Psychiatric Triage and Screening:

Trends, Parameters, and Limitations When Evaluating Patients in an Emergency Room Setting

Malik Abdur-Razzaq

DISSERTATION.COM

Boca Raton

Psychiatric Triage and Screening:
Trends, Parameters, and Limitations When Evaluating Patients in an Emergency Room Setting

Dissertation.com
Boca Raton, Florida
USA • 2011

ISBN-10: 1-61233-766-X
ISBN-13: 978-1-61233-766-1

Acknowledgements

I would like to acknowledge first and foremost God for giving me the guidance, inspiration, and perseverance in completing this memorable event in this lifetime. Secondly, my wife Jacqueline Abdur-Razzaq, Esq. must be recognized for giving me the strength and support in accomplishing this milestone. She has been my backbone for which this endeavor may not have successfully concluded. She has stood by my side throughout this exhibition—always demonstrating patience during my long and tedious hours in study. I love you dearly for standing by me and for supporting me in this undertaking.

I don't know what I would have done without my editor, Carol Kopay. A mutual friend introduced us, and traveling this path with Carol since our introductions has truly been a blessing. I recall during this journey and while submitting my iterations to my Chair, he said to me: "Malik, you need to get an editor; it is getting frustrating reading your work." I was somewhat devastated. I think we all want to believe we have something to offer, but more importantly, that our writing is worthy and that it represents a standard commendable of publication. After getting over my sulking, I did some self-reflecting and then I made a decision to consult with an editor. Carol said to me: "I can stick with you as you write; just keep submitting your papers." She has kept pace with me during this voyage and, in fact, has inspired me to add to each chapter I have written. I thank you immensely, Carol, for your insight, balance, coaching, and feedback.

I think my children have been intrigued by this whole process; not fully understanding what their father was doing all these long hours daily—constantly on the computer and protecting his limited space from their intrusions so he can accomplish this

goal. What I want for them and what they have continued to hear since their inception into this world is: "Don't shortchange yourselves. Capitalize academically and never stop thinking and contributing to humanity."

Dr. Patricia Goslee and Dr. Karen Williams must be recognized. Both were completing their doctoral programs at their respective institutions when I entered ATSU; both are former co-workers who gave me tremendous insight into this process. We have remained in touch throughout this endeavor, and their suggestions have been invaluable. Dr. Martin Atherton, Chad Womack, and Pius Essandoh represent my committee. Dr. Atherton is my committee chair and has remained by my side throughout this journey. His feedback has served to strengthen my fortitude and perseverance. I can only attribute my introductions to Dr. Essandoh and Dr. Womack as blessings in disguise. My contact with Dr. Essandoh was by way of his daughter, who is an MD. She and I began talking one day while at a local hospital, and she informed me that her father was a forensic psychologist and that he "may be able to help you." She arranged a meeting for me to meet him… and the rest is history. I also met Dr. Womack through a family member, and he readily agreed to become a committee member. Both have been an inspiration to my research.

Finally, my uncle and aunt (Daniel Brown and Louise Daniels) are the remaining living relatives of my father and mother's siblings. Both of my parents represented six siblings each, and now we are down to the last remaining two from each side of the family. I love you both dearly, and I hope you are proud of your nephew. I sincerely thank you, Brother William Henry, for standing by my side and always being supportive of my academic pursuits. I would also like to extend similar acknowledgements to my

children, nieces, nephews, aunts, uncles, cousins, and in-laws for helping me realize my potential to excel to levels I sometimes thought were impossible. I extend my love and gratitude to you all.

Malik

Abstract

Numerous societal factors have given rise to acute psychiatric conditions in patients referred for mental health evaluation and treatment at a specified emergency room (ER). Some of these risk factors include homelessness, domestic violence, unemployment, and poverty; acute and recurring mental illnesses; comorbid disorders, and the effects of war as evidenced by soldiers returning home from overseas with signs of post traumatic stress disorder (PTSD) symptoms. The increase in referrals from correctional facilities, jails, juvenile detention centers, group homes, nursing homes, and schools points to institutions overwhelmed and having difficulty managing their specific populations. As a result, these groups and individuals are referred for psychiatric emergency services.

Nurses at the selected ER are primarily trained to respond to patients with physical medical emergencies and occasionally do not understand psychiatric clinical descriptors that impact on mental health patients. There is a need to educate ER nurses regarding psychiatric conditions and how best to respond to a patient's illness predicament. In addition, no crisis specialist is assigned to triage duties in the ER to assist nurses in forming a comprehensive assessment that can determine if the referral to psychiatric screening is appropriate. Therefore, a mental illness triage protocol for non-psychiatric nursing staff in the emergency room will be proposed and, accordingly, compared to the existing protocol as a means for increasing the number of appropriate mental health referrals.

The purpose of the study is to increase the knowledge of nurses assigned to mental health patients, improve the number of patients referred, and to accurately assess the appropriateness of patients seen on the crisis unit. Consequently, this researcher proposes to provide a series of psychiatric screening classes and will offer them to ER and triage nurses who directly and indirectly have contact with the mental health population at the designated ER.

Table of Contents

List of Tables

Table

List of Figures

Figure

Chapter 1: Introduction

Community outreach programs exist in most communities to address ongoing healthcare needs of individuals affected by behavioral health impairments. A large component of this outreach effort is screening and evaluation designed to facilitate a referral to an appropriate level and type of healthcare intervention. Screening and evaluation are intended to detect potential illnesses in the community; they are typically the gateway for impaired individuals seeking access to diagnostic and treatment services along a continuum of therapeutic care provided by specialists and experts. Behavioral health services include outreach programs in the community for purposes of engaging the target population of those with some impairment. One component of this outreach is the screening and evaluation of mental health disorders for referral to an appropriate level of care. These services are distributed according to need and often co-located with ancillary services.

Screening and evaluation programs may also include crisis intervention. The goal of a screening and crisis intervention program (SCIP) is to provide stabilization to a client with urgent and immediate needs that have been identified within an outreach community service. The SCIP does not provide treatment and intervention, only an interim stabilization so that the client can then progress to the next stages of a confirmatory diagnosis and treatment if needed. Many behavioral health screening services include crisis intervention. The goal of a screening and crisis intervention program (SCIP) is to provide both on-site and off-site stabilization services in its designated county. SCIP is the county's designated psychiatric screening program that identifies community-based mental health services as an alternative, and when clinically appropriate, to inpatient

public psychiatric hospitals. All screening centers are located in, or adjacent to, emergency rooms. Screening centers operate 24-hours a day, 7 days a week for the purpose of evaluating patients for a mental illness.

Under the New Jersey psychiatric screening law, the Department of Mental Health Services (DMHS) is responsible for developing, updating, and readopting every 5 years, screening regulations to provide more detailed guidance regarding the state's screening system. DMHS considers public input critical to the development of accurate, current, and helpful standards. It has looked to the Governor's Task Force on Mental Health, Acute Care Task Force, Screening Regulations Work Group, State Mental Health Planning Council, Systems Review Committee, advocacy and industry groups, and ongoing communications with the public (New Jersey Division of Mental Health Services, 2008).

As recently as 2008, changes to New Jersey's screening law were proposed and consisted of the following recommendations:

1. Changing from a stationary center within a hospital to a more mobile service with greater community accessibility;
2. Expanding mission from crisis response and hospital referral to early intervention and linkage to community resources;
3. Performing psychiatric evaluation through telepsychiatry;
4. Adding greater detail to the provisions role in commitment evaluation, including instances when conditional discharges are violated;
5. Updating staffing qualifications, training and certification requirements;
6. Updating the waiver section;

7. Updating designation section, possibly adding provisions regarding the termination or suspension of a designation; and
8. Updating the confidentiality section (New Jersey Division of Mental Services, 2008, p. 6).

SCIP administrators are presently exploring the option of moving from a hospital setting to a mobile clinic to provide greater accessibility. The move from the ER would give the program its own environmental structure as well as greater latitude in providing psychiatric screening to mental health patients.

At present, there are between 300 and 400 patients who present to the designated county ER monthly and who are then referred to the screening and crisis intervention program (SCIP) for a mental health evaluation. SCIP is under contract with the Department of Mental Health (DMH) to provide psychiatric mental health screening in a designated county in New Jersey and is based at the selected ER. SCIP represents a cross section of the services available to the community (correctional facilities, juvenile detention centers, military bases, schools, nursing homes, group homes, state agencies, and private residencies). SCIP is employed by a larger non-profit agency to provide mental health services in a designated county and are not employees of the selected ER.

All patients must be triaged in the ER and when medically cleared by an ER physician, will be referred to the mental health crisis unit if they require further evaluation. Those patients referred to the crisis unit will be assessed by a crisis specialist and, in some cases, seen by a psychiatrist to determine if hospitalization is justified.

Not all triage staff at the selected ER are mental health nurses or psychiatric screeners; thus questions conveyed to patients by triage staff sometimes do not include the essential preconditions to establish mental status:

- Is depression evident?
- Is there suicidal/homicidal ideation present?
- Are there paranoia, psychosis, catatonic or substance induced behaviors?

Not all ER staff is trained to follow the crisis screening protocols, nor are crisis specialists assigned to the ER to assist with the screening process. Lack of representation of crisis staff in the ER can sometimes complicate referrals to a crisis unit when triage nurses are unclear of reason for referral; they lack understanding of chronic and acute mental health history and cannot assess for mental status criteria.

The mental health triage protocol used in the ER is intended to determine if a patient meets criteria for a crisis screening. Nurses are occasionally unable to articulate the protocol when questioned by crisis staff and often will arbitrarily send patients to crisis screening without consulting first with a certified crisis screener. This has led to questions regarding the appropriateness for the referral and tension between crisis specialists and ER staff. The protocol, as interpreted by the crisis team, is that the ER nurse must alert a crisis specialist in advance when a referral to the crisis unit is initiated. This advance notification by ER nursing staff promotes a collaborative effort in determining cause/reason for referral and helps in providing psychiatric justification for the referral since most ER nurses are trained in physical medical emergency, not mental health assessment and treatment.

Nurses in the selected ER are not all trained to triage mental health patients or provide mental status examinations on the crisis unit. There is occasionally resistance primarily from administrators at the selected ER to have crisis specialists stationed in triage to assist nurses with establishing a mental status disposition as well as to coach, teach, and advise. The absence of these teaching and coaching tools has given rise to increased frustrations on the part of crisis clinicians as some referrals are deemed inappropriate and counterproductive to the screening referral process. On the other hand, there is benefit in collaboration as some ER nurses have expressed a desire to understand mental health triage and assessment. The problem is nurses are pulled in different directions and assigned where their superiors believe they are most required.

The applied dissertation (AD) will research the importance of the effectiveness of the psychiatric screening process for mental health patients at a selected emergency room in the state of New Jersey. The intent of this study is to improve clinical skills and awareness of assessment, treatment, and diagnosis of mental health patients amongst ER nurses, techs, and mental health associates at the selected ER. As an ER nurse, he or she may take part in collecting data from various sources to be used in considering the impact of services to the patient, expectations of treatment, and limitations and successes. The assessment is a guide for nurses/clinicians to assist in securing and building therapeutic rapport and in creating meaningful and efficacious treatment plans and outcomes. In evaluating patients for a psychiatric referral and disposition, they must consider the following questions and return to them often:

1. *What will help you understand a patient's psychiatric history as you probe to understand and (or) identify clinical treatment options?*

This area of the assessment considers the patient's previous treatment, outcomes, and compliance and also examines current psychiatric treatment. Discussing the patient's history will help you understand the patient's overall experience and familiarity with his or her diagnosis and treatment. The history may also serve as a prognostic indicator. A good history will help you avoid repeating treatments that have previously been unsuccessful.

If you have not already done so, ask the patient if he or she has a psychiatric diagnosis. If yes, ask the patient to tell you what the diagnosis means to him or her and how it affects him or her. For patients with long and complex histories, it may be difficult for the patient to provide you with a detailed account. You may need to repeatedly ask, "And what happened next?" It is your responsibility to help the patient organize his or her memories to create a meaningful history.

2. *How you will assess a patient's mental status as you work to arrive at a clinically appropriate disposition?*

The mental status exam (MSE) is the clinically accepted tool used to evaluate a patient's current emotional, cognitive, and behavioral functioning. The MSE utilizes a standardized format and should describe pertinent positive and negative symptomology and features. A well-written MSE captures the essence of the patient as the writer gives specific examples and quotes whenever possible.

The MSE form in this assessment provides you with key concepts and cues to use as you conduct the evaluation. As you become more experienced in conducting the MSE, you will be able to do so by having a structured conversation with the patient. Your notes will allow you to incorporate and organize your finding into the MSE format. The MSE is

structured so that you begin with more general information (appearance and mood) and as rapport is established, gradually move to more personal and sensitive material (i.e. suicidal/homicidal ideation, auditory hallucinations).You are evaluating for congruence between the patient's subjective experiences and your objective observations (i.e. mood vs. affect; responding to internal stimuli).

As a result, this researcher proposes to provide a series of mental health screening classes and will offer them to ER staff as well as other employees at the designated ER that directly and indirectly come into contact with the mental health population to improve referrals and dispositions.

Problem Statement

A mental illness triage protocol for non-psychiatric nursing staff in the emergency room (ER) will be developed and compared to the existing protocol as a means for increasing the number of appropriate mental health referrals.

Sub-problems. Two sub-problems will also be addressed within the study:

1. Are there a greater number of referrals with the new protocol compared to the old protocol?
2. Does the new protocol admit more patients than the old protocol?

This researcher possesses over 24 years of human services, mental health screening, and working in an emergency room crisis setting. This researcher has knowledge in administrative management and community corrections; has directed intensive Level 3 treatment foster care programs; and has provided services to children in their own homes to assist families with structural community stabilization.

This researcher's present assignment is in directing the day to day operations of a

crisis screening center located at a selected ER in the state of New Jersey. Duties include overall supervision of the screening center to include scheduling, covering shifts as needed; on-call coverage, representing the program in the community; and planning, developing, and evaluating the effectiveness of the program. Licensed as a mental health screener for the state of New Jersey, I can screen patients for involuntary hospitalization or remove them from the community for further evaluation at a designated screening center. Additional responsibilities will also factor in the assessment of patients referred for a mental illness. The diagnostic criteria and final disposition determines if a patient will be hospitalized or discharged from the crisis unit with referrals to community mental health clinics. Presentation of clinical criteria and recommendations are always reviewed with a psychiatrist prior to final disposition.

A psychiatrist is available on-site at the crisis unit Monday through Friday between the hours of 7 a.m. and 7 p.m. During after hours, weekends, and holidays, a psychiatrist is available on-call and conducts clinical evaluations via telepsych, as indicated. Telepsychiatry is a relatively new addition to mental health screening and assessment as it offers the patient the option of speaking with the psychiatrist live via close circuit TV. A patient has the right to see a psychiatrist face-to-face at the crisis center and, therefore, can refuse a telepsych consult. In this case, the patient will remain at the crisis center overnight and will see the psychiatrist during normal business hours.

The Screening Crisis Intervention Program (2009) will notify a psychiatrist for the following reasons:

- After all crisis evaluations
- With any use of restraints unless physician in ER orders restraints

- When keeping a patient against his or her will for evaluation
- For any recent suicidal and/or homicidal threats or behavior
- For elopement during evaluation or from in-patient unit
- When medication is prescribed through a pharmacy in the community (Psychiatrist can call in a prescription for psychotropic medication.)
- If the patient is evaluated twice (2x) for an emergency within a 48-hour period
- If the patient refuses evaluation and requests to leave against medical advice (AMA)
- When a patient is referred for hospitalization and/or commitment
- For all suicide attempts, gestures, ideations and plans
- When a request from emergency room physician to consult and/or to see patients face to face prior to discharge from hospital
- When medication is administered through the ER
- When patients are brought to crisis unit by the police due to disruptive behavior in the community.
- Whenever the crisis worker feels the need for additional input or has a concern
- For all outreaches in the community
- For all patients under the age of 18
- For all patients with insurance coverage that requires a psychiatrist's involvement.

A report that I helped to generate specific to SCIP's indicators specified that in fiscal year 2007-08, 4,047 patients were referred to psychiatric screening and crisis for a

mental illness evaluation. The program's contractual commitment set its indicators at 3,952 patients during this fiscal year. In the same fiscal year (2007-08), there were 1,088 voluntary hospitalizations, 362 referred to acute care services; 1,793 referred to other community services; 627 commitments; 612 referred to short care units (STCF); and 904 face-to-face mobile outreaches.

It is anticipated these numbers will continue to rise due, in part, to a decrease in community mental health services as well as the present realities of the economy, i.e., unemployment, poverty, domestic violence, limited education, homelessness, and crime. These factors have given rise to acute psychiatric behaviors in patients referred for mental health evaluation and treatment.

Patients referred for a mental health screening at the local ER must undergo a mental status examination (MSE) that will assess for dangerousness to self, others, and /or property. Mental health screening preferably should be performed by a crisis specialist in conjunction with ER personnel to determine the best course of treatment at time of triage. The purpose for a crisis specialist to see the patient in the ER before he or she is escorted to the crisis unit is to assess for the following MSE criteria:

- Previous suicidal and or homicidal thoughts
- Previous attempts to harm self or others
- Most recent attempts to harm self or others
- Methods used/severity of
- Lethality of
- Access to/means to weapons
- Plan

- Intent
- Triggers/stressors/contributing factors
- Level of insight now
- Level of judgment now
- Level of impulse control now
- Ability and means to keep self/others safe now
- Baseline functioning versus new behaviors
- Current treatment and frequency of
- Reason for evaluation happening today
- Psychiatric Advanced Directive Status (Screening Crisis Intervention Program, 2009).

Many ER nurses have voiced opposition when assigned to the crisis unit, and this has sometimes contributed to the agitation of mental health patients through verbal abuse, taunting, and harassment at the selected crisis unit. On the other hand, nurses who volunteer to work on the crisis unit and do not feel intimidated by the acuity level of many of the patients are often pulled off the unit to attend to duties in the ER. Likewise, nurses assigned to the selected ER and crisis unit frequently lack the mental health experience to understand the psychiatric criteria for referral. Still others, including ER administrators, have circumvented the crisis unit policy and procedure by undermining the efforts of crisis staff to maintain rapport with patients. This undermining by ER staff often leads to divisions as crisis clinicians are unable to enforce guidelines on the crisis unit, thus creating an atmosphere of discard among crisis specialists and ER staff.