a more cost-effective option than the SGAs. For the most severely agitated patients, combined haloperidol and lorazepam IM remains an extremely effective option.¹⁴

Residents must feel comfortable managing acute agitation in the ED to proceed with their assessment, and also be able to write treatment orders that may involve the need for ongoing chemical and mechanical restraint.

Each hospital will have their own least-restraint policies in place, and staff and residents need to be aware of the protocols specified institutionally. Treatment capacity is not typically assessed in the ED, thus medication is used to contain behaviour. At times, the agitated patient may not immediately respond to interventions in the ED. A Code White should be called for added assistance at any time. Should an assault occur, the incident should be documented, and a process for debriefing and review should be initiated immediately. Residents will have support from their training programs, their department and the hospital in question.

Suicide

Risk assessment is important as a part of every psychiatric assessment, and even more so in the ED. Most referrals in the ED to psychiatry are for an assessment of suicide risk. Predicting suicide is an inexact science at best, and the emergency psychiatrist is ultimately in the position of determining the level of risk and whether the patient is safe for discharge or requires an admission on a voluntary or involuntary basis. Determination of suicide risk encompasses a complex range of diagnoses and clinical presentations. The resident trainee will need exposure to many assessments to determine the level of risk, whether the patient presents as chronically suicidal, with self-harm but no clear intent, or as more acutely suicidal. Documentation will need to reflect the impression of the risk assessment, be it low, medium or high, and the plan will follow accordingly. The need for specific documentation in this regard cannot be overemphasized—this will be the only record should a suicide occur after the ED visit.¹⁵

Patients with suicidal ideation will be referred, following an attempt or in a state that has the emergency physician concerned about the possibility of suicide as an outcome. More than 90 per cent of patients who complete suicide have a known psychiatric illness,¹⁶ and the psychiatrist may be in the best position to determine what illness could be contributing to the presentation and what the options are for treatment. Interventions need to be targeted at the modifiable risk factors, and treating the underlying illness, while addressing substance use. Other approaches in managing the lower-risk patient in the ED will be therapeutic in nature, using psychotherapy techniques. In addition, psychoeducation regarding mindfulness, emotional regulation and distress tolerance, as noted in the dialectical behaviour therapy literature, are particularly helpful for the chronically suicidal patient.¹⁷ When possible, the option of an emergency hold to reassess the suicide risk once the immediate crisis settles is ideal and can be therapeutic for the patient.

Residents must be comfortable asking direct questions about suicide in all emergency assessments. Histories and documentation need to include details about current

suicidal ideas (active or passive thoughts of death) and intent, prior suicidal ideas, plans and attempts, and associated symptoms of anxiety, hopelessness and impulsivity. The use of substances, access to means and the presence of psychosocial stressors are also important details to note. As well, protective factors should be discussed and documented, whether present or absent.

Substance Related

Substance-related problems are a frequent cause of ED visits, occurring in close to 20 per cent of presentations.¹⁸ Substance abuse can occur alone or in combination with other psychiatric difficulties. Studies report that upwards of one-third of people with psychiatric illness have comorbid substance use pathology.¹⁹

The list of substances, beyond the most common intoxicants of alcohol, stimulants, opioid and hallucinogens, is ever changing. Media attention has alerted the public to bath salts, a new central nervous system stimulant, and herbal marijuana alternatives, with street names such as Spice and K2.^{20,21} These newer agents may not be detectable in current toxicology screens. Given this state of ever-expanding substances to use and misuse, it is essential that education in this area continues well past residency.

The evaluation of patients with comorbid substance use and psychiatric illness may rely on review of past presentations, the time course of symptoms and collateral history. Standardized scales, such as the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised, and Clinical Opiate Withdrawal Scale, may delineate the seriousness of withdrawal and monitor its progression.^{22,23} EDs often defer the decision for toxicology testing to the psychiatric team. Psychiatry may opt for a toxicology screen under particular circumstances: unknown substances ingested, clinical presentation not in keeping with the reported substances or substance-related psychiatric illness.

Ideally, referrals to psychiatry should be made to assist with risk assessment, diagnosis or management when the patient is free from substances. The reality is that patients will often be referred prior to full detoxification owing to the pressures on EDs, but residents cannot properly assess intoxicated patients. The Canadian Medical Protective Association provides guidance on detaining the intoxicated patient until a proper assessment can be completed, without the need for involuntary certification.²⁴

Residents may also be called to recommend or assist in suggestion of addiction resources, such as detoxification centres, 12-step programs and rehabilitation programs. The emergency psychiatry team will need to liaise and cooperate with medical and addiction colleagues to provide optimal care to this challenging patient population.

Medically Complex

Medical comorbidity is common and contributes to the complexity of assessing patient in the ED. Psychiatric patients have similar risk of medical illness as the general population, if not greater. Patients may not have a family physician or follow up with medical care; they may have poor lifestyles owing to poverty and (or) symptoms of their illnesses; psychotropic medications may have significant medical side effects; and physicians may attribute symptoms to the psychiatric illness and not adequately screen for medical comorbidities.^{25,26}

There is a significant literature about medical stability (a preferable term to medical clearance), and no one definition exists.²⁷ As a result, educating trainees about the medically complex patient population in the ED is challenging, given this continued debate. In addition, the threshold at which one deems a patient medically stable will vary depending on the facility, the medical support available and the time of day. Trainees need to be aware of the policies of the hospital in which they work, specifically regarding the approach to consultation, should an acute medical problem be discovered.

Beyond the site-specific issues, trainees will need differing degrees of support for the medically complicated patient in the ED. The discussion with the referring physician is paramount in determining the specifics of medical stability. Navigating these interprofessional communications can be challenging, particularly if the reason for referring a patient is vague or the issue is a contentious one between services. Delirium and dementia are two examples of diagnoses that can strain the relationship between specialty services, thus residents may require assistance in developing skills to negotiate care for these patients.

Emergency Interventions

Interventions in a psychiatric emergency can range from the treatment of a specific symptom to the initiation of treatment for a psychiatric disorder. Both the resident trainee and the staff psychiatrist must be comfortable with the options available. Treatment may be required only on a one-time basis, or it may herald the need for ongoing psychiatric care into the future. Capacity must be assessed if treatment is to be initiated. A biopsychosocial approach to emergency management is optimal.

Pharmacotherapy on an emergency basis often is to address significantly distressing symptomatology so that patients can more actively participate in their care. Common medications used in emergency psychiatry include BZDs and APs for agitation, anxiety and insomnia. Residents need to have both academic and practical knowledge of the medications they are prescribing in the ED. Caution should be exercised

in prescribing medications at the point of discharge, particularly if follow-up is uncertain.

Psychological interventions may begin during the interview itself, using active listening and employing techniques from motivational interviewing and brief psychodynamic models, while information is being gathered.^{28,29} It is essential for patients and their families to have an understanding of the diagnosis and its implications for treatment. Residents need to be taught the components of effective psychoeducation—explaining the meaning of the diagnosis, forming an alliance and communicating the importance of treatment adherence—as this will have a significant impact on clinical outcomes.³⁰ These skills are typically needed promptly and often in challenging circumstances.

Crisis intervention skills are required in the emergency setting. People working with emergency psychiatry patients need to develop the ability to establish rapport, identify the crisis precipitants and assist in managing distressing emotions while generating alternative coping strategies.³¹ Each step involves special skills that need to be acquired during the residency training so that crisis intervention becomes more than a catch phrase written in a treatment plan.

Lastly, many social problems are the root cause of psychiatric emergency presentations or, at the very least, contribute to worsening the clinical picture. Optimally, the emergency psychiatry team will consist of professionals who have more detailed knowledge of community resources. Ideally, residents will learn from the multidisciplinary team to better service emergency patients, when on call or working independently.

Education

Education in emergency psychiatry begins with the undergraduate medical students, during either pre-clinical lectures or clinical rotations in psychiatry. Little evidence exists to provide guidance about the timing or content of this training, but common sense would dictate that exposure to the assessment of patients and safety aspects occurs prior to the clinical clerkship years. Novel teaching strategies, using standardized patients and role-playing, increase comfort with assessing and treating patients in crisis while decreasing learner anxiety.³² Some evidence also exists to support independent case-based study in emergency psychiatry for medical students as a means of improving test scores.³³

Regarding postgraduate education, the RCPSC requires that psychiatry residents be able to identify and appropriately respond to clinical issues that arise from suicide, self-harm or harm directed toward others.³ Residents must be proficient in crisis intervention and de-escalation techniques as part of the CanMEDS Medical Expert role. Emergency psychiatric training

sites are optimal for meeting these objectives, while also providing opportunities for residents to gain enhanced skills in the roles of Advocate, Collaborator, Communicator and Manager. It is recommended by the RCPSC that psychiatry training in the first postgraduate year (PGY-1) include four weeks of emergency psychiatry, but currently a separate rotation is not a requirement.³⁴ The AAEP recommends that a minimum of two months of dedicated emergency psychiatry clinical training occur in the first or second year to achieve competency to provide good care in crisis situations and across all settings.³⁵

Lastly, continuing medical education in emergency psychiatry is paramount. Both junior and senior staff requires orientation to on call policies and updates of emergency psychiatry skills. Courses are currently being offered at local and national levels to maintain these skills.

Discussion

Emergency psychiatry has advanced since the CPA 2004 position paper regarding clinical practice and education. From the previously described 2013 survey sampling residency programs across the country, it is also evident that the practice and teaching of emergency psychiatry varies widely. Programs are restricted by size and available resources, and there may be limitations in what can be provided in the teaching curriculum. At a minimum, programs should include dedicated didactic sessions, a core clinical rotation and follow explicit on call and handover standards.

The survey respondents suggest that programs provide less than 10 hours of didactic teaching in emergency psychiatry. This is clearly insufficient. To do this area justice, residents need teaching on suicide, agitation, the medically complex patient, substance abuse in the ED, documentation, crisis intervention and psychotherapeutic techniques, emergency psychopharmacology, mental health legislation, self-defence and safety. Additional topics might include medical-legal issues in the ED, community resources and special populations (such as dual disorders, personality disorders, geriatric and child, cultural competency and domestic violence). A curriculum as described would require at least 20 hours and occur early in training prior to the resident's independent on call assignment. The use of standardized patients and simulation techniques would optimize the teaching program.

Regarding the clinical training requirements, the RCPSC recommendation of four weeks in the PGY-1 year provides a foundation, but an additional month, as per the AAEP's Education committee model, should be offered later in the residency program to update and maintain skills and knowledge.³⁵ Trainees must be observed directly by supervisors who have expertise in emergency psychiatry and (or) comfort with people

who are acutely ill. Teaching sites must meet safety standards and, if available, offer exposure to the psychiatric patient, both in general and in psychiatric hospitals. Residents should be part of a multidisciplinary psychiatric emergency team, at whatever site they are working, with opportunities to learn from others who have expertise in the field.

Currently, the on call requirements are highly variable from program to program, with a frequency ranging from 1 in 10, to 1 in 3, and call shifts taking place in-hospital or at home. Competency-based education would demand a minimum expected call structure to ensure that skills are both developed and maintained. Many factors will influence call frequency, but at least three times per month of in-house overnight call duty is recommended, one being a weekend shift. However, the call frequency alone will not ensure that there is sufficient exposure to the numbers, and diagnoses needed to achieve competence in emergency psychiatry. The use of logs in the ED would help to quantify patient encounters while on call. Additional educational interventions may be prescribed based on the analysis of the logs and the resident's need for more exposure. Details of specific competency-based requirements for emergency psychiatry will need to be established,³⁶ and this discussion should include training programs through the Coordinators of Psychiatric Education (commonly referred to as COPE), national educational groups at the CPA and the RCPSC Specialty Committee in Psychiatry. Graduated on call responsibilities should be incorporated for the resident moving from the junior to senior years. The senior resident should be more comfortable in the decision-making process and can be expected to supervise the junior trainees while on call.

Handover rounds at the beginning and end of the call shift are of both clinical and educational value and have been shown to reduce medical error.³⁷ This approach becomes even more important as emergency holding units have more of a presence in our hospital system, and the on call team is responsible for all patients in the unit. A structured handover that includes the resident must occur following each call shift.

Education in emergency psychiatry continues beyond the junior resident years. There should be opportunities for additional training on an elective basis. The psychiatric ED is an excellent setting in which to refine managerial skills and enhance confidence in preparation for practice. Staff may want to take advantage of updates in acute care psychiatry to better offer an informed supervisory role. The next wave of educational formats includes online modules, smartphone applications for use while on call and websites, both for patient psychoeducation as well as for clinician continuing education. Technology offers exciting future potentials to enhance the education and clinical practice in this regard.

Emergency psychiatry remains a dynamic subspecialty area that requires comprehensive knowledge and unique clinical skills to best provide care to a challenging yet rewarding patient population.

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