Advantages of Separating the Triage Function From the Psychiatric Emergency Service

Rose Ries, M.D.

At the Allegheny University Hospitals–Hahnemann in Philadelphia, evaluations of adult walk-in patients who request psychiatric services begin outside the psychiatric emergency service in an initial contact called triage. During triage, an evaluating clinician determines whether a patient should be admitted to the psychiatric emergency service for further evaluation and crisis management. This column describes the relationship between the hospital's psychiatric emergency triage service and its psychiatric emergency service and discusses three major reasons for separating the two services.

A triage service

From January to December 1995, Allegheny University Hospitals–Hahnemann recorded a total of 1,870 psychiatric emergency triage visits. In 63 percent of the visits (N=1,172), patients were discharged without entering the psychiatric emergency service. In the remaining 37 percent, patients were admitted to the service for treatment and observation, then discharged or admitted to an inpatient unit.

The hospital's psychiatric emergency service is separate from the medical emergency department and located behind it. A patient who comes into the hospital requesting psychiatric services is directed by a security guard to the registration desk near the main entrance of the hospital. If the patient is visibly agitated or imminently suicidal, the security guard takes the person directly into the psychiatric emergency service, bypassing registration.

Patients who are not acutely agitated or suicidal are seen by a psychiatrist for triage evaluation in an area designated for this purpose outside the psychiatric emergency service. This area is connected to the psychiatric emergency service by a hallway and is also close to the medical emergency department. If a psychiatrist cannot attend to the patient right away, a psychiatric nurse begins the interview and monitors the patient until the psychiatrist arrives. No patient leaves the triage area without having been seen by a psychiatrist. A chart is generated for every patient, in accordance with hospital policies and procedures.

The evaluating clinician determines the patient's chief complaint and the intensity of the patient's distress. The Crisis Triage Rating Scale (1) and the *DSM-IV* Global Assessment of Functioning scale are used to quantify the patient's level of risk, support system, motivation or ability to cooperate, and level of functioning. The clinician determines whether the patient needs a more thorough evaluation in the psychiatric emergency service. Patients who need only outpatient referrals may be discharged after triage.

The triage interview differs from a comprehensive emergency psychiatric evaluation that is done in the psychiatric emergency service. It is a succinct but empathic reconnaissance that is not meant to take longer than 15 minutes. Baxter and associates (2) reported that for more than half of psychiatric patients presenting to a large urban hospital, dispositional decisions could be made in five to 15 minutes.

Advantages of separate triage

Three major reasons for making the initial contact with patients outside the psychiatric emergency service are to increase safety, to allow boundaries to be readily established, and to improve management of medical conditions.

Safety. Potentially violent individuals must be identified and contained in an area that is immediately accessible to security guards before the patient enters the psychiatric emergency service. The proportion of patients who bring weapons into crisis centers has been estimated to be between 4 and 8 percent (3,4). At Allegheny University Hospitals–Hahnemann, we surveyed 100 consecutive cases in spring 1995 and found seven patients carrying weapons, including a knife, a box-cutter, broken glass, and a razor blade.

Some patients come to the psychiatric emergency service to seek shelter or protection and may return to the hospital frequently. Malingering and drug seeking by addicts are not often obvious at the triage level unless these persons are known to the mental health system. When such patients are confronted with their hidden agendas, anger and hostility predictably ensue. However, their aggressive behavior rarely gets out of hand in the presence of security guards. Such patients can be escorted off the premises directly from triage without disruption to the psychiatric emergency service.

Of the patients discharged at the triage level in 1995, a total of 263, or 22 percent, were given primary axis I diagnoses of substance abuse or dependence. Some were also assigned the v code of malingering. Many expressed their frustration loudly, but only five, or 2 percent, dramatized their anger by

Dr. Ries is clinical assistant professor and director of the psychiatric emergency service at Allegheny University Hospitals–Hahnemann, Broad and Vine Streets, Philadelphia, Pennsylvania 19102. Ole J. Thienhaus, M.D., M.B.A., is editor of this column.

behavior such as flinging their belongings, spitting at the examiner, or kicking the wall. Although two attempted assaults of staff members occurred in 1995, no injuries resulted. The presence of security personnel provided triage staff with a feeling of safety.

Establishing boundaries. A separate location for triage may help in the management of agitated patients with personality disorders. Before admitting a patient with prominent borderline pathology to the psychiatric emergency service for further evaluation, behavioral limits can be negotiated in the triage contact.

Patients with borderline pathology who are not admitted to the psychiatric emergency service may demonstrate "suicidality" in public, for example, by superficially lacerating their wrists or teetering along the edge of traffic outside the hospital. These aggressive displays necessitate their being brought back to the hospital for admission to the psychiatric emergency service for brief stabilization. In our experience, it is less disruptive first to help such a patient regain control in the triage area, removed from other patients, before taking him or her into the psychiatric emergency service, rather than to initiate control in the confines of the psychiatric emergency room proper.

The triage area also provides a quiet place for the first meeting between the patient and the clinician, which often sets the tone for later interactions. The clinician may find it useful to have the initial meeting in an area insulated from disquieting interruptions associated with crisis management of acutely ill patients in the psychiatric emergency service.

Medical emergencies. Occasionally, patients require immediate medical attention during psychiatric triage. Furthermore, some patients who are addicted to drugs and are homeless report histories that suggest communicable diseases, such as tuberculosis. Obviously, it is imperative that the dispersion of infectious diseases be kept in check. Standard protocols for management of emergencies and communicable diseases can be expedited when the problem is recognized in this sequestered area before the patient has been admitted to the psychiatric emergency service.

Design of the triage area

Ideally, the triage area should be designed and used only for triage and should meet safety and comfort standards described in the literature (5–7). At Allegheny University Hospitals–Hahnemann, the triage area is under surveillance by a hospital security guard who stands a few yards away, out of earshot of normal conversation but within range to provide unobstructed assistance should the patient become loud or threatening. The triage area is close to both the psychiatric emergency service and the medical emergency department but is not contiguous with either.

The triage area is free of impediments, allowing sufficient interpersonal space and ease of egress by both the clinician and the patient so that neither feels cornered by the other. A portable hand-held metal detector is available in the psychiatric emergency service and may be taken to the triage area. Tesar (6) and Tardiff (8) have suggested that the psychiatrist should stand or sit between the patient and the door. We have found a triangular arrangement of patient, psychiatrist, and door useful: the patient forms the vertex of a triangle in which the psychiatrist sits near the door and at arm's length from the patient. The patient, who is seated somewhat farther from the door, has a clear view of the exit. This arrangement minimizes feelings of claustrophobia or entrapment.

Conclusions

Campbell and Hensie (9) defined psychiatric triage as "the immediate sorting out and classification of psychiatric casualties so that patients may be referred to appropriate psychiatric treatment services." Maxmen and Tucker (10) described a "preadmission screening" as the first stage of a two-stage process for "gathering only as much history as is necessary to determine if the patient should be admitted to that particular institution" and to "instill a sense of hope . . . and to set a proper tone." These definitions describe the triage function at our hospital. Triage does not simply mean labeling patients for different destinations. Rather, triage involves making a crucial determination, within several minutes, about an individual's course of treatment. The decision is fraught with risk. Triage clinicians cannot entirely rely on numerical scales and descriptive criteria applied to a patient's pathology. They must also factor in their own reaction to the patient and their empathic feel for the person who is requesting help.

In 1980 Gerson and Bassuk (11) wrote that "psychiatric emergency services must be conceived of as organizationally unique facilities" and that it is necessary to have "a model aimed at relatively rapid evaluation, containment, and referral of the patient in crisis." As psychiatric emergency services evolve into self-contained treatment centers providing various levels of care, the triage arm should literally be an extension of the psychiatric emergency service and should be accorded the distinction and status it deserves as a critical interface in patient management. ♦

References

1. Bengelsdorf H, Levy LE, Emerson RL, et al: A crisis triage rating scale: brief dispositional assessment of patients at risk for hospitalization. Journal of Nervous and Mental Disease 172:424–430, 1984
2. Baxter S, Chodorkoff B, Underhill R: Psychiatric emergencies: dispositional determinants and the validity of the decision to admit. American Journal of Psychiatry 124: 1542–1548, 1968
3. McNiel DE, Binder RL: Patients who bring weapons to the psychiatric emergency room. Journal of Clinical Psychiatry 48:230–233, 1987
4. McCulloch LE, McNiel DE, Binder RL, et al: Effects of a weapon screening procedure in a psychiatric emergency room. Hospital and Community Psychiatry 37:837–838, 1986
5. Eichelman BS, Hartwig A (eds): Patient Violence and the Clinician. Washington, DC, American Psychiatric Press, 1995
6. Tesar GE: The agitated patient, part I: evaluation and behavioral management. Hospital and Community Psychiatry 44:329–331, 1993
7. Schuster JM: Psychiatric consultation in the general hospital emergency department. Psychiatric Services 46:555–557, 1995
8. Tardiff K: Management of the violent patient in an emergency situation. Psychiatric Clinics of North America 11:539–549, 1988
9. Campbell R, Hensie L: Psychiatric Dictionary, 4th ed. New York, Oxford University Press, 1970
10. Maxmen JS, Tucker GJ: The admission process. Journal of Nervous and Mental Disease 156:327–340, 1973
11. Gerson S, Bassuk E: Psychiatric emergencies: an overview. American Journal of Psychiatry 137:1–11, 1980