Frontline Reports

Treating Patient Well-Being in a Psychiatric Emergency Room

Psychiatric emergency rooms are important points of access into the mental health care system, and visits offer opportunity to intervene and initiate robust mental health treatment. Therapeutic programming therefore should be provided as soon as possible to help reduce patient distress and improve well-being and overall satisfaction with care.

Within our Comprehensive Psychiatric Emergency Program (CPEP), we created and implemented the CPEP Well-Being Initiative (CWI). Located within a university hospital center in north Manhattan, our CPEP receives about 6,500 visits annually, and most individuals have a diagnosis of psychosis and co-occurring substance use disorders. Most patients stay in CPEP 16–24 hours, although it is licensed for 24- to 72-hour stays. Patients routinely receive a comprehensive psychiatric assessment, social work intervention, medication administration, and nursing care, as well as disposition planning. To enhance patients' therapeutic experience, the CWI utilizes trained volunteers, usually undergraduate students, to provide a variety of support services for CPEP patients and their visitors. Volunteers receive training on various topics, including an introduction to psychiatric diagnoses, supportive techniques, verbal de-escalation, group facilitation, and an introduction to the principles of trauma-informed care.

CWI volunteers engage patients in many activities; however, one of their most important roles is to orient patients to the CPEP milieu and ensure that their basic needs have been met. Once they have been addressed, the CWI volunteers engage patients in recreational activities depending on patient and volunteer preference. These include coloring and drawing, poetry writing, clay sculpting, aromatherapy, solving puzzles, board and card games, listening to sounds or music, breathing exercises, viewing relaxing light projections, and dancing and movement. CWI volunteers are also encouraged to conduct wellness groups under the supervision of a CPEP staff psychiatrist, nurse, or social worker. Group topics have included sleep hygiene, medication management, calming techniques, controlling anxiety, mindfulness, movement and stretching, coping skills, and music and imagery. Volunteers also spend time talking and actively listening to patients as needed. When appropriate, patients' visitors are invited to participate in CWI programming, activities, and groups.

CWI volunteers are also intended to improve overall CPEP safety by immediately reporting to staff any patient behaviors that are concerning as well as patient-disclosed information. Examples include new suicidal thoughts, reports of abuse, or worsening agitation or distress. Physicians, security personnel, and nurses help direct volunteers to patients whom they believe would benefit from specific activities, as well as alert volunteers to patients whom they believe may be too agitated or disorganized to safely participate in CWI programming.

Volunteers meet monthly as a group to debrief and process individual volunteer experiences, discuss program updates, and share best practices. Volunteers are also encouraged to take on leadership roles to support program operation and evaluation.

Volunteers created a comfort cart, with squeeze balls, modeling clay, coloring books, and magazines. One particularly popular activity on the cart is the aromatherapy. We obtained citrus- and lavender-scented aromatabs that patients can stick onto their gowns. A patient with comorbid bipolar disorder and substance use disorder who is well known to our CPEP entered one day, yelling loudly, and as the nurse started calling for the doctor, the patient yelled, "No, I don't need medications! Get me the girl with the smelly stickers!" She was offered an aromatab and then walked to her stretcher quietly and was able to calm down without any further interventions.

We evaluated the views of a subset of patients, the CWI volunteers, and CPEP staff regarding CWI between February 2016 and May 2017. Of the 103 patients surveyed, we found that patients who interacted with CWI volunteers were highly satisfied with their CPEP stay, that the 21 CWI volunteers surveyed reported more comfort with psychiatric patients and greater familiarity with psychiatric concepts, and finally, that staff surveyed on 12 random days perceived the CWI services as beneficial and enjoyable for patients and as having a calming effect on the CPEP program.

One future direction of the CWI is to expand the volunteer base, including the recruitment of peers, to achieve a steady presence of volunteer-led programming in the CPEP. We hope our description of the success of the CWI will encourage others to replicate this model in their psychiatric emergency facilities.

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Addressing the Opioid Epidemic in Rural America

In 2013, Ohio's Hancock County Alcohol, Drug Addiction and Mental Health Services Board saw the opioid epidemic forming and began to prepare its community and health system for a collective response. Five years later, living in the belly of Ohio's opioid epidemic, this rural county has significantly increased treatment and reduced opioid deaths through broad community education and involvement, an over 500% increase of medication-assisted treatment, and over 6,000 hours of volunteer support annually to survivors, families, and service systems.

Hancock's leadership began by identifying gaps in its behavioral continuum of care. Key health leaders and citizens met to affirm the "value of each life" in their community and the need to collaboratively address all substance use. Treatment gaps were identified and began to be filled, including linking any public service where mental or substance issues might appear (courts, jails, emergency rooms, health centers). Criminal justice agencies and treatment providers were joined in newly established drug and family courts. Naloxone education, distribution, and support for trained first responders became a top priority. Increased access and capacity for treatment, especially medication-assisted treatment, became paramount. Root-cause analyses of each overdose death strengthened possible intercept points and shaped system change—for example, maintaining treatment for detainees being released from jail and supplying citizens with naloxone. This provider-community collaboration included prevention efforts to all high-risk populations and information campaigns to combat stigma and educate parents and families on proactive steps.

With Hancock County being mostly rural, administrators quickly uncovered a shortage of skilled workers and launched three new "workforce development" initiatives. The University of Findlay, located in Hancock County, designed an Addiction Minor and Certification Program, open to all students in the Health Sciences Department (social work, nursing, pharmacy, etc.). Successful completion of the program ensures individuals have met the academic requirements for Ohio's Certified Chemical Dependency Counselor Assistant Preliminary License. Moreover, all citizens with lived experience had an opportunity to become part of the peer workforce. Graduates in health fields leave the university dually credentialed within their major with an addiction minor, and the community at large has increased the skills needed to enhance public safety through a stronger addiction workforce.

An underutilized community drop-in center was transformed into a recovery center where those in recovery can meet, advance ideas, and mobilize to give back to the community. Two recovery homes were established under the auspices of this recovery center. Persons in recovery were called on to become peer supports, share their lived experience, and provide hope to others. These peers, whether agency employed or volunteers from the recovery center, work as "connectors," providing a "warm handoff" to persons from high-risk populations (e.g., postincarceration, postrehabilitation, pregnant and addicted women, youths and families, veterans, overdose survivors).

The local medical community, led by its community hospital (Blanchard Valley Health System) and key physician and psychiatric staff, joined with public health agencies (health department and coroner) and community physicians to better understand addiction treatment in their community and across all disciplines of medicine in their county. Specialist physician gaps were addressed by expanding the knowledge of all physicians about addiction, leading to a natural expansion of interest in substance use and of hospital and community medical services, such as establishing inpatient withdrawal management and specialized programs for pregnant and addicted women and their newborns. Nurse practitioner development with a behavioral emphasis is in design at the university.

Hancock County has experienced a saturation of opioid use more than most counties, but deaths have been reduced from 18% of the 72 seeking such treatment in 2009 to 6% of over 594 seeking opioid treatment in 2017. Its three major treatment agencies now record 90-day treatment retention for an average of 43% of their clients. As important, the community is now engaged in the solution through prevention, early intervention, expanded awareness, and ongoing dialogue about the illness to end stigma. Beyond saving lives, Hancock's long-range plan has imbued a philosophy for measurable recovery. Previous gaps between access to formal treatment and overdose are being bridged by an attentive, adaptive system and a community working together to address a complex societal malady.

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