

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

A Call for Behavioral Emergency Response Teams in Inpatient Hospital Settings

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Abstract

Medical rapid response teams, now ubiquitous throughout hospitals, were designed to identify and proactively treat early warning signs of acute medical decompensation. Behavioral emergencies—including clinical psychiatric emergencies, coping/stress reactions, and iatrogenic injuries—are not responded to with the same vigor. At worst, behavioral crises are treated as unarmed security threats. Limited or inappropriate responses to such crises can lead to suboptimal outcomes on numerous levels, especially avoidable harm to patients and frontline clinicians. Widespread implementation of behavioral emergency response teams for patient-centered behavioral interventions has been impeded by a pervasive perception that these endeavors are medically unnecessary and optional. This article calls for a paradigm shift in responding to behavioral emergencies by arguing that security-driven risk management practices during behavioral emergencies are incompatible with fundamental medical and ethics principles.

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Responding to Emergencies

Medical rapid response teams (RRTs) were first promoted as standard of care within hospital medicine by the 100,000 Lives Campaign of 2004.¹ Although medical procedure codes already existed at that time for bedside cardiopulmonary resuscitation, RRTs advanced care of medical emergencies by placing a new emphasis on proactively identifying early warning signs of patient destabilization and delivering specialized, team-based treatment to avoid further decompensation. Hospitals around the country unified their efforts to innovate solutions for meeting and exceeding the project's goal of saving lives. What once was groundbreaking is now nearly ubiquitous in hospital medicine. Today, hospitals employ individualized medical intervention teams to mitigate risk during clinical crises such as cardiopulmonary arrests, strokes, surgical trauma,

obstetrical emergencies, and more. Behavioral emergencies, however, are less successfully addressed in the United States.

Behavioral emergency is an umbrella term describing symptoms of acute behavioral distress experienced by patients, including those on inpatient medical or surgical units. Behavioral emergencies comprise 3 distinct subtypes: clinical psychiatric emergencies, coping/stress reactions, and conflicts due to iatrogenic insults (see Table). *Clinical psychiatric emergencies* are fundamentally medical or pharmacological (ie, agitated delirium), developmental (ie, severe autism spectrum disorder), or neurobiological (ie, decompensated psychosis) in nature or are substance induced.^{2,3} Patients' *coping/stress reactions* describe their experiences of behavioral dysregulation after they receive bad news, such as a prognosis or diagnosis, or when they are feeling overwhelmed by the hospital course itself. *Conflicts due to iatrogenic insults* occur when patients experience emotional and behavioral distress after receiving poor clinical care due to **clinician bias** and stigma. Patient families might also experience coping/stress reactions and iatrogenic insults. In summary, although clinical psychiatric emergencies (related to the "disease process") are the most cited reason for behavioral emergencies,⁴ it is critical to note that there are numerous instances when patient distress is psychosocial and perhaps exacerbated by clinicians' own behaviors.^{4,5}

Table. Behavioral Emergencies and Their Subtypes

Behavioral Emergencies		
Clinical Psychiatric Emergencies	Coping and Stress Reactions	Iatrogenic Insults
<p>Clinical deficits in behavioral control +/- impairments in verbal expression</p> <ul style="list-style-type: none"> • Medical/Pharmacological: eg, adult with postoperative delirium • Developmental: eg, teenager with severe autism with behavioral dysregulation after painful procedure • Neurobiological: eg, adult with decompensated schizophrenia admitted for diverticulitis who becomes agitated due new bowel perforation but is unable to express why • Substance Induced: eg, adult with undetected alcohol withdrawal 	<p>Instances in which patients experience extreme psychological duress due to receiving bad news or due to the difficulty of the hospital and clinical course itself</p> <ul style="list-style-type: none"> • Example: A father becomes emotionally distraught and kicks a chair upon learning that his child will not survive a car accident 	<p>Patient emotional and behavioral distress that is a by-product of receiving poor clinical care and/or negative interpersonal encounters due to clinician-level stigma and bias</p> <ul style="list-style-type: none"> • Example: A female patient with a co-occurring psychiatric diagnosis and full decision-making capacity feels disrespected and begins yelling after clinicians repeatedly invalidate and argue against her wishes not to undergo a nonessential diagnostic procedure.

Widespread implementation of behavioral emergency response teams for patient-centered behavioral interventions has been impeded by a pervasive perception that

these endeavors are medically unnecessary and therefore optional and, at worst, can be treated as unarmed security threats. The objective of this article is to create awareness of the ethical pitfalls of the prevailing security-driven paradigm of behavioral emergencies. This article calls for a paradigm shift in the handling of behavioral emergencies, arguing that security-driven risk management practices during behavioral emergencies are incompatible with fundamental medical and ethics principles.

Current Management

The standardized emergency code suggestions of 21 state hospital associations fail to endorse a protocol for general behavioral emergencies that is distinct from security-only protocols.² Instead, behavioral emergencies in the United States are frequently equated with safety threats (see Figure). RRTs are called for medical emergencies, yet US clinicians are commonly trained to call a security code when confronted with behavioral crises. These security calls dispatch teams trained to suppress imminent violence rather than promote patient-centered treatment and support. This practice discriminates against people diagnosed with psychiatric disorders and begins a cascade of poor clinical, workplace safety, and financial outcomes.²

Figure. Shared Features of Clinical Behavioral and Unarmed Security Threats^a



^a A comprehensive intervention must function interchangeably under both domains.

Although behavioral emergencies are medical or patient-centered emergencies that might share features with unarmed security threats, it might be difficult for clinicians to immediately determine their cause. Security emergency codes do not alert trained clinicians to address acute medical needs and patient-centered concerns, and medical RRTs do not include trained personnel to address potential acute safety needs. A robust behavioral intervention must deliver both clinical oversight and patient advocacy while

seamlessly integrating security assistance to closely monitor for physical danger to staff members or patients.

Behavioral Emergency Response Teams

British Columbia has progressively implemented provincial-wide behavioral intervention teams since the 2000s.⁶ Some US hospitals have independently pioneered behavioral intervention teams, often called behavioral emergency response teams (BERTs).^{2,4,7} BERTs are a heterogeneous mixture of interdisciplinary, psychiatrically trained team members who deploy to behavioral emergencies across the hospital, similar to the way that medical RRTs respond to medical crises. But BERTs are by no means the only solution to the problem of providing more ethical interventions for behavioral emergencies. Many efficacious interventions have been described that improve responses to behavioral emergencies on medical and surgical inpatient units, the majority of which involve proactive psychiatric consultations.⁸ One drawback is that many of these interventions rely heavily on full-time psychiatry staff and dedicated psychiatric funding, which is not feasible in systems with minimal access to these types of resources. The flexible and collaborative care design of BERTs allows them to be universally implemented in any hospital regardless of geographic setting, psychiatric staffing, and psychiatric financial resources.

The following discussion of BERTs will focus on their most salient and fundamental features in order to better illustrate the inadequacies of security protocols. It is important to note, however, that an exhaustive overview of BERTs is beyond the scope of this article. Furthermore, focusing on the nuances of BERTs might paradoxically distract attention from the ethical obligations underlying their use. Here, we briefly summarize 2 recent literature reviews that extensively analyze and report promising data about BERTs' team composition, risk management strategy, and activation criteria, as well as financial considerations and clinical and workplace safety outcomes.^{2,7}

At a minimum, all BERTs include a primary, psychiatrically trained clinician and some form of secondary security assistance. The primary BERT clinician might be a psychiatrist, a mid-level practitioner, or a floor nurse, for example. Some primary BERT clinicians are fully employed within mental health while others are cross-trained general medical or surgical clinicians. Social workers, pastoral care workers, patient advocates, and psychologists might also join BERTs, depending on local staffing resources.

Like medical RRTs, BERTs emphasize identifying early warning signs. Early warning signs of behavioral distress are accorded behavioral urgency. When patient-clinician relationships become fraught, interdisciplinary BERT members are all trained to preserve patient-centeredness through de-escalation and problem solving while simultaneously reprioritizing proactive clinical investigation and treatment as indicated.^{2,7} Security staff are available but frequently are not involved or even seen by patients in these cases. Thus, a BERT is ideally activated before a patient demonstrates an outward act of internal distress akin to a behavioral emergency. Importantly, BERTs include reserve security staff who operate under the direction of the clinician and who might assist in a primary security response if needed. As primary teams witness BERTs de-escalate and favorably interact with patients, however, fewer BERT calls are required, as staff members become more skilled themselves in responding to behavioral crises.⁷

Ethics of Behavioral Emergency Responses

Using evidence-based practices for acute behavioral crises should not be a voluntary, optional undertaking. Just as the 100,000 Lives Campaign pushed proactive care

through RRTs, so must BERTs or clinically equivalent interventions become standard of care for acute behavioral emergencies. We argue that behavioral interventions for behavioral emergencies are ethically imperative based upon the 4 ethics principles of beneficence, autonomy, justice, and nonmaleficence.⁹

Beneficence vs neglect. Beneficence mandates treating patients in accordance with best available practices, but security interventions activated for clinical psychiatric emergencies fail to treat modifiable and potentially life-threatening medical diseases underlying patients' behavior. Neglect of patients' clinical needs more generally is evidenced by suboptimal morbidity and mortality outcomes of patients with co-occurring clinical psychiatric needs on inpatient medical and surgical units,² who primarily suffer from medical or surgical (as opposed to psychiatric) complications, such as procedural or medication errors, infections, skin breakdown, and acute renal failure.¹⁰ Security interventions also neglect the basic human rights of patients experiencing difficulty coping or iatrogenic insults from poor care. Instead of supporting patients and families during a vulnerable time, security enforcement negates and neglects the humanity of their experiences. Making BERTs an obligatory hospital service would support patient-centered, compassionate care.

BERTs advance practice and therefore represent best practice for acute behavioral dysregulation even when hospital psychiatric consultation-liaison services might be available. Clinicians often attempt to obtain an emergent psychiatry consult when they suspect a psychiatric component to a patient's distress. However, these efforts do not provide security backup and lack the fail-safe reliability, efficiency, and robustness of other medical emergency protocols like BERTs.^{2,7} Furthermore, the presence of a lone psychiatrist is insufficient to safeguard against the multifactorial inputs that contribute to poor medical and safety outcomes or iatrogenic discrimination.²

Beneficence also requires removing financial barriers to patient care. Currently, health systems are often disincentivized from considering distinct, nonsecurity interventions for behavioral emergencies due to poor insurance reimbursement for psychiatric care and a false perception that such interventions depend upon limited psychiatric financial resources.² BERTs, however, can be cost neutral.² Moreover, health systems that uphold beneficence by treating patients' behavioral emergencies as more than security threats create opportunities to recoup significant cost savings that would otherwise be lost to poor patient and provider outcomes.^{2,3,7,11}

Autonomy vs intentionality. Respect for patient autonomy requires clinicians to "consult people and obtain their agreement before we do things to them."⁹ Associating behavioral emergencies with security threats implies a level of intentionality to patients that does not exist for medical diseases. For example, a patient hospitalized for severe ulcerative colitis is understood to have frequent bloody bowel movements as a byproduct of medical illness, not because they desire it. Should this same patient develop steroid-induced psychosis with behavioral symptoms of agitation during treatment, the patient's behavioral distress is equally a byproduct of medical illness and equally undesired. Yet, patients who experience a clinical psychiatric emergency during their hospitalization receive security interventions with names like "code strong" that are prompted by plain language, such as a "show of force."³ One state goes as far as inserting the language of a "strike team" in security codes.¹² These codes promote aggression against patients' unintentional medical or psychiatric symptomology, thereby treating patients similarly to hospital intruders who pose intentional "safety threats" to others.

Respecting patients' autonomy means not only avoiding false assumptions that their behavior is intentional but also avoiding false assumptions that their behavior is merely a byproduct of mental illness. It is noteworthy that a psychiatric diagnosis does not automatically confer responsibility for behavioral crises upon patients. Although perhaps counterintuitive, incidents of coping/stress reactions and conflict due to iatrogenic insults collectively outnumber BERTs triggered by clinical psychiatric emergencies. Indeed, excluding clinical psychiatric emergencies, the top 5 of 6 root causes for one health system's BERTs were uncontrolled pain, inadequate nutrition, grief, loss of autonomy, and discharge concerns.⁴ These are mainly psychosocial needs that can be elucidated or modified by encouraging clinicians to engage in patient-centered dialogue. Indeed, communication, listening, and **respect for autonomy** are at the heart of patient-centered care. Furthermore, shared decision making reduces patient anxiety and enables care to better align with a patient's values.¹³

Clinicians undoubtedly strive for impartiality and equality. Yet, 35 studies found evidence of unconscious clinician bias—including racial, ethnic, gender, and age bias—and those that investigated relations involving unconscious clinician bias found that it was associated with lower quality of patient care.¹⁴ Take, for example, an African-American teen with a sickle cell crisis who is experiencing excruciating pain in an emergency department. The clinician, due to unconscious racial bias, assumes that the patient is intentionally drug seeking and fails to uphold patient-centered care by repeatedly ignoring the patient's request for analgesia. If the patient's pain goes untreated and the patient becomes exasperated, shouts, and throws a cup at a nurse, a call to security is prompted for "patient violence." Thus, the clinician's bias and resultant lack of patient-centeredness will have precipitated a behavioral emergency due to both a coping/stress reaction and an iatrogenic insult. Opportunities frequently arise for BERT members to demonstrate effective communication to primary teams and to provide corrective behavioral oversight. Respect for autonomy can be reestablished by providing role models, such as patient advocates and chaplains, by educating staff in behavioral de-escalation, and by debriefing clinicians on how to improve their future interactions with patients.^{2,4,7}

Justice vs scarcity. Justice is promoted by nondiscriminatory patient access to finite health care resources. Mismanaged behavioral emergencies unnecessarily consume additional resources needed for other patients. In addition, devastating clinician injuries from mismanaged behavioral emergencies can result in clinician burnout, staff shortages, overtime costs, and decreased safety,² as well as litigation costs for affected patients and clinicians. BERTs reduce hospital waste through improving patient and staff outcomes during behavioral emergencies, thereby liberating limited health care resources.^{2,7,11} However, treating patients with incidental behavioral emergencies cannot be confined to a psychiatric unit. Medical and psychiatric clinicians must mobilize for clinical psychiatric emergencies, just as patient advocates must mobilize for coping/stress reactions and conflicts due to iatrogenic insults.

Of course, all hospitals will at least call a medical RRT should they suspect a neurological crisis. Hospitals with greater access to stroke specialists, equipment, and funding might become certified as primary and comprehensive stroke centers to mark their ability to provide the highest level of stroke care.¹⁵ Like strokes, behavioral emergencies might one day be recognized as necessitating a tiered response. BERTs might represent a baseline level of intervention for all hospitals. The composition of BERTs already varies based upon locally available resources.^{2,4,6,7} Hospitals with

superior psychiatric resources might perhaps seek certification one day to become the equivalent of a primary or comprehensive stroke center.

Principles of justice and beneficence are upheld when hospitals instantiate clinical best practices in accordance with their resource limitations. Heterogeneity is welcomed in BERTs! Cross-training existing personnel allows the expansion of medical, psychiatric, and patient-centered expertise. For example, one institution significantly improved clinical outcomes and workplace safety by training security officers to become mental health technicians with distinctive, nonsecurity uniforms demarcating their specialization.¹¹

Nonmaleficence vs accountability. Nonmaleficence cautions clinicians to “first do no harm.” Coercive practices like security enforcement, involuntary chemical sedation, and nonconsensual physical restraints risk traumatizing patients and causing iatrogenic physical harm.¹⁶ For instance, prolonged immobilization from excessive restraints promotes skin breakdown and respiratory distress.²

Harm must be considered in a larger social context, as mistrust of police correlates with mistrust of health care institutions.¹⁷ Because patients with psychiatric diagnoses have a high prevalence of various childhood, medical, physical, sexual, racial, military combat, or police traumas,¹⁸ frontline **security presence can foster mistrust** and potentiate intensified behavioral dysregulation, with resultant iatrogenic physical or psychological injury. Security interventions absolve clinicians of accountability for potential additional psychological and physical trauma because they are justified as being for “the safety of others.” Superior, patient-centered workplace safety alternatives exist.

Conclusion

Security enforcement in behavioral emergencies promotes clinicians’ protection at the expense of patient care. A compassionate, patient-centered response to behavioral emergencies reprioritizes clinicians’ medical and ethical mission to provide care while also protecting clinicians from harm. To date, widespread implementation of BERTs in the United States has been impeded by perceptions that these teams are optional and expensive. This article has argued that, in order to adhere to the ethical tenets and traditions of medicine, we are ethically obligated to employ evidence-based, best practices when treating behavioral emergencies, which requires reframing behavioral emergencies as opportunities for clinical intervention and patient advocacy. Like the 100,000 Lives Campaign, unified efforts to innovate ethical interventions for behavioral emergencies can lead to solutions that respect the dignity of everyone who comes to us for care. First, however, ethical obligations must fuel motivation to innovate.

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Citation

AMA J Ethics. 2020;22(11):E956-964.

DOI

10.1001/amajethics.2020.956.

Acknowledgements

The authors wish to thank Dr Rebecca Miller for her invaluable patient-centered perspectives on how to ensure the equitable treatment of all patients during behavioral emergencies. Dr Wong's contribution was supported by a Mentored Clinical Research Scholar award (KL2TR001862) from the National Center for Advancing Translational Sciences of the National Institutes of Health.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980