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Psychiatric Crisis Centers and Emergency Departments:

Emerging Trends, Drivers and Examples

October 13, 2020

Francis Murdock Pitts, FAIA, FACHA, ACHE, OAA

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October 13, 2020
Moderated by: Yvonne Nagy AIA

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Master’s Studio

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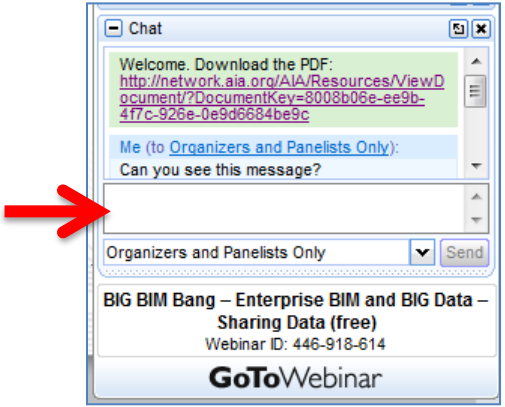

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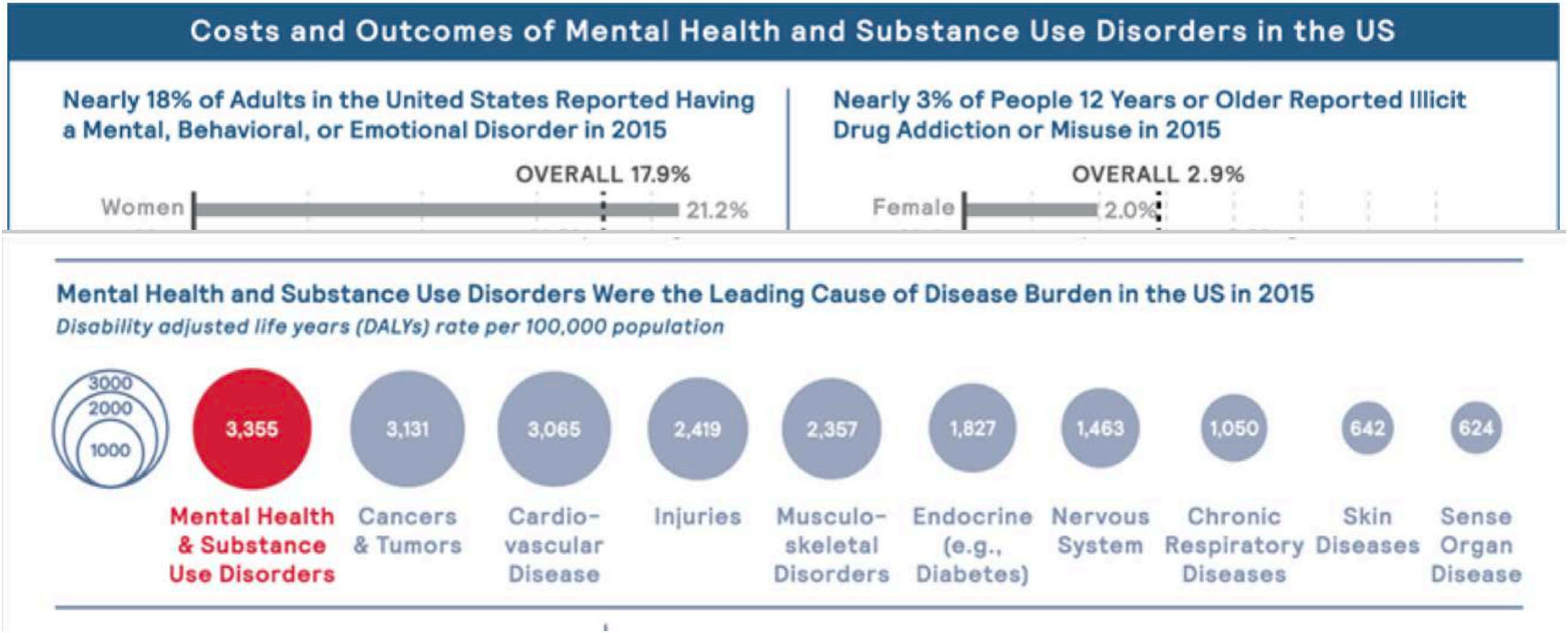
Introduction

Today's Topics

- The Challenge of the Psychiatric ED
- Topologies and Typologies
- Recently Built/Designed Examples
- Some Drivers and Considerations

The Underlying Systemic Issues

Stigma, Late Diagnosis, Delayed Treatment, Broken Patients



The Underlying Systemic Issues

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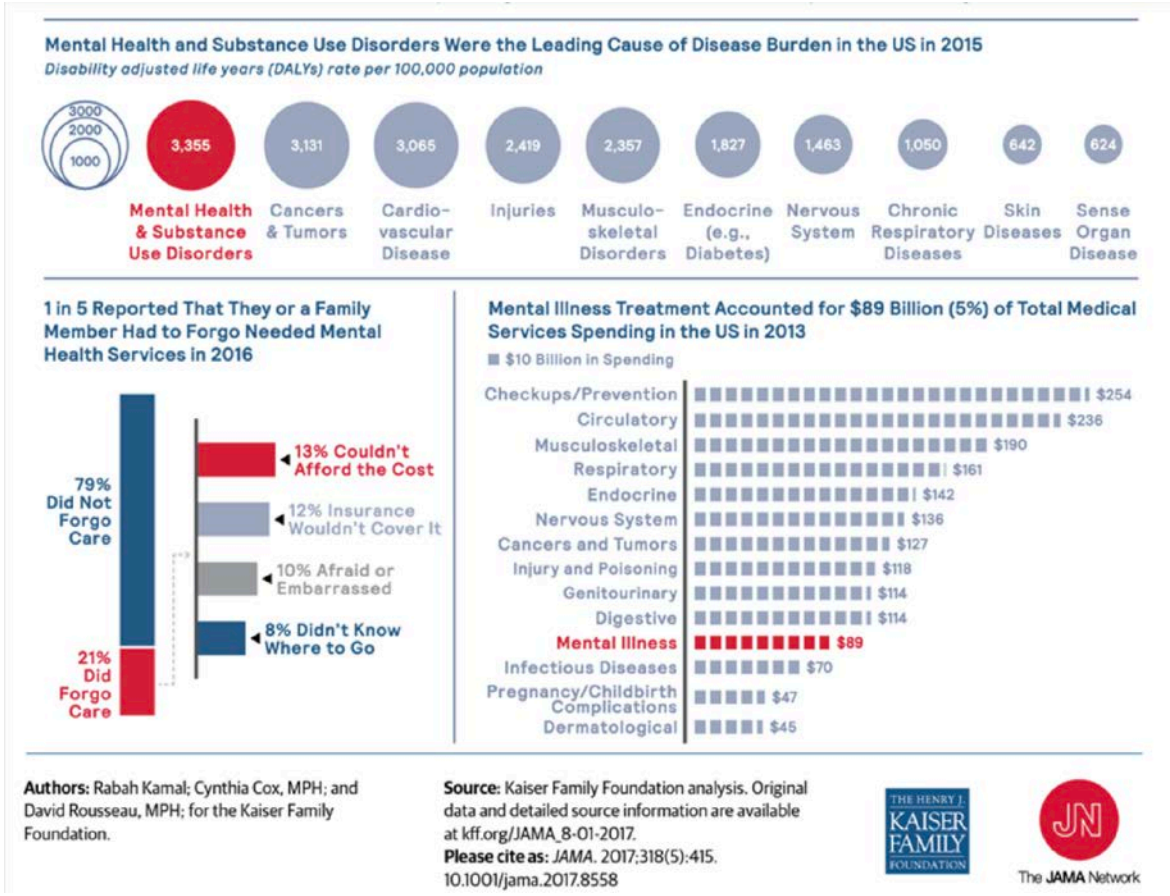


Utilization and Impacts

Before Covid-19

- 1 in 8 ED visits related to mental health or substance abuse issues
- 44% increase between 2006 and 2014
- 56 % increase for pediatric patients and nearly 41% increase for adults between 2009 and 2015
- Suicidality up 414%
- ALOS increase from 6.5 to 9.0 hours

Utilization and Impacts
During Covid-19

- 32% of adults report mental health negatively impacted, March 2020
- 53% mid-July 2020
- Existing mental illness exacerbated
  - Social isolation
  - Postponed treatment
  - Continued delays in diagnosis and treatment

Mind and Body

The Two Presentations of Trauma

Mind and Body

The Two Presentations of Trauma

Mind and Body

Triage and Stabilization Begins

Mind and Body

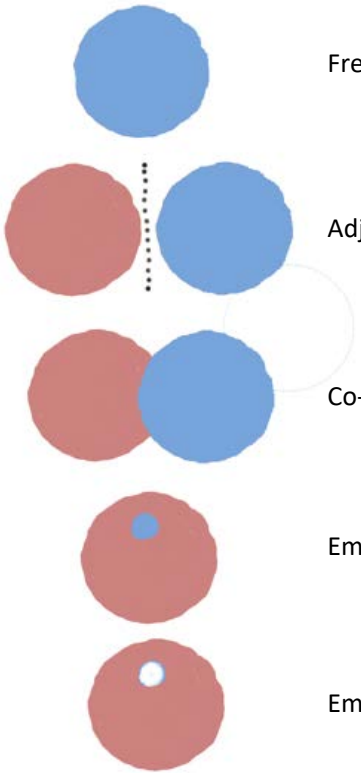
Triage and Stabilization Begins

Terminology and Typology

If You've Seen One Psych ED, you've seen one psych ED

- Psychiatric Emergency Service/Department
- Comprehensive Psychiatric Emergency Program (CPEP) **NYS**
- Mental Health Crisis Center
- Behavioral Health Crisis Services
- Mental Health Assessment Center
- Admissions
- EmPATH

Topology
Where's Waldo?



Free-Standing

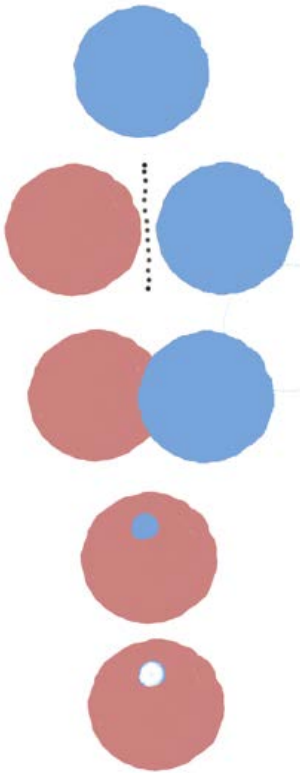
Adjacent or Nearby

Co-located with Shared Services

Embedded: Dedicated Rooms/Suite

Embedded: Multi-purpose Rooms/Suite

Topology
Why Waldo?



Free-Standing

Adjacent or Nearby

Co-located with Shared Services

Embedded: Dedicated Rooms/Suite

Embedded: Multi-purpose Rooms/Suite

Typology Drivers/Issues

- Volume
- Medical Clearance
- On-site aftercare/Inpatient Care
- Academic Medical Center
- Licensure/Reimbursement Models
- Accountable Care Organizations
- Comprehensive and Continuous Systems of Care
- Specialist Availability
- Patient Safety

Parts and Pieces
Typical

- Vehicle Sallyport
- Walk-In and Visitor Entrance
- Reception, Security and Sallyport
- Triage
- Care Desk
- Waiting
- Patient Lounge (Recliners)
- Consultation Rooms
- Treatment/Procedure Room
- Quiet Room
- Seclusion
- Extended Observation Beds
- Back of House Support

Parts and Pieces

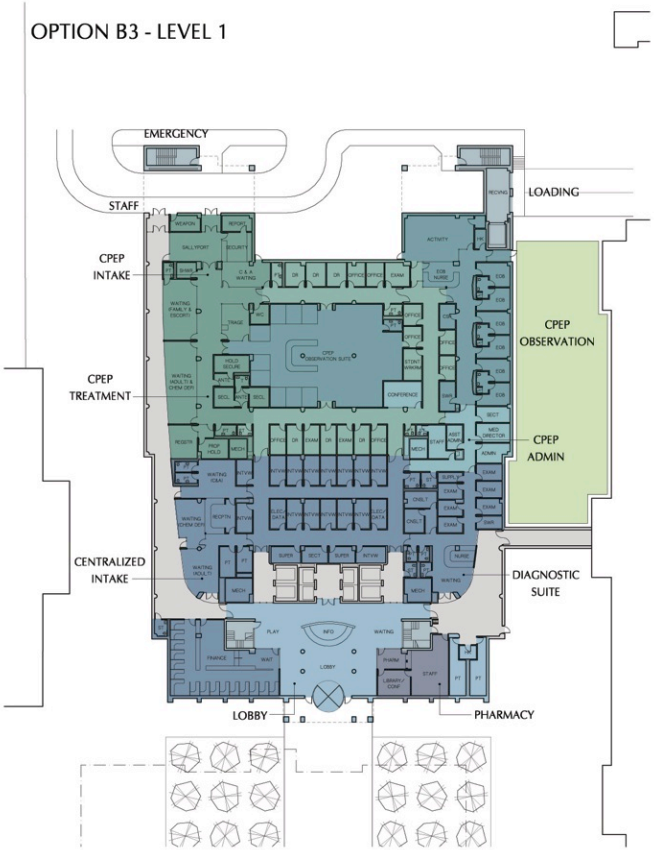
Nationwide Children's Hospital

Free-Standing

Parts and Pieces

Nationwide Children's Hospital

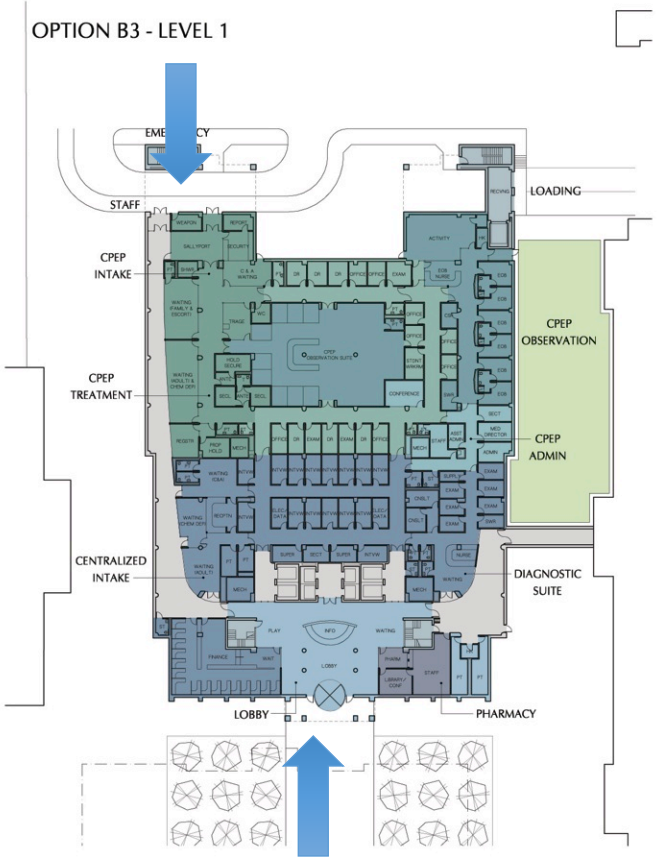
Sections and Flows
Kings County Medical Center

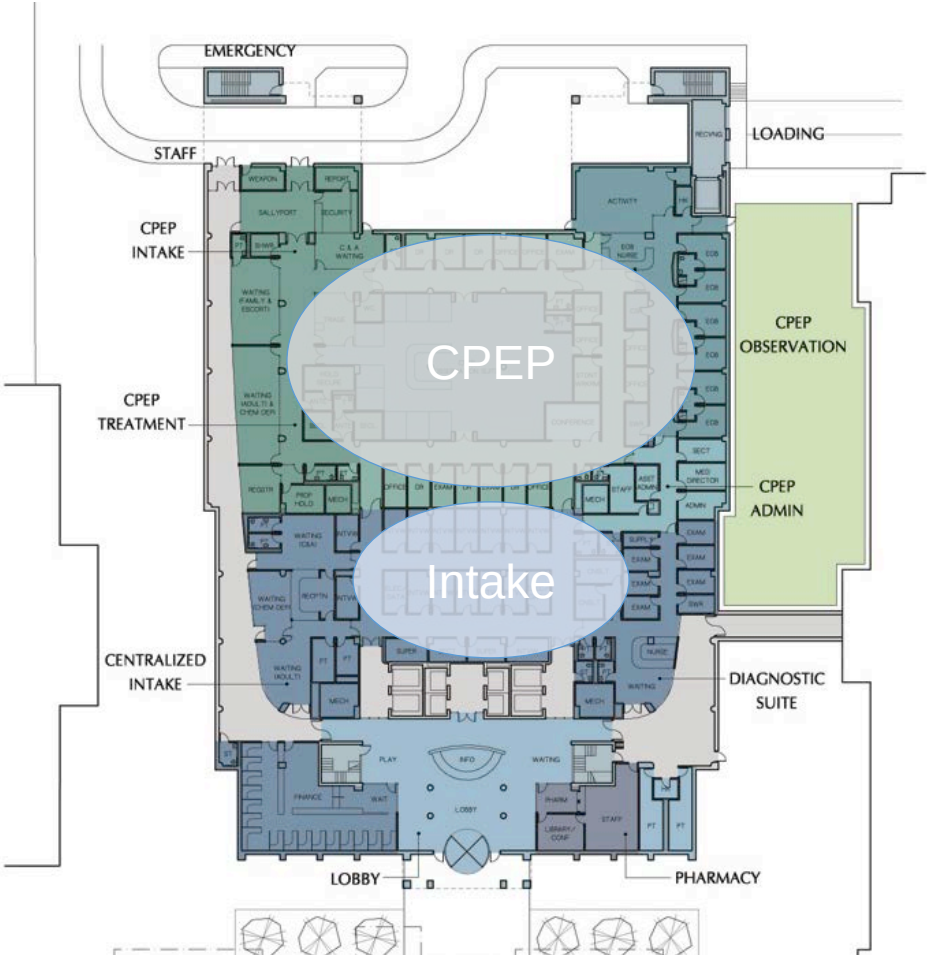


Free-Standing

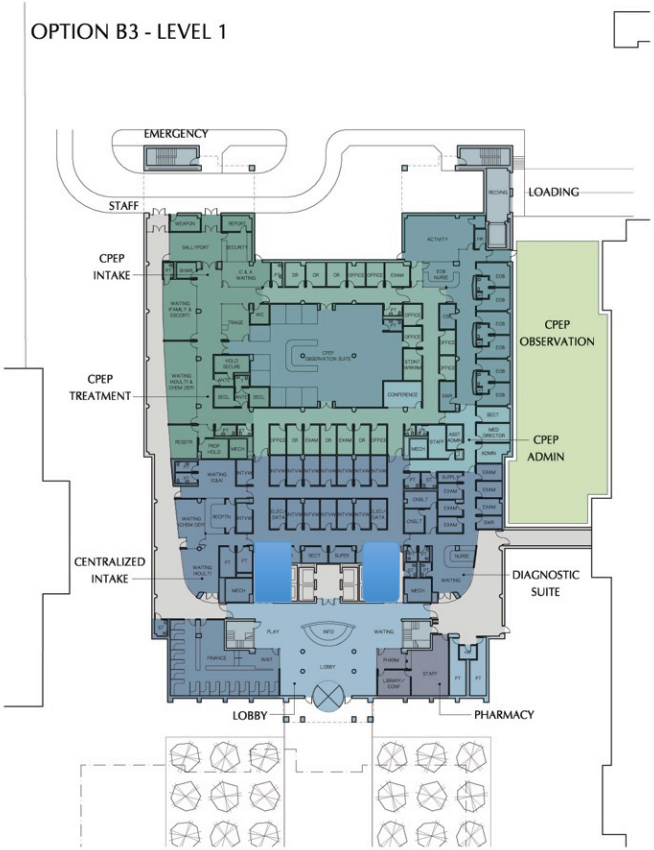
Sections and Flows

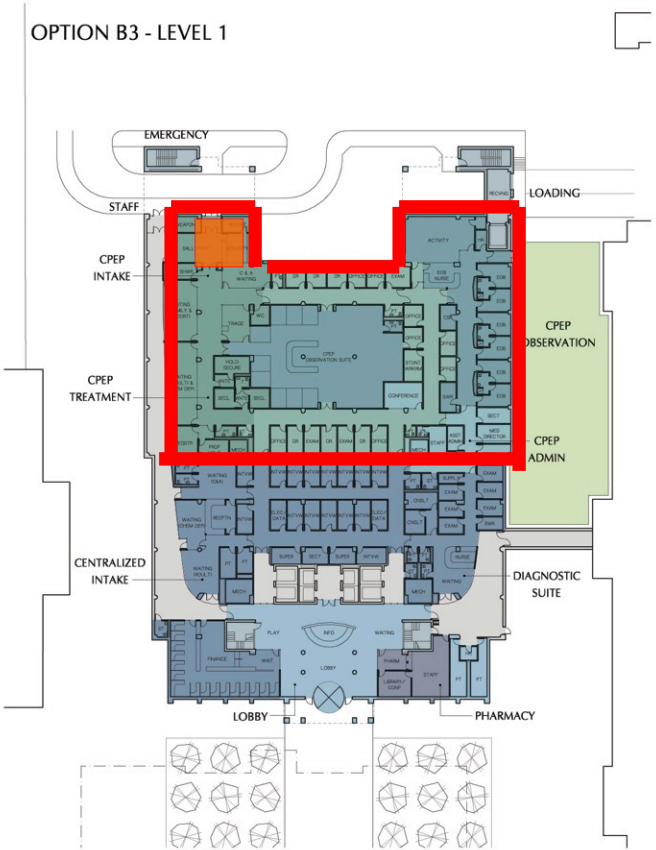
Kings County Medical Center



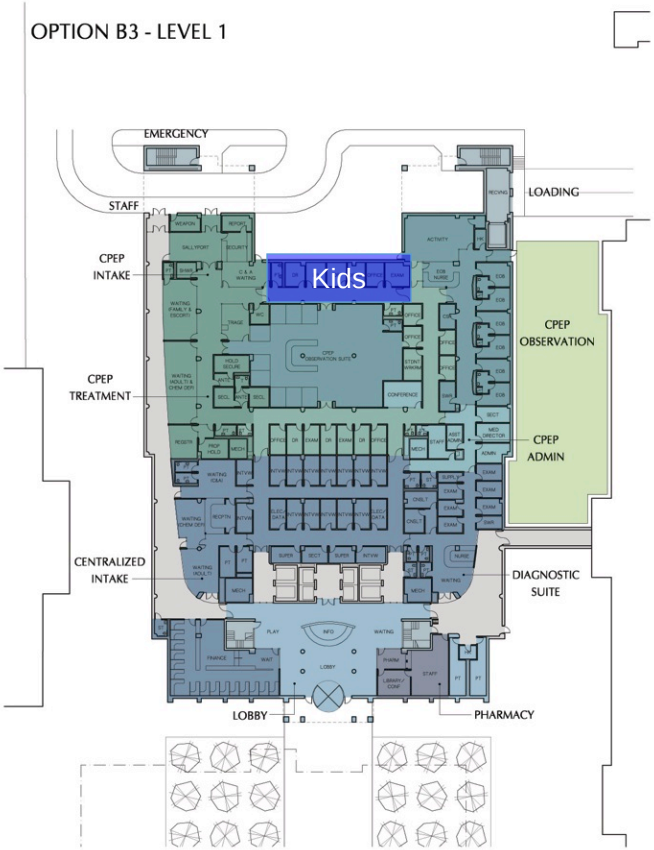


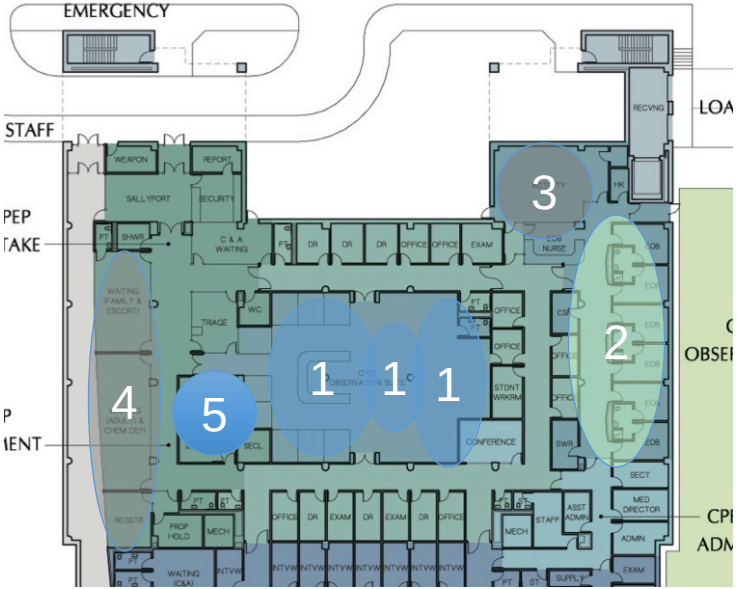
Sections and Flows
Kings County Medical Center





Sections and Flows
Kings County Medical Center



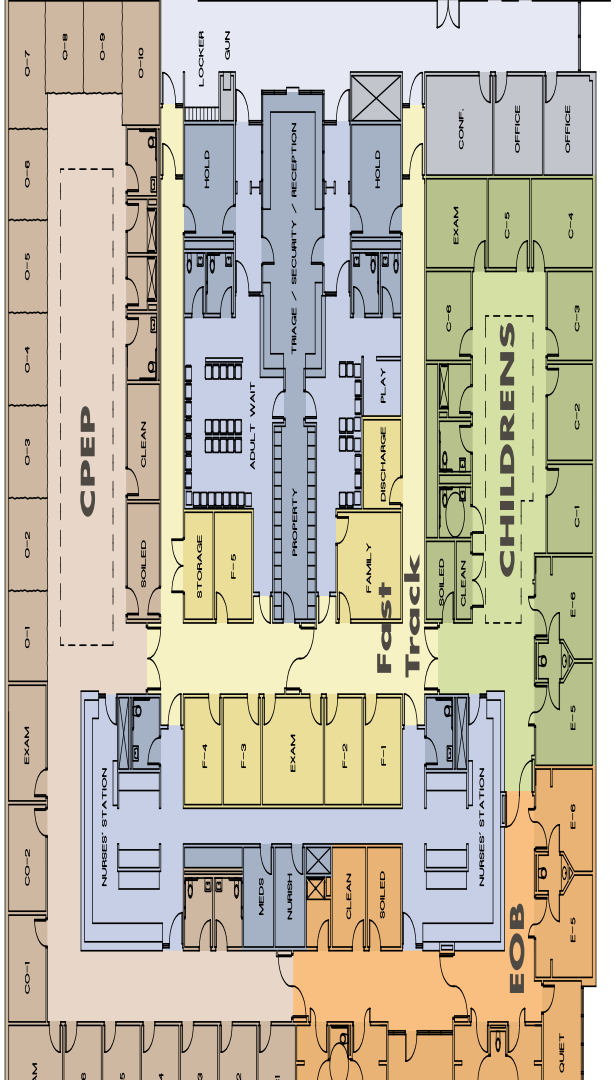


Internal flexibility

1. Three changeable central zones
2. Extended observation beds
3. EOB day space as extended CPEP
4. Waiting as extended CPEP
5. Secure holding

Sections and Flows

Erie County Medical Center



Adjacent or Nearby

Patient Safety
CMS and the Joint Commission

Ligatures and Suicide Risk Reduction - Emergency Department - Ligature-resistant Requirements

Do emergency departments need to be ligature resistant ?

No. Emergency departments do not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment. Patients in emergency departments often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature resistant. However, organizations must implement safeguards to keep patients with active suicidality safe during the course of treatment in that setting (see also the FAQ titled *"Do we have to assess every patient for suicide risk who comes into the emergency department ?*). In designing the emergency department environment, the organization must first consider state rules and regulations (typically the state health department).

This FAQ was also published in the Perspectives® Newsletter, July 2018, Volume 38, Issue 7 - The Official Newsletter of The Joint Commission.

Standards FAQ Details

Wednesday 4:30 CST, October 25, 2017

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Ligature Risks - Assessing and Mitigating Risk For Suicide and Self-Harm

What are the Joint Commission expectations for identifying and managing ligature risks in the hospital setting?

For inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units DESIGNATED for the treatment of psychiatric patients (i.e. special rooms/safe rooms in Emergency Departments or Medical Units):

The requirements found in the Environment of Care (EC) chapter of the accreditation manual at EC.02.06.01 require hospitals to establish and maintain a safe, functional environment. Element of Performance # 1 states "Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided". Therefore, ligature and self-harm risks must be identified and eliminated. While risks are in the process of being eliminated, policies and procedures must be developed and implemented to mitigate the harm posed by such risks. Mitigation plans must include, at a minimum the following:

- Ensuring that leadership and staff are aware of the current environmental risks
- Identifying patients' risk for suicide or self-harm, then implement appropriate interventions based upon risk.
- Ongoing assessments and reassessments of at-risk behavior as defined by the organization.
- Ensuring the proper training of staff to properly identify patients' level of risk and implement appropriate interventions
- Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program - see LD.01.03.01 EP 21.
- If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e. medical beds with side rails on a geriatric unit), the organization must consider these risks in patients' overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks

In non-behavioral health units (i.e. Emergency Rooms or Medical Inpatient Units) that are NOT DESIGNATED specifically for the treatment of psychiatric patients; however, where psychiatric patients may temporarily reside, ligature/self-harm environmental risks must also be identified.

All physical risks not required for the treatment of the patient that can be removed, must be removed. Furthermore, an appropriate level of effective surveillance must be implemented if self-harm risks remain in the environment. Organizational policies and procedures must adequately guide staff in the assessment of patients' risk for suicide/self-harm and the implementation of interventions based upon the patients' individual needs.

For non-inpatient programs surveyed under the Hospital Accreditation manual, an environmental risk assessment should be completed. Based upon the results of that assessment, taking into account the individuals they serve, the organization determines if any modifications to the environment should be made. Policies and procedures should also be developed and implemented to address the immediate action to be taken by staff when a patient is assessed to be at risk for suicide.

Additional Resources for assessing suicide risk:
Sentinel Event Alert # 56
Facility Guidelines Institute: Design Guide for the Built Environment of Behavioral Health Facilities
Suicide Risk Booster - available to accredited organizations via their Secure Extranet Site

Was this response helpful?

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Patient Safety
NYS-OMH Patient Safety Guide

NEW YORK STATE | Office of Mental Health

Patient Safety Standards, Materials and Systems Guidelines

Recommended by the

New York State Office of Mental Health

With respect to NYS-OMH operated facilities, these Guidelines apply solely to new construction and major renovation projects. Existing facilities should use these Guidelines as a reference document whenever they make improvements.

24th Edition | July 31, 2020

Developed in association with architecture+

The Regulatory Process
Regulations? What regulations?

"Be vewy, vewy cawful!"

Elmer Fudd

- The psych ed is rarely regulated separately as an entity.
- The FGI is in the process of addressing this issue.
- Seek direction from your client's counsel.
- Failing that, consider
  - Use FGI Emergency Department standards for the Free-standing Psychiatric Emergency Department
  - Use FGI Psychiatric Inpatient standards for Extended Observation Units

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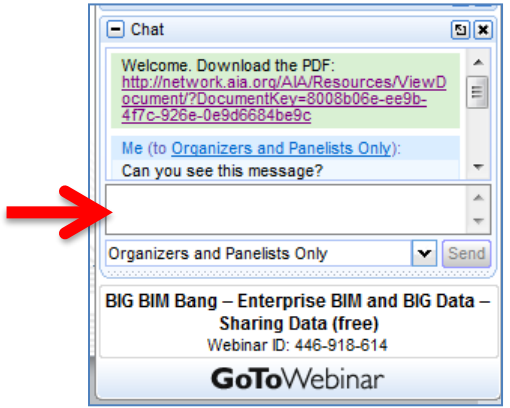
Question Reminder

Submit your questions and comments via the chat box.



EmPath

Credit to Scott Zeller

Recording

Zeller's Six Goals for Emergency Psychiatric Care

1. Exclude medical etiologies and ensure medical stability
2. Rapidly stabilize the acute crisis
3. Avoid coercion
4. Treat in the least restrictive setting
5. Form a therapeutic alliance
6. Formulate an appropriate disposition and aftercare plan

Zeller, *Primary Psychiatry*, 2010

Recording

EmPATH

Emergency **P**sychiatric **A**ssessment **T**reatment **H**ealing

Research shows that 75% or more of severe psychiatric emergencies can be **stabilized within 24 hours**

What makes the EmPATH Approach Different?

- Designated destination for all medically-cleared patients in crisis prior to determination of disposition or IP admission; not viewed as an alternative destination but *THE* destination
- Designed and staffed to treat all emergency psychiatric patients – philosophy of “no exclusion”
- Immediate patient evaluation and treatment by a psychiatrist, constant observation and re-evaluation
- Provides a calming, healing, comfortable setting completely distinct from the Medical ED
- Wellness and Recovery-oriented approach

Recording

Physical Space Design

Calming, healing environment that prioritizes safety and freedom

Large, open 'milieu' space
where patients can be together in the same room – high ceilings and ambient light, soothing decor

Designed to facilitate
socialization, discussion, interaction and therapy

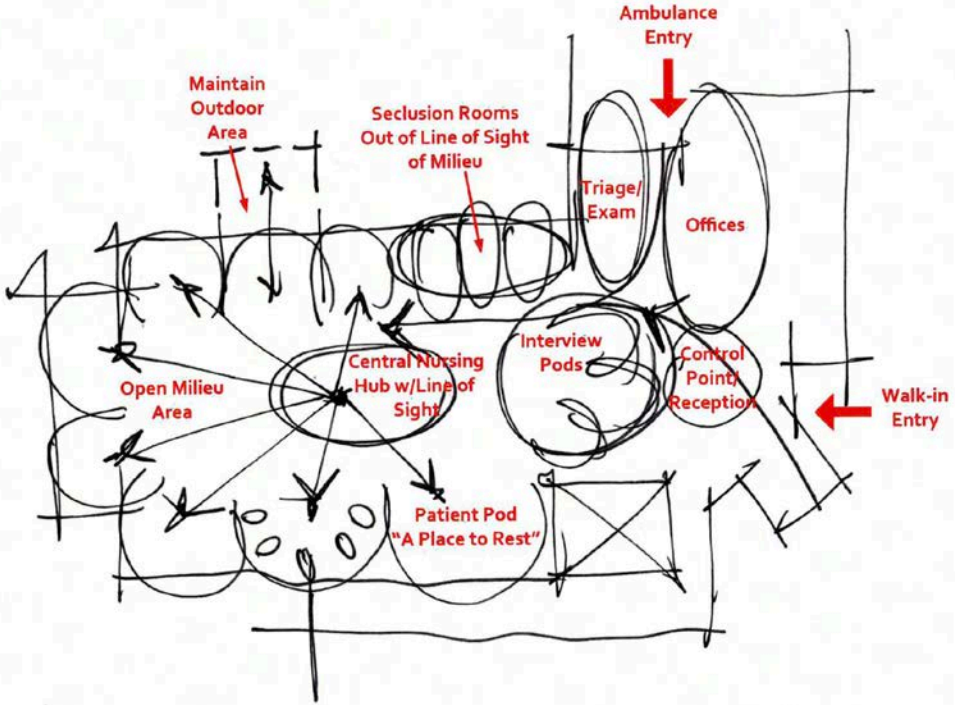
Per chair model
outfitted with fold-flat recliners

Space recommendation
80 sq. ft. total per patient, which includes 40 sq. ft. patient area around each recliner

Open nursing station w/instant access to staff
No 'bulletproof glass fishbowl' separate from the patients

Voluntary Calming Rooms
Avoids locked seclusion rooms or restraints

John George Hospital
The Alameda Model



The Devenney Group

John George Hospital
The Alameda Model

First Floor Plan Diagram - Day Time Mode

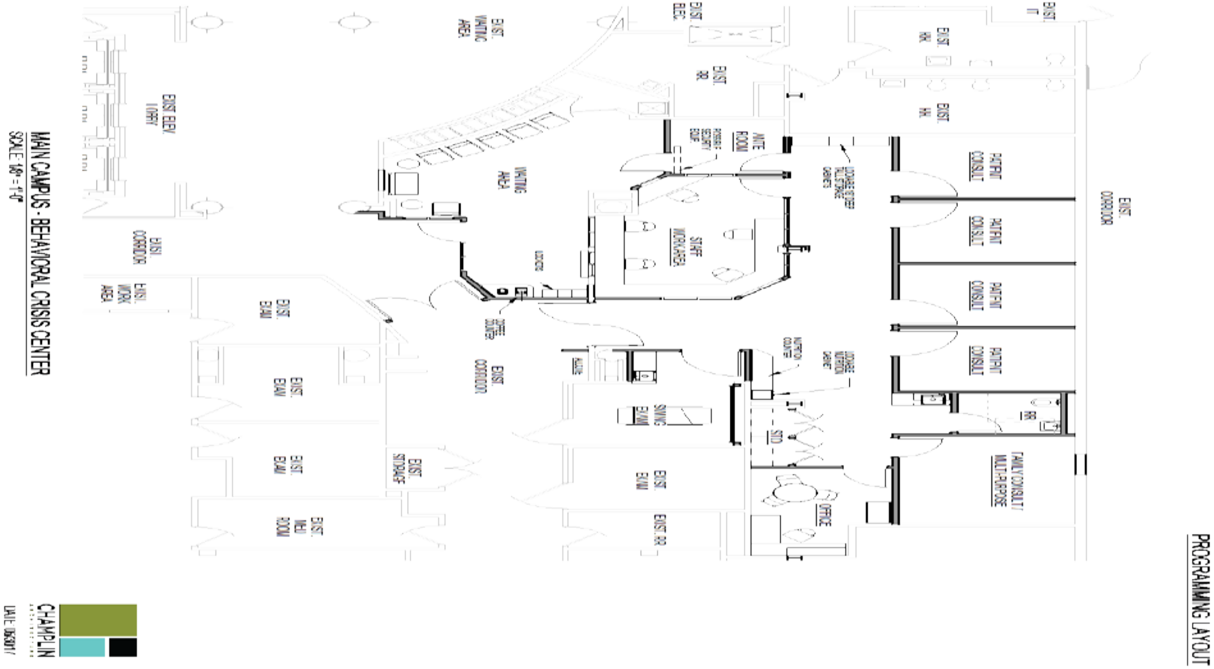
This plan indicates likely configuration for day time operation. The recliners in the central area would be pushed off to other areas to allow for larger gatherings. The goal is to open up the heart of the milieu to allow greater freedom of movement for patients who pace. The tables down the middle of the room may be rearranged for various functions or left in a spine. In addition, group functions such as dining or other group activities might be conducted in the central area or in one or more of the pods. The recliners in the smaller pods are shown largely folded up, although patients in the pods will be able to self select to sleep or rest, reclined and out of the way, if they so choose.

Free-Standing

Recommended Concept 4-9

Dayton Children's Hospital

Behavioral Crisis Center



Co-located with Shared Services

Violence and Aggression Reduction

Ulrich et al.

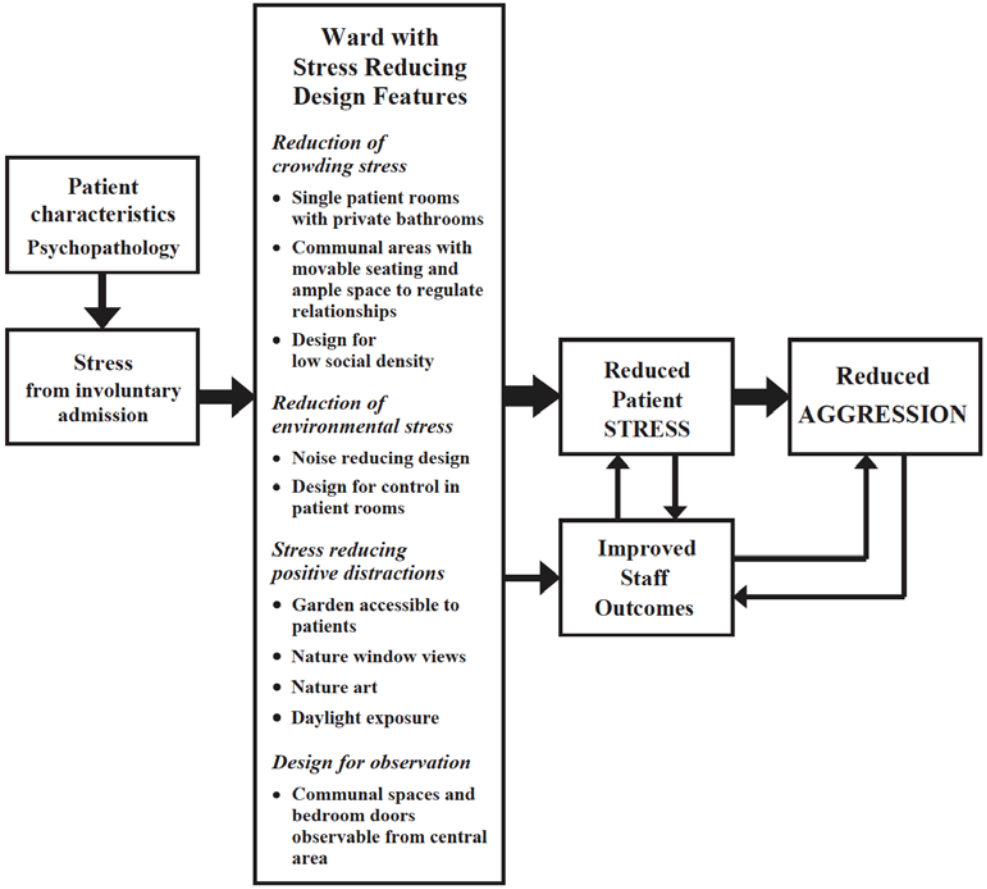


Fig. 1. Conceptual model for designing inpatient psychiatric wards to reduce aggression.

Ulrich, Bogren, Gardner, Lundin
Journal of Environmental Psychology 57 (2018) 53–66

A New Normal

Reduce and Eliminate Stigma

Moving Forward

- Mental Health Crisis Teams
- Purpose-built Facilities
- Part of a Continuum of Care
- Research Informed
  - Clinical
  - Environmental

Thank you!

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Time for Questions and Comments

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The URL to the webinar survey https://www.research.net/r/AAH2008 will be emailed to you or the individual who registered your site.

The survey closes **Friday, October 16, 2020** at 12:30am ET.

For questions, please email knowledgecommunities@aia.org

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Upcoming Webinars

Date	Series	Topic
11/17	**Beyond the Basics**	This Session is a “Disaster” *(an FGI presentation)*
12/8	**Case Study**	From Centralized Nursing Unit to a Decentralized Nursing Unit with Academic Learning Space
2/9	**TBD**	TBD

Dates & topics are subject to change