American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved April 2020

Care of Patients with Behavioral Health Emergencies and Suspected or Confirmed COVID-19

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A joint policy statement of the American Association for Emergency Psychiatry, American College of Emergency Physicians, American Psychiatric Association, Coalition on Psychiatric Emergencies, Crisis Residential Association, and the Emergency Nurses Association

As with environmental disasters and other crisis events, pandemic may exceed people's usual coping skills and capacity which, in turn, may lead to problems with anxiety, depression, increased use of substances, as well as exacerbation of underlying psychiatric disorders. Factors including, but not limited to, social and physical isolation, uncertainty, fear, evolving facts, changes in how individuals access outpatient care and public health recommendations contribute to this stress. This impacts people with and without pre-existing psychiatric illnesses and can contribute to a number of challenges for our already taxed emergency and crisis healthcare system.

The most severely ill people with psychiatric illness have high rates of baseline medical comorbidity, reduced access to primary care medical resources, and may lack resources to participate in telehealth services. As a result, this group may have elevated vulnerability to COVID and have limitations in accessing services other than emergency and crisis settings.[1]

For care of the behavioral health patient with suspected or confirmed COVID-19:

1. Encourage preparedness by supporting education and training on the treatment of psychiatric disorders and best-practices for the care of the behavioral health patient.
2. Staff must have access to appropriate, adequate personal protective equipment (PPE).
3. Encourage the use of existing, available behavioral health crisis services to mitigate unnecessary visits to the emergency department for psychiatric emergencies or for diverting people from psychiatric hospitals whenever possible.
4. Support medical screening via telehealth/telephonic and clinical pre-admission screenings and assessments by qualified, licensed

professionals. Additionally, we advocate for expanded use of telehealth, including prescribing of controlled substances for opioid use disorder via telemedicine, for patient and provider safety in line with infectious disease recommendations (i.e. social distancing). Encourage novel use of telehealth in high-risk environments for diversion and mitigation of unnecessary ED visits.

5. Recognize that patients who present with psychiatric complaints may also have co-occurring medical disorders that should have proper medical evaluation. Use pre-existing, evidence-based recommendations and screening algorithms in order to perform appropriate and directed medical evaluations. Encourage providers to identify alternate methods and modalities to make those assessments in the current COVID environment.
6. Understand that people will present in acute psychiatric crisis who are at risk of, have symptoms consistent with or have tested positive for COVID-19, who will not meet medical admission criteria but will meet criteria for further psychiatric care. Mental health and substance use care, based on the needs of the individual, must remain available.
7. Discourage the use of restraints while keeping people in the least restrictive setting possible that corresponds to their condition or presenting symptoms.
8. Ensure that medical personnel are evaluating for signs of domestic violence in children, partners and spouses, the elderly, those with intellectual and developmental disabilities, and other vulnerable populations, as implementation of social distancing and home-based self-quarantine could increase those risks.
9. Encourage staff to formulate aftercare services that are based on existing resources and partnerships in the community.
10. Provide individuals at risk of suicide with local and national resources of people to talk to if they are feeling suicidal (local crisis call center number, National Suicide Prevention Lifeline, Trans LifeLine, The Trevor Project, and Crisis Text Line).
11. Encourage the creation and use of Psychiatric Advanced Directives by patients, wherever local jurisdictions permit, that will help provide treatment guidance for providers by patients before their symptoms worsens to the point of impairment in psychiatric medical decision making.
12. Encourage and promote self-care amongst those providing care to our patients and their families. Acknowledge that healthcare workers will be committed to assisting all shortages/vacancies during these times of crisis, and that it is just as important to maintain one's individual health and wellness for the overall stability of the patients and the care delivery system. In addition to using one's own internal coping skills and resources, staff should be made aware of all other local, state, and regional options for care.
13. Ensure that there is adequate funding, governmental, non-governmental and private, to support all activities noted above and ensure that all insurance agencies, public and private, provide appropriate and reasonable reimbursement for the care and treatment of patients with behavioral emergencies.

[1] Osborn, David P J. 2001. "The Poor Physical Health of People with Mental Illness." Western Journal of Medicine 175 (5): 329–32.