

Maryland Citizens in Psychiatric Crisis: A Report

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The conclusions drawn in this report are those of the authors and do not necessarily reflect the viewpoints of those who provided us with information and feedback. Everyone that we interviewed, however, agrees that Maryland can and must---do better for its citizens with psychiatric disabilities and all are dedicated to the effort. We provide this report in the hope that stakeholders will set aside differences and competing interests and work together to achieve the promise of a comprehensive and quality community crisis response system.

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my voice is valued,
but not in the hospital.
You have even less of
a voice in the ER.”**

--Paula, Focus Group Participant



Executive Summary

In other situations, my voice is valued, but not in the hospital. You have even less of a voice in the ER. People with physical problems seem to be more important. Their needs take precedence over yours. If you're there over 48 hours, you're just a burden. You can't even assert you want something to eat or that you need your medicine, without getting yelled at.

--Paula, Focus Group Participant

Emergency departments in Maryland are the primary resource for people in psychiatric crisis. They are expensive and rarely optimal places to provide the attention and calm that people need when they are in acute emotional distress. Emergency departments are also often the principal recourse for people with psychiatric disabilities seeking basic emotional support, medical care, medication refills, or even food and shelter, especially late at night, on weekends, and at the end of the month. Emergency departments, already strained to the limit, are being asked to provide more care and services than they reasonably can or should be expected to deliver.

In addition, once they arrive at an emergency department, individuals with a psychiatric disability are nearly twice as likely to be admitted to an inpatient bed as are individuals presenting with medical conditions.¹ This impacts Maryland's entire mental health system, using resources better spent to strengthen community diversion and crisis services. Emergency department and inpatient services are the costliest and the scarcest forms of psychiatric care, and should be conserved for those who truly need them.

A survey of over 300 Maryland citizens with psychiatric disabilities confirms that, while many are grateful to have emergency departments available to them when in need, most would prefer to receive crisis services elsewhere. They wait in the emergency department for many hours and sometimes days in claustrophobic rooms, or just sitting in chairs in segregated areas with patients who are intoxicated or high. A variety of emergency department practices and policies frighten them. For example, some people with histories of sexual abuse are afraid and retraumatized when they are asked to remove all their clothes for a psychiatric examination. If they refuse, their clothes may be

forcibly removed by male security guards. Most of all, people with psychiatric disabilities complain that they are not believed when they have medical complaints, and that they are not given information about what is happening, what medications they are being prescribed, or where they will be sent.

The State of Community Crisis Services

Despite years of promises, people in psychiatric crisis have very few places to turn in Maryland. In 2002, the State established the Mental Health Crisis Response System, which ---on paper---contained all of the necessary elements for a comprehensive and coordinated system. In the preamble to the legislation, the General Assembly specifically found that the lack of comprehensive crisis intervention services and supports had resulted in over-utilization of costly acute care State hospital beds. Implementation of the Crisis Response System, however, was made contingent upon receipt of federal funding or funding from “any other private or public source.”² Sufficient funding has yet to materialize and thus crisis services in Maryland’s 24 jurisdictions (23 counties and Baltimore City) are largely fragmented and scarce.

For example, the Mental Health Crisis Response System includes community crisis beds, which can provide cost-effective diversion before individuals go to emergency departments, as well as diversion after individuals are evaluated at the emergency department. But community crisis beds are scarce, and those that exist are not well utilized. Only 6 out of 24 jurisdictions have their own crisis beds; an additional 3 counties have regionalized services that include crisis beds. Several of the counties without crisis beds ostensibly have access to beds in other counties. However, there are simply not enough beds and even in cases where a bed in another county is open, there are many obstacles, both logistical and clinical, to transporting an individual in crisis across counties. In total, the State currently has 91 crisis beds for its approximately 100,000 Public Mental Health System clients, a dismal ratio of 1 crisis bed per 1,099 individuals receiving public mental health services.

Other crisis services do not fare any better. Of the 9 jurisdictions that have mobile crisis teams, only 5 have both mobile crisis teams *and* crisis beds. Even in those jurisdictions with both mobile teams and beds, only 3 consistently evaluate and refer people directly to crisis beds; the other 2 counties- despite having the components of

diversion services available to them-- still refer individuals in psychiatric crisis to expensive, overcrowded emergency departments. In addition, unlike emergency departments which operate on a twenty-four hour basis, most of the community crisis services that do exist are only available during limited hours. Only 2 counties have mobile teams available around the clock. Several jurisdictions do not even have hotlines or warm lines available around the clock. With rare exceptions, a person in psychiatric crisis in Maryland is certain to be referred, or taken, to an emergency department.

Emergency departments are the primary destination for people in psychiatric crisis not only because of a lack of alternatives, but also because the function of crisis beds in many jurisdictions is not diversion from the front door of the emergency department. Instead, beds are frequently used as step-down or transition from inpatient units or as diversion after the individual has been assessed in the emergency department. Despite the well-publicized strain on emergency departments, there is no uniform strategy to promote the proper use of crisis beds for diversion.

Many hospitals themselves fail to refer individuals to crisis beds from the emergency department. While in some instances there are reported clashes between emergency department staff and crisis provider staff, a primary issue appears to be that, as required under federal law, emergency departments must complete medical and psychiatric evaluations and stabilize the individual before discharge. During the lengthy wait, often in adverse environments, a person's condition may deteriorate, leading to the decision that inpatient hospitalization is required. Thus, some inpatient demand is in effect created by emergency department conditions. Alternatively, the individual may improve and be discharged---frequently without the supports and referrals that could be offered by a crisis provider. Another significant obstacle is the largely unwarranted yet pervasive fear that hospitals have regarding legal liability should a person discharged to a crisis bed attempt or commit suicide.

Simultaneously, many family members, police officers, nursing home and residential rehabilitation program staff, group home operators, and case managers use emergency departments as a place to solve their own difficulties with people in their care or custody who are presenting behavioral problems. Some of these visits represent appropriate uses of the emergency department. However, often these "secondary utilizers" contribute to the over-burdening of emergency departments by depositing individuals in ED waiting rooms rather than developing skills to deescalate behavioral problems in the community.

It is imperative that crisis services, including crisis beds, are not only expanded, but used to appropriately divert individuals away from emergency departments. It is also critical to ensure that consumers, community mental health providers, police, family members, and emergency department staff are educated about the availability and appropriate use of crisis services.

Fragmented Social Services

The State is not only failing to provide people with psychiatric disabilities the crisis care that they need, it is also failing to provide coordinated social services and supports and easily accessible and affordable medical care. Many people with a psychiatric disability utilize emergency departments to refill prescriptions, receive treatment for minor injuries or conditions, or simply to find a sympathetic ear, a meal and a bed. Some consumers readily admit that they will claim an intention to commit suicide to get respite from life on the streets or a difficult situation. Without a sufficient and coordinated social services system, emergency departments are being asked to provide care and services that should be provided elsewhere. Further, without access to affordable 24/7 urgent care clinics, many people flock to the emergency department to get care for conditions that could be treated more quickly and affordably elsewhere. Once in the emergency department, mental health consumers face lengthy waits for assessments and disposition, increasing the likelihood of eventual inpatient admission.

The State must increase its efforts to assist consumers in finding appropriate alternative access to medical care and substance abuse services. Adding caseworkers, particularly for those individuals who frequently utilize the emergency department, would be cost-effective in the long-term and would greatly improve the lives of those mental health consumers needing assistance to access benefits and services throughout different systems. In addition, the clinics and programs serving consumers should focus on helping consumers strengthen existing community ties and interpersonal relationships to use as no cost supports in a crisis.

Increasing Strain on the Public Mental Health System Budget

Some stakeholders, including community hospitals, are calling for an increase in the number of state-operated acute

care beds. While seemingly an easy short-term solution, it is not a fiscally viable option for the foreseeable future as the Mental Hygiene Administration budget is at risk of future cuts as the State seeks to remedy the structural deficit of its budget. It is also not sound policy to expand the most costly and restrictive care settings, which would further hamper the State's ability to develop a robust system of community care.

Simultaneously, the Mental Hygiene Administration budget is being increasingly squeezed by the uncontrolled demands of the criminal court system that it provide competency assessments and treatment of individuals charged with crimes without commensurate budgetary increases. In addition, many individuals found "not criminally responsible" and committed to state facilities for treatment of a mental disorder remain in hospitals months and years past the time that inpatient care is clinically indicated because courts frequently demand that scarce intensive residential services be provided, sometimes for decades, as a condition of release. Currently, fully 50% of state hospital beds are taken by these forensic clients.

It is crucial for the Mental Hygiene Administration to fully examine the fiscal impact that criminal courts place on its resources and ensure that sufficient services are available for all Public Mental Health System clients. In addition, the State must plan to rebalance the mental health budget by replacing aging and exorbitantly expensive institutions--which significantly drain resources--- with a full continuum of community care.

Mental Health Consumer Experiences within Emergency Departments

In order to get the perspective of persons diagnosed with a psychiatric disorder about their experiences with crisis care, the Maryland Disability Law Center and Center for Public Representation conducted surveys and focus groups. We found that satisfaction with emergency department care is strongly correlated with being accompanied by a friend or family member, receiving information and updates on a regular basis, and having basic needs met, such as food and medicine. Many survey and focus group respondents cited caring staff, both emergency department and mental health, as the reason for their overall satisfaction. Others were pleased when appropriate community referrals were provided and they were able to escape the cycle of frequent ED utilization.

Those who were dissatisfied cited being treated differently based on psychiatric disability, not being provided

with basic necessities, crowded conditions, being held with persons who are intoxicated or high, and long waits. Understandably, many individuals were frustrated with lengthy waits, often in very adverse environments, that frequently ended with a discharge but no referrals for community services. Other individuals noted that they came to the emergency department for a medical condition, but as soon as a prior history of psychiatric illness became known, they were forced to undergo a psychiatric evaluation.

The survey and focus group responses indicated a number of steps that hospitals can undertake to improve quality of care in their emergency departments, including reducing wait times, which will not only increase patient satisfaction, but will likely lead to reduced inpatient admissions as exacerbation of emotional crises is minimized. Consumers also identified effective community services and assistance that would better serve them and would prevent unnecessary trips to the emergency department.

The following recommendations are based on the input received from a wide range of stakeholders, including mental health consumers, community crisis and mental health providers, hospitals, service agencies, and advocates.

SUMMARY OF RECOMMENDATIONS

• Reduce the Number of Mental Health Consumers Needing Acute Crisis Care

Mental Hygiene Administration: Develop plans--in conjunction with the Maryland Health Care Commission Task Force's comprehensive statewide mental health needs assessment to identify the community resources necessary to assist mental health consumers remain stable in their recovery---to provide a comprehensive array of community services to prevent acute crisis; support extended hours at community mental health programs with counseling and routine medical care; increase Public Mental Health System client access to a broad range of available social services, including transportation assistance; developing and increasing access to affordable housing.

Hospitals: Increase outreach, educational and collaborative efforts with community mental health, substance abuse and social services agencies to reduce the use of emergency departments as the default point of access to systems and services.

Executive/Legislature: Fully fund the community resources needed to reduce the use of costly acute care.

- **Strengthen and Expand Outpatient Crisis Services**

Mental Hygiene Administration: Set uniform priorities applicable state-wide for use of services and beds to increase diversion before a person goes to the emergency department; increase crisis services coordination with police departments and community providers; conduct community crisis awareness campaigns for hospitals, police, consumers, family members and providers.

Hospitals: Develop uniform medical clearance policies to reduce delays in the emergency departments and allow individuals to return to community crisis services faster; increase diversion of emergency department patients by developing and monitoring standards for appropriate discharge to community crisis beds and strengthening relationships between community crisis providers and emergency department staff.

Executive/Legislature: Fund the full range of community crisis services operating 24/7.

- **Reduce Frequent ED Utilization**

Mental Hygiene Administration: Identify, in Baltimore City, the top fifty users of emergency departments and, with patient consent, assign case managers with the direct responsibility to reduce ED use by connecting these individuals with alternative services; assign a case manager statewide to consumers, with consent, who use an emergency department more than five times in one year; work with hospitals to identify community program providers who inappropriately utilize the emergency department to avoid conflict with a consumer or for routine medical care and take measures to control this practice; and provide transportation vouchers to individuals in emergency departments.

Hospitals: Provide transportation vouchers so that individuals may access follow-up care.

- **Increase Access to Needed Community Inpatient Acute Care by Uninsured Individuals**

Mental Hygiene Administration: Resolve disputes over the adequacy of rates and the definition of acute care; purchase beds as needed for patients needing longer lengths of stay; provide around the clock assistance to emergency departments to find available acute care beds.

Hospitals: Accept transfers of uninsured patients from emergency departments without an in-patient psychiatric unit.

Legislature/Executive: Provide oversight to ensure that uninsured individuals are provided necessary community hospital in-patient acute care without delay; provide universal mental health care coverage.

- **Maximize Efficient Use of the Mental Health Budget**

Mental Hygiene Administration: Reduce the number of intermediate and long-term beds and transition patients to the community; minimize forensic bed expansion by individualizing release plans and services; develop uniform standards for evaluation and treatment of persons found incompetent to stand trial; track resources utilized by persons court-ordered for evaluation or treatment.

Legislature/Executive: Ensure that savings from state hospital bed closures do not revert to the general fund but are instead allocated to community-based services; develop alternative budget mechanisms to minimize the drain on the mental health budget by court-ordered patients; plan to close aging, inefficient and costly institutions and develop smaller, regional-based facilities.

- **Improve Quality of Care Provided to Psychiatric Patients in Emergency Departments**

Hospitals: develop plans for representation by consumers of mental health services on hospital boards and/or committees; include consumers of mental health services in staff training, especially training on restraint and seclusion; develop positions for consumers, such as emergency department sitters, to assist individuals in crisis; ensure attention to medical complaints raised by persons with a psychiatric disability by investigating current practices, conducting chart audits, and increasing staff training regarding both common co-morbid conditions such

as diabetes and the impact of stereotypes and stigma on medical assessment; ensure that emergency department staff are obtaining informed consent for treatment; evaluate clothing removal policies to ensure that clothing is never forcibly removed from patients in the emergency department unless a true medical emergency exists or restraint/seclusion standards are met; understand the impact of clothing removal requests on patients with histories of trauma or sexual abuse; reduce the use of restraint and seclusion by collecting and evaluating data, increasing emergency department and security staff training, identifying at-risk populations, evaluating environment and policies to identify factors that may contribute to escalation and, if time permits, conduct debriefing with the patient about the event; ensure that security is used sparingly and appropriately by collecting data to monitor interactions involving security guards' use of force or threat of force and requiring regular training on de-escalation; prohibit use of pepper spray or handcuffs except in situations involving criminal activity.

[..... described patients whose need for

admission arose because of escalation or agitation in response to emergency department conditions.

]

Introduction



Background

In 2003, the Center for Public Representation (CPR) embarked on a national research project to improve the care of psychiatric patients in emergency department settings. It surveyed thousands of psychiatric patients nationally about their emergency department experiences, and interviewed scores of ED nurses, administrators, physicians and psychiatrists. It found that the rate of emergency department admissions to inpatient psychiatric units was very high at many hospitals, leading to increased demand for scarce beds and increasing delays in disposition. Many factors contributed to the high rate of admissions. One of those factors, “iatrogenic” admissions, described patients whose need for admission arose because of escalation or agitation in response to emergency department conditions or policies which often unwittingly exacerbated psychiatric crisis.

CPR gathered a group of national experts, including urban, rural, and mid-size city emergency department physicians, managed care representatives, researchers, patient and family advocates, and state mental health representatives as its National Advisory Council. Council members identified twelve key areas that contributed to unnecessary admissions and/or adverse patient experiences in emergency departments. The National Advisory Council created a set of consensus standards which, if implemented, would significantly reduce unnecessary admissions and adverse patient experiences. These standards concern seclusion, restraint, informed consent, advance directives, mandatory disrobing, security guards, medical clearance, medical treatment, trauma, accompaniment, and maximum waiting time. The standards were published by Oxford University Press in 2006.³

That same year, the Jacob and Hilda Blaustein Foundation and the Leonard and Helen R. Stulman Charitable Foundation funded the Maryland Disability Law Center (MDLC) and the CPR to undertake a two-year project to (a) survey Public Mental Health System (PMHS) clients and uninsured mental health consumers about their experiences in emergency departments; (b) work with selected emergency departments to review their policies and

data and propose hospital-specific recommendations to improve the quality of care; and (c) work collaboratively with hospitals, consumers, advocates and other stakeholders to identify structural issues in Maryland's PMHS that contribute to emergency department overcrowding and to propose recommendations for system reform.

During Phase I of the project, MDLC and CPR conducted surveys and focus groups with PMHS clients and uninsured mental health consumers and met with various stakeholders, including Maryland Hospital Association members, State Mental Hygiene Administration officials, advocacy organizations, and community crisis providers, to gather information about issues of concern. We elicited commitment from three hospitals, Johns Hopkins Bayview, Sinai, and Baltimore Washington Medical Center, to formally participate in Phase I and these hospitals generously shared their data and policies and provided tours of their emergency departments to representatives from MDLC and On Our Own of Maryland, Inc. MDLC then prepared confidential reports for each of the three participating hospitals, which provided hospital-specific feedback on consumer experiences, analysis of policies and data and recommendations for quality improvement.

During Phase II, MDLC, with assistance from the Mental Health Association of Maryland, surveyed the Core Service Agency⁴ of each county and Baltimore City to compile data on existing services and called several hotlines and crisis providers to ascertain what information, referrals and services are provided. We then analyzed all of the information collected during Phases I and II and drafted this Report. A wide-range of stakeholders, including those who had provided information and data, were provided an opportunity to comment on a draft of the Report before it was finalized. Not all of the comments were ultimately incorporated, either because they involved issues that were outside the scope of the Report or because we were unable to verify the accuracy of the information provided.

Purpose and Scope of Report

The purpose of this Report is to provide hospitals, advocates, State officials and public policy-makers with an accurate snapshot of the experiences of Public Mental Health System (PMHS) clients and uninsured individuals in emergency departments, and to propose recommendations for action to improve both the quality of care individuals receive and the quality of the PMHS. Many of the system proposals can be implemented through Maryland's Mental Health Transformation grant, which includes a goal to "increase the efficiency of the service system with regard to emergency department utilization, diversion from hospitalization using community alternatives, and reducing waiting times associated with access to inpatient care when needed."

The Report also presents recommendations for actions that hospitals can take to reduce unnecessary inpatient admissions, shorten waiting times, minimize use of restraint and seclusion, increase patient satisfaction, and improve the quality of care they provide to people with psychiatric disabilities in emergency department settings.

The Report does not address the barriers to treatment encountered by mental health consumers covered by private insurance. Many of the issues identified in the report, such as practices in the emergency department, are universal and not dependent upon insurance status. Other issues, such as lengthy waits in emergency departments for disposition and in-patient admission decisions, may depend upon insurance status. We note that there are many community crisis and other mental health services, in certain jurisdictions, that are available *only* to PMHS clients. However, the problems reported to MDLC by our clients, advocacy organizations, service providers and hospitals that prompted this project primarily impact economically disadvantaged individuals who are uninsured or who are PMHS clients. Therefore, while we acknowledge an urgent need to increase access to mental health services by privately insured individuals, our analysis and recommendations are, by design, limited to the PMHS.

We also chose to not specifically address the many complicating issues confronting consumers who have co-occurring mental health and substance abuse disorders. We believe that it is important to note, however, that the separate programmatic requirements and funding streams for addiction services and mental health services create barriers to adequate treatment. Hospitals, community rehabilitation providers and crisis services providers all report

that a high percentage of the consumers who have difficulty maintaining stability in the community are those with a co-occurring substance abuse disorder. There have been ample reports produced by committees focused exclusively on this population and we strongly encourage the State to adopt the well-considered recommendations that would increase access to mental health and substance abuse treatment.

**“I was sick and tired of
being sick and tired,
so I wanted to go on a
psych unit.”**

---Focus group participant, asked why he went to the ED

Part I: Emergency Department Utilization by People



with Psychiatric Disabilities

A. Why Maryland Citizens with Psychiatric Disabilities go to Hospital Emergency Departments.

“I was sick and tired of being sick and tired, so I wanted to go on a psych unit.”

--Focus group participant, asked why he went to the ED

In order to get the perspective of people with psychiatric disabilities on their experiences in Maryland emergency departments, MDLC/CPR conducted surveys of almost 300 people with psychiatric disabilities who had visited emergency departments in the last two years for medical or psychiatric reasons or both. These surveys were prepared with the input of Maryland hospital representatives and On Our Own of Maryland, Inc., the state organization of mental health consumers, and were handed out at over thirty venues, including hospital emergency departments. In addition to conducting the surveys, MDLC/CPR held four focus groups with thirty-six people who are frequent users of multiple emergency departments.

The surveys and focus groups reflected the lives that poor people with psychiatric disabilities lead, and how the hospital emergency department has emerged as one of the only stable sources of support in times of crisis. When asked what situations or events contributed to their most recent visit to the emergency department, people's answers included “stress, mother died,” “niece murdered, mother sick, suicidal thoughts.” The surveys provided a window into the overwhelming problems facing respondents, and the broad variety of issues for which they seek help from emergency departments:

I wanted help with my depression and also with my pregnancy... I didn't even get prenatal vitamins that I asked for. I lost my car, my job, I'm homeless, found out I was pregnant, and my fiancé is in jail. ⁵

While pregnant women should receive prenatal care, the venue for that care should not necessarily be the emergency

department. Frequently, people said they went to the emergency department for “comfort.” A man reported going to the ED because it was “my outlet, a place to talk instead of using drugs.” Another respondent wrote, “I want someone to talk to about my feelings and care for me.” Many were worded concisely: “drinking,” “fight” and even “smoking” (for someone with respiratory difficulties) and “eating wrong foods.” Even more sadly, others visit the emergency department for food or shelter.

1. What Would Prevent a Return Visit to the Emergency Department?

Survey respondents and focus group participants emphasize that they would utilize alternatives if those resources were as available as the emergency department, both in terms of affordability and accessibility. This is an important caveat. Any attempt to divert people from inappropriate use of emergency departments must ensure accessibility. For example, Baltimore Crisis Response, Inc. (BCRI) provides assessments and services wherever the individual is located and provides needed transportation to link clients to supports. This convenience and accessibility to needed services was repeatedly mentioned by focus group members. People, including secondary utilizers, are familiar with emergency department locations, and know that they are open around the clock. Alternative services must be just as easy to access, and just as affordable. Impoverished people with psychiatric disabilities who desperately need psychiatric medication to remain stable often visit emergency departments at the end of the month when their funds have run out, simply to get medications. This places emergency departments in untenable situations. While EDs should not be expected to serve as welfare agencies or pharmacies, failure to supply the medications may mean that the individual shows up at the emergency department shortly thereafter now truly needing emergency psychiatric care.

However, survey respondents and focus group participants were able to identify other forms of assistance that had served them equally well or better, at a far less expensive rate. Most of the alternatives identified by these respondents and participants all exist in Maryland today, but are scarce or non-existent in many jurisdictions. Moreover, even where such services are in place, many consumers are unaware that they are available and would benefit from assistance in accessing what they need.

a. Mobile Treatment Teams/Visiting Nurses

One respondent who had no money for medicine and went to the ED simply to get a refill of his medication said that a mobile treatment team to dispense medicine would help him. A woman admitted to the ED for an “accidental overdose” on medicine said “someone coming to my apartment to check... if I’ve taken my medicine” would help her. Another woman who was admitted to a psychiatric inpatient unit believes she could have avoided both the ED visit and the admission if visiting nurse programs were extended to psychiatric patients as well as medical patients. Still others said they would not go to the ED if they could have “a home visitor”[sic] or “staff therapist coming to visit.”

b. Transportation Assistance

One reason why home based services were suggested so often is that many respondents lack transportation to access existing services. One woman wanted to attend AA meetings, but in order to go she had to cross a number of wide, heavily trafficked streets. She said that rides to AA meetings and appointments would help keep her out of EDs. Another man wrote “I would like help with... getting around to pharmacies to pick up medicine.” Because this was a survey response there was no way to find out whether the man could have found a pharmacy that delivered to his residence. However, the survey responses and focus group discussions clearly indicated that transportation remains a significant barrier to accessing services for many PMHS clients.

c. Crisis Beds

While many consumers were unaware of the availability of crisis beds as an alternative to the emergency department, those who had used this service were generally very satisfied. Respondents noted favorably that crisis bed providers, unlike emergency departments, were frequently able to link them to needed community services, including housing, and provided follow-up care. There were vastly fewer complaints about discriminatory treatment or use of force

by crisis bed providers, who were generally seen as both more knowledgeable about mental health issues and more focused on the individual than emergency department staff.

d. Crisis House

Several respondents said a crisis house would enable them to avoid going to the emergency department. A crisis house is conceptually different from “crisis beds” in a variety of respects. “Crisis beds” are generally short-term, more medical-model in terms of both staffing and approach, and are designed to avert visits to the emergency department, unnecessary hospitalizations or both. Crisis beds are part of a continuum of care within an existing service system, and their use is more often decided or recommended by persons other than the consumer, such as the consumer’s provider or, sometimes, police.

Crisis houses, on the other hand, generally emphasize a home-like environment. They have kitchens which are available for use by residents, and sometimes laundries. They are geared to somewhat longer stays, have a more egalitarian staff model, and often have peers as part of the staff. Their philosophy tends to be more holistic and the longer lengths of stay allow staff to assist consumers with issues such as housing and employment. Crisis houses have been operated successfully in diverse areas, including upstate New York, rural Colorado, and urban San Diego. The crisis house model that works best operates 24/7, with no predetermined threshold of psychiatric distress, and minimal screening (felons, active substance abusers, and those requiring significant medical care).⁶

e. Mental Health Programs with Extended Hours

As noted earlier, many consumers reported going to an emergency department late at night simply to talk, or get assistance coping with grief or other situational problems. Access to community mental health programs after hours would divert those simply needing counseling and could help others avoid getting to the point of crisis. The Mental Hygiene Administration (MHA) should develop plans to extend community mental health program hours and encourage programs to hire peers to staff mental health centers for after-hours drop in programs.

f. Substance Abuse Treatment

Access to drug treatment is critical for many people with psychiatric disabilities. A woman who visited the ED thirteen times in two years said access to a drug and mental health program would have helped her. Hospitals and community providers identified that consumers with a co-occurring substance abuse disorder are at high risk for repeated crises and frequent emergency department utilization. There are very few community programs equipped to treat both substance abuse and mental health. Even if a program has the capacity to staff certified and licensed substance abuse professionals, getting authorization for treatment from managed care organizations is reportedly exceedingly difficult.

g. Increased Housing

“Please help find more housing for people who are homeless such as I. Treatment for three days or one week in a hospital is great. But when you’re released to homelessness, it’s but a brief respite.”

--Danny Lighthiser⁷

An individual who estimated a total of twenty-five emergency department visits in the last two years, responded to the question of what could have prevented the need to go to the emergency department, by writing “Definitely housing, sleeping in the street.” Another respondent wrote simply “an apartment.” Another wrote, “I need help getting a place, i.e. social services.”

Housing is a critical issue for many PMHS clients and uninsured consumers. Many people who are homeless go to emergency departments hoping for an inpatient admission simply to have a bed and meals for a brief period. MHA should expand efforts to link PMHS clients with housing programs. It is frequently difficult for individuals who are chronically homeless, particularly those with co-occurring disorders, to find and remain in traditional housing. An innovative housing model, called Housing First, meets the client where he or she is in recovery and works with the individual to maintain housing during the recovery process. Housing First, which has a successful track record in

New York, is being developed in Baltimore City and should be expanded.

h. Case Management/Medical Assistance

A number of people went to the emergency department because they were out of needed medications and could not get assistance from their community residences or mental health programs: “I was out of blood pressure medications had no \$ or insurance & Alliance had no provisions to assist.” This individual ultimately had a “major blood vessel rupture in eye” as a result, and then went to the ED and was treated. Another was refused treatment by her doctor because of inability to pay: “I was in a rehab. I had unpaid bills due to lack of paperwork on rehab’s part. That’s why service was refused at my doctor’s office. If my doc had taken me, I could have avoided ER.” Another person who went to an ED to see if a blister was infected said that she would have gone to a clinic if she could find one where the fee was about twenty-five dollars. In another case, availability of flu shots at a known location would have prevented a trip to the ED.

Through the increased use of case management services, MHA could better ensure that individuals eligible for medical assistance are enrolled and could help people to access care at lower cost community clinics and, where available, urgent care centers.

2. Missed Opportunities by Emergency Departments in Making Referrals to Community Resources

Although there is no question that people with psychiatric disabilities use emergency departments for care that could be obtained elsewhere, the surveys and focus groups suggest that EDs sometimes miss opportunities to provide referrals or links to more appropriate care. One man who reported going to the ED eighteen times in the past two years stated that when he went to the ED for a sprained ankle and pain due to bone spurs and an old fracture, he was not given any referrals but advised to return when he needed care. He added that the more often he goes, the more he is comfortable because the procedures and staff are familiar to him.

Another survey respondent who went to the ED for blisters caused by footwear reported explicitly asking ED personnel for a referral to an inexpensive clinic so that she could avoid return visits to the ED. She was given no referrals. A man who reported going to the ED because “the ER was my outlet, a place to talk instead of using drugs” was given no referrals to any drug rehabilitation programs. People responded to survey questions about why they went to the ED with answers such as “want someone to talk to about my feelings and care for me” or “comfort” also reported being given no referrals.

Appropriate referrals, when provided, can help many individuals avoid future trips to emergency departments. At one hospital, a man who had gone eight times in two years was given, on his eighth visit, referrals to “support groups, homeless aids” that “were a godsend. The freedom I now enjoy has so improved my state of mind... I can’t foresee ever having to go to the ED again.”

Sometimes referrals are provided without attention to the practicalities of ensuring that there is follow-up. One individual who wanted and needed specialized care was given appropriate referrals but could not go because he did not have money for transportation. There should be transportation vouchers available at EDs to assist individuals in obtaining follow-up care, which would ultimately redound to the benefit of the ED. One common marker for quality assurance and risk assessment programs are return visits shortly after discharge from EDs, and ensuring that patients have the ability to access follow-up care might reduce return visits to the ED for the same condition. This is particularly troubling because survey and focus group responses indicated that when people received referrals, they used them if they were affordable and transportation was available.

Hospitals should also assist eligible uninsured individuals obtain Medical Assistance or access to other available medical benefits programs. Johns Hopkins Bayview researchers found that follow-up on referrals for community medical care was significantly linked to payment method: 63% of those who qualified for a sliding fee or insurance completed three or more visits, compared to 19% of those who were self-pay.⁸ If emergency department care is essentially free to the user while less costly forms of medical care are inaccessible or too expensive for the consumer, emergency departments will continue to be utilized rationally by people with few resources.

B. Secondary Utilizers and Misuse of Emergency Departments

An extremely salient fact about emergency department use by survey respondents is that they are, in large measure, brought to the emergency department by someone else. The theory of “secondary utilizers” hypothesizes that emergency departments are used as much by social service agencies, families, and police to solve problems they perceive as being created by an individual with psychiatric disabilities as by individuals who arrive seeking help on their own. While the motivations of others could not be explored by the survey, the vast majority of respondents, more than two-thirds, reported that their visits were accompanied by family, police, or mental health service providers.

While accompaniment does not necessarily indicate secondary utilization, the group of respondents accompanied by mental health service providers reported questionable use of the emergency department in many instances. For example, the medical problems cited as reasons for the visit could have been more appropriately handled at an urgent care center or doctor’s office. Three survey respondents who reported being accompanied to the emergency department went for, respectively, a “bloody nose,” “treatment for boyle [sic]”, and to “find out if blister was infected.” In addition, the behavioral health examples, while clearly reflecting only one side of the story, indicated that some people were taken to the emergency department for behaviors that could have been deescalated in the community. It did not appear that efforts were made to have mental health professionals associated with the service provider perform an assessment of the individual’s psychiatric condition prior to transportation to the emergency department.

Another potential misuse of emergency departments by community residential providers and nursing homes, not raised by consumers but by several hospitals, involves “dumping” undesirable clients. Once the client is safely in the emergency department, he or she is discharged from the program. Frequently, providers dump individuals with behaviors related to a development disability or elderly clients with behavioral problems related to dementia or brain injuries at emergency departments. Disagreements over responsibility for the now displaced client make timely discharge to an appropriate placement exceedingly difficult.

C. Community Crisis Services System

The non-crisis services and supports identified by survey respondents and focus group participants, including medical benefits, clinics, substance abuse treatment and housing, would help them to avoid non-emergent visits to EDs and would also help them to remain stable so as to avoid going into psychiatric crisis. It is equally important to develop an adequate community crisis services system to divert people from emergency departments and acute in-patient care. Hospitals are the costliest form of care and the vast majority of people would prefer an alternative. Throughout this project, we discovered that Maryland's crisis services system is neither adequate nor well-utilized.

1. Inadequate Services

a. Crisis Beds

The number of crisis beds in Maryland is abysmal. There have been no crisis beds in the entire Eastern Shore for three years. Residents of counties close to Delaware are sometimes referred to that state for a crisis bed. Frederick County has 4 beds, but they are exclusively for county residents. In Southern Maryland, three counties share 4 adult crisis beds and 8 child/adolescent beds.⁹ Baltimore City has 3 child and adolescent crisis beds and only recently expanded the number of available crisis beds for adults from 12 to 21. Although this is the largest number of crisis beds in any single jurisdiction, is still only a ratio of 1 crisis bed per 1,305 of the city's more than 30,000 clients.¹⁰

Anne Arundel County, which serves nearly 30,000 PMHS clients annually, has no crisis beds of its own, nor do Allegany, Caroline, Carroll, Cecil, Dorchester, Harford, Howard, Kent, Queen Anne's, Somerset, Talbot, Washington, Wicomico or Worcester. Recently, Allegany County was approved to open 4 crisis beds and Wicomico was approved for funding for 3 crisis beds.

Even with the addition of these 7 beds in early 2008, there will be a total of only 98 crisis beds for approximately 100,000 PMHS clients, an appalling ratio of 1 bed per 1,020 people. In Western Massachusetts alone, by contrast,

there are 40 state-operated crisis/respite beds for 3,278 individuals eligible for mental health services, or about 1 crisis bed per 82 people.

b. Mobile Crisis Teams

Maryland does not fare any better with mobile crisis services. Only 9 out of 24 jurisdictions have mobile crisis teams---Baltimore City, Baltimore County, Anne Arundel, Frederick, Harford, Howard, Montgomery, Prince Georges and Worcester counties. Baltimore County, however, only has mobile crisis team services available in part of the County. Only 2 teams, in Montgomery and Prince Georges counties, operate around the clock. In the other jurisdictions with mobile crisis teams, after hours callers are referred to the emergency department or instructed to call 911. In addition, only 5 of the 9 jurisdictions with mobile crisis teams also have crisis beds. While many people can be served in their home, others cannot and, if crisis beds are not available, such individuals will wind up in the emergency department.

Not only must mobile crisis teams be available in all jurisdictions, the teams should be linked with law enforcement for diversion from both emergency departments and, where appropriate, the criminal justice system. The Baltimore City crisis provider, BCRI, works closely with the Baltimore City Police Department and police officers now frequently make referrals to BCRI rather than taking individuals to an emergency department. Montgomery County mobile crisis teams also work closely with law enforcement and reports positive outcomes in terms of diversion.

c. Detox/Holding Beds

Frequently, a crisis is related to drug or alcohol use. Therefore, it is critically important that community detox beds are available. Without such beds, a person who is high or intoxicated has to be sent to an emergency department.

Ideally, the crisis and detox beds would be operated by the same provider. In the entire state, however, only BCRI is currently dually certified to provide both detox and crisis beds, which allows the individual to be medically supervised during detox and then transitioned to a crisis bed.

In addition to beds dedicated strictly for detoxification, “23-hour holding beds” are cited as a necessary component of crisis care. Emergency departments at hospitals with a 23-hour observation unit can refer individuals who are high or intoxicated, as well as those needing further evaluation or stabilization treatment. Such a unit can provide a better environment for a person in crisis than a chaotic emergency department and studies show that it can significantly reduce the number of inpatient admissions. Currently, only 4 jurisdictions in Maryland have 23-hour holding beds.

d. Urgent Care Clinics

Clinics should be available round the clock, 7 days a week and accept walk-ins and same day appointments. Currently, very few jurisdictions have urgent care clinics that provide extended hours. Further, without the ability to obtain a same-day appointment, many consumers are referred to the emergency department.

e. Hotlines

Virtually every county provides access to a 24/7 hotline, whether county-specific or state-wide. However, the emergency department remains the primary referral for people in psychiatric crisis. Worse, some hotlines routinely advise calling 911 and many hotline workers have limited knowledge--or no knowledge--about the availability of crisis beds or the criteria for admission.

f. Mental Health Clinics with Extended Hours/Transportation Assistance/Mobile Treatment

Community mental health clinics also have limited hours. As noted previously, several survey and focus group respondents admitted going to an emergency department simply to have a professional to talk to. Extending clinic hours and having peer support staff available would help to reduce the number of people inappropriately using the emergency department. It would also be cost-effective to staff mental health clinics with medical professionals or paraprofessionals for basic care, such as dressing minor wounds, providing flu shots, etc.

In addition, as noted above, many consumers cited transportation issues as a reason that they were unable to access community services. Expanding mobile treatment is a critical component of ensuring that individuals receive the care that they need and transportation vouchers should be widely available, including at emergency departments.

	24/7 Hotline	Mobile Crisis Teams	Crisis Beds / Stabilization Center	Detox / 23-hour Holding Beds	Urgent Care Clinic
Allegany County	X				
**NOTE: Allegany CSA Expects to Add 4 Crisis Beds in 2008.					
Anne Arundal County	X	X			X
Baltimore City	X	X	X		
Baltimore County	X	X	X		X
Calvert County	X		X		
Carroll County	X				
Cecil County	X				
Charles County	X		X		
Frederick County	X	X	X		
Garrett County	X		X		
Harford County	X	X			X
Howard County	X	X			
Mid-Shore Area	X				X
Montgomery County	X	X *Crisis Teams Run 24/7	X		
Prince Georges County	X	X *Crisis Teams Run 24/7	X	X	
Somerset County	X				
*NOTE: Somerset CSA Expects to Add Mobile Crisi Team in 2008					
St. Mary's County	X		X		
Washington County	X				
Wicomico	X				
*NOTE: Wicomico CSA Expects to Add Crisis Beds in 2008.					

2. Lack of Community Awareness of Crisis Services

Education about the appropriate use of available crisis beds and other community services is urgently needed and should be a top priority for MHA. When we started this project by surveying consumers and conducting focus groups, we discovered that at least half of respondents and attendees, many of whom participate in community mental health programs, have no idea where to go in a psychiatric crisis except to an emergency department, or, sometimes, to a series of emergency departments. This was particularly troubling because the focus group members were primarily Baltimore City residents, which has the most crisis beds and one of the best models for crisis services in the State.

Even more distressing, many entities that should routinely be referring people to crisis beds are failing to do so. We found a startling lack of awareness about the availability of crisis services or when to appropriately refer individuals to a crisis bed. Some Core Service Agencies in jurisdictions without crisis beds are unsure whether beds are available to them in other counties. For example, one county on the Eastern Shore advised that referrals are made to Wicomico County, which hasn't had crisis beds for the past 3 years. Another Core Service Agency stated that it used crisis beds in Frederick County, despite the fact that Frederick County beds are available only to its own residents. Another Core Service Agency advised that it only refers those who are homeless or uninsured to its crisis beds. Yet another stated, without explanation, that it refers all callers to the emergency department even though the County has crisis beds.

Hotline workers were similarly unaware of whether crisis beds existed in their counties and many did not know the criteria for an appropriate referral. Many community mental health programs also did not know what crisis services are available--other than the police or the emergency department---in their county.

Finally, as discussed previously, most emergency departments fail to refer people for crisis beds. We encourage hospitals to develop and monitor standards for appropriate discharge to community crisis beds, where available, and to strengthen relationships between community crisis providers and emergency department staff.

3. Inappropriate Use of Crisis Beds

It is evident that, in many jurisdictions, the true mission of crisis beds---diversion from the front door of the emergency department---has been distorted or is not well understood. Currently, most of the referrals for crisis beds in many jurisdictions come from hospital in-patient units, which use the beds as a step-down from in-patient care. While the use of crisis beds to transition individuals from in-patient care has support and results in some cost savings, it does nothing to alleviate the problems associated with emergency department use, including unnecessary inpatient admissions.

In other jurisdictions, diversion occurs primarily after the individual is admitted to the emergency department. MHA has developed a pilot project, currently underway in Montgomery County and Anne Arundel County, to have crisis teams assist emergency departments with diversion of uninsured individuals. Early reports from those counties indicate that the project is successfully diverting a number of individuals who otherwise would have been admitted in-patient to crisis beds and other community services, including substance abuse programs. This is a promising project that should reduce the lengthy “boarding” in emergency departments experienced by uninsured individuals. It should also serve to demonstrate to other emergency departments around the State that fears of liability for bad outcomes after discharge to a crisis bed or to other community services are unwarranted.

While MHA’s diversion pilot project will resolve some of the bottleneck that occurs when uninsured individuals are referred for inpatient beds, it does not address unnecessary admissions overall, nor does it promote use of community resources as a first response to an acute care need. While it does not cost MHA anything for a PMHS client to use an emergency department or a community hospital acute care bed, it places enormous strain on hospital budgets and resources. We strongly urge MHA to focus efforts on diversion *before* a person is taken to the emergency department.

A model that should be replicated exists in Baltimore City with BCRI, which has mobile teams to conduct assessments of persons in psychiatric distress. People assessed as appropriate for a crisis bed are taken directly to the

residential crisis program. As described earlier, another significant aspect of BCRI is that it operates detox beds, so that persons needing to detox can do so under medical supervision and then, if necessary, transfer to a crisis bed in the same facility. Unfortunately, BCRI mobile crisis teams are not funded, as are those in Montgomery County, to operate around the clock. BCRI funding must be increased so that mobile crisis services are available on a 24-hour basis.

4. Inadequate Use of Crisis Beds

Even where crisis beds exist, most individuals who cannot be served in-home are directed to an emergency department rather than to a crisis bed provider. This is true even in many of those jurisdictions with both mobile crisis teams and crisis beds. Our survey revealed that only the Baltimore City, Montgomery and Frederick County mobile crisis teams routinely refer individuals directly to crisis beds.

Although many counties are in desperate need of crisis beds (or additional beds) and emergency departments are filled with patients waiting over 16 hours for disposition, crisis beds state-wide record only 70% average occupancy. There have been multiple reasons offered for this inability to operate at or near capacity. One reason is that many key players---community providers, CSAs, police, and even consumers and family members---are comfortable using or referring people to emergency departments and are unable or unwilling to change. A crisis bed provider advised that it has made numerous unsuccessful attempts to get referrals for crisis bed services from a variety of community programs. The mobile crisis team for that particular county confirmed that it rarely, if ever, refers individuals to a crisis bed. Another factor cited is that mobile crisis teams are either not available in a jurisdiction with crisis beds or not available during the late-night hours in which many people experience crisis.

One crisis provider, while conceding that it is not getting many referrals for beds as diversion from emergency departments, cautioned that a 70% occupancy rate does not necessarily indicate poor utilization, but rather occurs because there are no “waiting lists” for crisis beds. If they are full, people in crisis will be turned away and be forced

to go to an emergency department. However, many beds could suddenly open at once as people are discharged and it may take several days to fill those beds. Thus, MHA should not use the 70% average annual occupancy rate as an indication that additional crisis beds are not needed, but should instead develop a centralized computer data system on currently available crisis beds throughout the state that is available to Core Service Agencies, MAPS-MD, mobile crisis teams and hotline workers. MHA should also ensure that referrals are being appropriately made and that the community is educated about the availability and appropriate use of crisis beds.

5. Restrictive Criteria for Crisis Bed Admission

Those consumers who had used crisis beds were generally well-satisfied with them, but noted that crisis bed programs may have a number of rules that operate to limit access. Some of these rules are understandable, e.g., other than BCRI, crisis bed providers will not accept a person who is intoxicated. Because of the shortage of detox services, many individuals end up in emergency departments who could be better and less expensively served in detox facilities.

Other requirements imposed by crisis services are less understandable. We were told that some crisis providers will not accept an individual who is too acutely suicidal. Some people were told they needed to get medical clearance from an ED before showing up at a crisis bed. For some people, with ongoing severe medical issues, a medical clearance makes sense. But a medical clearance should not be a uniform or blanket requirement prior to receiving crisis services, because it defeats the purpose of diverting use of emergency departments. Sending a person to an emergency department for medical clearance is a likely prescription for a long wait and ultimate inpatient admission.

D. Access to Community Hospital Acute Care

Diversion from emergency departments through expansion of community crisis, mental health and other social services will also help ease the demand for acute care hospital beds. As noted earlier, a disproportionate percentage of individuals coming into emergency departments for psychiatric evaluations are admitted, as compared to those seeking care for physical complaints. Hospitals face increasing demands for acute care services across all disciplines, have workforce challenges that make it increasingly difficult to recruit and retain psychiatrists and other specialty professionals, and must go through a cumbersome approval process to increase psychiatric beds and/or open new inpatient psychiatric services. Therefore, easing the demand for in-patient acute psychiatric care is essential.

However, the State must also ensure that there is adequate access for all, regardless of insurance status, to in-patient care when such care is needed. In interviewing emergency department staff and MHA officials for this project, we were told repeatedly that the individuals who experience the lengthiest waits for a bed in emergency departments are those without insurance. Historically, the State provided in-patient acute care for the uninsured but has, over time, decreased the number of in-patient beds. MHA wants to eventually eliminate its acute care beds, a move that we fully support. Thus, it is imperative that general hospitals and private psychiatric hospitals are able and willing to provide care for uninsured patients.

According to MHA, however, if a person without insurance at an emergency department in a hospital that does not have a psychiatric inpatient unit is determined to need inpatient treatment, he or she is referred to either a private hospital, where the State will purchase a bed if one is available, or to a State hospital, which has a waiting list. When no beds in those settings are immediately available, the person is stuck waiting, often for days, in the emergency department. MHA asserts that this constitutes discrimination against persons with a psychiatric disability because uninsured individuals needing other types of specialty care do not face this barrier.

The Maryland Hospital Association disputes this assertion and states that such transfers between hospitals occur “routinely, on a daily basis” and that the factors leading to the inability to find a bed---such as availability and

sufficient staff, are the same issues faced by State facilities. We do not have data that would support either claim. We do know, however, that emergency department staff readily identify that it is individuals without insurance who face the lengthiest delays. And we know that, for example, a hospital in Prince Georges County is currently under investigation by Maryland's Office of Health Care Quality for taking the extreme step of making out emergency petitions on uninsured individuals arriving to its emergency department and calling the police to transport them to a nearby emergency department at a hospital that does have an inpatient psychiatric unit.¹¹

Hospitals also claim that the rate for uncompensated care is insufficient, a claim which MHA hotly disputes. According to MHA, rate reviews in 2004 and 2005 found that rates for psychiatric services were profitable, except for patients with higher acuity and corresponding longer lengths of stay. As a result, beginning July 1, 2006, hospitals now receive additional payment for providing psychiatric care in these more complex cases. Nevertheless, the Maryland Hospital Association continues to maintain that the rates are not sufficient. The Hospital Association also notes that, while a portion of the uncompensated care costs associated with caring for the uninsured is included in the hospital's rate structure, this is not the case for physician's services. As a result, physicians are increasingly demanding subsidies/assistance from hospitals to make up for the cost of providing services to this population---a cost that is not, according to the Hospital Association, reimbursed under that rate-setting system. While we take no position on the adequacy of the rates, it is clear that these financial issues must be examined and resolved as soon as possible.

It is evident that attention must be focused on ensuring access to needed hospital care by uninsured individuals. However, we also urge elected officials to continue the work of expanding Medicaid coverage. This would resolve the issue of responsibility for providing care for uninsured individuals needing psychiatric care. More importantly, without public insurance, relatively poor mental health consumers lack access to the services that they need to remain stable, contributing to their frequent need for costlier in-patient care.

Another issue that contributes to the reluctance of general hospitals to admit certain patients involves the definition of acute care. There is no agreed upon clinical standard regarding the length of acute care. It appears to be strictly

payer-driven. Private insurance generally covers up to ten days of acute inpatient care. Medicaid, while not restricting length of stay, imposes financial disincentives for longer lengths of stay in the aggregate. The State, on the other hand, has no such urgent financial limitation on lengths of stay for patients in its facilities. Thus, it is no surprise that general and private hospitals define acute care as under ten days, where as the State defines it as “up to thirty days.” Some states resolved this dilemma by having its public mental health system assume financial responsibility for patients needing more than 9 days of acute care in its community hospitals. We believe that this would be a reasonable solution. At the same time, it is true that state facilities, not burdened with same urgency to treat and discharge patients, often keep patients longer than necessary. This should also be addressed through better training and strengthened standards of care at State-operated facilities.

E. Barriers to Reform

In gathering information in preparation of this report, it became clear to the authors that there exists an unsettling amount of distrust and blame-laying between critical entities. Community acute care hospitals are accused of discriminating against persons with psychiatric disabilities, in particular, the uninsured. Some are perceived as “cherry-picking” the most desirable patients (i.e. voluntary, short-term and insured) to keep their in-patient units filled and being unconcerned with steering individuals to community resources. State officials are accused of shirking their obligation to provide acute care for the uninsured and for failing to provide an adequate array of community services, including crisis services, which result in inappropriate or unnecessary use of emergency department services. Community providers also find blame by others for using emergency departments to dump difficult clients or for routine medical and mental health care that they should be responsible for providing.

Consumers and emergency departments are bearing the brunt of lack of communication and coordination, shortages, and fragmentation at different points throughout the system. The solution is not, as some propose, to expand state bed capacity. Such a move, while temporarily easing some of the strain on emergency departments, would be fatal to the goal, as articulated in the President’s New Freedom Commission, to “replace unnecessary

institutional care with effective, efficient community services that people can count on.” As a matter of public policy, State institutions must be the setting of last resort and efforts must be strengthened to reduce the lengths of stay of those who wind up in this deepest end of the system.

Failing to do so is also contrary to Maryland’s Mental Health Transformation goal to “increase the number of consumers who move toward greater recovery in their lives.” Institutions are not places of hope and recovery. As one consumer reported to MDLC, capturing a common theme among our clients, “when they put me in a state institution, I lost all hope. That’s when I felt like I was crazy. It took me years to recover from that experience.”

Not only is expanding State beds counter to the public policy goal of community-based care, it is fiscally irresponsible to continue to pour scarce funds into the most costly and restrictive care setting. Currently, State facilities account for nearly one-third of the annual mental health budget, while serving less than 1% of PMHS-eligible clients. In addition, approximately 16% of the institutional budget is spent each year just to keep two ancient facilities, with badly impaired infrastructures, operating.

At the same time, DHMH must use a substantial and increasing amount of its available resources for people who are sent by the criminal justice system for court-ordered evaluation, restoration to competency, or other assessments. Persons found “not criminally responsible” for a crime are committed to DHMH facilities for indeterminate--and frequently lengthy---periods. Courts often refuse to release these patients until an intensive, monitored, residential community program bed is available. Courts also frequently extend initial three to five year “conditional releases” numerous times. At the same time, due to budget constraints, MHA has frozen expansion of community residential beds for the past several years. Understanding the degree to which the needs of PMHS clients are at the mercy of the criminal courts is fundamental to solving the increasingly urgent problems presented by psychiatric crisis care.

With no immediate or even mid-term prospect of additional dollars being allocated to the MHA budget, it is incumbent upon the various players in the system to work together toward a coordinated resolution to the problem

of emergency department overcrowding. It is clear that the issues facing emergency departments and mental health consumers cannot be resolved without addressing the barriers and insufficiencies along the entire mental health continuum of care. The 2007 Joint Chairmen's Report (JCR) directed the Maryland Health Care Commission to develop a plan to guide the future mental health service continuum needed in Maryland. This plan must include a statewide mental health needs assessment of the demand for inpatient hospital services and community-based services and programs needed to prevent or divert patients from requiring inpatient mental health services (including emergency department services). The JCR requires the Commission to form a Task Force to guide the development of the plan. After a lengthy delay, the Task Force is scheduled to have its first meeting in early 2008.

Through this project, we have identified inadequate community crisis and other resources, a need to better utilize public mental health funding and existing services and supports, and a need for better education, communication and coordination among key players throughout the system. We propose the following recommendations for system reform which, if acted upon, will strengthen Maryland's community-based system of mental health care and reduce the inappropriate or unnecessary use of costly emergency department and in-patient hospital care.

[

Provide

Develop

Resolve

Increase

Fund

Conduct

Strengthen

Continue

Require

Work Provide Reduce Minimize Track Plan



Part I: Recommendations For System Reform

Reduce the Number of Mental Health Consumers Needing Acute Crisis Care

Mental Hygiene Administration:

- Develop plans---in conjunction with the Maryland Health Care Commission Task Force's comprehensive statewide mental health needs assessment to identify community resources to assist mental health consumers remain stable in their recovery---to provide a comprehensive array of necessary community services to prevent acute crisis.
- Support extended hours and staffing of community mental health programs.
- Develop plans to keep several community mental health centers open 24/7 with counseling services available and plan for adding medical staff to provide routine preventive care and treatment for minor medical conditions.
- Resolving funding and programmatic barriers to treatment for mental health and co-occurring substance abuse and develop an adequate number of community programs that treat both disorders.
- Increase PMHS-client access to non-mental health treatment and supports including subsidized housing programs and primary care treatment.
- Provide transportation assistance to assist mental health consumers in accessing community-based services.

Hospitals:

- increase outreach, educational and collaborative efforts with community mental health, substance abuse and social services agencies to reduce the use of emergency departments as the default point of access to systems and services.

Executive/Legislature:

- Fully fund the community resources needed to reduce the use of costly acute care.

Strengthen and Expand Outpatient Crisis Services and Other Community Supports**Mental Hygiene Administration:**

- Set uniform priorities for the use of crisis services and beds to, first, increase diversion before a person goes to an emergency department and, second, diversion from the emergency department. Using crisis beds as step-down from an inpatient unit should be permitted only where there is sufficient supply of beds for emergency department diversion. Ensure that CSA staff, community crisis programs and hospitals are all aware of these priorities.
- Conduct an awareness campaign to educate all mental health consumers and program providers about available crisis services and alternatives to emergency department care. Train MAPS-MD care managers on appropriate diversion to community crisis services.
- Strengthen collaboration between Core Service Agencies and community hospitals, clarify roles and responsibilities, and develop annual performance objectives for each.

- Continue expansion of the hospital diversion project, which provides staff to triage uninsured individuals in emergency departments to crisis services or other appropriate community settings.
- Increase coordination with police departments for training and referrals directly to crisis services.

Hospitals:

- Develop uniform medical clearance policies to reduce delays in the emergency departments and allow individuals to return to community crisis services faster.
- Increase diversion of emergency department patients by developing and monitoring standards for appropriate discharge to community crisis beds and strengthening relationships between community crisis providers and emergency department staff.

Executive/Legislature:

- Fund the full range of community crisis services operating 24/7.

Reduce Frequent ED Utilization

Mental Hygiene Administration:

- In Baltimore City, where emergency departments are particularly burdened by poor and uninsured individuals with complex social and treatment needs, identify the top fifty users of emergency departments who are PMHS clients and, with patient consent, assign case managers to connect them with services, including primary care physicians where possible, and transportation services.

- Statewide, assign a case manager for consenting PMHS clients who use a hospital emergency department more than five times in one year to ensure access to appropriate and cost-effective services.
- Require the development of uniform medical clearance policies. Facilitate agreements between crisis providers and emergency departments for transferring a patient from the emergency department to a crisis bed following medical clearance.
- Work with hospitals to identify community providers who misuse the emergency department for non-acute psychiatric and routine medical care. Educate community programs about the inappropriate use of emergency departments and financially penalize programs for continued misuse.
- Provide transportation vouchers at EDs to ensure individuals' ability to follow through with recommended follow-up care.

Hospitals:

- Provide transportation assistance to increase access to recommended follow-up care.

Increase Access to Needed Community Inpatient Acute Care by Uninsured Individuals

Mental Hygiene Administration:

- Community hospitals, MHA and the HSCRC (which sets reimbursement rates for uninsured patient care) must achieve consensus on a financially viable rate for acute psychiatric inpatient care.
- Resolve disputes with hospitals regarding the definition of acute care.

- Purchase needed community beds for uninsured and PMHS-eligible patients needing longer lengths of care.
- Provide contact person available 24/7 to broker beds as needed.

Hospitals:

- Accept transfers of uninsured patients from emergency departments without an in-patient psychiatric unit.

Legislature/Executive:

- Provide oversight to ensure that uninsured individuals are provided needed community hospital in-patient acute care without delay.
- Provide universal mental health care coverage.

Maximize Efficient Use of Mental Health Budget

Mental Hygiene Administration:

- Reduce the number of intermediate and long-term (non-forensic) state beds by developing independent assessment teams, comprised of consumers and mental health professionals, to identify the services and preferences of non-acute care patients and plan for discharge within a reasonable timeline. Project need for non-forensic intermediate and long-term beds based on maximized community care capacity and plan for rebalancing existing institution beds with community beds and services.
- Minimize future forensic bed expansion. Review status of persons committed as not criminally responsible,

including criminal charge, length of stay, and barriers to discharge. Conduct independent assessments, as described above, and plan for discharge within a reasonable timeline. Individualize conditional release plans to provide only those conditions and services that are reasonably necessary.

- In consultation with an independent forensic expert, develop uniform standards for evaluation and treatment to restore competency to stand trial; set timelines and mandatory reviews of status, and provide hospitals with expert consultation on individual cases as needed.
- Track data on how MHA resources are being utilized by individuals sent from the criminal justice system.

Legislature/Executive:

- Ensure that savings from state hospital bed closures do not revert to the general fund but are instead allocated to community-based services.
- Develop alternative budget mechanisms to minimize the drain on the mental health budget.
- Plan to close aging, inefficient and costly institutions and develop smaller, regional-based facilities.

“ I was very scared.

No one would tell me what was going on.”

**“When they did find time to talk to me,
they used words I didn’t understand...
They did not say why they drew blood.”**

Part II: The Experiences of Individuals with A Psychiatric Disability Who Use Emergency Department Services

Because of the scarcity of crisis and community mental health services, people with psychiatric disabilities often seek help at emergency departments when they are lonely, frightened, depressed, and need comfort. Emergency department staff, however, may see them as potentially disruptive patients whose requirements for both medical clearance and mental health evaluations means long delays and inevitable dispositional difficulties. There are few standards for hospitals to follow in emergency department treatment of people with psychiatric disabilities, and practices vary widely from hospital to hospital.

Thus, it is not surprising that respondents to the MDLC/CPR survey and the focus group participants reported widely differing experiences at individual Maryland hospital emergency departments. There was, however, a fairly consistent pattern of complaints throughout the surveys: that respondents' medical problems were minimized once their psychiatric disabilities were known, and that they were given insufficient information about their treatment, including being told to take unidentified medications. This led on occasion to serious consequences, including allergic reactions, which could have been avoided if the medicine had been identified to the individual. Others complained that staff or family members were given information about their condition, but they were not told.

Some respondents also found that emergency department waiting areas for psychiatric patients were frightening and chaotic places where they were segregated from medical patients and lumped in with actively intoxicated people. They resented being ordered to remove all their clothing just to talk to someone, and some with histories of sexual abuse were traumatized by having their clothing stripped from them involuntarily when they refused to disrobe. Respondents also reported that needed medications, and even food and water, were sometimes forgotten in the rush. Both survey respondents and focus group participants had mixed stories about security guards- some compassionate and caring, but others rough, physical, and insensitive.

At the same time, almost two-thirds of survey respondents and more than half of focus group participants reported

being satisfied with their treatment in emergency departments. It should be noted, however, that satisfaction was closely associated with accompaniment to the emergency department. While 75% of people surveyed who were accompanied reported being satisfied with the care they received, only 50% of unaccompanied people reported being satisfied.¹² Focus group participants confirmed the perception that “if you got support there with you it makes a big difference [in how you are treated].” (Maurice). Separation from available support was also an issue. One older woman experiencing her first psychiatric crisis was extremely upset at being forced to wait in a separate area from her daughter.

People with psychiatric diagnoses were also deeply grateful when they were treated with caring and respect, and went out of their way to identify nurses, aides, security guards and doctors who treated them well. There are clearly remarkable individuals working in emergency departments in Maryland who take the time and trouble in the rush to treat patients with kindness and concern. More should be done to recognize and reward these individuals.

A. Minimizing or Failing to Treat Medical Conditions

The surveys suggested, and the focus groups confirmed, that a high proportion of respondents had chronic medical conditions, including diabetes, hypertension, seizure disorders, brain injury and cardiac conditions, which they managed often, if not primarily, through emergency department visits. Fully one third of focus group participants had diabetes. This is a stunning figure, compared to the 7% prevalence for the population at large.¹³ The focus group, while small, had participants with brain injury, seizure disorders, serious cardiac problems, blindness, and a number of other chronic conditions. Research amply confirms that people with psychiatric disabilities often have serious co-occurring medical problems, and do not receive adequate medical care from primary providers for these conditions. This does not mean either that emergency departments should function as primary care providers, or that they should be subject to onerous medical clearance requirements by inpatient psychiatric facilities as a condition of admission. It simply means that when psychiatric patients come to the ED with medical complaints, those complaints should be taken seriously, and not obscured or sidetracked by concerns, however legitimate, over the person's mental state.

Survey respondents and focus group participants who were most dissatisfied with their experiences in emergency departments tended to be unaccompanied, and to have sought medical care from the ED only to have staff focus on their psychiatric history at the expense of their medical needs. One respondent, who had “wanted an evaluation for arthritis,” because he had started falling, reported:

They treated me like a mental patient. Didn’t give me regular meds but gave me haldol... they didn’t give me physical even though I went because I was falling.

Both focus groups and surveys underscored that some of the worst ED experiences for people with psychiatric disabilities take place when their medical symptoms are interpreted as psychiatric symptoms. For example, one focus group participant reported:

I go in for my epilepsy and they find out I have schizoaffective disorder they go crazy and start calling for people to make sure I’m not going to kill myself or half of New York City. And one time I had a seizure that messed up my mental status and I got terrified. The next thing I know I’m in restraints. And I just don’t think that’s fair. (Sheila)

Seizure disorders were not the only medical conditions whose manifestations were interpreted as psychiatric symptoms. Allergic reactions, diabetic complications, brain injury, and even an ovarian cyst were overlooked by emergency department physicians, who interpreted symptoms through the lens of the patients’ psychiatric disorders:

I had pain in my abdomen. Once the doctor found out that I was in Sheppard Pratt for an eating disorder, she blamed the pain on eating food. The next day I found out I had a cyst in my ovary. They thought it was pain from re-feeding syndrome. They didn’t believe it was real pain. The doctor didn’t listen about my pain and didn’t run any tests besides blood work.

The issue of how people with psychiatric disabilities are treated when they present for medical conditions is particularly significant because so many of the people surveyed and in the focus group had serious co-occurring medical conditions. In some cases, they received virtually all their treatment for these medical conditions through emergency department contacts. The assertion that hospital staff may not sufficiently credit or evaluate medical complaints of psychiatric patients is one that has been made on a number of occasions over the years, including testimony during the hearings on the Americans with Disabilities Act.¹⁴ Research also shows that physicians abbreviate their evaluations and workup of patients with psychiatric disabilities.¹⁵ In 2007, a research study examining unexpected deaths within seven days of emergency department discharge found that persons with psychiatric co-morbidities constituted a statistically significant proportion of unexpected mortality following discharge, and detected potential error or misdiagnosis in more than half the cases.¹⁶ A Public Citizen report on EMTALA fines found a substantial number of EMTALA violations involved people with psychiatric disabilities; several cases involved failure to treat complications of diabetes in people with psychiatric disabilities, including one case of life-threatening diabetic ketoacidosis.¹⁷ This issue merits serious attention by hospital risk management and ED physicians.

B. Informed Consent Relating to Medications and Treatment

“I was very scared. No one would tell me what was going on.”

“When they did find time to talk to me, they used words I didn’t understand... They did not say why they drew blood.”

“I wanted info about symptoms of heart attack or stroke and never got any” (from a patient in the emergency department for chest pain).

“I kept refusing meds but they gave them to me anyway.”

The surveys and focus group respondents repeatedly reported receiving little or no information about either their condition or the treatments they were being given. Disturbingly, more than three quarters (27) of the focus group participants had been given medication without being told what the medication was, its purpose, or expected side effects. Complaints related to informed consent, alone among the issues discussed here, are probably common to medical as well as psychiatric patients in the emergency department. Problems relating to informed consent range from routine failure to identify medications, their purpose, and potential side effects, prior to administering them, to providing little or no information about the person's condition and treatment during the emergency department stay. They also include providing information to the person's family member or caretaker but not to the patient, and failure to obtain information about current medical conditions and medications.

Over half of focus group participants reported not being asked what medications they were already taking. This subject was raised repeatedly. "They gave me a shot that put me out for a long time. I didn't know what it was. They didn't ask me what meds I was on." (Maurice). One participant, when asked to describe his best experience in an emergency department, picked an occasion when he said (with no trace of irony), "they actually gave me a diagnosis," adding, somewhat apologetically, "I like to be informed a whole lot." (Jesse).

On several occasions, participants reported having severe adverse reactions to medication which they had been told to take without being informed of the nature of the drugs. "They just told me take this, they didn't ask what meds I was taking... [she had an allergic reaction] then they had to pump them pills out of me." (Ella) In one case, the participant could have avoided the reaction if she had been asked to name medications to which she was allergic or told the medication she was being given. (Violet).

Respondents reported that some ED professionals reacted angrily to requests for information about their treatment:

"They tried to put me on medication I didn't want. I wanted to research the interactions with psych meds. I didn't understand the doctors. I didn't want to feel like a zombie... I asked the doctor to

explain reactions/interactions. It could kill you. The Doctor said, “No, I’m the doctor, you do what I want.”

One area of complaint that probably would not happen to a medical patient unless he or she was intoxicated, was forcible medical procedures and tests, including catheterization, intubation and/or medication without consent in non-emergency circumstances. Competence issues are, of course, thorny and complex, especially for patients in crisis, but in our experience hospitals rarely have clear, enforced directives clarifying the circumstances under which treatments and procedures can be forcibly administered to patients. Individuals with psychiatric disabilities have the same legal rights as any other patient to refuse both treatment and intrusive assessment procedures. Emergency department staff do not have to accede to police requests to conduct tests for evidence which are not otherwise medically indicated and which are refused by the patient.

There was an almost perfect correlation in survey responses between dissatisfaction with care at the ED and a perception that insufficient information had been provided by the ED staff about diagnosis or procedures being undertaken. Patients in the emergency department are often confused and frightened, and appreciate even the most basic information with a gratitude that seems disproportionate to the effort required to meet this need. In addition, of course, information about medications and side effects, as well as inquiry about the patient’s current medications (if known) are important components of successful treatment. Such information is also an obligation of the doctor-patient relationship, even though focus group respondents indicated that when they did receive information, it was usually through the nurses.

C. Mandatory Clothing Removal

“The security guard said you’re taking your clothes off, spun my head around and pushed me against the wall. I thought my problem was mental.”(John)

“They’ll strip you down of all your clothes and then they’ll just have you sit there from one day into another day.”(Michael)

“The first time I was hospitalized they asked me to remove my clothes. I said no and then I started screaming and resistant and three guys came and gave me the needle. Stuck a needle in my leg. I went unconscious and ever since then I just take them off and do what they say.”(Oliver)

“I said I just want to sit and talk to someone for fifteen minutes and my anxiety will wear off. I won’t be anxious anymore. The nurse said you’re suicidal. Take your clothes off.”(Paula)

Most hospitals in Maryland have policies that require all, or almost all, psychiatric patients to remove their clothing when they come to the emergency department and change into hospital Johnnies. Eighty-eight percent of focus group participants had been asked to take their clothes off in emergency departments whether they went for medical or psychiatric reasons.¹⁸ Fifty percent of the focus group participants had been restrained in emergency departments; fully half of those were restrained because they refused to remove their clothes.

Hospitals have routinely asked people who arrive at the emergency department to remove their clothing for a variety of overlapping reasons. Some state openly that it reduces risk of elopement; others state concerns that people with psychiatric disabilities might conceal razor blades or weapons on their person and use those implements to harm themselves; still others point to the fact that most inpatient units require the emergency department to search a psychiatric patient prior to admission to the inpatient unit. While hospitals may, of course, routinely ask patients to remove clothing as long as they do so for medical purposes or because of individualized security concerns, hospitals may not discriminate in their practices (e.g. asking all psychiatric patients to disrobe regardless of their emotional condition for security reasons, while asking medical patients to disrobe only when necessary to meet medical needs). When a patient refuses a request to remove his or her clothing, however, the stakes are raised. The reason for refusal may be a trauma history, and forcible removal of clothing may exacerbate rather than ameliorate the psychiatric condition that brought the patient to the emergency department in the first place.

The surveys, and especially the focus groups, reflected that people with psychiatric disabilities have different reactions to these policies depending on the context. Some focus group participants did not resent being asked to remove their clothing if they went to the ER for medical reasons, or if they were being admitted to an inpatient unit, but felt that being forced to remove their clothing simply to participate in a psychiatric assessment was unnecessary and stigmatizing.

There was, however, a significant minority of people responding to the surveys and in the focus groups, almost all women but also some men, for whom removing their clothing, even voluntarily, was extraordinarily difficult and traumatic. Clothing removal made these patients feel “nervous and scared,” “humiliated,” “threatened,” “scared,” “traumatic,” “sad to be naked,” and “self-conscious and exposed.” Significantly, the single word that was used most frequently to describe the experience of having to remove their clothing in the emergency department was “violated.” In part this is because the Johnnies leave patients feeling exposed, and a few expressed a preference for pants that are distributed by some hospitals. In part it was because security guards were often present, and were often male when the patient was female, creating even more discomfort and anxiety.

Interestingly, focus groups showed a relationship between clothing removal and expectation of admission that we had not anticipated. At least one focus group participant welcomed being asked to take his clothes off because it was a sign that he might be admitted (Jesse). Several people were highly resentful at removing their clothing, waiting for twelve to thirteen hours, and then being told to change back into street clothes and leave. (Frank; Michael).

The discomfort and anxiety caused by being asked to remove clothing is, of course, greatly magnified when security guards forcibly strip clothing. This results in a great deal of trauma, especially for women, and anger, especially for men. One man in a focus group put it this way:

Well, okay when I didn't want to take my clothes off and they said you're going to take your clothes off I thought they should handle it number one professional. Like, maybe say we can't admit you until you take your clothes off and leave it there and walk away. I was there to be treated. I came in

voluntarily. I came in to get my medicine. I walked in. When they ripped my clothes off, all bets were off. I decided I wasn't going to take my medicine. They could have asked me to pick up my hat off the floor and I would have told them no. (John)

The issue of forcible clothing removal is seen by hospitals as one related to safety and risk, but it is rarely analyzed either in terms of the medical and psychiatric impact on traumatized patients, or in terms of the violation of existing federal and state licensing requirements and accreditation requirements relating to use of restraints on patients. MDLC and CPR fully recognize that hospitals have legitimate safety and security concerns. In many cases, requests to remove clothing do not raise serious concerns for the patient. However, the use of force against people who refuse to remove clothing raises safety and security concerns of its own, and forcible removal of clothing under circumstances where the patient is otherwise calm contravenes federal and state regulations regarding restraint.

D. Restraint

“I would have them make sure the person needed physical restraint before they do it because most of the time they just do it. Like when I was hospitalized at [**], they asked me to remove my clothes but really I didn't understand what was going on because my wife told me that I was suicidal and hearing voices. So I really didn't know what was going on so I asked them and they really didn't say, they just grabbed me [and restrained him] and injected me with the medication.”

The focus group participants with many years experience in the mental health system (15% had only one psychiatric episode), were virtually unanimous that restraint use in hospital emergency rooms has dropped perceptibly. Yet half of the focus group had been restrained in an emergency department setting. As noted above, half of those restrained reported that the restraint resulted from a conflict over refusing to remove their clothing. Restraint was also associated in focus group responses with lack of information, delays in providing food/hydration, hospital policies prohibiting accompaniment, and with delay in assessment and treatment. Restless, bored or agitated patients will

often seek information or reassurance by leaving their rooms, and several people reported being restrained because they didn't stay in their rooms:

“I got tired of laying on the bed. They told me I have to stay in the room. I felt like I was in jail, and I hadn't done nothing. I became not compliant with them. They put you in restraints because you won't stay in the bed.” (Maurice)

It is possible to substantially reduce, and even eliminate, the use of restraint in hospital emergency departments. A number of hospitals have succeeded in reducing ED restraint by a number of different means.¹⁹ At least one major hospital in the United States has been able to eliminate restraints from both its psychiatric unit and its emergency department. Salem Hospital has the busiest emergency department in Oregon, seeing more than 65,000 people a year. After a determined and successful campaign to eliminate restraint and seclusion from its inpatient psychiatric unit, the hospital has also succeeded in eliminating restraint in its emergency department in the past year.²⁰ Dr. Satya Chandragiri, Medical Director of the Psychiatry department, credits a trauma-informed approach, intensive training, and daily consultations between the psychiatric inpatient unit and the emergency department. The elimination of restraint has not been accompanied by an increase in staff injuries; to the contrary, there has been one minor injury to a staff member, inflicted by an elderly patient. The success of hospitals in reducing restraint in their emergency departments demonstrates that leadership and consistent commitment to the goal is the most important factor in achieving substantial restraint reduction, as it was in earlier efforts to reduce restraints on inpatient psychiatric units.

E. Security Guards

“The security guards were laughing when they emptied my purse and made some negative comments about mentally ill patients being brought in.”

“They grabbed me by the arm. I felt like a convict. Seemed like police. It seemed like they kind of roughed me up.”

“They were friendly and respectful.”

Reported satisfaction across the survey plunged if the respondent had contact with security guards. At first we assumed that this reflected an artifact of pre-existing difficulty— that the security guards would not have been called unless there was a problem, and the patient’s dissatisfaction might be more related to the underlying problem than to the resulting contact with security guards. But focus group participants told us that they resented the routine use of security guards by emergency departments to deal with psychiatric patients, regardless of how the patient is behaving. Security guards are used as escorts, to monitor bathroom visits and clothing removal, and to secure possessions. For some patients, security guards were the hospital employees with whom they had the most personal contact. Furthermore, the focus group participants perceived that these routine uses of security guards were limited to people presenting for psychiatric/substance abuse conditions, not medical conditions. This is a source of considerable dissatisfaction, and seen as an expression of discrimination and hostility by the hospital. While individual security guards were praised for their sensitivity and competence, respondents generally associated the use of security guards with the discrimination they felt as psychiatric patients. When asked for their recommendations to hospitals, many focus group participants responded with references to security guards: “security should stand back,” “more doctors instead of security officers, then they couldn’t hurt us so much.” For example, a depressed and suicidal man waited seven hours at one hospital emergency department in “little plastic chairs with six or seven others” to be evaluated. He waited forty-eight hours to be transferred to a bed, and in that time observed the guards yelling at people who stood up, and physically restraining those who couldn’t stay seated. It was a “nightmare for people who were severely mentally ill, fights occurred,” and he would rather “perish” than return.

Hospitals evaluating the emergency department experiences of their psychiatric patients should understand the pivotal role in the patients’ experience of the emergency department played by security guards. Many people with psychiatric disabilities who have had previous experience with police are very aware of how security guards dress, what weapons they carry, and how they comport themselves when dealing with psychiatric patients. Both survey respondents and focus group participants reported mixed experiences with security guards, ranging from one focus group participant who admired the skills of security guards in talking down extremely intoxicated patients

in the waiting area to people who were physically injured by security guards and required medical treatment. Most hospitals do not realize how wide-spread litigation has become against hospitals for the actions of security guards, and some hospitals do not recognize that when their clinical emergency department staff is calling security on a frequent and regular basis, it may indicate that ED staff are not feeling adequately trained or equipped to deal with the symptoms of the patients that they see, and too readily reframe these symptoms as security problems.

It is our experience that hospitals focus insufficiently on security guards' interaction with patients, both in terms of its impact on patients, and as a potential source of liability for the hospital. Security guards, especially off-duty policemen or guards with police backgrounds, are more often sources of personal injury claims against hospitals than is generally realized. Security guards should receive annual de-escalation and restraint training, and ED staff use of security guards should be monitored to ensure that mental health symptoms are treated as such, and not transformed into security issues. All hospitals should ensure that security guards take no action, except in clear emergencies, without the direct order of a nurse or physician.

Finally, there is generally no need for security guards to carry either guns or chemical weapons such as pepper spray or mace. The majority of hospitals do not arm their security guards, even hospitals in area with high violence and gang rates. While uniforms may be necessary for immediate recognition, it would be helpful to differentiate security guard uniforms from police uniforms (i.e. security guards may wear blue blazers and gray pants rather than military-style uniforms).

F. Hostility, Prejudice, and Misunderstanding

“When you tell them your problem, you get to your problem, the first thing they do is lean back, and look for the security guard. I hate that.”(Michael)

It is important to note that slightly more than half of survey respondents did not feel that they had been treated differently in the emergency department because of their psychiatric disability, which speaks very well for emergency

department staff, given the many institutional pressures on staff to err on the side of perceived safety in dealing with psychiatric patients, and the policies and practices which do differentiate between medical patients and psychiatric patients to the disadvantage of psychiatric patients. However, a substantial plurality of survey respondents and just over half of focus group participants did feel subject to discrimination as a result of their psychiatric diagnoses, and a similar survey result from African-American, Hispanic, or female patients would certainly be unacceptable to hospital executives.

Perceived hostility or discrimination broke down into a number of analytically distinct categories. First, survey respondents and focus group participants experienced many standard ED policies and practices applicable only or primarily to psychiatric patients as demeaning or adverse, such as making them remove their clothing, putting them in a segregated area, restricting their visitors, requiring them to use plastic cutlery with food, and accompanying them to the bathroom and monitoring their activities there. Many reported that complaints or even inquiries about why they had to do something were met with seclusion or even restraint (although less frequently than in the past).

The second and more pervasive complaint about discriminatory treatment was the degree to which patients' narratives of their own circumstances were disbelieved once it was revealed that the patient had a psychiatric diagnosis.

What led up to my visit was a burglary and vandalism at my old workplace (the last of 4). He left threatening messages. This was done by the same person who had committed an economic crime against us. I had to walk through the place. If the doctor had asked me what he could do to help, and believed me when I said this was what led up to my visit, I may have told him how the ordeal of talking to the police and everything else made me see things, and that I was having the same experiences in the ER and with him. When I told him I had caught the person embezzling, I think he thought I was delusional and grandiose. This is a crime that happens regularly and apparently he didn't see me as capable of reading a bank statement and putting two and two together.

The third was the deep resentment felt by psychiatric patients who were not substance abusers that psychiatric diagnoses appeared to be automatically associated with substance abuse, especially the fact that they were forced to wait in the same area as people who were actively intoxicated.

Finally, many respondents and focus group participants expressed the feeling that emergency department staff did not understand that their behavior or unresponsiveness was due to suffering, confusion, or hallucinations, and grew impatient or frustrated with them, which only exacerbated their difficulties in responding to questions.

Some of these complaints raise complex issues. Focus group members wanted to be believed, but several focus group participants readily acknowledged lying about their degree of suicidality to gain admission to inpatient beds, as did some survey respondents. When this issue was explored, the focus group members who admitted to lying explained that they would lie about the severity of their feelings or intentions, such as suicidality, to gain inpatient admission, but not about the facts of their situation. Again, while two-thirds of the focus group participants were not substance abusers, fully one-third reported currently abusing substances. For example, although Maurice resented “the way security guards frisked you, they thought I had been smoking pot,” upon inquiry, he acknowledged that he had, in fact, been smoking pot just prior to his arrival at the hospital. However, there were no more substance abusers in the group than diabetics, and emergency department staff do not necessarily assume psychiatric patients have diabetes.

A significant amount of the problem stems from policies, practices and attitudes designed to maximize safety, which generally are over-inclusive, but which hospital executives justify by the unpredictability of patient behavior and the unacceptability of an adverse outcome. Our recommendations do not compromise safety, but rather suggest a more individualized focus on safety and a broader evaluation of adverse outcomes, including injuries that can result from practices allegedly intended to ensure safety. For example, currently the use of force against hospital patients in the form of restraints or forcible removal of street clothing is not currently considered an adverse outcome. But both practices, which arise from an imperative to ensure safety, substantially increase the potential for injury. The most important variable, and the hardest to quantify, is attitude. An unhurried, unpressured, respectful attitude, conveying caring and concern, combined with information about what was happening and what to expect, goes

far to ameliorate dissatisfaction. Most survey respondents and focus group participants who felt respected reported being satisfied with ED treatment, even when they were subject to extensive delays, were frisked by security, or did not receive the services they wanted, such as inpatient admission.

**... mockery or harassment
or deliberate discourtesy
is unacceptable ...**

Recommendations for Emergency Department Practices

Both survey respondents and focus group participants were asked for comments and recommendations



as to how hospital emergency departments could improve their practices. Focus group participants were asked to answer the question “How would you change the way emergency departments treat people with psychiatric disabilities?”

This section begins by simply reproducing the words of respondents and participants themselves. It continues with recommendations for principles of improvement and concrete implementation steps based on national expert consensus and model programs from around the country in the areas discussed above: treatment of medical complaints, informed consent, removal of clothing, restraint, security guard interaction, and perceived discrimination.

A. What Helps: The Words of People with Psychiatric Disabilities

“They always ask if you are hallucinating, but I don’t remember them trying to assess how you are feeling in human terms... If you know someone is hallucinating, but you don’t know how they are experiencing it, I don’t think you can help them feel better beyond giving them medicine.”

“It takes someone with the ability to work with frightened people. The conditions of the ED create fear.”

“I would like for people to stop looking and talking about me like I don’t know what’s going on.”

“Don’t classify people as psych when they’re on drugs.”

“Understand that mental patients have a heart, it’s okay to treat them as a person.”

“As a capable person with the knowledge of how I experience the world at different times that comes from 41 years of experience, I would like to be given my due of being treated as an equal to whoever is treating me. I may not know the medical terms but I know a lot of what we could do as partners to alleviate my distress in the present and I could take fewer drugs as a result.”

“There are ways. One way that helps me immediately is if I can sit by the open door with my clothes on and they sit as far away from me as possible. It’s not a cure but it helps an awful lot.”

B. Specific Recommendations for Hospitals to Improve Emergency Department Treatment of People with Psychiatric Disabilities

1. Medical Treatment of People with Psychiatric Disabilities

PRINCIPLE: Patients with psychiatric diagnoses or co-occurring psychiatric symptoms who complain of medical conditions should receive the same attention, workup, and testing that a patient without a psychiatric history would receive, unless the ED physician documents substantial and objective evidence that there is no medical basis for the purported medical complaint.

Implementing steps:

- a. Hospital risk management and/or quality assurance departments/committees should perform chart audits or otherwise investigate how the hospital emergency department treats medical complaints by persons known to have psychiatric diagnoses.
- b. Hospitals should conduct trainings of emergency department staff to emphasize that minimizing

medical problems of psychiatric patients is poor medical practice, may endanger lives, constitute malpractice, and may violate anti-discrimination laws. An important component of the training should be addressing the professionals' own stereotypes about people with a psychiatric disability, and how those stereotypes interfere with good medical practice. At least one training should be led by a person with a mental illness through On Our Own of Maryland or other groups of consumers of mental health services.

- c. Teaching hospitals should incorporate the principles and steps above into everyday teaching rounds.

2. Informed Consent Relating to Medications and Treatment

PRINCIPLE: Patients are entitled to information about tests, procedures, symptoms, and treatments, and to receive answers to reasonable questions in each of these areas. Competent refusals should be respected, and conclusions that a patient is incompetent should be documented after an assessment by a physician. Force should not be used to perform procedures, tests, or treatments on an unwilling person absent a documented medical emergency.

Implementing Steps:

- a. In the absence of a documented behavioral or medical emergency, no patient should be given medication without identifying the name and dosage of the medication and information about its purpose and likely effects, and being asked if he or she has any questions.
- b. In the absence of a documented behavioral or medical emergency, no patient should undergo a test or procedure without identifying the test or procedure, its purpose and likely effects, and being asked if he or she has any questions.

- c. Hospitals should adopt policies clarifying that police requests for procedures or tests are insufficient to overcome the refusal of a competent patient.
- d. Hospitals should adopt policies clarifying that an inpatient unit's requirement of a toxicology screen for medical clearance and admission is not a sufficient reason to involuntarily catheterize a patient. A patient may be informed of the non-medical consequences of refusing a procedure, e.g. delay or denial of inpatient bed.

3. Clothing Removal Requirements and Security Concerns

PRINCIPLE: Hospitals should end any blanket or uniform requirement of clothing removal based solely on an individual's psychiatric diagnosis or the fact that the individual came to the hospital seeking psychiatric treatment. These requirements are both clinically unjustified and discriminatory. An order of involuntary detention, standing alone, is not sufficient reason to require clothing removal, nor is prevention of elopement sufficient reason to forcibly remove an individual's clothing.

Hospitals should base decisions regarding clothing removal on either

- Conduct creating a danger to self or others;
- Immediate medical necessity; or
- A documented assessment by a professional that the emotional and physical risk to the individual of requiring removal of clothing is outweighed by the medical or individualized security concerns presented by the individual.

If the individual refuses to remove his or her clothing, the individual may not have the clothing involuntarily or forcibly removed in the absence of conduct that meets federal and state standards for restraint procedures.

Implementing Steps:

- a. All staff, from psychiatrists to security guards, should be educated about the effects of a prior history of sexual abuse on patients' response to requests to remove clothing.
- b. Pajama or scrub pants should be uniformly provided rather than Johnnies.
- c. Consider patdowns, with pockets turned out, rather than clothing removal, as utilized by a number of hospitals.
- d. Patient refusal to remove clothing should trigger a call to either a psychiatric consultant, or, if this is impractical, senior ED staff certified to approve restraint procedures, who should evaluate the patient and the situation.
- e. Clothing should not be forcibly removed unless patients meet standards for restraint, since restraint will be involved in forcible clothing removal.
- f. A written policy should be adopted that male security guards cannot remove the clothing of female patients.

4. Restraints

PRINCIPLE: Hospital leadership should make a genuine commitment to ongoing, continual reduction of restraint and seclusion, including in the emergency department, and set specific goals and milestones to meet the goals. Leadership should communicate this goal to staff in meaningful ways, including rewarding staff who are successful in avoiding the use of restraint, and holding unit leadership accountable for reducing restraints in their units.

Implementing Steps:

- a. Data collection and analysis is a crucial step in restraint reduction. Hospitals should collect data on restraint by episode, length of episode, form of restraint (physical, mechanical or chemical), and hospital unit at the very least, and at best seek to understand hospital policies, practices, environment or other systemic causes of restraint use.
- b. Prevention: hospitals should establish a culture that educates staff members about the risks of using restraint and teaches specific techniques, not only to deescalate but to prevent escalation in the first place.
- c. Hospitals should conduct an environmental and policy audit to determine features of the environment and aspects of policy that may contribute to escalation (bare waiting areas; lack of access to bathrooms, food, water; or telephones; insufficient patient contact and communication).
- d. Staff should be given flexibility around unit rules to avoid unnecessary escalation generated by rigid adherence to rules and policy.
- e. Standards: Hospitals should examine their policies and practices to ensure that restraint standards are in compliance with current legal requirements of imminent harm to the patient or others, and eliminate any use of behavioral health restraint based on restlessness, patient history or “disruption to the therapeutic environment.”
- f. Hospital policy and training should also specifically identify populations at particular risk of significant adverse medical or psychiatric outcomes associated with use of restraints, including patients who are morbidly obese, patients with known serious respiratory conditions or respiratory distress, patients with histories of sexual abuse, and patients who are deaf and use sign language to

express themselves.

- g. Training: Hospitals should send key leaders in the emergency department to witness emergency departments, such as the ED in Salem, Oregon, where restraints have been eliminated.
- h. Restraint reduction and de-escalation training should be on-site if possible and involve role-playing, experience of restraint, and participation by consumers of mental health services.
- i. Debriefing: If time permits, debrief as to the reason that restraint ended up being used, and how it can be avoided in the future. Debriefing is particularly important with frequent users of the ED who are frequently restrained. At the very least, hospitals should examine the records of frequent users of the emergency department to see whether they are restrained during their visits, and seek to understand why the restraints occur and how they could be prevented.

5. Security Guards

PRINCIPLE: Security guard interaction with psychiatric patients is an important part of the patients' experience, the hospital's potential liability over injuries and use of force, and reflects the culture projected by the emergency department.

Implementing Steps:

- a. Implement data collection to monitor frequency of security guard interactions with psychiatric patients involving use of force or threat of force.
- b. Consider whether aides could accomplish the same functions as security guards.

- c. Hire more female security guards.
- d. Provide substantial and regular de-escalation training from MANDT or similar sources, and follow up to ensure security guards are implementing the training.
- e. Police-style uniforms should be rejected in favor of distinctive but more professional garb, such as gray pants and dark blue blazers. This is particularly true for security officers assigned full-time to psychiatric emergency services or the psychiatric area of an emergency department.

6. Hostility, Prejudice, and Misunderstanding

PRINCIPLE: Any treatment of psychiatric patients that involves mockery or harassment or deliberate discourtesy is unacceptable and will be grounds for serious discipline. The hospital will seek feedback from psychiatric patients on an ongoing basis about their experiences and incorporate that feedback into policy assessments and staff evaluations. Individualized professional assessments of risk are always superior to blanket assumptions about a person on the basis of a diagnosis or reason for presentation. ED staff should be trained about psychiatric disabilities and misunderstandings in a pragmatic and non-blaming fashion, e.g. to understand the degree to which some psychiatric disabilities create difficulties involving confusion, lack of concentration, difficulty understanding, and apparent non-responsiveness. ED staff who are identified as having particular talents in assisting people with psychiatric disabilities should be publicly and meaningfully rewarded.

Implementing Steps:

- a. Hospitals should ensure that patient satisfaction surveys they currently use include psychiatric patients (many do not), and if not, take steps to receive meaningful feedback from their psychiatric patients about hospital services. This feedback should be analyzed and taken seriously in reviewing hospital policies and employee assessments.
- b. Hospitals should check each of their ED policies or guidelines that are applicable only or primarily to psychiatric patients, including segregated or locked areas, clothing removal, restrictions on accompaniment or visitation, bathroom monitoring by security guards, use of security guards, plastic cutlery, etc. and seriously review these policies to determine whether they might be detrimental to patient care in some cases (i.e. some depressed patients might do better if accompanied by a family member; some people with serious histories of sexual abuse might decompensate if asked to remove their clothing). If so, hospitals should determine whether these practices should be based on individualized assessment of the patient rather than the patient's diagnosis or presence in a particular zone or area of the hospital.
- c. Hospitals should proactively identify staff members in the ED who are particularly talented at assisting people with psychiatric disabilities and publicly and tangibly reward them.
- d. Hospitals should provide staff the opportunity to raise questions and concerns about how best to assist psychiatric patients and provide pragmatic training, including by a member of the Maryland consumer group On Our Own, in response to their requests.
- e. Hospitals should severely discipline staff who are found to have mocked, harassed, or been discourteous to psychiatric patients, up to and including termination.

Conclusion

Conclusion

Consumers, crisis providers, hospital administrators, emergency department staff, and state officials all agree that appropriate diversion from emergency departments is urgently needed to both alleviate the strain on emergency departments and better serve individuals with psychiatric disabilities. To date, however, Maryland has failed to adequately fund the full spectrum of community-based services. As a result, increasing numbers of people are forced to use the emergency department for services that could be provided far less expensively elsewhere. Those in psychiatric crisis, particularly the uninsured, frequently endure lengthy waits in often cramped and chaotic environments. Hospitals are seeking help in the form of more State-operated institutional beds, a solution that would ease some of their problems but would further hamper community-based service expansion. Further, not a single survey/focus group respondent expressed a desire to go to a State hospital (although several did want to be admitted inpatient at a general hospital).

Hospitals are, however, also seeking help from MHA for services and supports--including crisis diversion and case management--that, if provided, would reduce emergency department overcrowding at a far lower cost. These are also among the services that mental health consumers identified as necessary to avoid repeat trips to the emergency department.

At the same time, many emergency department and hospital mental health staff are aware that there are practices and policies that could be improved to minimize negative experiences---some of which can cause significant emotional harm- of patients seeking psychiatric crisis care. Such quality of care improvements will also reduce admissions that are prompted by escalating behaviors within emergency departments resulting from poor treatment or environments.

Maryland is at a crossroads: it can continue to plug the increasing holes of a poorly funded and fragmented system or it can rebalance the system from costly care in aging institutions to a comprehensive network of community

supports and services which promote recovery and independence. Failing to address the problems now will result in ever-increasing strain on emergency departments, the criminal justice system and its own chronically under-funded budget. In addition, more mental health consumers will endure needless cycling in out of institutions and homelessness. With current legislative attention on the problem of emergency department overcrowding and Maryland's participation in the federal "Mental Health Transformation" grant program, there is no better time than the present to seriously address the issues identified in this report.

[Endnotes]

¹ Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding, Maryland Health Care Commission, January 1, 2007.

² In addition, any annual funding from State general funds for implementation was capped at \$250,000.00.

³ Susan Stefan, Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements (Oxford University Press 2006).

⁴ Core Service Agencies are the local mental health authorities that oversee the administration of community Public Mental Health System services.

⁵ Although this respondent was dissatisfied with her treatment, she acknowledged that “Some of the staff were very nice and helpful while others were short with me and didn’t seem to care... most of the medical staff was a lot nicer than mental health staff.”

⁶ Susan Stefan, Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements (Oxford University Press 2006) discusses these models at pp. 125-128.

⁷ Mr. Lighthiser allowed us to use his name. In the space on the survey for “mailing address,” he wrote: “none.”

⁸ Melissa Lee McCarthy, Jon Mark Hirshon, Rebecca L. Ruggles, Anne Boland Docimo, et al. “Referral of Medically Uninsured Patients to Primary Care,” 9 Acad Emerg Med. 639 (2002).

⁹ Adult crisis beds fall under the “alternative model,” which by regulation requires that a person be dangerous to self or others. “Prevention model” beds are for those who are not considered dangerous to self or others. Staffing requirements are thus lower for prevention model versus alternative model. Eight crisis beds for children and adolescents are under the prevention model.

¹⁰ Baltimore City had only 12 crisis beds until early in FY 2008.

¹¹ This same hospital was cited by the Office of Health Care Quality a few years ago for illegally restraining a patient with a psychiatric and developmental disability for several days as they unsuccessfully attempted to find an inpatient bed for him. Following that publicized incident, the hospital reportedly began the practice of moving uninsured and other hard to place patients out if its emergency department through the emergency petition process.

¹² There are a number of potential reasons for this, some of which we explored. We tested the hypothesis that people who were accompanied more frequently had obvious dispositional alternatives (back home

to the program or back home with family) which reduced their length of stay and increased their satisfaction. However, there was no difference in reported length of stay between accompanied and unaccompanied respondents.

¹³ National Institute of Health, <http://diabetes.niddk.nih.gov/dm/pubs/statistics/Indes.htm#7>.

¹⁴ Testimony of Dr. Patricia Deegan, Hearing on H.R. 4498, Arnold and Porter Committee Print 1990(28B) at 1251, see Susan Stefan, Unequal Rights: Discrimination against People with Mental Disabilities and the American Disabilities Act 195 (APA Press 2001).

¹⁵ M.K. Popkin, “Consultation-liaison psychiatry,” in Kaplan and Sadock, Comprehensive Textbook of Psychiatry (4th Ed. Williams and Wilkins 1997).

¹⁶ D.P. Sklar, C.S. Crandall, E. Loeliger, K. Edmunds, et al., “Unanticipated Death after Discharge home from the Emergency Department,” 49 Annals of Emergency Medicine 735 (2007).

¹⁷ Kaija Blalock, R.N., J.D., Sidney Wolfe, M.D., “Questionable Hospitals: 527 Hospitals that Violated the Emergency Medical Treatment and Labor Act: A Detailed Look at Patient Dumping (Public Citizen: July 2001), available at <http://www.citizen.org/documents/qhcompletereport.pdf>.

¹⁸ Four focus group participants reported being permitted to keep their clothing when they went for purely medical reasons.

¹⁹ B. D’Orio, D. Purselle, D. Stevens and Steven J. Garlow, “Reduction of Episodes of Seclusion and Restraint in a Psychiatric Emergency Service,” 55 Psychiatric Services 581 (May 2004).

²⁰ Communication from Dr. Satya Chandragiri, Medical Director, Department of Psychiatry, Salem Hospital, July 16, 2007.

[Appendix A]

Experiences Of People With Psychiatric Disabilities In Maryland's Emergency Departments: Survey And Focus Group Responses

Survey Of Emergency Department Use By People With Psychiatric Disabilities

In order to obtain the perspective of people with psychiatric disabilities on their experiences in Maryland emergency departments, MDLC/CPR conducted surveys of almost three hundred people with psychiatric disabilities who had visited emergency departments in the last two years (2004-2006).

Survey Design

The initial draft instrument was one used nationally by the Center for Public Representation. We invited the comments of the three hospitals participating in the project, in order to ensure that the information obtained would be responsive to their needs, and solicited the input of On Our Own, Maryland's primary organization representing people with psychiatric disabilities.

After incorporating the comments of the hospitals and On Our Own, we had a three page survey which included a combination of open-ended and yes/no questions (e.g. "What services or treatment did you want to receive by going to the emergency department?" "Did you receive those services?"); as well as structured questions with a choice of answers ("Once you were taken back to be assessed, how long did you have to wait?"). Information was solicited on the nature of the visit (medical or psychiatric); whether it could have been prevented, and if so, how; the best and worst aspects of the experience; accompaniment; and how emergency department care could be improved. The survey was revised several times prior to completion and is attached to the report.

Survey Distribution

Surveys were distributed widely through a variety of venues. In addition to being distributed by the three participating hospitals, it was distributed by several other hospitals and by On Our Own of Maryland. The Maryland Disability Law Center also hired a surveyor who distributed the survey throughout the Baltimore Metropolitan area in over thirty different locations, including public and private inpatient facilities, crisis residences, community mental health centers, psychiatric rehabilitation programs, a variety of consumer group meetings, such as the Depression and Related Affective Disorders Association (DRADA), drop-in centers, conferences attended by consumers of mental health services, including the Baltimore County Mental Health Town Fair, and homeless shelters. Some venues with high turnover in clientele were visited more than once. Consumers of mental health services were surveyed in Aberdeen, Annapolis, Baltimore, Catonsville, Dundalk, Ellicott City, Glen Burnie, Rosedale and Westminster. The following counties were covered: Anne Arundel County, Baltimore City and County, Carroll County and Frederick County. Although this was a sample of convenience, and in some respects the respondents were self-selected, the large number of responses provides useful information that was previously unavailable about the experiences of people with psychiatric disabilities in Maryland's emergency departments. Survey respondents reported 649 ED visits in two years to 42 different Maryland hospital's emergency departments, including every hospital in Maryland's Region III.¹

Although the survey was not intended to be scientific, survey respondents are probably a representative sample of poor people with psychiatric disabilities who are frequent users of the emergency department, and for whom disposition creates difficulties, including clients of the Public Mental Health System. Survey respondents were not a representative sample of privately insured people with psychiatric disabilities. However, for the purposes of helping to resolve the kinds of difficulties described by hospitals in serving people with psychiatric disabilities, this is a very representative sample.

Survey Collection

All surveys were initially collected by the Maryland Disability Law Center, where they were copied and sent to the Center for Public Representation. The Center for Public Representation numbered the surveys and conducted the survey analysis. Over three hundred surveys were received, but not all could be used. Some people reported experiences in emergency departments more than two years ago; others denied having psychiatric diagnoses or disabilities. In some cases, respondents did not complete all questions in the survey; if a majority of the questions were answered, the responses were included for analysis as to the questions answered.

Data Analysis

The Center for Public Representation tabulated the non-open ended responses on spread sheets and converted the raw data to percentages expressed as pie charts for such categories as number of visits to the ED, accompaniment, reason for visiting the ED, hours waited, etc. These pie charts are reproduced with discussion below. The responses to the open-ended questions were used to identify trends, and to follow up with focus groups (e.g. high number of co-occurring chronic medical conditions) and for the larger report.

Surveys which specifically described experiences in the three participating hospitals were then segregated and separately analyzed for confidential reports to the three participating hospitals, which were also visited by representatives of the Maryland Disability Law Center and On Our Own. Strengths of each hospital were identified, as well as area for improvement, and recommendations were made at meetings at each of the hospitals.

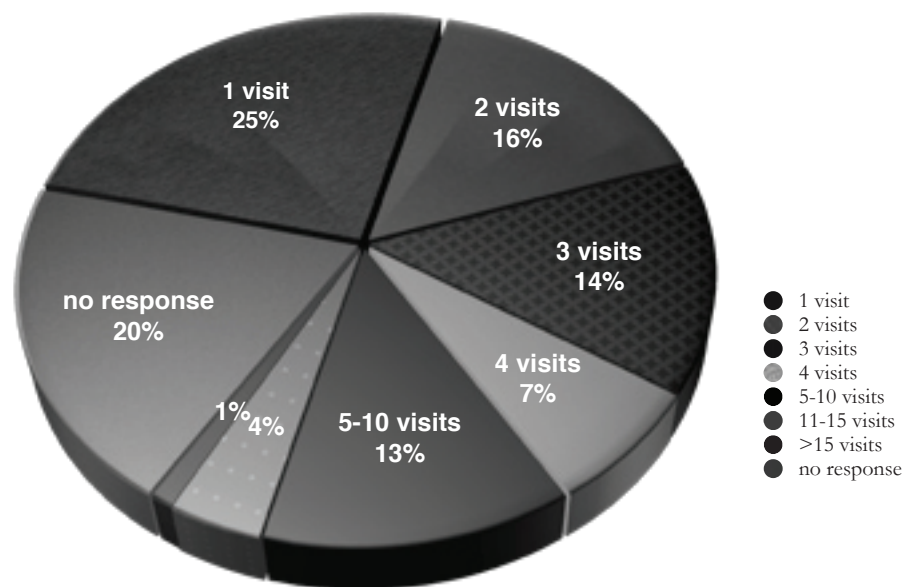
Number of Surveys

A total of 310 surveys were returned. Nineteen were returned after the totals below were compiled. Two respondents stated that they did not have diagnoses of psychiatric disabilities. Four of them reported zero visits within the past two years, and were excluded, leaving the total surveys recorded at 280. In those surveys, some questions were left blank, but those surveys are still counted as to the questions that were answered.

Number of Visits

The majority of people who visit emergency departments for a psychiatric reason only come in once in a year. A somewhat smaller majority of survey respondents visited the ED once a year or less.² The number of visits chart reflects the response to question 1 of the survey, which asked how many ER visits the respondent had made in the last two years. Twenty percent of respondents did not write anything in the blank, and thus they were recorded as “No Response”. Twenty-five percent reported making just one visit, another 30% reported 2-3 visits, 7% reported 4 visits, 13% reported 5-10 visits, and 5% reported more than 11 visits. The largest reported number of visits was 20³.

ER Visit Frequency Among Survey Respondents



Contacts with more than one ED

Fewer than a third of respondents⁴ listed contacts with more than one hospital. Those who reported visiting more than one hospital often listed only two hospitals. The survey design included three lines to name hospital emergency departments visited in the last two years, so there was no question of insufficient space to name more than one or two hospitals. In addition, some people used the margins to list more than three hospitals. Respondents with more total visits in the past two years were more likely to report visits to multiple emergency departments.

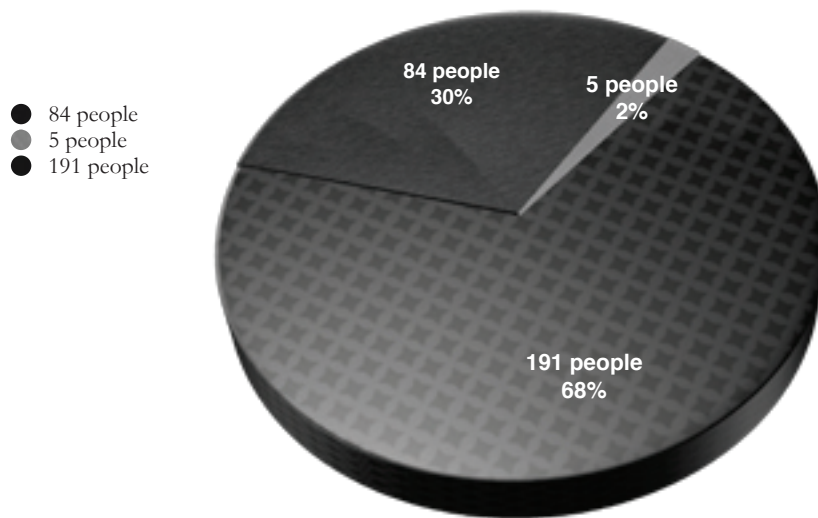
Accompanied

More than two thirds of survey respondents were accompanied to the emergency department (see discussion of “secondary utilizers” of emergency departments, below). Of the 280 surveys, 191 respondents reported being accompanied to the emergency room, 84 reported coming in alone, and 5 did not respond. Respondents who were accompanied reported coming in with (see table):

Table 1: Number of People Reporting being Accompanied by:

Ambulance	31
Family Member	45
Case Manager	6
Friend	8
Other ⁵	49
Police Officer	36
Ambulance + Police Officer	2
Ambulance + Other	2
Family Member + Friend	1
Family Member + Police Officer	1
Did Not Specify	10
Total	191

Percentage of Respondants Who Were Accompanied To The ER



Voluntarily

Most respondents (82%) reported going to the ER voluntarily. However, it was clear that respondents' concept of voluntariness might be open to question, since a number of people who were escorted to emergency departments by police reported going voluntarily. Only forty-four respondents said they went involuntarily, and six did not respond to the question. This issue was followed up in the focus groups, and it became clear that people considered themselves "voluntary" even if they felt coerced or that they had no choice about going to the emergency department if they arrived without being petitioned.

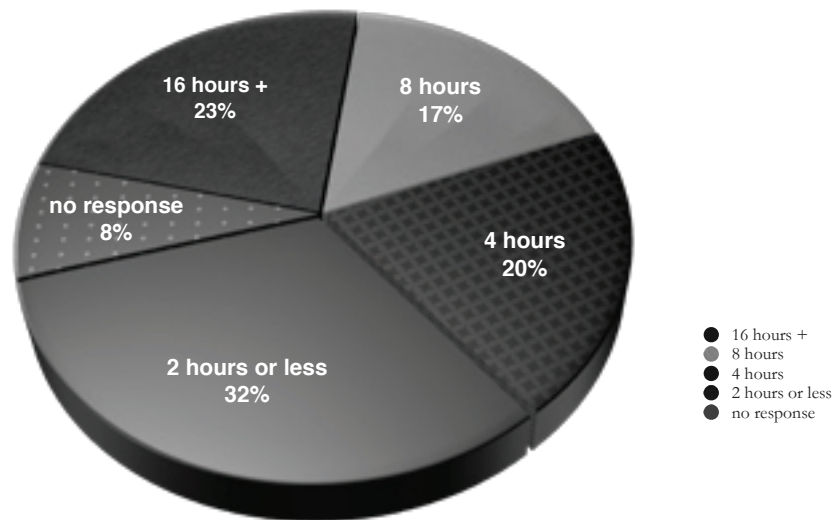
Satisfied

Almost one-third of respondents (85 or about 30%) reported being dissatisfied with their care, while just under two thirds (about 63%) reported being satisfied with their care. Four respondents wrote in responses indicating that they were somewhat satisfied, and fourteen did not respond to the question.

Satisfaction scores of hospitals participating in this project tended to be higher than overall satisfaction scores. Survey respondents were unaware of the identity of the participating hospitals. Focus group participants also tended to rate participating hospitals more highly, although they certainly had complaints. Correlations with reported satisfaction are discussed below.

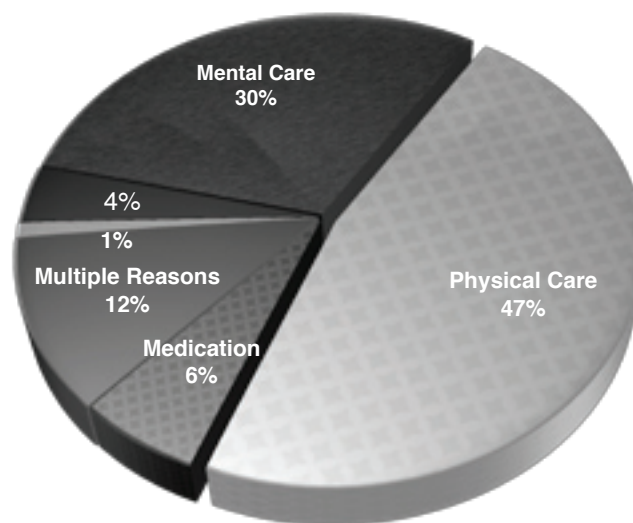
Contact with Security

Contact with security was a strong determinant of dissatisfaction with care. Although just under one in five respondents reported any contact with security at all, (55 or just under 20%), a majority of those who reported contacts with security reported being dissatisfied with their care (29 or just under 53%). Forty-four percent of patients with contacts with security were satisfied with their care, and two reported being somewhat satisfied.



Reported Overall Wait Times

Wait Time	#
2 hours or less	87
4 hours	57
8 hours	48
16 hours+	65
No Response	23



Services or Treatment Sought

Reason for Seeking Care	#
Mental Care	85
Physical Care	130
Medication	17
Multiple Reasons	34
Other	3
No Response	11

General Satisfaction with ED Services

Three survey questions were asked to gauge overall experience in emergency departments:

“Did you receive [the services or treatment] that you wanted?”

“Were you satisfied with the care you received overall?” and

“Do you think going to the Emergency Department helped you?”

Interestingly, many respondents answered the three questions differently. This indicates that hospitals contemplating patient satisfaction surveys should word questions thoughtfully, depending on the information they seek. For example, the third question, “Do you think going to the Emergency Department helped you?” was answered affirmatively by many people who said that they had not received the care they sought, or that they were dissatisfied with the care they received, or both.

Some reasons for the disparities in responses to the three questions are obvious. Delay in receiving care was one reason that people who received the treatment they wanted, and were helped by it, were not satisfied with the care they received. Waiting over sixteen hours for services was often correlated with dissatisfaction (although not always), and over a quarter of survey respondents spent 16 hours or more at the emergency department before they were admitted or discharged. People who were accompanied to the emergency department were far more satisfied with the care they received than people who were not accompanied. Whether that is because people who are accompanied are treated better, or because they experienced fewer delays, is impossible to know. People who had experience with hospital security guards were far less satisfied with the care they received, even if they were not restrained or secluded by the security guards.

II. FOCUS GROUPS

In addition to the surveys, four focus groups were conducted over two days with individuals who had used services of the participating hospitals' emergency departments, as well as numerous other emergency departments. The focus groups totaled 36 individuals. These were divided into 24 men and 12 women. Twenty were African-Americans, 13 Caucasians, and 3 Hispanics. A substantial number of participants in the focus group reported serious, chronic medical problems, ranging from brain injury, cardiac problems, and seizures to diabetes. Some of these medical problems were diagnosed in the emergency department. One focus group participant was blind. Almost a third (11) admitted being active substance abusers. Unlike the survey respondents, focus group discussion was aimed in part at getting as much information as possible about respondents' experiences with the three participating hospitals.

A. Characteristics of Focus Group Participants

The focus groups were recruited to follow up on the information obtained in the survey. People responding to the survey generally represented average ED users with psychiatric disabilities who were on Medicaid and/or were clients of the Department of Health and Mental Hygiene. Their experiences with emergency departments were, for the most part, limited to no more than one or two visits over a two year period (only 25% reported five or more visits, which is, of course, still very much higher than the average Marylander). Survey respondents had not been to many Maryland emergency departments (only one third reported visiting more than one emergency department). The large number of emergency departments captured in the survey was a function of the number of people surveyed.

By contrast, the focus group participants were recruited specifically as people with experience and the ability to compare a number of different hospital emergency departments over time. We called them experts on emergency department services to people with psychiatric disabilities, especially in the Baltimore area; hospitals might pejoratively consider them "frequent flyers." Most focus group participants had been to at least five emergency departments, and had at least five visits in the past two years. Although no attempt was made to ensure that people

with dual diagnoses of substance abuse and mental illness were specifically represented, the attempt to recruit frequent visitors to emergency departments apparently naturally produced a significant representation of people with dual diagnoses. Likewise, while we intended to ask questions about chronic medical conditions, no attempt was made to specifically recruit people with co-occurring medical problems. Again, the recruitment of frequent visitors to EDs apparently naturally resulted in a high number of people with serious chronic medical conditions. A deliberate attempt was, however, made to ensure racial and gender diversity. The group consisted of thirteen women and twenty three men, and fifteen Caucasians, four Hispanics, and seventeen African-Americans. There were also several individuals who were physically disabled, including one blind individual.

B. Recruitment of Focus Group Participants

The focus group participants were recruited in a number of different ways: through chapters of On Our Own, by asking survey participants if they were interested in a follow-up focus group, and through day treatment programs at community mental health centers. Each participant was paid twenty dollars to participate in a focus group lasting roughly two hours. Participants were also given coffee or soda and snacks. Each participant signed a consent form to have the focus group taped, and to have their first names used in connection with any quotations used in the final or hospital reports.

C. Focus Group Process

Efforts were made to provide some level of uniformity in the focus groups. Each of the four focus groups was facilitated by the same person, Susan Stefan of the Center for Public Representation. Each participant in each of the four groups was asked a series of identical questions, including which hospital emergency departments they had visited and when those visits had occurred, which emergency department provided the overall best experience, and why; which emergency department provided the overall worst experience, and why; their experiences with restraint, clothing removal, and security guards, whether they had ever experienced discrimination in emergency departments,

and their suggestions to improve the care and treatment of psychiatric patients in emergency departments. After participants in the first focus group revealed, through discussing the answers to these questions, an unusually high proportion of substance abuse and chronic medical conditions, each succeeding focus group member was asked questions about these issues. The groups then discussed their responses to each of these questions with each other, until the next question was asked. Their responses were recorded as much as possible on butcher paper taped to the walls. In addition, the surveyor hired by the Maryland Disability Law Center sat in on each session and took notes, and the discussions were taped. The focus group facilitator also took notes.

Analysis of Focus Group Discussions

Although not all taping sessions were completely clear, the tapes of the sessions were transcribed as much as possible. In addition, the butcher paper notes were transcribed, and the notes of both the facilitator and MDLC surveyor were used. The use of focus groups permitted deeper exploration of certain issues, such as the different experiences and perceptions of people with psychiatric disabilities who are not also substance users, and who expressed fear and anger that they would be lumped together by hospital emergency departments in the same category as intoxicated people; the degree to which EDs are being used as primary treatment providers for chronic medical conditions, the different responses of men and women to clothing removal requirements and encounters with security guards, and other issues which are discussed in both the Final Report and in reports to the individual hospitals.

The use of focus groups was also key in obtaining specific feedback on the three hospitals participating in the project, as most of the participants had experiences in one or more of the participating hospital emergency departments. Specific comments from focus group participants were included in individual hospital reports, which were presented to the three hospitals on a confidential basis.

HOW MARYLAND HOSPITALS COMPARE TO HOSPITALS NATIONALLY

It is useful to look at the data from Maryland hospitals and compare it to that to national data, to help identify where improvements are indicated. Since we may assume that Baltimore City emergency departments have a higher volume of individuals seeking psychiatric care than many other hospitals in Maryland, we have included data from other major urban area hospitals serving a high concentration of poor and/or homeless and/or substance abusing populations where available.

Percentage of Psychiatric Patients in Proportion to all Patients Seen in Emergency Department

National Data: The most recent national data covers the year 2005 and indicates that there were 2,654,000 visits to emergency departments where the “principal reason for the visit,” as explained by the patient, was listed as “symptoms referable to psychological and mental disorders.” This number is out of a total of 115, 323,000 visits, or about 2.3% of the total number of visits to emergency departments. By the time the patients were screened and diagnosed, the number of visits to emergency departments where a physician considered “mental disorder” the primary diagnosis increased to 4,002,000, or 3.5% of the total visits to emergency departments.⁶

Maryland Data: In Maryland, about 4.3% of total visits were by individuals presenting with psychiatric symptoms.⁷

Increase in Emergency Department Visits by Patients Presenting with Psychiatric Crisis

National Data: The percentage of all visitors to emergency departments who arrive for reasons of mental disorder has been inching up slowly. In 2002, 1.9% of people who presented at emergency departments presented with mental disorders, although 3.2% had mental disorders listed as a principal diagnosis on discharge. In 2003, 2.2% of people who presented at emergency departments gave mental disorders as the principal reason for their visit, and 3.3% of discharge diagnoses involved psychiatric disorders. In 2004, 2.2% of people the same as 2003 presented with psychiatric difficulties as their main complaint, and 3.4% of discharges listed psychiatric difficulties as the

principal problem. Thus, the 2005 figures presented above 2.3% of people presenting with a primary complaint of mental disorder, and 3.5% diagnosed with a primary diagnosis of mental disorder, represents an incremental increase.

This increase is hardly the stuff of crisis, but (as in Maryland statistics) the total national figure conceals the urgent and increasingly impossible situation of urban hospital emergency departments who serve large proportions of patients with psychiatric disabilities who are poor, homeless, substance-abusing, have complicating medical morbidity, or, most often, some combination of these characteristics.

Maryland Data: An increase of 5.7% in emergency department visits for psychiatric reasons between 2002 and 2005 has been reported.⁸ However, at the same time, an increase in all visits of 10.4% is reported.⁹ Therefore, visits by psychiatric patients to emergency departments throughout Maryland have been increasing at a substantially lower rate than increases in all visits to emergency departments.

Percentage of Inpatient Admissions

National Data: Of all emergency department visits, only 13.3% result in inpatient admission. There is no nationwide data on the percentage of visits associated with psychiatric crisis that result in inpatient admission, and in fact there is wide variation nationally in ED admissions (between 20% and 90%) based on a number of factors. Various studies on hospitalization of individuals most likely to be hospitalized for psychiatric reasons, those who have just attempted suicide, overdosed, or engaged in deliberate self-injury, report an admission rate of 46-52% of those populations.

Maryland Data: In Maryland, 17% of ED hospital visits result in admissions, but almost 30% of people who come to the ED for psychiatric reasons are admitted.

Urban Hospitals: Boston Medical Center, a busy urban hospital in Boston, where an articulated commitment has been made that hospital admission should be a “last resort alternative,” has reduced inpatient admissions to about

20% of psychiatric patients. San Francisco General's Psychiatric Emergency Services, which sees many people who are homeless and have substance abuse problems, has an inpatient admission rate of 35%.

High Users of Emergency Departments

National Data: There is no national standard for what constitutes “high use” of emergency departments. Various studies have picked different numbers. One California study found that although only 2% of Californians had been to the ED three or more times in one year, their combined visits constituted 35% of all ED visits in California.¹⁰ The Kaiser Family Foundation study defined “frequent use” of emergency departments as four or more visits over the course of two years,¹¹ while a recent study in Massachusetts considered frequent visitors those with five or more visits during a year.¹² Only 1% of residents were frequent users, but they made 17.5% of all ED visits in fiscal year 2003 in Massachusetts.

Maryland Data: The top 5% of ED users across Maryland in 2001 visited the emergency department an average of three times in one year.

Wait Time/Delay¹³

National Data¹⁴: The average time spent in emergency departments is 3.3 hours nationally. One quarter of patients are seen in less than fifteen minutes.¹⁵ Psychiatric patients take longer, sometimes twice as long. There are multiple reasons for this. One reason that hospitals can address is the delay created by the dual track nature of medical clearance and psychiatric assessment. Another is that all patients who are admitted take longer, and psychiatric patients are admitted at a rate two to three times as high as medical patients.

Maryland Data: The average time a patient waits in emergency departments in Maryland is not known. Emergency department waits for psychiatric patients are also not known.

Urban Hospital Data: The average time that an individual with a psychiatric disability waits in an emergency department in Boston is up to 14 hours. However, Boston Medical Center, an urban hospital that sees 128,000-130,000 patients a year, has an average wait time for psychiatric patients of four hours. As noted earlier, Boston Medical Center is committed to hospitalization of psychiatric patients as a last resort, with only about 20% of psychiatric patients admitted. On the other hand, San Francisco General Psychiatric Emergency Services, which also try to avoid hospitalization if at all possible, have a 23 hour ALOS from admission to disposition, in part because attempts are made at crisis intervention and resolution in the emergency department itself.

Source of Financing

National Data: Overall, the majority of visitors to emergency departments nation-wide are privately insured.

Maryland Data: While individuals with private insurance comprised 41% of all emergency department visits, only 29% of patients diagnosed with mental health conditions who visited the emergency department had private insurance.¹⁶ According to the Department of Health and Mental Hygiene, utilization of EDs for psychiatric reasons by individuals with Medicaid has been declining since 2003 in Maryland as a whole.

(Endnotes for Appendix)

1 Information about specific visits was taken from the 2nd part of the first question on the survey, where respondents were asked to list specific visits. Note that the number of visits the respondents reported in the first part of the question (“how many visits have you made to an ER in the past 2 years?”) did not always correspond to the number of specific visits the respondents enumerated in the section below the initial question. Only specifically enumerated visits were recorded here. Visits from 6/2004-present were counted. Where respondents merely wrote “2004” as the date, wrote only a month, or did not record a date at all, the visit was assumed to be within the allowable time, and was recorded.

2 The analogy cannot be perfect for several reasons. First, because the survey addressed visits over a two year period, we considered responses reflecting one to two visits in two years as equivalent to hospital figures of once a year. Second, the survey asked for all visits to the ED, including visits for medical reasons. While the survey did ask respondents to differentiate between visits for medical reasons and visits for psychiatric reasons, it is difficult to parse out the many versions of responses received to this question.

3 Survey #284.

4 Ninety-two respondents, or just under 33%, reported contacts with more than one hospital in the last two years.

5 Other included staff from various programs, care providers, roommates, neighbors, etc.

6 Advance Data No. 386, Ambulatory Health Care Survey, National Center for Health Statistics, June, 29, 2007.

7 Department of Health and Mental Hygiene, Mental Hygiene Administration, 2006 Joint Chairman’s Report, M00L01.01, p. 103, Addressing the Issue, Utilization of Emergency Departments by Individuals with Psychiatric Illness.

8 Id. p. 3.

9 Id.

10 California Health Care Foundation, Issue Brief: Overuse of Emergency Departments Among Insured Californians (October 2006), available on the web at www.chcf.org.

11 Elizabeth M. Peppe, Jim W. Mays, and Holen C. Chang, Actuarial Research Corporation, “Characteristics of Frequent Emergency Department Users,” Kaiser Family Foundation (October 2007), available on the web at <http://www.kff.org/insurance/7696.cfm>.

12 Kathleen Kerwin Fuda and Rachel Immekus, “Frequent Users of Massachusetts Emergency Departments: A Statewide Analysis,” 48 Annals of Emergency Medicine 9 (July 2006), also available on the web at <http://www.bu.edu/mvp/Library/Fuda&Immekus2006.pdf>.

13 Caveat: It is crucial to understand that waiting time after assessment is not necessarily an indication of poor service quality. It may represent a decision to observe an individual, or to perform crisis intervention in the ED itself, in order to avoid inpatient hospitalization. We recommend that hospital QA focus on delays between presentation and assessment in the case of people presenting with psychiatric disabilities, intoxication, or both. We present the statistics below because the statistics we would prefer to use are not widely available.

14 Conflicting figures exist for national data on emergency department use by people with psychiatric disabilities. The National Academy of Emergency Medicine consistently reports higher usage, and increasing trends of usage, while data compiled by the National Center for Health Statistics reflects relatively less usage and no significant increase in use of emergency departments by people with psychiatric disabilities. Where the National Center for Health Statistics has data, that data is used, because the data compilation appears to include a larger sample and more sophisticated methods, and therefore be more likely to be reliable.

15 National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey (2006). The data is for 2004.

16 Id. The report does not make clear whether the ED visits by people with mental health conditions were for treatment of those conditions or for treatment of medical conditions.

[Appendix B]

SURVEY OF EXPERIENCES OF MENTAL HEALTH CONSUMERS IN EMERGENCY DEPARTMENTS

1. How many times have you visited an emergency department in the last two years? _____.
Please name the hospital, the purpose of the visit and the dates (if you aren't able to give the exact date(s), then provide the month/year of admission(s). If you need more space use the backside or another piece of paper.

<u>Name of Hospital</u>	<u>Date</u>	<u>Purpose: Mental Health or Physical Health?</u>

2. If your purpose for going to the Emergency Room was for physical health care and not mental health care, do you feel you were treated differently because you have a history of psychiatric diagnosis? ☐ Yes ☐ No

If so, tell us about that experience and where it happened.

3. What services or treatment did you want to receive by going to the Emergency Room?
4. Did you receive what you wanted? ☐ Yes ☐ No
If no, do you know why you received a different service?
5. What situation or events led up to your most recent visit to the emergency department?

6. Did you go voluntarily? ☐ Yes ☐ No
7. Were you accompanied/taken by someone? ☐ Yes ☐ No
If yes, who?
8. Once you were taken back to be assessed, how long did you have to wait to see the mental health professional?
☐ Less than 15 minutes ☐ 15 minutes to 30 minutes ☐ 30 minutes to 1 hour ☐ 1 hour to 2 hours
☐ 2 hours to 3 hours ☐ 3 hours to 4 hours
☐ 4 hours to 5 hours ☐ 5 hours or more
9. How long did the assessment take?
☐ Less than 5 minutes ☐ 5-15 minutes ☐ 16-30 minutes ☐ 30 minutes to 1 hour ☐ 1 hour or more
10. How long did you wait overall before being either discharged or transferred to an inpatient bed?
☐ Less than 30 minutes ☐ 30 minutes to 1 hour
☐ 2 hours ☐ 4 hours ☐ 8 hours ☐ 16 hours ☐ 24 hours
☐ 48 hours (two days) ☐ 72 hours (3days)
☐ 94 hours+ (4 days or more)
11. What were the most helpful aspects of your treatment?
12. What were the least helpful aspects of your treatment?

13. Was there a difference in how personnel performing medical tests (drawing blood, physical examinations, etc.) treated you and how those performing the mental health assessment treated you? ☐ Yes ☐ No

If yes, what was the difference in how you were treated?

14. Were you satisfied with the care you received overall? ☐ Yes ☐ No

15. Did you receive enough information about what was happening and about the assessments and procedures that were being conducted? ☐ Yes ☐ No

16. Did you have any interaction with security guards? ☐ Yes ☐ No
If yes, please explain:

17. Were you required to remove your clothing? ☐ Yes ☐ No

Were you placed in seclusion? ☐ Yes ☐ No

Were you placed in restraint? ☐ Yes ☐ No

If you answered yes to any of the above in question 17, can you explain how it happened and how you felt about it?

18. Were you ☐ discharged or ☐ admitted to an inpatient bed?
If discharged, where did you go?

19. Were you provided information about services in the community to prevent another crisis? ☐ Yes ☐ No

If yes, what were they? Did you follow-up with them and did they help?

20. Do you think going to the Emergency Department helped you? ☐ Yes ☐ No

21. Is there anything that would have worked, or would work in the future, to prevent the need to go to the Emergency Department? [For example, alternatives such as people coming to visit you where you live, a crisis house/apartment, a mobile treatment team, or a respite program).

Please provide any additional comments that you would like to make about your experiences in the emergency department:

Would you like to be part of a focus group on improving the treatment that consumers of mental health services receive in emergency departments and developing and improving crisis alternatives? If so, please list contact information below:

Name:

Phone/Email:

Mailing Address:

Best time to call:

**PLEASE RETURN THIS SURVEY TO: MARYLAND DISABILITY LAW CENTER
1800 N. CHARLES ST., #400
BALTIMORE, MD 21201
FAX: 410. 727. 6389**