

American Association for Emergency Psychiatry Recommendations to Address Psychiatric Staff Shortages in Emergency Settings

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Objective: The psychological sequelae of the COVID-19 crisis will increase demands for psychiatric care in already strained emergency and mental health systems. To address the shortage of psychiatrists (and nurse practitioners and physician assistants) in emergency settings (ESs), the American Association for Emergency Psychiatry (AAEP) has established recommendations for utilizing nonprescribing mental health professionals in the evaluation and management of psychiatric patients in these contexts.

Methods: Faced with limited research on the roles and competencies of nonprescribing psychiatric emergency clinicians (PECs), a multidisciplinary committee of members of AAEP was tasked with developing recommendations for use of PECs.

Results: The committee developed eight recommendations regarding the role of PECs in evaluation and management of patients who present to ESs with behavioral emergencies. PECs should have the following competencies: conducting independent psychiatric and substance abuse evaluations;

managing behavioral emergencies; aiding in the recognition of confounding medical illnesses, intoxication and withdrawal states, and adverse drug reactions; developing appropriate treatment plans; recognizing when consultation from a psychiatrist or emergency physician is indicated; possessing self-awareness and recognizing clinician-patient dynamics; understanding medicolegal issues, such as involuntary holds and decision-making capacity; and collaborating with clinical teams in ESs. PECs are not meant to replace psychiatrists but to extend the psychiatrist's reach. Use of PECs has already been implemented in some areas of the country.

Conclusions: On the basis of the AAEP recommendations, ESs can address staffing shortages while ensuring safe management of patients with behavioral emergencies. With appropriate orientation and training, the PEC can serve effectively and competently in an ES.

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Between 2009 and 2015, the number of adult psychiatric patients presenting to emergency departments (EDs) rose by more than 41% (1), and between 2006 and 2014 the number of suicidal patients presenting to EDs rose by 414% (2). It is estimated that the psychological sequelae of the COVID-19 crisis will further increase demands for psychiatric care on the already strained emergency and mental health care systems (3).

Psychiatric patients presenting to emergency settings (ESs) may never be seen by a mental health professional of any discipline and may be discharged prematurely (4). To offset the lack of psychiatrists available to see these patients, hospitals and other facilities have hired advanced practice psychiatric nurse practitioners (N.P.s) and physician assistants (P.A.s), but there are still not enough of these professionals to handle the volume of patients (4). To ease this staffing burden, the American Association for Emergency

Psychiatry (AAEP) has endorsed the use of independently licensed clinical social workers (M.S.W.s), clinical psychologists (Ph.D.s), and licensed mental health counselors (L.M.H.C.s), collectively referred to as psychiatric emergency clinicians (PECs). With proper orientation and training, these professionals can enhance their skills to meet the needs of emergency psychiatric patients and serve as primary psychiatric evaluators. They are not meant to replace psychiatrists but to extend the psychiatrist's reach. This practice has already been implemented in some areas of the country (5).

These clinicians already have extensive training and experience treating psychiatric patients. They understand the importance of establishing rapport and can make alliances even with patients with the most complex presentations. They are already familiar with a variety of psychiatric conditions. Their skills prepare them to evaluate psychiatric

BOX 1. Positions for psychiatric emergency clinicians**Settings**

- Hospital emergency department
- Academic medical center
- Community crisis clinic
- Mobile crisis

States

- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Hawaii
- Kansas
- Kentucky
- Maine
- Massachusetts
- Michigan
- Ohio
- Rhode Island
- Texas
- Virginia

Professional degree

- L.I.C.S.W.
- L.M.H.C.

- Ph.D. (training fellowship)
- B.A.

Summary of duties

- Telephone triage
- Triage to determine acuity and prioritize more acute patients
- Performing comprehensive psychiatric evaluation, including mental status evaluations
- Applying differential diagnostic skills using *DSM* criteria
- Risk assessment, including need for involuntary hospitalization and *Tarasoff* duty to warn
- Determining level of care, including involuntary hospitalization
- Performing "functions of an involuntary emergency admission as needed, including filing for involuntary hospitalization acting as petitioner when necessary, and attending/following through with the court system for the hearing" (5)
- De-escalation
- Restraint management
- Brief therapy and crisis therapy
- Providing consultation to other therapists, agencies, or families
- Coordination of clinical disposition to inpatient psychiatric care

patients in crisis. Their skill set can be broadened by learning the principles of differential diagnosis, rapid assessment, clinical decision making, and features of medical illness.

A Google search of "psychiatric emergency clinician" in February 2020 found 49 available nationwide positions for nonprescribers to perform psychiatric emergency evaluations, indicating widespread use of this model (5). The requirements ranged from M.S.W., Ph.D., and L.M.H.C. degrees to bachelor's-level clinicians (B.A.s), and job descriptions included diagnostic psychiatric evaluations, risk assessments, and the determination of need for involuntary hospitalization. Some positions required review of cases by telephone with a backup psychiatrist before final disposition was made; in other positions, clinicians were required to independently advise on dispositions or work with the emergency physician to determine the level of care. No universal standards for these positions exist. Box 1 summarizes the various duties and settings for these positions.

AAEP recommends a collaborative and interdisciplinary approach to the management of psychiatric patients in the ES (e.g., hospital EDs, psychiatric emergency services, crisis centers). Although we recognize that state regulations and hospital resources may vary, these recommendations are meant to inform and describe the most effective staff allocation and competency-based educational models for clinicians, so that the clinicians can address the needs of patients and support emergency physicians.

Ideally, an ES should have 24/7 access to a behavioral health team consisting of either a psychiatrist, psychiatric N.P., or psychiatrically trained P.A. as well as an

independently licensed mental health professional (e.g., M.S.W., Ph.D., or L.M.H.C.). Some models expand the interdisciplinary team even further to include individuals with lived experience (i.e., a peer or recovery support specialist), psychiatric registered nurses, and psychiatric technicians (6). Any model used in an ES will invariably depend on local resources as well as patient volume and type of setting. With the advent of telemedicine, an ES can access the expertise of a psychiatrist more readily. However, the continued shortage of staff psychiatrists and the increasing volume of patients will still require onsite cost-efficient interventions. In conjunction with various other providers, the PEC plays a prominent role in triage, assessment, collection of collateral information, management of behavioral dysregulation, and disposition. The purpose of this article is to outline the role of these clinicians and their core competencies

METHODS

A multidisciplinary, multisite subcommittee of members of AAEP developed the recommendations outlined here. The members consisted of four psychiatrists and an M.S.W. Each had at least 20 years of direct emergency psychiatry experience and their own curriculum models to draw upon. A face validity method was used. The committee began with the premise that nonprescriber clinicians have a role in the evaluation of acute psychiatric patients. They began by conducting a literature review on the topic of nonphysician mental health providers in the emergency setting to search

for guidelines and principles to support this premise. The following search terms were used: emergency psychiatric clinician; crisis evaluations; emergency level of care assessment; behavioral health evaluations; and emergency psychiatric clinician staffing roles for social worker, psychologist, nurse, and nonmedical prescribers. Articles describing roles that were not direct psychiatric evaluations (e.g., ED social workers involved only in case management) were eliminated.

Results of MEDLINE, Google Scholar, and PubMed searches produced only a few relevant publications, and most were decades old (7–11). The committee drafted a list of specific competencies based on the realities of contemporary emergency mental health in the United States. One of the authors (J.S.R.) has experience utilizing this model in several emergency settings and has worked in five such settings (hospital EDs using this model) within the Boston metropolitan area. Some of these settings have been utilizing this model with nonpsychiatrist emergency clinicians for over 30 years. The committee modeled these guidelines after an earlier publication that outlined a recommended curriculum for psychiatry residency training in the ES (12). These recommendations and guidelines were approved by the AAEP board. They were also reviewed by the Emergency Nurses Association and the National Association of Social Workers, without any modifications.

The committee concluded that nonprescriber clinicians have a role in the ES, supporting and assisting the other care providers, and provided an outline of necessary skills to perform these tasks. The role includes conducting independent psychiatric and substance abuse evaluations; managing behavioral emergencies; aiding in the recognition of confounding medical illnesses, intoxication and withdrawal states, and adverse drug reactions; developing appropriate treatment plans; recognizing when consultation from a psychiatrist or emergency physician is indicated; possessing self-awareness and recognizing clinician-patient dynamics; understanding medicolegal issues, such as involuntary holds and decision-making capacity; and collaborating with ES clinical teams. We recommend that the PEC have the following competencies to accomplish these duties.

RESULTS

Recommendation 1: Perform Independent Psychiatric and Substance Abuse Evaluations

The PEC must perform independent psychiatric and substance abuse evaluations, with a focus on triage, stabilization, and safety assessments. Strong skills in triage, assessment, differential diagnosis, treatment planning, and documentation are required. The PEC should be able to perform evaluations independently and recommend necessary treatments for a variety of behavioral health conditions. Although some presentations of psychiatric or behavioral disturbances may be clear cut, others may be more nuanced or the result of underlying medical illnesses. Clinicians must

quickly determine whether someone needs medical observation or workup even before additional mental health intervention can proceed. The core competency in psychiatric assessment is a developed skill set unique to psychiatric clinicians—one that involves rapid establishment of rapport concurrent with diagnostic interviewing.

The PEC must be able to perform a comprehensive mental status examination, including but not limited to assessment of mood, anxiety, psychosis, cognition, insight, and judgment. Some training will likely be required for clinicians to recognize general medical comorbidities or toxic conditions and when medical consultation is necessary. The PEC must have a basic, practical understanding of medical issues and the effects of substances, including but not limited to physical illness and intoxication syndromes and, for more experienced clinicians, adverse drug effects and interactions.

In addition to eliciting the chief complaint, the PEC must have the acumen to ascertain an underlying need or request, especially regarding reluctant patients, malingering patients, or patients who have been brought to the ES against their will (9, 10). In some cases, a more detailed evaluation may need to be deferred in the interest of safety for the patient, other patients in the ES, or caregiving staff. Instead, a brief assessment resulting in a focused differential diagnosis is conducted.

The ability to gather collateral information from sources other than the patient is required to make an accurate clinical appraisal and to identify care needs. This process often begins when a patient is first brought to the ES (with important input from first responders and law enforcement officers) and continues throughout an episode of care in discussion with family members, friends, guardians, case managers, psychotherapists, outpatient physicians, and other invested parties. Central to the process is risk assessment, requiring attention to imminent potential for suicide, homicide, or impaired judgment that could result in unsafe behavior. The PEC must then be able to document the assessment and the corresponding treatment plan clearly and concisely.

The patient presenting with suicidal ideation is a common example of a clinical scenario where strong evaluation skills are needed. A PEC with knowledge of psychiatric assessment and therapeutic interventions can make a professional determination that discharge may be a better option for some of these patients. Work of this kind requires the PEC to have advanced training to carry out targeted and systematic safety assessments. Ideally, the PEC provides leadership and consultation to medical and nursing staff. In turn, the emergency physician receives expert opinions on a variety of high-stress situations. This scenario would include patients for whom hospitalization may be expedient or appear safer but would not necessarily offer the best clinical pathway.

In the role of expert consultant, the PEC not only collaborates with staff but also serves as teaching faculty for medical students, residents, and other trainees. The PEC

takes leadership in providing clinical opinions, collaborating with individuals from other disciplines, and sharing expertise between and among members of the clinical team.

Recommendation 2: Manage Behavioral Emergencies

The PEC must manage behavioral emergencies (using verbal de-escalation to obviate the need for restraint). The PEC must be skilled at verbally de-escalating the agitated patient and working collaboratively with nursing staff, security, and police. There is evidence that effective verbal de-escalation can reduce the need for restraints and forced medications (13). Psychiatric literature and experiential training programs, such as the Crisis Prevention Institute (CPI), can assist clinicians in developing this competency (6). Supervision by a more senior clinician can provide an added layer of expertise.

Recommendation 3: Detect Medical Illnesses, Intoxication and Withdrawal, and Drug Reactions

The PEC must assist in the recognition of general medical illnesses, states of intoxication and withdrawal, and adverse drug reactions presenting as behavioral health emergencies. An essential competency is the ability to recognize that medical illness, intoxication and withdrawal states, and adverse drug reactions can all give rise to behavioral emergencies. The PEC must have a high index of suspicion for undetected medical illness (14, 15) and be able to assess the need for medical evaluation—or, in some cases, reevaluation—when further information is elicited or obtained. The PEC must be effective in engaging emergency doctors in persuasive but respectful conversation when negotiations are necessary to revisit medical clearance decisions that have already been made.

A basic understanding of vital signs, medications, and general medical conditions and their potential impact on a patient's mental status and physical presentation is essential. The PEC is not expected to diagnose medical illness but rather to recognize when a behavioral health presentation may have nonpsychiatric contributing factors and to request medical evaluation. PECs have a unique advantage: they can spend longer periods with the patient and engage collateral resources. This ability not only aids an emergency physician in treatment planning but also can reveal more nuanced elements of the patient's history and help physicians identify possible medical issues manifesting as psychiatric disturbance.

Recommendation 4: Develop Appropriate Treatment Plans

The PEC must develop appropriate treatment plans, including disposition planning, determination of potential need for medications, and subsequent impact of such treatment. The PEC conducts an assessment that includes both an understanding of the underlying biopsychosocial issues and a working differential diagnosis. The PEC may provide immediate crisis intervention and interact with family and other collaterals to assist with discharge disposition and

outpatient follow-up. If admission is indicated, the emergency physician and PEC can even begin treatment, in consultation with a backup psychiatrist, while a bed search is conducted. In these situations, the PEC can follow the patient while the patient is in the ES. The PEC can observe the patient for both symptom reduction and side effects in collaboration with the medical and nursing staff. Initiation of treatment in the ES can alleviate acute symptoms of distress and may improve a patient's well-being to the point of stabilization and discharge. When treatment is begun in the ES, staff morale improves because they can directly observe a move toward recovery, instead of providing only custodial care while boarding the patient. Mutual trust among the PEC, emergency physician, and ES staff is crucial to design such treatment plans. An experienced PEC can have enormous impact on individual patient care and, by extension, on the local mental health system.

Recommendation 5: Recognize Circumstances Needing Specialized Consultation

The PEC must recognize circumstances in which specialized consultation from a psychiatrist is indicated. Knowing one's limits and determining when to call for consultation is essential. The type and the timeliness of supervision will vary depending on whether a PEC is working directly with a psychiatrist or with an emergency physician as backup. Although, ideally, the PEC would have a psychiatrist for clinical backup and supervision for patients with complex presentations, this arrangement may not always be possible if local resources are limited. If the psychiatrist is the supervising physician, a PEC's scope of practice may encompass broader aspects of psychiatric evaluation and treatment. In either case, it is recommended that the PEC's institution clearly determine the level of supervision and liability of both the PEC and supervising physicians.

Recommendation 6: Possess Self-Awareness and Recognize Clinician-Patient Dynamics

The PEC must possess self-awareness and recognize clinician-patient dynamics that may complicate medical and psychiatric examinations. Temperament is key. A PEC who is comfortable working in a fast-paced and sometimes chaotic environment, where decisions need to be made quickly and often with limited data, would do well. Those with experience in inpatient psychiatry or suicide prevention are particularly well suited to this role because of their familiarity with acute psychiatric presentations. A successful PEC is someone flexible enough to move out of the role of traditional psychotherapist (13). He or she must be comfortable with a biopsychosocial model of practice and be willing to learn the basics of general medical illness, pharmacology, and laboratory and radiological findings.

Self-awareness is important for effective management of psychiatric emergencies. When severe agitation, character pathology, or family dysfunction are encountered, the ability to recognize one's own countertransference reactions to

such situations can be of clinical benefit. The ability to help the ES staff acknowledge their own reactions to psychiatric patients is another valuable tool for effective communication and optimal treatment. Countertransference and stigma are powerful factors with clinical relevance in the ES.

Recommendation 7: Demonstrate Knowledge of Medicolegal Issues

The PEC should demonstrate knowledge of medicolegal issues, such as involuntary holds and decision-making capacity. The ability to assess and then clearly document a rationale for involuntary psychiatric hospitalization is crucial. The initial assessment leading to treatment against a patient's expressed wishes is medicolegally essential in the justification of subsequent interventions that impose upon a patient's autonomy. The PEC may be asked to comment on the decisional capacity of patients who refuse medical treatment, admission, or a necessary procedure. A working knowledge of the concept of capacity is essential to properly advocate for patients. Also necessary is knowledge of how legal determinations (i.e., decision making and involuntary treatment) are made in the jurisdiction both where the patient resides and where treatment is proposed (16).

Recommendation 8: Collaborate With ES Clinical Teams

The PEC must collaborate with ES clinical teams across disciplines and specialties. Working in the ED requires an ability to collaborate with medical professionals from multiple disciplines, including emergency physicians, P.A.s, N.P.s, registered nurses, and a host of ancillary staff. All emergency personnel work at a fast pace, and their workflow is designed for urgency.

However, many clinicians have previous training and expertise in clinical care settings that place value on slowing down and focusing on fine details to fully evaluate the patient. This is not always possible in the ES. It is important for the PEC to balance the benefits of slowing down with the need for efficiency in the ES.

A focused examination is preferred over a detailed diagnostic workup or intake usually done in a traditional outpatient clinic setting. Even before meeting with a patient, the clinician should have a sense of the patient's or emergency physician's request and of what symptoms to look for and should be able to form hypotheses regarding the differential diagnosis, potential treatment, and disposition options. The PEC must be comfortable making decisions based on the limited data and resources available in the ES, especially during evening and weekend hours when community connections are difficult to obtain. Otherwise, patients will remain in the ES well past what can be tolerated by the demands of patient flow.

The PEC can help emergency providers manage their own expectations about what is necessary for high-quality and efficient emergency psychiatric care. The PEC can assist the ES staff in recognizing that speaking with and

understanding psychiatric patients simply takes more time and depends on measures that do not provide definitive results (e.g., lab tests) to guide decision making. Psychiatric patients may still have longer stays, but they can also get better care when a PEC is present.

Often, the assessment of a patient is interrupted by other tasks, such as the arrival of an agitated patient or a call from collateral sources or an insurance company. The ability to multitask is crucial, with one case often impinging upon another. Finally, PECs doing this demanding work must be given resources to manage their own job stress as well as a schedule that allows for collegial interactions, ongoing learning, and time between shifts to sustain interdisciplinary relationships and personal well-being. Boxes 2 and 3 are schematics of the above recommendations.

DISCUSSION

Because time and historical information are often limited in an ES, PECs must have expertise in the diagnosis of mental and substance use disorders and risk assessment as well as knowledge about local community resources needed for disposition planning. They need a basic working knowledge of common medical illnesses, psychopharmacology, and behavioral manifestations of general medical disease. We believe these skills can be learned through a combination of didactic presentations, apprenticeship, and competency-based evaluation by psychiatrists, other physicians, and more experienced PECs.

Training is provided with incremental levels of responsibility. The clinician initially shadows more senior clinicians. Then the training PEC conducts the exam with the senior clinician present. When the PEC begins to see patients independently, the patient's case is presented to the supervisor, who can then ask about unexplored areas. The PEC learns what elements of the exam need further exploration. Once the PEC is fully trained, the exam is comprehensive and anticipates areas that a senior clinician would cover.

Of utmost importance, the PEC must foster collaboration and mutual trust between and among members of an ES team. The objective is not to substitute for or replace the psychiatrist with PECs, but rather to extend the reach of psychiatrists in locales where there are few if any available. As Zun and Rozel (17) suggest, "When a psychiatrist is unavailable, even a designated psychiatric clinician, nurse or other mental health clinician integrated into the medical emergency department may be helpful." With a projected increase in mental health issues resulting from the COVID-19 crisis (18), adding these clinicians to the work pool would help ease the workforce burden.

Although we recommend on-the-job training with graded levels of responsibility, a certification program would be a logical next step. Such training can be initially time intensive, but the result can be effective and ultimately cost saving. The best way for such training to occur includes two parts:

BOX 2. Summary of recommended competencies for psychiatric emergency clinicians

- Perform independent psychiatric evaluations, with a focus on triage, stabilization, and safety assessments
- Manage behavioral emergencies (verbal de-escalation and reducing need for restraint)
- Assist in the recognition of medical illnesses, states of intoxication and withdrawal, and adverse drug reactions presenting as behavioral health emergencies
- Develop appropriate treatment plans, including but not limited to disposition planning, determination of potential need for medications, and subsequent impact of such treatment
- Recognize circumstances in which specialized consultation from a psychiatrist or emergency physician is indicated
- Demonstrate knowledge of medicolegal issues, such as involuntary holds and decision-making capacity
- Possess self-awareness and recognize clinician-patient dynamics that may complicate medical and psychiatric examination
- Collaborate with emergency service clinical teams across disciplines and specialties

formal didactic presentations and apprenticeship with seasoned providers.

How much a PEC should know before beginning to practice independently will depend on the needs of the institution and the background of the PEC. At baseline, the PEC should possess sophisticated interviewing skills, including but not limited to risk assessment and de-escalation, and an understanding of the criteria for involuntary hospitalization. The PEC should be facile at conducting a focused psychiatric examination that includes a thorough history of present illness, other relevant history, and a mental status examination. The PEC needs to have a general understanding of how medical illnesses can present as behavioral emergencies. As the PEC gains experience and receives supervision, the level of knowledge can be broadened to include most if not all the competencies listed in this article.

The limitations of this article are those inherent in a consensus document addressing an area with a paucity of

literature. The guidelines endorsed by AAEP are the first to address what is needed to perform safe, effective treatment in today's ESs with limited psychiatric prescriber resources. Although state and local regulations for supervision of clinicians and requirements for onsite prescribers will vary across settings, the core clinical concepts outlined can serve as a guide for any ES with limited resources seeking to address the care of psychiatric patients.

Another question we addressed is whether these practices already exist and how prevalent they are. A Google search yielded a list of nationwide position openings indicating that this practice is widespread; however, the search also indicated that the positions are inconsistent regarding the experience levels and duties required. One of the authors (J.S.R.) has firsthand experience with this model and has worked in or knows of programs that have functioned successfully for over 30 years. Empirical research is needed, particularly with respect to the level of experience and training that are required for PECs in these positions.

BOX 3. Core clinical elements of independent evaluation**Triage**

- Prioritize patients with clinically urgent and emergent cases ahead of routine situations, including the ability to attend to multiple patients with acute symptoms simultaneously
- Manage emergency telephone calls from patients or clinicians adeptly and understand the limits of such interventions

Assessment

- Engage the patient quickly and establish rapport
- Utilize advanced interviewing skills to elicit pertinent history
- Elicit and understand the patient's chief complaint and the request
- Perform a rapid, focused evaluation (rapid psychiatric assessment leading to comprehensive differential diagnosis)
- Assess risk, including high-level risk of suicide, homicide, or impaired judgment
- Perform a comprehensive mental status examination
- Perform a psychiatric and medical review of systems

- Assess need for medical evaluation (or reevaluation) to rule out acute, potentially contributory medical conditions
- Gather collateral information

Differential diagnosis

- Maintain an index of suspicion for underlying medical illnesses presenting with behavioral disturbance
- Generate a psychiatric differential diagnosis and determine a final diagnosis when evident

Management

- Skillfully utilize verbal de-escalation techniques
- Assess the benefit, impact, and judicious use of medications
- Assist in disposition planning

Documentation

- Write a psychiatric note, including a full history of present illness and mental status examination, biopsychosocial assessment, and differential diagnosis
- Describe the necessity for hospitalization
- Clearly document the rationale for releasing patients who may have risk factors, when appropriate

CONCLUSIONS

This article addresses an effective way to evaluate and care for the growing number of patients with psychiatric conditions presenting to an ES by recruiting and utilizing non-prescribing mental health professionals who have the pertinent skills and expertise. AAEP offers a formalized set of competencies for the ES considering or already using this model of care. Use of PECs offers an immediate and practical solution to the shortage of psychiatrists while other strategies, such as telepsychiatry, are being explored. Successful models for high-quality emergency psychiatric care require close collaboration between and among multiple disciplines. Models involving PECs should draw upon the strengths of each profession represented, maximize limited resources, and judiciously use a backup psychiatrist (the most limited resource in the current landscape of ES crisis management) to lend consultative support. Well-trained and appropriately supported PECs can vastly enhance the level of care available to individuals presenting with behavioral health crises and can do so efficiently and competently. A very experienced PEC may achieve all or nearly all of the competencies discussed in this article, whereas less experienced clinicians will need more direct supervision. Our guidelines can aid the ES in its hiring practices, as the ES seeks to meet the expanding needs for emergency psychiatric services.

Research is needed to assess the utility of these proposed guidelines and how PECs can achieve each of these competencies. This article provides an initial framework for training nonprescribing clinicians for practice in the ES. The goal is for a PEC to meet all these competencies; however, this objective would be achieved only over time and with appropriate support and supervision. Given the crisis in emergency services, a vast pool of underutilized mental health clinicians can be mobilized and trained to meet this demand.

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