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**STANDARDS FOR MENTAL HEALTH COVERAGE IN EMERGENCY
DEPARTMENTS AND URGENT CARE CLINICS IN VHA FACILITIES**

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy to ensure the provision of safe and secure mental health services during all hours of operation for Emergency Departments (EDs) and Urgent Care Clinics (UCCs) in VHA.

2. BACKGROUND

a. The Department of Veterans Affairs (VA) recognizes the importance of providing emergent and urgent mental health services to patients seeking or requiring acute psychiatric care in VHA EDs and UCCs. It is estimated that 50 percent of behavioral emergencies requiring acute intervention in hospitals occur in the ED and UCCs.

b. In the interest of safety for patients and staff, emergent and urgent psychiatric care needs to be routinely available in all VHA EDs and UCCs. Psychiatric Emergency Services (PES) needs to be considered an integral part of ED and UCC services and be readily available to improve safety and expedite handling of these complex and potentially difficult cases. *NOTE: The majority of patients who present to EDs and UCCs with mental health problems are not violent.* Patients determined to present a danger to self or others need to receive priority treatment by the ED and UCC physician and the psychiatric consultative staff, with disposition accomplished as expeditiously as possible.

c. Facility police must be available when requested by the ED staff to provide standby assistance or intervention for the management of any patient who presents a danger to themselves or others, who is potentially violent, or who exhibits violent or agitated, unpredictable behavior.

d. ED staff and facility police must follow current VHA policy regarding the use of breathalyzers when addressing intoxicated Veterans who are attempting to leave the ED and UCC. Specific attention is to be paid to the assessment of level of intoxication, mode of transportation, and withdrawal risk.

e. Suicidality must be treated as a life-threatening condition and needs to take priority as in any other life-threatening condition. Patients presenting with suicidal ideation are to be placed on one-to-one observation by clinical staff and evaluated immediately. One-to-one observation needs to remain active up until the time the patient is no longer deemed a risk by the ED physician or psychiatric consultant, or until the patient is transferred to another appropriate setting. Patients who exhibit highly agitated, disorganized, aggressive, or violent behavior require one-to-one surveillance while in the ED. For patients who are discharged from the ED, referral for mental health assessment and follow-up appointment must be completed prior to discharge.

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f. It is recognized that patients seeking or requiring treatment may be identified as being under the influence of drugs or alcohol. This limits the ability of mental health staff to perform an appropriate evaluation.

(1) Care must be used to establish and promote a clinical relationship of trust and compassion providing for an opportunity to engage the patient in further clinical assessment and appropriate follow-up with clinical services.

(2) In the case of suspected overdose, the patient, if medically stable, must be referred for further mental health assessment and follow-up to include direct assessment of substance use behavior. The referral for mental health assessment and follow-up must be completed regardless of the perceived intent of the overdose (accidental or intentional).

g. Facilities may consider using metal detectors (magnetometers) to screen patients for weapons upon entering the ED and UCC. Metal detectors provide some, but not absolute, assurance of safety with respect to metal weapons. When metal detectors are used, they are to be used for all individuals entering the ED and UCC and are not to be used selectively for psychiatric patients. VA policy requires that two VA facility police officers be assigned to a magnetometer station for the safety of the officers and the public. *NOTE: A protocol needs to be established for the management of patients screening positive when using a metal detector.* Persons found to be in possession of weapons or other contraband during metal detector screening are subject to arrest and prosecution (see VA Directive and Handbook 0730, and successor documents which address specific requirements for the use of metal detectors).

h. Creating national standards for psychiatric ED and UCC space is a challenge considering the variations existing in size, age, and existing design of facilities. Still, a system cannot function well without a sense of the requirements for an ideal design that would foster smooth functioning and be acceptable to Veterans, their families, and staff. Space design needs to take into account control of opportunities to exit, and access of patients to potentially hazardous medical equipment and other environmental objects which may be used as weapons or for self injury.

i. The Mental Health Environment of Care Checklist from the VHA National Center for Patient Safety found at: <http://vaww.ncps.med.va.gov/guidelines.html> (*This is an internal Web site and is not available to the public*) provides guidance in designing space used for the evaluation of patients presenting to EDs and UCCs with psychiatric issues. New construction need to take into account the requirement to care for both male and female Veterans, as well as the need to provide separate restroom facilities for men and women. *NOTE: Some facilities have introduced the concept of a Psychiatric Intervention Center within the ED and UCC specially designed to assess and meet the initial needs for care of those outpatient Veterans experiencing emotional, behavioral, or psychosocial problems.*

j. It is recognized that the training, quantity and quality of staff and the policies guiding their functions can overcome many design barriers. Good design alone cannot compensate for administrative and staff deficiencies.

k. VHA has a computerized warning system available for patients who have been assessed to be at “high risk for violence.” The Patient Record Flag (PRF) system has been shown to dramatically reduce violence in the ED. PRFs are also used for patients at high risk for suicide (see current VHA policy on National Patient Record Flags).

1. **Definitions**

(1) **Emergency Care.** Emergency care is the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition posing a threat of serious jeopardy to life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

(2) **Emergency Department (ED).** The ED provides resuscitative therapy and stabilization in life-threatening situations; it is staffed and equipped to provide initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and psychiatric disorders, regardless of the level of severity. Emergency care is provided in a clearly defined area dedicated to this function, and is available 24 hours a day, 7 days a week (24/7).

(3) **Urgent Care.** Urgent care is unscheduled ambulatory care for an acute medical or psychiatric illness or minor injuries for which there is a pressing need for treatment to prevent deterioration of the condition or impairment to possible recovery.

(4) **Urgent Care Clinic (UCC).** An UCC provides ambulatory medical and psychiatric care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or psychiatric illness, or minor injuries. UCCs can exist in facilities with or without an ED. In either case, UCCs are not designed to provide the full spectrum of emergency medical care. Urgent Care is to be provided in a clearly-defined area dedicated to this function and according to defined hours.

(5) **Waiting Area (Rooms).** The waiting area is a room where patients and families can wait until they can be seen. It needs to be a sufficiently spacious room with seating arranged so that patients do not feel crowded. It must be organized so that staff may observe any disturbed behavior. This may include direct observation (preferred) or by video camera.

(6) **Psychiatric Intervention Room.** A psychiatric intervention room is a room where seriously disturbed, agitated, or intoxicated patients may be taken immediately on arrival. It provides an environment suitable for the rapid medical and psychiatric evaluation of dangerously unstable situations and the capacity to safely control them. When possible, it should be away from the waiting area and near the nursing station. While it is not a seclusion room, it should meet the standards for seclusion room construction outlined in the Mental Health Environment of Care Checklist (found at: <http://vaww.ncps.med.va.gov/guidelines.html>) *NOTE: This is an internal Web site and is not available to the public.*). If possible, all VHA EDs and UCCs need to have one room meeting these requirements in the ED or UCC.

(7) **Interview Rooms.** Interview rooms are where space is provided so that a psychiatric interview can take place with privacy, comfort, and safety. Such rooms need to be arranged so

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that assistance may be summoned rapidly if needed to deal with a dangerous situation; it needs to be equipped with a panic alarm system. They need to be large enough to accommodate at least three persons without feeling crowded. Interview rooms need to meet the standards for staff offices outlined in the Mental Health Environment of Care Checklist found at:

<http://vaww.ncps.med.va.gov/guidelines.html> *NOTE: This is an internal Web site and is not available to the public.*

(8) Observation Rooms

(a) Observation rooms need to allow for patients to be observed for up to 23 hours and 59 minutes, contain a bed where a patient can sleep, and allow crisis stabilization and brief treatment to take place. Examples of appropriate patients for observation rooms include those with drug or alcohol intoxication; those found to be a potential suicide risk, where the precipitant needs to be clarified; and those suffering from an acute situational disturbance that time or brief intervention may remedy. *NOTE: This room does not have to meet the requirements for a Psychiatric Intervention room.*

(b) Some large facilities provide observation using a small unit adjacent to the ED staffed by nurses, social workers, and psychiatry staff. Other facilities provide this function by having a similar unit within the ED itself or by utilizing some of their regular unit beds to serve in this capacity when needed. When present, the observation area needs to meet the standards for patient rooms contained in the Mental Health Environment of Care Checklist (found at: <http://vaww.ncps.med.va.gov/guidelines.html> *NOTE: This is an internal Web site and is not available to the public*).

(9) One-to-One Observation. One-to-one surveillance is defined as the constant observation of the patient by staff. Any staff member has the ability to initiate one-to-one surveillance, but only the ED attending physician or the psychiatric consultant can discontinue it. While under one-to-one surveillance, the patient is not to be allowed to leave the room for smoking or snacks; any restroom visit requires an escort who can visually monitor the patient for suicidal behavior. Such restrictions on the Veteran's freedom must be consistent with statutory and regulatory authority.

3. POLICY: It is VHA policy that EDs and UCCs have mental health coverage by an independent licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, physician assistant, or advanced practice nurse) during all hours of operation, either on-call or on-site; however, Level 1a facilities must provide ED-based on-site mental health coverage from 7:00 a.m. to 11:00 p.m.

4. ACTION

a. **National Director for Emergency Medicine.** The National Director for Emergency Medicine is responsible for providing national guidance to ensure a standardized approach for the provision of safe, quality care within VHA's EDs and UCCs; this includes policy and directions for the delivery of safe and secure mental health services during all hours of operation.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring that all EDs and UCCs within the VISN are providing mental health coverage during operational hours.

c. **Facility Director.** Each facility Director is responsible for:

(1) Determining the need for on-site or on-call coverage at the facility.

(2) Ensuring the presence of appropriate mental health staff in the ED and UCC areas:

(a) All VHA EDs and UCCs must have mental health coverage available during all hours of operation either on-site or on-call. This coverage is to be provided by an independent licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, physician assistant, or advanced practice nurse). Psychiatric residents or post-doctoral psychologists may also be used with appropriate supervision.

(b) For VHA complexity Level 1a facilities (those facilities that have higher utilization, higher-risk patients, specialized intensive care units, and research, educational, and clinical missions), mental health coverage must at a minimum be on-site (based in the ED) from 7:00 a.m. to 11:00 p.m. At other times, it may be on-site or on-call. Mental health providers covering on-site from 7:00 a.m. to 11:00 p.m. may participate in activities throughout the medical center; however, they must not undertake any medical center activities that would prevent them from coming immediately to the ED if called. Psychiatric residents and psychology postdoctoral fellows, where available, may provide ED coverage. If that coverage is on-site, the psychiatry or psychology supervising attending must also be present in the ED. Psychiatry resident or psychology fellows who are on call and respond to requests for ED consultation are expected to contact their supervising practitioners while the patient is still in the ED, in order to discuss the case and to develop and recommend a plan of management. For other facilities, coverage may be either on-site or on-call at all times.

(c) When a VHA ED has on-call coverage for mental health, this requires a telephone response within 20 minutes and the ability to implement on-site evaluations within a period of time to be established on a facility-by-facility basis. Psychiatric residents and psychology postdoctoral fellows, where available, may provide ED coverage; when on-call and responding to requests for ED consultation, they are expected to contact their supervising practitioners while the patient is still in the ED in order to discuss the case and to develop and recommend a plan of care management.

(d) All VHA facilities with EDs are required to have resources that allow for extended observation or evaluation for up to 23 hours and 59 minutes.

(3) Ensuring all ED and UCC staff including receptionists, nurses, nurse extenders, and physicians receive training in Suicide Prevention and Prevention and Management of Disruptive Behavior (PMDB). **NOTE:** *PMDB is VHA's accepted training in verbal de-escalation, personal defense, and safety/ physical containment for managing disruptive and potentially violent patients.*

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(4) Ensuring refresher training in all aspects of PMDB and routine drills are available on an annual basis.

(5) Providing a safe and secure area where patients seeking or needing mental health services can be evaluated and observed.

(6) Ensuring VA medical center police are trained and available to provide standby assistance when requested by ED and UCC staff. Facility police are to be available when requested by the ED staff to provide standby assistance or intervention for the management of any patient who presents a danger to self or others, who is potentially violent, or who exhibits violent or agitated, unpredictable behavior. Patients who have been determined by clinical staff to be a threat (or danger) to themselves or others, are not to be allowed to voluntarily leave the ED or UCC until a discharge plan is in place. In these situations, facility police are to prevent their departure, consistent with applicable statutes, regulations, or departmental policies. Whenever this occurs, the facility police are to use the minimum amount of force determined necessary to control the situation.

(7) Determining that the level of mental health services provided by the ED and UCC is congruent with the capabilities, capacity and function of that facility.

(8) Ensuring appropriate employees receive training in recognizing and responding immediately to the presence of all PRFs.

(9) Ensuring mental health providers in the ED and UCC are equipped with reliable cell phones or pagers.

(10) Ensuring the advice of the VA General or Regional Counsel, and the local U.S. Attorney's Office, is sought concerning the applicability of Federal, state, or local laws regarding weapon possession by a psychiatric patient. Such advice must become a part of the local facility's established policy and procedures.

d. **The Chief of Staff, the Nurse Executive, and the Mental Health Care Line Manager.** The Chief of Staff, the Nurse Executive and the Mental Health Care Line Manager are responsible for:

(1) Providing sufficient support services to the ED and UCC to ensure necessary and appropriate care is consistently delivered in a timely fashion.

(2) Mandating on-site or on-call mental health coverage for ED and UCCs during their hours of operation by an independent licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, physician assistant, or advanced practice nurse) or appropriately supervised psychiatric residents or postdoctoral psychologists. If the ED and UCC are not open 24/7, the telephone system must direct patients to the nearest ED that is able to provide appropriate emergency mental health service, and to provide the National Suicide Hotline number,

1-800-273-8255. Similarly, patients who arrive at UCCs when they are closed must be directed by appropriate signage to an ED that will best serve their needs; this signage is to include the National Suicide Hotline number.

(3) Ensuring that patients presenting with acute psychiatric emergencies, such as severe agitation, active psychosis, suicidal, or homicidal ideation receive priority treatment by the ED and UCC physician and the psychiatric consultative staff. This disposition must be accomplished as expediently as possible. If the patient with suicidal or homicidal ideation becomes highly agitated, assaultive, or attempts to leave and staff intervention is unable to stabilize the situation, the VA medical center police must be summoned to intervene, using only the minimum amount of force determined necessary to control the situation.

e. **Facility Chief of Police.** The facility Chief of Police is responsible for ensuring that:

(1) Local VA police standard operating procedures include legal guidance from the VA Regional Counsel and the United States Attorney's Office regarding the handling of appropriately committed patients. Such guidance needs to address state commitment laws and define when the movement of committed patients may be restricted.

(2) VA police officers receive recurring in-service training on topics directly relating to dealing with psychiatric patients. Patients who have been determined by clinical staff to be a threat (or danger) to themselves or others are not allowed to voluntarily leave the ED or UCC until a discharge plan is in place. In these situations, VA police must prevent their departure, consistent with applicable statutes, regulations or departmental policies. Whenever this occurs, VA police are to use the minimum amount of force determined necessary to control the situation.

f. **ED and UCC Directors and Managers.** ED and UCC Directors and Managers are responsible for ensuring that:

(1) Staff has received requisite training in the initial evaluation, treatment, and stabilization of acute emergent and urgent psychiatric patients.

(2) A physician is physically present in the department 24/7 if the facility has an ED, and on-site during hours of operation of the UCC.

(3) All patients presenting to the ED and UCC are screened at some point during the visit for suicide and homicide risk. Patients recognized on screening as being at-risk for suicide or homicide or who exhibit disruptive, aggressive, or violent behavior require one-to-one observation while in the ED and UCC until the time they are no longer deemed a risk by the ED and UCC attending physician or a psychiatric consultant. Immediate treatment of life-threatening conditions always take precedence over this screening process.

(4) All patients admitted to the ED have appropriate physical and laboratory examinations to diagnose medical conditions that could be responsible for their psychiatric condition. As part of that diagnostic process, patients are asked to wear a hospital gown or pajamas and an inventory of their belongings must be carried out by clinical or nursing staff. These items must be safely

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placed in a bag, separated from the patient. If during this process, weapons or contraband are discovered, facility police must be notified. **NOTE:** *The question of whether a weapon found in the possession of a psychiatric patient can be returned to that patient is subject to Federal and state laws (see subpar. 4c(10)).*

(5) A policy is in place for appropriate transfer of the patient after stabilization to a facility that can provide a higher level of care, or provide an involuntary admission if it is deemed necessary and not available at the VHA facility. Transfers need to comply with applicable provisions of Title 42, Code of Federal Regulations, § 489.24 that implement the Emergency Medical Treatment and Active Labor Act (EMTALA). **NOTE:** *While not technically subject to EMTALA and the regulations implementing the Act issued by the Centers for Medicare and Medicaid Services (CMS), VHA complies with the intent of EMTALA requirements regarding the transfer of acute patients among health care facilities.*

(6) Patients who are or who appear to be intoxicated as evidenced by a breath or blood alcohol level greater than the legal limit (typically .08) or who are manifesting behavioral signs of intoxication and who indicate any verbal or non-verbal intent to operate a motor vehicle are encouraged, or assisted in making other arrangements for transportation. These patients may also remain at the facility for an extended period of time until additional follow-up indicates that the patient is no longer showing signs of intoxication. Should a patient elect to leave the ED or UCC, this patient must be informed, in the presence of a witness, of safety concerns and advised not to operate a motor vehicle, and informed that the facility police will be contacted due to concerns for public safety. This information must be documented in the medical record. **NOTE:** *For local procedures for notification of VA police in such situation see subparagraphs 4c(10) and 4e(1) and (2).*

(7) In those patients for whom there is a reasonable likelihood that the presenting complaint may be related to a substance abuse problem, ED and UCC staff are to appropriately screen for alcohol, drug abuse, and dependence. Specifically, screening would be indicated in patients presenting with reported suicidal ideation and among trauma patients given the likelihood of increased risk and co-occurrence evident with these two patient populations. In all cases where there is reasonable likelihood to suspect that a patient may have a substance use disorder, referral for further evaluation and treatment, if appropriate, must be completed. Veterans who are at risk for withdrawal from a substance are to be referred for withdrawal management to a designated bed section as determined by local medical center policy.

(8) The facility Suicide Prevention Coordinator is informed of any patient presenting to the ED with suicidal ideation.

(9) For patients who are discharged from the ED, referral for mental health assessment and follow-up appointment is completed prior to discharge.

(10) Transfer agreements are developed in advance with local and regional health care partners.

5. REFERENCES

a. Mental Health Environment of Care Checklist, VHA National Center for Patient Safety, Department of Veterans Affairs, Version 4-21-2008.

b. VHA Handbook 1160.01.

c. Deputy Under Secretary for Operations and Management Memorandum on Mental Health Care in VHA Emergency Departments, dated July 2008.

d. 2008 Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH), The Joint Commission.

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services (11), Medical-Surgical Services (111) is responsible for the contents of this Directive. Questions may be referred to the National Director for Emergency Medicine at (202) 461-7120.

7. RESCISSIONS: None. This VHA Directive expires February 28, 2015.

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