A Review of Psychiatric Emergencies

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Faculty

James Trent, PhD, earned his doctorate in clinical psychology from the University of Mississippi in 1977. He has worked in rural community mental health, where psychiatric emergencies were managed without the benefit of adjacent inpatient psychiatric facilities. He has managed an independent practice of psychology since 1979, a practice that has included managing patients presenting with psychiatric emergencies. Dr. Trent taught at Middle Tennessee State University and Capella University, lecturing graduate students on psychopathology and psychotherapy. He supervised practicum students and interns at the VAMC Nashville, Tennessee, and at the Vanderbilt University Psychological and Counseling Center. In 2017, Dr. Trent retired from the Charleston, South Carolina, VAMC Home Based Primary Care program, where he provided psychological services to elderly veterans with chronic, comorbid illnesses that precluded their ability to receive care at the hospital and managed psychiatric emergencies among home-based veterans. Dr. Trent also acts as the Psychology Division Planner at NetCE.

Faculty Disclosure

Contributing faculty, James Trent, PhD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Audience

This intermediate course is designed for psychologists, especially those working in emergency care settings.

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Course Objective

The purpose of this course is to help psychologists recognize psychiatric emergencies, identify common psychiatric illnesses that may share symptoms with physical illness, and improve the management of psychiatric emergencies.

A complete Works Cited list begins on page 40.

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Learning Objectives

Upon completion of this course, you should be able to:

1. Outline the history and appropriate use of the emergency department (ED).
2. Cite statistics regarding ED utilization.
3. Describe the medical evaluation of psychiatric patients in the emergency setting.
4. Discuss components of a psychiatric assessment in the ED.
5. Review common medical conditions that may be linked to psychiatric issues.
6. Define imminent danger.
7. Identify common psychiatric conditions that may precipitate emergencies in adults.
8. Recognize psychiatric illnesses in children and adolescents that may necessitate emergency intervention.
9. Describe the appropriate management of psychiatric emergencies, including the necessity for providing information in the patient's native language.
10. Outline appropriate discharge planning for patients who have been treated for psychiatric emergencies.
11. List interventions that should be utilized in the case of a psychiatric emergency in an office setting.
12. Discuss legal issues associated with psychiatric emergencies.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Hospital emergency departments (EDs) were initially used to provide immediate care for patients experiencing acute medical conditions or trauma. Their role expanded to provide more extensive management of people with other types of conditions that require immediate care, including people experiencing psychiatric emergencies. Now, EDs are experiencing increased use by people who do not have a primary care physician and use EDs for routine medical care, causing stress on available healthcare resources.

A psychiatric emergency has been defined as, "any behavior that cannot be dealt with as rapidly as needed by the ordinary mental health, social service, or criminal justice system in a community" [1]. A consensus definition developed by a task force of the American Psychiatric Association (APA) has indicated that a psychiatric emergency is "an acute disturbance of thought, behavior, or social relationship that requires an immediate intervention as defined by the patient, the family, or the community" [2]. Psychiatric illnesses, some of which have the potential of becoming emergencies, occur in adults, adolescents, and children. Each diagnosis is based on the presence of certain symptoms; however, symptoms are not unique markers for each diagnosis. As such, some symptoms overlap into more than one diagnosis. It is helpful for healthcare professionals who do not work closely with psychiatric patients, but who may come into contact with them in various settings, to recognize common and overlapping symptoms of psychiatric disorders.

As with physical conditions, psychiatric episodes may become emergencies. It is important for the professional staff in various settings (e.g., correctional facilities, nursing homes, clinics, offices) to recognize a psychiatric emergency when it occurs and know how to manage it based on available resources.

Psychiatric emergencies can manifest in different ways and places. The emergency with the most potential for damage to the patient and others involves a person who is suicidal, homicidal, or unable to avoid common dangers. Managing any of these problems involves both general and specific actions.

EMERGENCY DEPARTMENTS

As noted, the emergency department evolved from the emergency room, which was used to stabilize and provide immediate care to patients experiencing a medical emergency. Once stabilized, patients could either be discharged to another unit for additional evaluation and treatment or to their home, if appropriate.

EDs now offer many more resources than the original emergency rooms. In addition to stabilizing and treating the patient in need of immediate care, the ED has more diagnostic and treatment options than were previously imagined. As EDs became self-sufficient units within larger medical centers, they became an integrated part of the patient's continuum of care. In-house specialty physicians are usually immediately available to consult with the ED physicians and nurses. The presence of a psychiatrist or psychiatric resident, when a training component is available, facilitates the development of a working diagnosis and immediate treatment for patients experiencing a psychiatric emergency. Of course, psychiatric patients are not impervious to other medical emergencies. The existence of a comorbid psychiatric condition may complicate the diagnosis and treatment of medical problems. In such cases, consultation with a psychologist or psychiatrist may help the ED physician and staff distinguish psychologic issues from medical problems that may be present [3].

MISUSE OF EMERGENCY SERVICES AND OVERCROWDING

The misuse of emergency services by patients who do not have primary care physicians and use the ED for routine office visits is a continuing problem in the United States and can contribute to ED crowding. According to an analysis by the Centers for Disease Control and Prevention (CDC), the foundation of the overcrowding problem is that the demographics of the U.S. population have changed over time (e.g., a greater number of older Americans, higher incidence of obesity and diabetes) and there are fewer EDs [76]. Although the percentage of Americans visiting the ED each year has remained consistent, the number of visits increased 34% between 1995 and 2010 and the number of EDs decreased by 11% [76]. One in five people visit the ED at least once each year, but frequent users (i.e., four or more visits in two years) are a dilemma. They represent 1% of all users, but are responsible for 18% of visits [76]. These individuals typically have poor general health and chronic conditions, lower socioeconomic status, and are older than 65 years of age.

There are many myths regarding ED usage. It is often asserted that most visits to EDs are for nonurgent conditions, but the reality is much different. Based on 2012 CDC triage survey data (gathered in 2009–2010), roughly 80% of adult and pediatric ED visits nationwide were classified as urgent or semi-urgent and only 10% of pediatric visits and 8% of adult visits were classified as nonurgent [76]. The remainder (8% and 12%, respectively) were classified as emergent. It is also often reported that Medicaid patients or the uninsured are using EDs as primary care; however, the number of adult visits classified as emergent, for example, was similar among noninsured, privately insured, and publicly insured patients [76]. However, the percentage of pediatric visits classified as semi-urgent was higher among those with Medicaid (49%) versus private (44%) coverage [76]. The prevailing belief is that poor, uninsured/publicly insured individuals are the problem, when in fact there has been a disproportionate increase in ED use as primary care among privately insured individuals [75; 76].

Misuse of emergency services is an expensive aspect of medical care. Treatment in EDs is seven times more expensive than in primary care offices; even so, the nonurgent use of emergency rooms continues to grow [4; 76]. Many of these nonurgent visits may be avoided if patients are able or willing to receive care (and preventive care) from a primary physician. Research has shown that people are more likely to use emergency services if they do not have a regular healthcare provider [75]. This is unfortunate because primary care providers will typically have the patient's history as a resource, avoiding unnecessary tests. However, it has also been shown that many individuals visit the ED with what turns out to be non-life-threatening conditions because they are experiencing symptoms that mimic those of more serious conditions (e.g., chest pain) [67; 76].

In addition to the financial cost, crowded waiting areas, long waiting times, and actual or potential delays in receiving medical care, exacerbation of psychiatric conditions are serious problems in hospitals. Crowded, busy, noisy, and frightening EDs become sources of stress for the psychiatric patient having difficulty maintaining tenuous contact with reality. A situation that begins as a decompensating process, which is upsetting to the patient and family, deteriorates into agitation and eventual loss of control. This process leads to a dangerous situation for both the patient and others, as the patient becomes more frightened and agitated.

ASSESSMENT OF PSYCHIATRIC PATIENTS IN THE EMERGENCY SETTING

Because persons with psychiatric symptoms and disorders will often be encountered in the ED, understanding the clinical features and differential diagnoses for various disorders that commonly present in a medical setting is vital. There are several aspects of assessing an apparent psychiatric emergency. In all cases, physical illness should be considered, both as a causal and a comorbid condition. Management of acute behavioral problems may be necessary at this point in order to gain an accurate history and examination. After medical conditions have been investigated, a psychiatric evaluation is essential. In all stages, the patient's potential for violence and/or self-harm should be assessed and taken into consideration.

MEDICAL EVALUATION

Thorough medical evaluation is clearly indicated for patients with psychiatric emergencies, although the feasibility and extent of screening may differ. The American College of Emergency Physicians (ACEP) has developed policies that address the diagnosis and management of adult psychiatric patients in the ED [5]. There are three elements to the initial assessment of a psychiatric patient in an emergency setting [5; 79]:

- Assess and differentiate patients with depression and agitation, evaluate patients with depression for risk of harm to self and/or others, and determine if patients with agitation require sedation, seclusion, or restraint.
- Establish whether the patient's symptoms are caused or exacerbated by a medical illness (e.g., toxidrome, delirium, medical disease) and treat any acute medical condition.
- Determine if the patient is intoxicated.

Patients with suggestive histories, abnormal vital signs, and/or abnormal physical examinations should be cleared of medical illnesses during their evaluation [5]. This generally requires more intensive diagnosis utilizing laboratory and radiologic screening. Several groups have been identified as necessitating further medical evaluation if presenting with psychiatric symptoms, including the elderly, those with substance abuse problems, those with pre-existing or new medical complaints, and those of lower socioeconomic status [6; 7]. In addition, patients without a prior psychiatric history should be carefully evaluated for possible physiologic causes of the behavioral changes [6].

Several areas should be addressed when taking the history of these patients. If the patient is unable to respond coherently, available family, friends, or law enforcement personnel may be questioned. Specific areas of importance include premorbid functioning, previous psychiatric history, alcohol use, substance abuse, recent injury, medical history, and medication use [8]. In addition, clinicians should determine if neurologic symptoms are present, including recent headaches, slurred speech, confusion, or ataxia [9].

As with all patients who present in the ED, vital signs should be taken. Abnormal vital signs indicate the need for further medical testing. A brief assessment of the head and neck for signs of trauma may also be indicated [8]. If possible, a brief neurologic exam may help elucidate causes of the behavioral abnormalities. The neurologic exam should include assessment of motor strength, speech quality, and reflexes [9].

Although some studies have indicated the use of laboratory and radiologic evaluation of all patients presenting with psychiatric disturbances in the ED, evidence does not support these interventions for most patients [5]. For alert, cooperative patients with no signs of physical distress whose primary complaint is psychiatric, the ACEP has recommended that diagnostic evaluation be directed by the history and physical examination. Routine

laboratory testing is not necessary, because it usually does not change the management or disposition of the patient [5]. However, there are several life-threatening medical conditions that may precipitate a psychotic emergency, including central nervous system or systemic infection, collagen vascular disease, drug overdose or intoxication, head trauma, hypertensive crisis, hypoglycemia, hypoxemia, sedative-hypnotic agent withdrawal, and thyrotoxicosis [8; 10]. If the cause of psychosis is unclear, these etiologies should be investigated.

In many cases, identification of alcohol and/or drug intoxication is necessary prior to psychiatric evaluation, as intoxication will complicate the assessment and treatment of both medical and psychiatric conditions. Many psychiatric facilities require toxicology screening prior to the transfer of an acutely intoxicated individual [79]. Although identifying intoxication in these patients is helpful, studies have indicated that routine urine toxicologic screens for drugs of abuse in alert, cooperative patients do not affect ED management and therefore need not be performed as part of the ED assessment [5; 65; 79]. The ACEP also has noted that there is no blood alcohol level at which it has been established that adequate cognitive functioning and decision-making capacity returns; thus, cognitive impairment secondary to intoxication should be individually assessed [79].

PSYCHIATRIC ASSESSMENT

A full psychiatric assessment is complex, the details of which are beyond the scope of this course. According to the APA, the purpose of an emergency psychiatric assessment is to [11]:

- Assess and enhance the safety of the patient and others.
- Establish a provisional diagnosis (or diagnoses) of the mental disorder(s) most likely to be responsible for the current emergency, including identification of any general medical condition(s) or substance use that is causing or contributing to the patient's mental condition.
- Identify family or other involved persons who can provide information that will help determine the accuracy of reported history, particularly if the patient is cognitively impaired, agitated, or psychotic and has difficulty communicating a history of events. If the patient is to be discharged back to family members or other caretaking persons, their ability to care for the patient and their understanding of the patient's needs should be addressed.
- Identify any current treatment providers who can provide information relevant to the evaluation.
- Identify social, environmental, and cultural factors relevant to immediate treatment decisions.
- Determine whether the patient is able and willing to form an alliance that will support further assessment and treatment, what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary.
- Develop a specific plan for follow-up, including immediate treatment and disposition; determine whether the patient requires treatment in a hospital or other supervised setting and what follow-up will be required if the patient is not placed in a supervised setting.

The American Psychiatric Association recommends that the initial psychiatric evaluation of a patient include assessment of the patient's need for an interpreter and cultural factors related to the patient's social environment.

(https://www.guideline.gov/summaries/summary/49527. Last accessed February 13, 2017.)

Level of Evidence: 1C (Recommendation based on low confidence that the evidence reflects the true effect)

TESTS THAT MAY BE INDICATED AS PART OF A PSYCHIATRIC EVALUATION	
Test	**Purpose**
Basic laboratory tests (e.g., complete blood count; blood chemistries, including lipid profile, B12, folate; urinalysis)	Used to screen for general medical conditions or provide baseline measures prior to treatment. Recommended frequency of screening may vary with health status and specific ongoing treatments (e.g., second-generation antipsychotics, lithium).
Medication levels	Used to monitor therapeutic levels of medications.
Pregnancy test	Some psychiatric conditions and treatments may entail risks to a pregnant woman or her fetus.
Fasting blood glucose or hemoglobin A1c	Used to diagnose diabetes or help determine risk. Patients prescribed second-generation antipsychotics may be at increased risk of developing diabetes.
Lyme serology, syphilis serology, HIV test	May assist in evaluation of cognitive and behavioral changes. Individuals with behavioral problems, such as impulsivity or drug use, may be at increased risk for HIV infection.
Thyroid function tests	May be important for patients with suspected mood disorder, anxiety disorder, or dementia. Used to monitor lithium effects.
Toxicology screen, blood alcohol level	Used to screen for substance use or abuse. Individuals with a mental disorder are at increased risk for substance abuse.
Electrocardiogram	Used to assess effects of medications that may influence cardiac conduction (e.g., tricyclic antidepressants, some antipsychotics). May also be indicated depending on age and health status.
Chest x-ray	Used to diagnose cardiopulmonary disorders (e.g., pneumonia, tuberculosis) that may contribute to delirium. May also be part of a pre-electroconvulsive therapy (ECT) evaluation depending on age and health status.
Imaging studies	Structural studies, such as computed tomography (CT) and magnetic resonance imaging (MRI), and functional studies, such as positron emission tomography (PET), single photon emission computed tomography (SPECT), electroencephalogram (EEG), and functional magnetic resonance imaging (fMRI), may indicate regional brain abnormalities related to a psychiatric illness and its management.
Lumbar puncture	Used to diagnose central nervous system infection (e.g., meningitis, herpes, toxoplasmosis, syphilis, Lyme disease). May be important for differential diagnosis of delirium.
Polysomnography	Used to diagnose sleep disorders, including sleep apnea. May be important for differential diagnosis of depression, psychosis, or other cognitive or behavioral changes.
Psychologic testing	May be requested when cognitive deficits are suspected or there is need to grade for severity or progression of symptoms over time. May also be helpful in establishing a diagnosis (e.g., dementia, mental retardation) or in delineating specific deficits that affect thought processes, treatment, or vocational planning.

Source: Reprinted with permission from the Psychiatric Evaluation of Adults: A Quick Reference Guide. Am J Psych. Copyright 2004. American Psychiatric Association. *Table 1*

Psychiatric assessments in an emergency setting differ in length and may last up to several hours. If possible, the medical and psychiatric assessments should be conducted in cooperation, as additional medical evaluation may be necessary during or after a psychiatric assessment. The clinician administering the psychiatric evaluation may also order certain tests to determine etiology or appropriate treatments (***Table 1***). Confidentiality may be an issue; however, necessary information may be conveyed to the ED staff in an emergency situation [11].

Risk for Suicide

During the evaluation of the suicidal patient, a number of significant questions should be asked and answered. The following questions should be asked, although additional items may be added as needed to develop a more thorough understanding of the patient's status.

Questions for Patients

- Have you ever attempted suicide?
- How long have you thought about suicide before coming here?
- What has happened to lead you to such a thought?
- Have you had any losses in the last few months?
- How would you commit suicide if you decide to try to do it?

Evaluation of Patient Responses

- Has the patient described a detailed suicide plan, or is it more of a casual thought?
- If there is a plan, is it well thought out and potentially lethal?
- Does the patient have the means available to carry out the plan?
- Is there anything (e.g., religious belief) that will stop a suicide attempt?

The interview of the potentially suicidal patient provides valuable information to determine the degree of risk present. Those who have a plan that either protects the feelings of others or is designed to cause as much emotional pain to others as possible are at much higher risk than individuals who have passive thoughts about suicide. Clinicians should consider the degree of planning as an indication of the seriousness of a potential attempt. Impulsive people present a more dangerous situation than those who are not impulsive; therefore, substance misuse increases the risk for suicidal behavior. The use of suicide predictive tools will be discussed later in this course.

According to the Department of Veterans Affairs, a suicide risk assessment should first evaluate the three domains: suicidal thoughts, intent, and behavior, including warning signs that may increase the patient's acuity. The suicide risk assessment should then include consideration of risk and protective factors that may increase or decrease the patient's risk of suicide.

(https://www.guideline.gov/summaries/summary/47023. Last accessed February 13, 2017.)

Level of Evidence: Expert Opinion/Consensus Statement

Risk for Violence

Until the 1990s, assessment of a patient's risk for violent behavior depended almost singularly on the experience and intuition of the clinician, and individual judgment is still an important factor. Several factors have since been identified as increasing the risk for violent behaviors. An intense feeling about harming others increases the risk, as does a well-developed plan and/or availability of a weapon. Impulsivity and substance abuse may further increase the urgency of the situation. Despite this knowledge, various studies have shown that clinicians' ability to predict violence falls somewhere between 14% and 53% [12]. Therefore, tools have been developed to assist in the assessment of the potential for violence in psychiatric patients.

The Historical, Clinical, Risk Management-20 (HCR-20) has been developed to assist in quantifying a psychiatric patient's risk for violent behavior. The 20-item checklist is divided into three sections: historical, clinical, and risk management [13]. The checklist may be administered regularly to identify any changes in risk. In several small-scale studies and meta-analyses, the HCR-20 has been shown to positively predict the level of danger in persons with mental illness; however, this tool offers better predictive accuracy for low-risk patients versus average- or high-risk patients [12; 14; 66]. Despite possible shortcomings, diagnostic

accuracy is improved compared to not using an assessment tool. HCR-20 is now in its 3rd version. The Rating Sheet for Version 3 of the HCR-20 is available online at http://hcr-20.com/hcr/wp-content/uploads/2013/03/HCR-V3-Rating-Sheet-1-page-CC-License-16-October-2013.pdf.

Another available resource is the Violence Risk Appraisal Guide (VRAG), which analyzes 12 variables to provide a probability of whether the patient will engage in violent behavior within a specified time [14]. Because the VRAG is an actuary tool, it does not require that the patient complete a checklist. Rather, the patient's psychosocial history is appraised, particularly childhood conduct, family background, antisocial and criminal behavior, and psychologic problems. Although the VRAG was originally developed for the assessment of inmates and violent crime offenders, researchers have suggested that it may also be of use in assessing psychiatric patients [14; 15].

The Classification of Violence Risk (COVR) program, developed by researchers involved with the MacArthur Violence Risk Assessment Study, is software designed to allow clinicians to assess adult patients' risk for violent behavior based on approximately "40 individualized questions, generated by computer algorithms in response to answers to previous questions" [12]. The COVR analyzes 106 variables, which the publisher contends may be ascertained from a chart review and a 10-minute interview with the patient [12].

More research is necessary to evaluate the usefulness of these tools in the ED. However, given the pressures and poor predictive values of clinician assessment for violence risk, the incorporation of an assistive tool may be warranted.

PSYCHIATRIC COMPONENTS OF MEDICAL EMERGENCIES

Common medical emergencies seen in the ED include chest pain, asthma attacks, motor vehicle accidents, intoxication, animal bites, suicide attempts, and trauma from physical assaults. While each of these emergencies has physical components that require treatment, almost all may involve psychiatric causes that should be treated as psychiatric emergencies.

It is normal for healthcare professionals to make decisions based on experience and observation of physical symptoms. This is valuable, especially when decisions must be made quickly to save a life or minimize injury to a patient. However, the most common emergencies may have hidden psychiatric reasons that cause or exacerbate the presenting complaint. For example, patients who complain of chest pain should be evaluated to rule out cardiac or other physical causes. It is when physical causes are ruled out that a different set of problems should be addressed. The ED staff may quickly reassure the patient that the chest pain is not signaling an impending heart attack and discharge him or her to a private physician for follow-up evaluation and care. Despite reassurance from the ED staff, the patient may feel sure that the chest pain is a precursor to a heart attack or other major problem. A crowded ED can be overwhelming to the ED staff, making it difficult for them to provide the additional reassurance that may be helpful. It is possible, perhaps even probable, that the patient complaining of chest pain without support of a physical diagnosis is having a panic attack. The diagnosis and treatment of this can easily be lost in the hectic ED. The presence of a consulting psychologist or psychiatrist may help diagnose and provide care for the patient.

In addition to chest pain, several other seemingly medical conditions may be linked to psychiatric issues. Asthma attacks certainly have a physical component, but they are also exacerbated by psychologic issues, particularly anxiety and fear. Intoxication can be a complicated and potentially dangerous condition that involves self-medication for an untreated or poorly controlled psychiatric disorder. Hopelessness has been found to be a feature in irritable bowel syndrome [16]. It is important to recognize that time constraints may lead professionals to depend on experience when the time to reflect on and investigate other possibilities is not available.

EDs in large medical centers frequently have specialized personnel, equipment, and technology. While psychiatric emergencies do not rely on specialized surgical procedures or technology, they do require a thorough understanding of the causes and events around the emergent situation. Knowledge of available psychotropic medications allows for a better decision about the type and dose to use. In small hospitals, psychiatric expertise may not be available to help the agitated psychiatric patient. Thus, the patient's behavior and the staff's response may escalate until the patient requires a stronger intervention to resolve the problem.

IMMINENT DANGERS

It is the responsibility of the professional staff, whether in an ED or elsewhere, to recognize and understand the types of imminent dangers that require immediate action. Every state and commonwealth has specific laws mandating how these situations are to be handled. It is important both to read the pertinent laws and post them where professional staff may refer to them when necessary. The specific laws of each state and commonwealth share basic characteristics, such as the three types of imminent danger: suicide, homicide, and the inability to avoid common danger. Despite the recommended approach associated with each, there are significant subjective decisions that should be made by the responsible medical personnel.

SUICIDE

EDs frequently are the first line of treatment for people with suicidal thoughts or behaviors. The increased attention that suicide research has received has been helpful to mental health professionals, crisis center workers, and others involved in suicide prevention. The ED professional staff should be able to determine the presence or absence of imminent danger.

Imminent danger is characterized by a patient describing or manifesting self-destructive behavior that shows a reasonable probability of happening in the immediate hours rather than days, weeks, or months later. Subjectivity comes into play with each professional's interpretation of the patient's statements. The time period for imminent danger may be modified depending on the patient's suicide plan.

There are two suicidal types: passive and active. Persons considering passive suicide will put themselves into harm's way. The goal of this action is to allow an accident to be the cause of death. When passive suicide attempts are treated in the ED, it is unlikely that the ED staff will identify them as suicide attempts, as the staff is focused on treating the injuries from the accident. An active suicide attempt requires a direct action by the suicidal person toward ending his or her life; it is not an accident or a mistake. The suicidal person is directly involved in setting up and causing the action that is intended to end his or her life. Some active suicide attempts are clearly self-inflicted and obvious to the ED staff. At other times, there may be enough doubt about the cause of the injury to make it difficult to determine whether it was self-inflicted or an accident. If in doubt, healthcare professionals should evaluate for the presence of suicidal behavior, as this may be one of a series of increasingly dangerous actions.

LEVELS OF SUICIDAL BEHAVIOR	
Level	**Characteristics**
Ideation	Frequent and specific thoughts of death and ways to die
Planning	A logical and well-prepared suicide plan with a good likelihood of success
Gesture	Behavior or activity that is dangerous and/or harmful, but not potentially lethal
Attempt	Clear, self-destructive actions with a good probability or expectation of lethality that do not result in death
Completed suicide	Destructive and harmful action that results in one's own death

Source: Compiled by Author *Table 2*

Suicidal Ideation

There are several levels to suicidal behavior (***Table 2***). The first level is suicidal ideation. People experiencing personal or financial duress commonly have passing thoughts about "not waking up," "just leaving the mess," or other fleeting thoughts of death. Suicidal ideation, though, is a much more significant pattern of thinking. Instead of transient thoughts when distressed or fatigued, an individual with suicidal ideation experiences frequent and specific thoughts about dying and possible plans of action. No longer is the thought about "not waking up;" it is about how to accomplish that end and either insulate family or friends or blame them for the suicidal decision. At the point of suicidal ideation, the person may not have a firm plan for suicide but instead thinks about it when driving, cutting vegetables with a knife, or engaging in a potentially dangerous activity.

Suicide Plan

If not interrupted, suicidal ideation can gel into a suicide plan. A suicide plan is one that is evidenced by specific strategies to end one's life. While fleeting ideation may suggest an impulsive action that might result in suicide, a suicide plan includes a logical and well-prepared action that has good likelihood of success. Instead of impulsively driving a car off the road, the person with a plan will know when and where to do so to increase the probability that it will be completed. Suicide plans may change the definition of imminent danger as well. Planning may not meet the definition of imminent danger, as it may not be immediately executed. However, careful planning and the need to complete the action via a predetermined series of steps in order to conceal intention are indicative of imminent danger.

Both suicidal ideation and suicide plans should be taken very seriously. Impulsive actions by these individuals can end in unexpected death. The decision about how to manage a patient with suicidal ideation or a suicide plan is affected by several variables. If the person is currently in therapy, the therapist should be called and involved in the management decision. This may involve immediate telephone or face-to-face conversations while the patient is in the ED. A follow-up appointment the next day is usually necessary. If the patient does not have a therapeutic relationship with a mental health professional, referral to one should be made before discharge. Individuals presenting with suicidal ideation may be discharged to home if there are responsible adults available who are willing to take on the responsibility of supervising the patient until treatment is started. If medication is provided to a suicidal patient, a responsible adult should be present to administer it. The entire quantity available should not be enough to reach a lethal dose.

Suicide Gestures

Persons with suicidal gestures are frequently brought to the ED. A gesture shows more behavioral activity than a plan, but less than an attempt, and is not potentially lethal. For example, a person takes a few pills (not enough to be lethal), tells someone about it, and identifies it as a suicide attempt. Two things make this a gesture but not an attempt. First, the person has not taken enough pills to cause death, although it may make the person sick or unintentionally cause other problems. Secondly, a second party has been notified about the action and the motivation, thereby allowing intervention. Patients who engage in suicidal gestures may show increasing lethality in future gestures. Depending upon the person's history and the severity of the current gesture, discharge to involuntary hospitalization for a period of evaluation and observation may be necessary. It is also appropriate, at times, for the ED to discharge the person to a responsible adult pending psychologic treatment.

Suicide Attempts

Suicide attempts involve clear, self-destructive actions. The actions provide a strong probability for lethality or the expectation for lethality. One example is an individual who takes an overdose of pills, with the belief that those pills in that quantity will be lethal, but lives because the pills are ineffective or the necessary quantity is incorrect. Because this person expects the action to be fatal, it is considered an active suicide attempt. Discharge from the ED will likely require inpatient psychiatric treatment.

Involuntary hospitalization is usually preferred to voluntary hospitalization for these patients because they are required to remain for observation and evaluation even if they change their mind. This period of observation and evaluation provides an opportunity to address the suicide attempt and the reasons behind it. After the period of imminent danger has passed, the person may be discharged with a recommendation to start outpatient therapy. It is important for the ED staff to recognize that the danger continues even after the physical condition has been stabilized or treated.

Professional staff should remember that the actions of suicidal people can be deceiving. In some cases, persons manifesting the symptoms of severe depression, including suicidal ideation, suddenly appear to be better. They no longer feel depressed, or at least not as depressed, and look calm or happy. It is at this point that the person may seem calm enough to be discharged to family or friends pending a mental health appointment the next day. However, patients who are discharged may seem calmer because they have resolved how and when to end their lives.

An investigation of suicide in older adults found that in addition to mental conditions these individuals are at high risk for suicide due to a variety of physical conditions [17]. Common health problems cited as possible precursors to suicide include cancer (particularly gastrointestinal cancer and brain cancer), liver disease, epilepsy, cerebrovascular diseases, cataract, heart disease, chronic obstructive pulmonary disease (COPD), osteoporosis, and arthritis. Multiple illnesses greatly increase suicide risk [17]. Mental conditions that may increase the risk for self-harm include anxiety, bipolar disorder, psychosis, and depression. When an elderly person is treated for medical conditions, healthcare professionals should also evaluate the patient for suicidal potential, as it may coexist with the health problems but may not be mentioned when treatment is sought.

HOMICIDE

Homicidal thoughts or attempts are another aspect of imminent danger that may be encountered in an emergency setting. It is usually the victim of the psychiatric patient who presents in the ED; however, contact with the perpetrator does occur. The major decision to make is determining whether the person with homicidal thoughts or behaviors is a criminal who should be dealt with by law enforcement or whether the person may be

assisted solely through psychiatric treatment. As with suicide, various levels of homicidal ideation or action present differing risks.

A key to correctly assessing and treating patients with homicidal ideation is understanding the motive. If the motive is due to involvement in criminal activity (e.g., a drug deal), it is a matter for law enforcement. It becomes a psychiatric emergency when the action is based on a psychotic disorder. For example, loss of contact with reality and the presence of paranoid thinking can lead to a dangerous situation in which homicidal ideation is present. In a psychiatric emergency, the thoughts of hurting someone are based on irrational beliefs that the patient is in danger from others and assault is the only protective alternative available. Irrational thinking may lead to a dangerous situation for others in the vicinity. For example, if the patient believes that someone wearing blue scrubs is dangerous, it is likely that everyone wearing blue scrubs will be seen as dangerous. Homicidal ideation due to psychiatric instability or illness requires involuntary hospitalization to protect both the patient and those whom the patient fears.

In the case of psychiatric patients, a homicidal attempt is comparable to a suicide attempt in that the actions are directed outward toward the perceived threat. When a homicidal attempt is based on a psychiatric condition, discharge from the ED should be to involuntary hospitalization for the protection of both the patient and others. While the patient is being treated in the ED, it is important to separate the patient from others in order to reduce stimulation and excitement and prevent the patient from becoming agitated and dangerous. Weapons should be removed, and the patient should wait in a room that does not contain items that could be used for harm (e.g., scalpels, syringes, blunt objects, glass cabinet doors). It is necessary to have someone wait with the patient. This can be a responsible adult or a member of the ED staff. It is often better not to have security wait with the patient, as the presence of a uniform and the accoutrements of law enforcement can upset a paranoid person. Nonetheless, security should be notified of the potentially dangerous situation and the actions being taken. Depending on the resources available at a particular hospital or medical center, it may be necessary to seek the assistance of community law enforcement officials to transport the patient to a secured unit.

INABILITY TO AVOID COMMON DANGERS

Another source of imminent danger is found among people who are unable to avoid common dangers. Psychotic, demented, or substance-impaired people may enter dangerous situations without understanding the associated risks. For example, persons with delusions of invincibility may walk into ongoing traffic without understanding that the traffic can kill them. When these patients are brought to the ED, it is usually because others are unable to manage their behavior. The patient's psychologic state may be so disrupted that he or she becomes a threat to others out of fear and confusion. Healthcare professionals should recognize the danger to the patient and others and take responsibility to initiate involuntary hospitalization.

ED physicians have the authority in all states to order involuntary hospitalizations [18]. Additionally, depending on state laws, clinical psychologists meeting certain criteria (e.g., doctoral degree, health service provider status, special training) are permitted to initiate involuntary hospitalizations. Some states require the receiving hospital to meet other requirements before a patient can be hospitalized involuntarily. Thus, it is the responsibility of psychologists and physicians to evaluate the data and determine if there is sufficient evidence to warrant involuntary hospitalization. A serious complication for psychologists and physicians arises when the patient has been in similar situations and is still able to minimize the outward symptoms or effects, thereby avoiding admission to a secured unit. This can make it difficult to decide whether the patient requires hospitalization.

AN OVERVIEW OF PSYCHIATRIC ILLNESSES

Aside from conditions that are sources of imminent danger, many psychologic conditions are commonly encountered in the ED. Although these conditions may not carry the risk of harm associated with suicide or homicide, they do have the potential to escalate to a psychiatric emergency. An understanding of the various psychologic states that can precipitate an emergency, including signs that the state may be a source of imminent danger, is a vital tool for any healthcare professional.

There is overlap between the symptoms associated with different adult psychiatric illnesses and possible medical conditions. It is therefore important for healthcare professionals, especially those who are not familiar with mental health problems, to realize that the differential diagnosis is based on a combination of reported or observed symptoms, underlying personality characteristics, and external circumstances. It is not necessary for all healthcare professionals to be experts on the diagnoses of various mental illnesses. However, it is important to recognize the factors related to diagnoses and consider them in the treatment and discharge plans. It is easy to accept that hallucinations are due to a thought disorder, such as schizophrenia, without considering the possibility of substance abuse. Careful and thorough diagnosis helps to identify and manage psychiatric emergencies.

In various studies, researchers have found that 4% of pediatric patients and up to 9% of all patients seeking medical treatment at EDs for nonpsychiatric reasons experienced suicidal ideation, suicide attempt, or self-harm; another 2% of patients had definite suicide plans [19; 82; 83]. Among those experiencing suicidal ideation or plans, 97% had depression, anxiety, or substance abuse problems. Thus, there may be a psychiatric emergency among people who do not initially present with psychiatric complaints. Because the reason for seeking treatment at an ED may not be psychiatric, it can be easy to overlook the risk of imminent danger.

Despite a comprehensive knowledge of behavioral emergencies, healthcare professionals continue to rely heavily on subjective judgment to make important decisions. For example, the presence of agitation has been identified as an important symptom to recognize when assessing psychiatric emergencies, yet the lack of an operational definition of agitation has resulted in a wide variation in its diagnosis [20]. The same is true for many other symptoms.

SUBSTANCE USE DISORDERS

Substance use disorders can involve alcohol, prescription medications, or illegal drugs. The misuse of any of these substances may lead to a medical emergency. Each type of substance use disorder presents with symptoms common for the specific substance and the level of abuse. Acute intoxication and the effects of chronic ingestion can both result in medical and psychiatric emergencies.

Intoxication refers to ingesting enough of a substance to impair functional ability in motor, cognitive, or physiologic behavior. The pattern of use may be one of infrequency; however, excessive use during periods of intoxication can be quite dangerous to intoxicated persons and those around them. Regular use of a substance that results in negative consequences in social, health, or occupational areas is defined as substance abuse or substance use disorder [21; 26]. Individuals diagnosed with substance use disorder continue to use a substance despite the serious negative effects. Dependence is diagnosed when substance misuse escalates beyond occasional use that might lead to problems and regular abuse that causes continuing deleterious effects on the person's life. Dependence is characterized by the use of a substance such that it is necessary for daily functioning; the dependent individual experiences serious physiologic or psychologic symptoms of withdrawal without it.

Alcohol Abuse

Alcohol is a common cause of psychiatric emergencies. Symptoms of alcohol intoxication are the presence of the odor of alcohol, slurred speech, confusion, and staggering gait. Depending on the amount of alcohol ingested, patients may develop inattention and memory loss and can progress to a stuporous state or coma. These symptoms can vary from a minor inconvenience to a truly dangerous medical emergency. Aside from the medical conditions that require treatment, there are behavioral changes that may make intervention difficult and risky. Alcohol reduces inhibitory control, which may lead to silly or embarrassing behavior. Of more concern for the medical staff and others working with and around the intoxicated person is the disinhibition of aggressive control. Some intoxicated people become very aggressive and may physically assault those around them.

Managing angry and aggressive intoxicated patients is difficult. They are not generally good candidates for reasoning or calming conversations. In some cases, a friend or family member can calm the aggressive patient. In a medical setting, the professional staff should decide if there is a coexisting medical condition that requires immediate medical care. If so, the staff must control the patient's agitation in order to treat the condition. For example, it may not be possible to suture lacerations while the patient is thrashing around. If acute alcohol intoxication is determined to be present, administration of naltrexone or other antidotes may be useful [22; 23; 24; 25]. If an antidote is used, it is important to monitor the patient for signs of withdrawal or adverse cardiovascular effects.

The potential interaction between the quantity of alcohol consumed and psychotropic medications may preclude calming the person with a sedative, although it is often the first-line approach. In extreme situations, it may be necessary to use physical restraints to diagnose or treat medical problems. Intoxicated patients who are irrational and aggressive are a threat to others and should, therefore, be as isolated as possible.

In inpatient facilities, it may be necessary to have security personnel control the patient and call for law enforcement to manage the patient after discharge. Of course, if the person has become sober enough to remain calm and allow a friend or family member to take him or her home, it may not be necessary to involve law enforcement. In outpatient settings, it must be determined whether the person requires medical care for observable symptoms or injuries. If the answer is yes, the appropriate response is to call 911. If there is no obvious need for medical care, the management of the intoxicated and aggressive person should fall to law enforcement personnel who have both the training and expertise to cope with this type of situation. It is dangerous for the intoxicated patient and those working in an outpatient facility if appropriate emergency resources are not used.

Stimulants

Amphetamines and other stimulants present a dangerous situation due to the cognitive and motor changes associated with their use. These substances can be prescription medicines, such as methylphenidate (Ritalin), or illegal substances, including cocaine and methamphetamine. An illegal substance is believed to represent a greater risk to mental and general health because the actual content and ingredients of the substance are unknown. Patients intoxicated with these substances may experience euphoria, hypervigilance, hypersensitivity, paranoia, psychomotor retardation, agitation, anxiety, anger, and poor judgment. They may misconstrue events taking place around them and be sensitive to physiologic changes, which can cause significant fear and distress. Those abusing these substances may also experience perceptual disturbances. Withdrawal from stimulants can be quite dangerous, as the person may experience frightening dreams, hypersomnia or insomnia, psychomotor retardation, or agitation in the context of poor judgment and aggression before reaching a period of stability.

Hallucinogenic Drugs

Hallucinogenic drugs alter the user's perception of reality, mimicking psychosis. The resulting behavior may be dangerous to the user as well as those around the user. Examples of these substances are d-lysergic acid diethylamide (LSD), phencyclidine (PCP), peyote, and hallucinogenic mushrooms. Patients under the influence of hallucinogens often experience periods of anxiety, during which aggressive behavior toward others may be seen, or depression, during which suicide is a serious risk. Paranoia is present along with impaired judgment. Hallucinogenic drugs produce ideas of reference, often influenced by mood prior to ingestion of the substance, in which the user reads personal messages in common events. For example, a song on the radio may be perceived as a special message. Because this is perceived as real, individuals may react protectively or follow orders from an auditory hallucination.

Inhalants

Individuals abusing various substances via inhalation, including glue, gasoline, and medical gases, present difficult situations to manage. The behavior of the inhalant abuser is frequently characterized by belligerence, assault, apathy, cognitive impairment, mood disturbance, and poor judgment [26]. It is often difficult to distinguish acute inhalant intoxication from other causes; furthermore, the symptoms of chronic abuse (e.g., dizziness, headaches, irritability, fatigue, cough) are nonspecific, especially in adolescent patients [27; 28; 29]. Withdrawal symptoms are rare, but when they do occur, they are similar to those seen in cases of alcohol withdrawal [26]. Efforts to assist the patient to stand or walk may be difficult due to poor coordination, unsteady gait, and diplopia or other visual disturbances. Attempts to help are often rebuffed, and the patient may respond quite violently.

Opioids

As with other abused substances, opiate misuse results in changes in cognition, mood, and judgment. Moods may range from euphoria and agitation to dysphoria and apathy. Opiate abusers who are euphoric are fairly cooperative, although some may be agitated and unwilling to follow any suggestions or orders. During periods of intoxication, ability to make rational decisions and use good judgment is impaired. The withdrawal syndrome from opioid abuse varies from patient to patient. Usually, it involves unpleasant physiologic changes that are not generally life-threatening; however, there are two withdrawal symptoms that should be followed particularly closely: anxiety and depression. Because judgment is impaired, anxiety may lead to dangerous attempts to acquire more of the drug to alleviate the withdrawal. Criminal behavior, including prostitution, is frequently engaged in to acquire more drugs. When depression is present, the patient may become suicidal.

DELIRIUM, DEMENTIA, AND AMNESTIC DISORDERS

Dementia, delirium, and amnestic disorders are included under the broader category of cognitive disorders. These disorders are based on medical, neurologic, or biochemical factors, generally organic in nature, that adversely affect brain functioning. Delirium and dementia are the primary psychiatric emergencies in this category. Patients experiencing acute or active phases of delirium or dementia require immediate medical care. As such, patients with these disorders are often assessed in EDs. Behavioral manifestations include disorientation, hallucinations, illusions, delusions, and personality changes. A normally mild-mannered person may become quite aggressive and assaultive.

Delirium is first and foremost a medical emergency, as without immediate medical treatment the patient is susceptible to injury or harm. If the condition has a rapid onset, the etiology is usually physiologic in nature. The behavioral symptoms of delirium may interfere with needed medical care. Confused, agitated, and frightened patients should be calmed or restrained to allow appropriate treatment. Distinguishing between the behavioral manifestations of delirium and those caused by methamphetamine abuse requires appropriate laboratory testing and thorough interviewing of knowledgeable family members or friends. Unlike those with substance use disorders, patients with delirium may benefit from a small dose of an antipsychotic medication.

Patients with dementia share some characteristics with people with delirium, and both may be present in one patient. However, delirium, when present, should be resolved before a diagnosis of dementia can be made. Demented patients experience disorientation and confusion, but they may also display hallucinations, poor judgment, and poor impulse control. Impaired cognition may be focused or diffused, depending on the type of dementia. The sense of immediacy seen in patients with dementia is not as great in those with delirium. Nonetheless, the demented person presents a difficult management challenge as a result of the associated symptoms. The management goal for dementia patients is to prevent harm to the patient and those who are in the patient's proximity.

Patients suffering from delirium or dementia cannot participate in healthcare decisions while actively impaired by their illness. In an emergency, family and knowledgeable friends can be valuable sources of information about the patient's health. However, the Health Insurance Portability and Accountability Act (HIPAA) regulations may complicate acquiring helpful information, as discussion of the patient's condition with other individuals may be restricted or impossible.

No figures have been reported about the incidence or prevalence of amnestic disorder in part because it often accompanies a variety of conditions and disorders. Amnestic disorder may be characterized and diagnostically categorized by memory impairment resulting from: a general medical condition (e.g., stroke, head trauma, hypoglycemia); or the persisting effects of a toxin or substance (e.g., alcohol, sedative, hypnotic). When the etiology is unclear, a diagnosis of amnestic disorder not otherwise specified is used [9; 21; 30].

SCHIZOPHRENIA AND RELATED DISORDERS

Psychosis is a term commonly used to describe schizophrenia and the associated diagnoses. The *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (DSM-5) considers the group of schizophrenias to include the initial episode of schizophrenia, diagnosed as schizophreniform disorder, and schizoaffective disorder, which is a manifestation of schizophrenic and affective symptoms [26]. There are also subtypes of schizophrenia (e.g., paranoid, disorganized, catatonic, undifferentiated) according to the predominant symptoms. Additional psychotic disorders include delusional disorder, brief psychotic disorder, shared psychotic disorder (i.e., folie à deux), and psychotic disorder not otherwise specified.

The diagnoses related to schizophrenia share a common symptom: loss of self. These patients are alienated from others and have lost a sense of personal identity. In some cases, even their body parts may be seen as not belonging to them. Those diagnosed with schizophrenic disorders experience hallucinations and delusions. Thoughts and speech are impoverished, and they may be unable to carry on a meaningful conversation. Words may be fabricated, making language incomprehensible to others. Motor behavior may be agitated or withdrawn.

Some diagnosed with schizophrenia exhibit catatonia, in which they are unresponsive to external stimulation. There is also an agitated form of catatonia in which the patient may exhibit incredible strength compounded with the loss of contact with reality. People diagnosed with the catatonic subtype of schizophrenia share an overall negativism, which can certainly interfere with any professional help.

People diagnosed with the disorganized subtype of schizophrenia manifest inappropriate affect and disorganized speech and motor behavior. Affect is incongruent with the content of their speech. For example, a disorganized person may talk about a serious loss while giggling or laughing about it. Motor behavior may seem unrelated to goal-directed action. It is the confusion and lack of organized thinking, feeling, and behaving that makes the disorganized type of schizophrenia difficult to manage in an open ED, private practice setting, or clinic. These patients may not present direct danger or risk, but they may get hurt or harm others due to the lack of inhibitory control and overall disorganization in their behavior.

Perhaps the most well-known type of schizophrenia is the paranoid type. The essence of this subtype is the attribution of harm or threat from others. Patients with the paranoid subtype of schizophrenia are very sensitive to the actions of people around them. For example, a couple laughing nearby may be perceived as sharing a disparaging joke or conspiracy against the paranoid person. Because this is believed to be real, the laughing couple may be confronted or attacked by the paranoid person. Paranoid hallucinations and delusions complicate treatment. A healthcare provider approaching the paranoid person with a syringe may be seen as a real threat, if the medicine in the syringe is considered poison. The person trying to inject the medicine may be seen as an assassin. The paranoid person simply takes defense to an irrational and potentially dangerous level.

Delusional Disorders

Another dangerous psychotic disorder that is difficult to diagnose is delusional disorder, which is defined according to the subtypes erotomanic, grandiose, persecutory, jealous, and somatic. The DSM-5 categorizes delusional disorder as part of the schizophrenia spectrum [26]. Those with delusional disorders have a fixed belief that is usually based partially on reality. Of course, that reality is seriously distorted in patients with a delusional disorder. Outside the delusion, the patient may appear quite normal and maintain effective work and school activities as long as the activities do not involve the delusion. Erotomania, the distortion of a real or imagined love object, may also develop. There is no actual relationship between erotomanic persons and the object of their love and attention. Celebrities are not the only people affected by erotomania; a simple smile from a clerk can lead to erotomania. Usually, there is a power differential between the weaker (erotomanic) person and the stronger (love object) person. Patients with this type of delusional disorder are unlikely to present with a psychiatric emergency unless they are seen as a danger to others as a result of their delusions.

The persecutory, jealous, and somatic delusional disorder subtypes are more likely to be seen as psychiatric emergencies. Persecutory and jealous types focus on a particular person instead of the more generalized thoughts seen in schizophrenia. Unless one is the focus of persecutory delusions or the object of delusional jealousy, these patients may not appear to be dangerous. If a patient with one of these types of delusional disorders is brought to an ED, it is generally because he or she has either acted on a delusion or is perceived by a victim to be threatening. Unless the psychosis is obvious, law enforcement may handle the problem without involving medical professionals.

Patients diagnosed with the somatic type of delusional disorder are frequent visitors to the ED, physicians' offices, and clinics. The delusion is focused on physical symptoms and conditions, so these patients are more likely to seek treatment from healthcare professionals rather than a psychologist or mental health professional. While these patients can be quite frustrating to physicians, they are generally more of a distraction and disruption than a danger.

MOOD DISORDERS

Patients with mood disorders frequently present in the ED with severe depression and suicidal behavior or because of manic behavior. The depressive symptoms that require emergency treatment include unremitting crying, severe loss of appetite and weight, suicidal ideation, self-criticism, and overwhelming guilt. Many of these patients lose interest in and energy for activities they once enjoyed; it is common for them to show anger and irritation when family or friends are trying to cheer them up or persuade them to do something. Attention and concentration are impaired, memory is fogged, and simple activities may be dangerous due to poor attention and concentration.

Major Depressive Disorder

Major depressive disorder can manifest either as a single episode or a recurring condition. Severity can range from mild to severe, and other factors, including postpartum depression and psychosis, may be present. At least five of the symptoms of this disorder (e.g., depressed mood, loss of pleasure or interest in activities, significant change in weight, sleep disturbance, psychomotor symptoms, fatigue, feeling of worthlessness or inappropriate guilt, diminished ability to think or concentrate, suicidal ideation) must be present nearly every day for at least two weeks for the diagnosis to be made [26]. Psychiatric emergencies with major depressive disorder are the result of the unremitting nature of the symptoms and the intensity with which they are felt. If treatment has either not worked or has not been undertaken for sufficient time, patients with major depressive disorder may become despondent and suicidal, as continuing life is perceived as too painful. Some become extremely withdrawn and experience catatonia, becoming so unresponsive to events around them that they stop eating and begin suffering the physical changes of malnutrition. This is more likely to happen when the person lives alone and does not see others on a frequent basis. Worried family and friends can be the reason that this person is brought to the ED or other professional setting.

Some patients with major depressive disorder experience psychosis, which may take the form of auditory hallucinations. This often includes a voice or voices telling the person how despicable he or she is and how much guilt should be felt. However, the differential diagnosis should rule out schizophrenia [26]. In some cases, the voices tell the person to commit suicide because he or she does not deserve to live. If the person has a weapon, or if other means of suicide are present, the patient is experiencing a life-threatening emergency that should be dealt with by professionals.

Persistent Depressive Disorder

Persistent depressive disorder (dysthymia) differs from major depressive disorder by its duration. Individuals suffering from dysthymia have experienced it for at least two years but may not experience the symptoms every day [26]. Unlike patients with major depressive disorder, patients with persistent depressive disorder have periods of feeling better in the context of overall depressive symptoms, although they do experience depressed mood for more days than not. People with persistent depressive disorder experience different degrees of depression, including hopelessness. These periods of hopelessness may lead to suicidal ideation or attempts. After years of living with painful depression, some people decide that it is not worth living that way [31]. However, despite the relationship between milder persistent depressive disorder and hopelessness, dysthymia is less likely to lead to suicidal behavior than major depression or bipolar disorder.

Bipolar Disorder

Bipolar disorder accounts for approximately 18% of all psychiatric emergencies [32]. It typically appears in the late teens or early 20s and affects men and women equally [33]. The disorder is characterized by manic phases of extreme activity, poor judgment, and loss of contact with reality, and depressive phases, in which the patient becomes depressed, lethargic, and possibly suicidal. Bipolar disorder is categorized as bipolar I or bipolar II disorder.

People diagnosed with bipolar I disorder typically experience extreme mood swings. The transition from a normal mood to hypomania and mania may be slow or may cycle rapidly from one mood state to another. When the patient is manic, psychosis may be exhibited through grandiose ideas or behaviors, poor judgment, impulsivity, or paranoia. Efforts to calm manic patients may produce irritability, anger, and aggressiveness. Rational individuals are seen as negativistic obstacles to the manic person's grandiose goals. An investigation of impulsivity and its impact on suicidal ideation or attempts found that as the number of suicide attempts increased, so did the level of impulsivity [34]. Although a laboratory method of studying impulsivity was used in this investigation, the relationship between clinical bipolar I disorder and impulsivity was relatively clear. A study that included data gathered from 21 countries has confirmed this relationship [35]. In another study, violence toward others was reported to be more likely seen in patients with psychosis, while those with severe depression or anxiety tended to be suicidal [36]. Thus, patients with mania are more of a threat to others, while depressed people are a threat to themselves. Of course, both mania and depression require treatment.

Bipolar II disorder differs from bipolar I primarily by the degree of mania experienced. There must be at least one instance of a bipolar episode and no history of manic episode. Patients with bipolar II disorder typically experience a less intense version, hypomania, which is characterized by increased energy, elated mood, expansive plans, and an increase in enjoyable behavior with some negative consequences. Sleep patterns change, and the patient requires much less sleep than is normal. Speech is often pressured, and there is more intensity toward goal-directed activities. During hypomania, the person's energy leads to more productivity. Hypomania coexists with recurring major depressive behavior in patients with bipolar II disorder. As with bipolar I disorder, the level of intensity can vary from mild to severe, with some individuals experiencing psychotic episodes. Mood swings may occur in rapid cycles in some and in slower cycles in others.

The issue that is most important when these disorders become psychiatric emergencies is the presence of behaviors associated with psychomotor agitation and retardation. When mood is elevated, the patient will show poor judgment, and behavior can be both self-defeating (e.g., sexual promiscuity) and potentially fatal (e.g., excessive use of a mixture of drugs and alcohol). If psychosis is present, the patient will display the effects of a loss of contact with reality. For example, a rational discussion to dissuade a manic person from pursuing a grandiose idea or spending large amounts of money may be perceived as an enemy getting in the way of a great idea. On the other hand, the depressive phase of the mood swings can lead to helpless and hopeless thinking. If one believes that he or she cannot do anything right and there is no hope that things will change for the better, suicidal ideation is likely to occur. This possibility changes into a probability if the person experiences psychosis, including any commanding hallucinations associated with guilt and worthlessness.

It is important to protect patients with mood disorders from self-destructive behavior. It is also important to protect others from patients' acting-out behavior.

ANXIETY DISORDERS

Patients with anxiety disorders generally experience symptoms that do not result in a psychiatric emergency, although there are times when emergencies occur. Anxiety disorders range from mild to pervasive and may have specific forms. There are also types of anxiety that can be caused by life events and may unpredictably recur. Generalized anxiety disorder (GAD) is experienced as anxiety throughout many of life's events and places. Patients with GAD often focus on real or perceived threats and dangers present in their lives. They may feel threatened around strangers or in situations in which their performance may be evaluated, often experiencing uncomfortable physical changes that may result in contact with emergency medical personnel. Heart rate, blood pressure, and startle reflexes may increase, and concentration is impaired. These patients worry excessively about things that they cannot control; the worry is disabling. The anxiety is present in addition to other symptoms, including sleep disturbances, inability to concentrate, irritability, and being on edge. People with GAD may be called "uptight" by friends and family. It is important to realize that a psychiatric emergency may develop when anxiety coexists with another serious stressor [37].

Phobias

Phobias are irrational fears regarding an object or situation. While they can be quite inconvenient, they are not usually disabling to the point of becoming emergencies. For example, a fear of snakes may keep someone from hiking or farming, but it has little effect on someone who is working or shopping in a city. More difficult in both urban and rural areas is social phobia. Social phobia is experienced when an individual is afraid of public performance or criticism from others. Unfamiliar people cause much anxiety for those with social phobia; criticism from those they know also increases the anxiety. Some with social phobia are vulnerable to panic attacks, which can lead to avoiding important and necessary activities. Those who do not avoid these situations may endure them, but with extreme anxiety.

Panic Attacks

Panic attacks often occur without any discernible trigger. They initiate with little warning and are characterized by intense feelings of anxiety, including rapid heart rate, chest pain or tightness, difficulty breathing, sudden increases and decreases of blood pressure, and intense fear. Patients experiencing a panic attack may believe that they are having a stroke, a heart attack, or "going crazy," and in many cases they do seek medical care. If the medical examination for a cardiac event is negative, these patients may be reassured and discharged to home. Usually, this is not acceptable for the patient because the symptoms are so intense. As a result, patients may experience anticipatory anxiety, as they worry about having another episode. This, of course, makes them more likely to have additional panic attacks.

An investigation into personality disorders, panic disorder, and suicide led to the discovery that persons with panic disorder and coexisting personality disorders have more severe degrees of impulsivity, depression, and hopelessness [38]. The participants with panic disorder were more likely to report suicide attempts and attempted suicide at a younger age than those without panic disorder.

Post-Traumatic Stress Disorder

Patients with post-traumatic stress disorder (PTSD) are frequently treated in EDs, whether the cause of the trauma was an individual event or a mass disaster. Although many people may have experienced the same traumatic event, not all are adversely affected in the long term. The causal event for those who develop PTSD may involve physical damage to the body or psychologic damage caused by observing or experiencing the trauma without being physically hurt. The consequences of the trauma may be experienced immediately (acute) or may occur much later (delayed). PTSD can be a chronic condition if the individual does not receive the necessary treatment.

The influence of PTSD on suicide ideation and suicide attempts was investigated using the National Comorbidity Survey [39]. The results indicated that people with PTSD were significantly more likely than those without PTSD to seriously think about or attempt suicide. Thus, if treatment solely focuses on the observable injuries, the life-threatening psychiatric factors may be left untreated. It becomes important for professionals to examine PTSD patients for suicidal ideation during the initial treatment and in the discharge planning, including follow-up treatment by a mental health professional.

PTSD and Veterans

PTSD secondary to deployment to a military conflict or war is another consideration when assessing patients, particularly due to the military operations in Afghanistan and Iraq. Individuals who have served in a war may develop PTSD due to several unique factors, including exposure to severe combat; having personally killed enemy combatants and, possibly, innocent bystanders; exposure to unpredictable, life-threatening attacks; postcombat exposure to the consequences of combat; exposure to the sights, sounds, and smells of dying men and women; and observation of refugees, devastated communities, and homes destroyed by combat [40]. Certain factors have been identified in veterans of the current conflicts that indicate a greater risk for development of PTSD, including [40; 41; 42]:

- Stigma
- Deployment with a National Guard or military reserve unit
- Military sexual trauma
- Survival after serious injury

Due to the perceived stigma against psychiatric disorders and PTSD, these patients may not seek treatment; this stigma appears to increase among symptomatic patients [43]. Furthermore, documentation of a psychiatric disorder can have an adverse effect on military advancement. As a result, veterans with mental health conditions may be seen more often in the ED or civilian healthcare settings [40].

Anxiety and Suicide

A study examining suicidal ideation and attempts among women with human immunodeficiency virus (HIV) and histories of intimate partner violence indicated that those with coexisting depression were 12 times more likely to have suicidal ideation or attempts. If anxiety coexisted with HIV or violence, suicide ideation or attempts were five times more likely than those without anxiety [44]. This clearly indicates an important area for assessment, as the presenting complaint in the ED or medical center may be HIV or partner violence.

Researchers have found that anxiety is one of the intense affective states associated with suicide ideation and that social phobia, specifically, is associated with suicide attempts [45]. Anxiety disorders have the highest prevalence of all psychiatric disorders. Although suicidal behavior is less likely to occur in patients with anxiety disorders than in patients with other psychiatric disorders, patients with anxiety disorders can be at risk for suicidal behavior, especially when comorbid conditions are present. Professionals providing treatment to anxious patients should assess the degree of suicidality present.

PERSONALITY DISORDERS

Personality disorders are divided into three major clusters based on similarities in associated symptomatology. Cluster A encompasses individuals who are suspicious and possibly experiencing transient psychotic episodes, including those with paranoid, schizoid, or schizotypal types. Cluster B personality disorders are more dramatic and include borderline, histrionic, antisocial, and narcissistic types. Finally, cluster C disorders are typified by avoidant, obsessive-compulsive, and dependent personalities. Cluster C personality disorders are also characterized by anxiety.

Cluster A Personality Disorders

Patients diagnosed with cluster A personality disorders are unlikely to present psychiatric emergencies. However, paranoid personality disorders are mainly associated with unreasonable suspiciousness toward other people, and patients with this type of disorder may counterattack or defend themselves against people whom they perceive as threatening. They are less likely to act out in a violent and dangerous manner than patients with schizophrenia or paranoid delusional disorders, as the suspiciousness does not reach a high level. A person with schizoid personality disorder neither wants nor needs contact with other people. Their isolation is one of choice rather than anxiety or fearfulness. Those diagnosed with schizotypal disorder may have periods of transient psychotic episodes that are seen as magical thinking or a belief that they can see or predict the future.

Cluster B Personality Disorders

Emergencies are more likely to develop from cluster B patients rather than cluster A due to the presence of dramatic and exaggerated behavior. Antisocial personality disorder patients are potentially dangerous because of the ease with which they are frustrated and their likelihood to respond in aggressive and assaultive ways. These patients do not have any regard for other people or their rights. Alcohol and drug abuse are often components of their behavior, which exacerbates the potential of acting out dangerously. Professionals providing treatment for antisocial patients should be aware of the dangers of aggressive behavior, as that is the likely emergency.

Patients with borderline personality disorder are likely to experience suicidal ideation and behavior. These individuals have extreme mood swings and conflictual relationships with others. They are dramatic in their behavior and may attempt suicide in order to seek attention. They may become physically aggressive, but it is more likely that they will be combative due to impulsivity and irritability. Suicide and other self-destructive behaviors among those with borderline personality disorder are prominent reasons for receiving medical treatment and are clear psychiatric emergencies. These patients may utilize the ED on a regular basis.

Histrionic personality disorder is also characterized by dramatic behavior, usually as a means to seek attention at any cost. Individuals with this disorder place great importance on physical appearance and use sexually provocative behavior to get attention. They are unlikely to present with physically aggressive or disfiguring suicidal behavior. However, other suicidal gestures, such as an overdose of medication, may be engaged in and should be taken seriously.

Finally, narcissism is the last of the cluster B personality disorders. These patients have an exaggerated sense of importance and entitlement, and because they see themselves as special and important, they are unlikely to manifest suicidal ideation or attempts. However, if combined with antisocial characteristics, they can be a threat to others. For example, if the narcissistic patient expects to be treated by staff with a certain level of respect and then decides that this expectation is not being met, he or she can become quite dangerous, as their thinking precludes empathy or appropriate interactions. Of course, the addition of substance abuse exacerbates the dangerousness associated with these patients.

Cluster C Personality Disorders

Cluster C personality disorders, which include dependent, obsessive-compulsive, and avoidant individuals, share anxiety as a symptom. Among patients with these disorders, the risk for suicide or harmful behavior usually emerges at the end of a chronic and painful mental illness. Dependent individuals seek the acceptance and approval of others; they will go to great lengths to avoid contradicting someone if they think it would make them angry or unhappy. When an emergency develops, it is because the cluster C personality is finally tired of being dependent on others. It is this sense of hopelessness that may ultimately lead to suicidal behavior.

An obsessive-compulsive person is overly meticulous and strives for perfection; failure to reach perfection leads to disappointment and frustration. These patients are rigid and dogmatic; flexibility is not part of their lives. Falling short of their personal expectations leads to anxiety. Before they reach a point of desperation, obsessive-compulsive individuals become unpleasant and make unreasonable demands of those around them. As relationships unravel and perfection is frustrated, loneliness and hopelessness sets in. Some patients will reach a point at which they believe that life is no longer worth living.

Avoidant personality disorder involves the inability to have close personal relationships with other people. Unlike schizoid personality disorder, the avoidance associated with this disorder is due to anxiety and fear of embarrassment or being hurt by an intimate personal relationship. Yet, avoidant persons desperately want friendships and the ability to comfortably interact with others. The risk for these patients comes from the chronic anxiety that they experience in anticipation of interaction or from real or imagined insults they receive from people around them. Because they have limited coping skills, they may feel hopeless when they experience failure around others. Eventually, these individuals may progress to suicidal ideation or attempts because their life is so unhappy.

Personality disorders are not usually the primary reason for seeking emergency treatment. They are, however, an underlying factor behind seeking help in some cases. For example, an overdose may be the reason for going to the ED and the primary focus of treatment; but, borderline personality disorder may be the psychologic cause of the overdose. The presence of personality disorders reportedly increases the clinical severity of patients with panic disorder and suicidal behavior [38]. Of all of the personality disorders, paranoid and borderline types are associated with the greatest risk for suicidal behavior. Although treatment of personality disorders is not necessary during emergency or crisis intervention, the diagnosis will help guide treatment and discharge planning. Consequently, the focus in the ED and crisis intervention should include an assessment of imminent danger, whether directed toward self or others. Treating the personality disorder will require long-term therapy by a nonemergency mental health professional.

ADJUSTMENT DISORDERS

Adjustment disorders occur after the experience of a distressing event. These events are often nontraumatic, such as losing a job or being diagnosed with a serious illness, and considered to be common experiences for most people. Symptoms of adjustment disorders begin within three months of the event and end within six months after the stressor has been resolved [26]. Most individuals learn to cope with the event and adjust to a new life. Those who are unable to adjust to the changes are diagnosed with another disorder.

It is easy to assume that adjustment disorders are either minor or easily resolved. Unfortunately, that is not always the case. There are individuals who cannot make the necessary adjustment and suffer severe disruptions in their lives. It is this group that may present with a psychiatric emergency.

Adjustment disorder is an umbrella diagnosis for several subtypes: depressed mood, anxiety, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance of emotions and conduct, and unspecified type [26]. The symptoms associated with this diagnosis are usually mild. Nonetheless, they may become severe and debilitating for some patients.

Treatment of an adjustment disorder emergency requires recognizing the stressful event that caused the symptoms and determining if the patient is dangerous as a result of the condition. If imminent danger is present, immediate action is necessary in order to protect the patient and/or others. It is not the responsibility of the emergency staff to provide counseling or reassurance for an individual suffering from a major loss. However, it is important to recognize the loss and its relationship to the patient's behavior. The causal event provides some direction for assessing danger when it is present.

Individuals experiencing job or financial loss, divorce, or the death of a loved one may be driven to suicide, homicide, or both. If there is reasonable belief that the event could have been caused or exacerbated by another person, it is important to ascertain whether the patient harbors any assaultive or homicidal ideation. In situations where blame is placed on others, patients with adjustment disorders often exhibit strong personalization of the event.

Internalized blame can also lead to suicidal behavior. In these cases, there may be little or no blame directed toward others, and if the person's depression is severe enough, suicide may be perceived as the best option. Professionals involved in the treatment of these patients should not try to treat the self-blame but should intercede to stop self-destructive behavior. A discharge plan should also be developed that includes referring the individual to an appropriate, long-term treatment resource.

PSYCHIATRIC ILLNESSES IN CHILDREN AND ADOLESCENTS

Child and adolescent psychiatric illnesses parallel those found in adults. However, there are certain changes in the symptoms that reflect the developmental stages of youth, including the continuing development of personality through late adolescence. Some psychiatric disorders, in conjunction with the developmental phase, can present a unique challenge in children and adolescents. This section of the course addresses the effects of psychiatric illnesses in children and adolescents that present a significant risk of danger. It should be noted that managing an aggressive child or adolescent criminal is often the responsibility of law enforcement, not that of the physicians, nurses, psychologists, social workers, or others working in healthcare facilities.

The issue of the management of children and adolescent psychiatric patients presenting in the ED or other healthcare setting is at least as significant as for adults. The prevalence of pediatric patient ED visits for psychologic emergencies continues to increase (from 4.4% in 2001 to 7.2% in 2011) and has become a worrying contribution to ED use [46]. This group of patients (and psychiatric patients in general) has been identified as being among those that need emergency department services the most [67].

It has been suggested that improper diagnosis and treatment for mental health issues in the pediatric population, in which approximately 20% suffer from a major psychiatric illness with at least some impairment, has precipitated the increase in emergency services utilization [47; 48; 49]. This is particularly true in patients with public insurance, who typically have limited access to mental health services and fewer treatment options [50]. Additionally, there has been a reduction in the number of inpatient beds available at state mental hospitals, where less than half are allocated

for acute care, while at the same time funding for outpatient mental health services has not increased to offset the losses [67]. Of pediatric ED visits for psychiatric illnesses, approximately 70% are made by adolescents, and more than 66% of these are classified as urgent [50]. For children and adolescents, the first symptoms of psychiatric illness may result in presentation to the ED, making accurate assessment and referral vital.

As with adult patients, the primary factor in assessing a pediatric patient for psychiatric emergency is determination of imminent danger. A classification system has been developed to measure risk for harm or other adverse events among pediatric patients [51]. According to this system, patients who exhibit suicidal or homicidal behaviors (actions that are potentially life-threatening) are considered class I. Class II designates patients who are in a "heightened state of disturbance" and require immediate assistance (e.g., rape victims) [51]. Serious but not life-threatening conditions, such as verbal threats of violence, are categorized as class III. Patients with class III conditions should be treated as soon as possible, but not necessarily immediately. Class IV refers to conditions or situations that require attention, but are not considered psychiatric emergencies, including misuse of emergency services or lack of a mental health provider. Classification based on this metric allows healthcare professionals to quickly assess the patient and determine the level of intervention that is warranted. Triage tools (e.g., the Mental Health Triage Scale) that may be incorporated into practice also have been developed based on this system [48]. All classifications require action, whether it is immediate psychiatric intervention or referral to the appropriate resource. This tool may also be helpful for social work, general health, and allied professionals who are attempting to determine if emergent treatment is indicated.

SUICIDE

Suicide is the second leading cause of death in the United States among persons 10 to 19 years of age [81]. In the 12 months prior to the 2015 Youth Behavior Risk Survey, 17.7% of high school students seriously considered suicide and 8.6% attempted suicide [54]. Suicidal ideation and attempt among high school students is much higher in girls (23.4% and 11.6%, respectively) than in boys (12.2% and 5.5%, respectively). Overall, planning and attempting suicide peaks during the 9th grade; 22.5% of female freshmen have made a suicide plan and 26.5% have seriously considered attempting suicide. Suicide ideation and attempt among girls increased significantly between 2009 and 2015 after many years of steady decline [54]. Psychosocial factors that have been identified as heightening the risk for suicidal behavior in children and adolescents include [55]:

- Social isolation
- Abuse and neglect
- Poor school performance
- Parental psychopathology
- Family history of completed suicide
- History of nonadherence with psychiatric treatment

It is common for suicidal youth to engage in risky behavior and ingest various substances for recreational use, self-medication, or as the primary vehicle for suicide. Young people who experience suicidal ideation, engage in risky behavior, or attempt suicide often feel lonely, neglected, and hopeless [80]. Those with severe symptoms of depression are more likely to engage in acts of nonsuicidal self-injury (e.g., burning, cutting) and suicidal ideation. Life becomes a struggle for many youths with depression, and insults may be exaggerated, which further leads to a sense of hopelessness. It is not uncommon for people, young or old, to compare themselves to others. As hard as the comparisons are for adults, they are even more difficult for children and, especially, adolescents.

Humiliating rejection can lead some to internalize or externalize intense feelings.

Children and adolescents also try to "save face" by not expressing how hurt or distressed they are by treatment from adults or peers. It may be important for the professional staff to carefully coach these patients to reveal some of their feelings, especially about other people. The presence of dramatic or intense emotional changes should cue professionals to further assess for the presence of causal factors. Internal factors may indicate a risk for suicidal behavior, while external factors may lead to aggressive acting out. A combination of both may result in an initial period of acting out followed by suicidal behavior. It is the responsibility of healthcare providers in contact with these children and adolescents to protect them and others from the poorly controlled anger or aggressiveness that they may exhibit.

There is some evidence that cues of suicidality vary among male and female children and adolescents. One study has indicated that male children and adolescents experience suicidal behavior in combination with depression and hopelessness, while females feel suicidal only in the presence of hopelessness [52]. Both males and females felt anxious, depressed, and suicidal in the absence of family support. Not surprising, these factors can lead to a sense of loneliness and worthlessness. If an individual believes that no one cares, development of hopelessness and suicidal ideation becomes easy. Engaging in many different types of (but not more frequent) nonsuicidal self-injury is strongly associated with suicide attempt, as are polysubstance abuse and aggression [80].

A 2013 study noted that although 0.6% of ED visits (in patients of all ages) are due to overt suicidal behavior, suicidal ideation is found in 3% to 11.6% of patients [69]. The Suicide Prevention Resource Center, the American Association of Suicidology, and the U.S. Substance Abuse and Mental Health Services Administration recommend that EDs use a screening method (including a screening instrument) appropriate for their particular setting and that suicide screening should become standardized in the same manner as screening for child abuse, intimate partner violence, and fall risk [70; 71]. They also recommend reviewing The Joint Commission's *National Patient Safety Goals*. After reviewing several instruments, the Mental Health Triage Scale, the Behavioral Health Screening—Emergency Department, the Manchester Self-Harm Rule, the ReACT Self-Harm Rule, and the P4 tool have been recommended by the Emergency Nurses Association for use in the ED to assess patients' potential for self-harm/suicide [68].

SUBSTANCE USE DISORDERS

Patients who misuse substances constitute a considerable number of the potentially dangerous encounters in the healthcare system. Drug use by adolescents, particularly polysubstance use, is directly related to suicidal behavior [80]. It is also a factor in the development of anxiety, depression, and hopelessness, which influence suicidal ideation or attempts [52]. Young people using or abusing substances experience an impairment of inhibitory control that may already be weak, which leads to poor judgment and bad decisions and contributes to aggressive, physically harmful, or suicidal behaviors. Substance abuse in children or adolescents is part of an overall risk-taking pattern that can be perpetuated or exacerbated as a result of continued use [80]. While intoxicated, there is a danger of acting out in ways that may harm others as well as themselves. The danger, however, is less clear when the child or adolescent is not actually intoxicated, although there is a persistence of negative feelings and thoughts that cause the repeated desire to become intoxicated [80].

Researchers investigated adolescents assigned to suicidal-only, suicidal-violent, and violent-only experimental groups, and a control group [53]. All of the teenagers in the experimental groups showed more internalized problems, risk-taking, and aggressiveness than the control group. Risk-taking behavior in this study included substance abuse. Those in the suicidal-only group showed high levels of depression, anxiety, and covert aggression. Suicidal-violent teenagers had the highest levels of depression, somatization, covert and overt aggression, and risk-taking behavior. Adolescents in the violent-only group had high levels of overt aggression, risk-taking behavior, failure to recognize or perceive risk, and use of marijuana. All of the participants in the experimental groups showed some risk of becoming a danger. Those showing overt aggression and disregard of the rights or lives of others were usually more easily managed as they clearly represented a risk to others. Less clear were the teenagers in the suicidal-only or suicidal-violent groups, as their danger was more likely concealed by withdrawal from others or complaints of physical problems. When the inhibitory controls fail, these adolescents may attempt suicide or harm someone else.

Substance abuse in children and adolescents can affect behavior as it does in adults. Depending on the substance used, behavior may include hallucinations, violence, agitation, or confusion. Substances, whether prescribed or illegal, present their own degrees of dangerousness from overdose, due to the toxicity inherent in the chemicals used. Medical treatment for the physical problems caused by substance abuse should be conducted in the context of someone who may be agitated, psychotic, or aggressive. Thus, the patient's psychiatric condition should be managed at the same time that health problems are addressed.

ACTING OUT OR IMPULSIVE BEHAVIOR

Acting out and impulsive behavior are the terms used to describe a variety of actions based on poor judgment and poor impulse control. Examples of these behaviors include shoplifting, driving too fast, and promiscuous sex. While these actions may have negative consequences for children and adolescents, they are not psychiatric emergencies. Joining a gang, vandalizing public and private property, robbing or assaulting people, and homicide can all be considered impulsive behavior or examples of acting out. Psychiatric emergencies are behaviors that are based on poor judgment or poor impulse control due to psychologic disturbances or abuse of mind-altering substances; they usually are not the result of logical and planned activity.

As noted, violent behavior occurs when strong emotions of anger and aggressiveness are displaced onto other people. Displacement serves to punish an individual or group considered responsible for losses or mistreatment. Hallucinations and delusions may influence the direction and focus of the aggression. At other times, persons are targeted because of low inhibitory control; this is based on the assumption that the patient would not be aggressive if he or she were in a normal state of mind. Thus, treating children and adolescents in these circumstances involves managing both immediate risks and delayed ones.

Thought disorders and psychosis are clear psychiatric emergencies for both adults and youths, impairing their ability to interact appropriately with the world. Those experiencing a psychotic episode represent a risk for both the people treating them and others. The challenge for healthcare professionals is identifying the danger during the treatment process and preventing or minimizing the harm to others. Equally important, but sometimes more difficult, is identifying the danger to others in general. If a psychotic person identifies a potential victim, then medical, psychologic, and mental health personnel have an obligation to protect or

warn the intended victim. Professional opinion is formed depending on the type and amount of information provided by the patient and allows a determination about how much truth to place on the statements. Children and adolescents make many statements about hating or killing someone else without ever meaning what they say. If healthcare professionals took every such statement at face value, an exorbitant amount of time would be spent with people who are not dangerous. Thus, there should be enough information to lend credibility to a threatening statement.

Children and adolescents who are depressed and anxious are usually considered threats for self-destruction rather than aggressive acting out. However, peers who humiliate and reject the child may become foci of retribution. Parents who are abusive or strict may be attacked in response to real or perceived mistreatment. These are the dangerous situations that the professional staff should ascertain during the assessment of depressed or anxious youth. Overlooking the potential for serious harm can lead to disastrous consequences.

Oppositional defiant disorder (ODD) and conduct disorder represent two diagnoses for children and adolescents that address acting out and impulsiveness. ODD is characterized by talking back, refusing to follow instructions, deliberately irritating others, and becoming more negativistic and hostile. While ODD youths are hard to tolerate, they do not usually cause harm to others. Youths diagnosed with conduct disorder present a much greater risk than ODD youths. Those who are diagnosed with conduct disorder are willing to use weapons to coerce or attack other people. Stealing is usually part of their behavior and, given the choice, they confront victims rather than stealing without confrontation. These children and adolescents display similar behavioral traits to antisocial personality disordered adults. When brought into a hospital setting or ED, they may steal medications or equipment if the opportunity is present. These patients may use violence to intimidate or coerce hospital employees. As with the antisocial personality disordered adult, this behavior may be difficult to distinguish from criminal behavior.

ENVIRONMENTAL BIOLOGY

Psychiatric illnesses can be considered organic or functional depending on etiology. Those caused by organic dysfunction have a physiologic basis, such as the irreversible changes in brain functioning that are associated with dementia. Those who are acutely intoxicated experience a change in brain functioning because of alcohol ingestion. Behavior that is based on organic changes can be either permanent or temporary, depending on the causal factor.

Psychiatric illnesses based on functional factors are either caused by experiences or learned. For example, individuals who have not had a history of an anxiety disorder may develop one after a traumatic event. The assumption is that the anxiety was developed after the trauma and would not have occurred otherwise.

Management and treatment approaches vary based on the etiology of the illnesses. This is particularly true if the organic changes are the result of a medical condition.

Research has shown a strong biologic component in disorders that were previously thought to be based on psychosocial factors [21]. Schizophrenia and bipolar disorder are two examples of mental illnesses that were once considered functional disorders but have since been recognized as organic in basis [56]. Researchers have suggested that the relationship between psychosocial and biologic factors be considered through the concept of "environmental biology" [21]. There are three subtypes involved in this system: biologic trauma from the environment; psychosocial trauma inducing biologic changes; and genotypes and phenotypes.

Biologic trauma from the environment involves the effects of environmental changes in the development of biologic factors. An example of this is fetal alcohol syndrome, whereby the presence of alcohol in the prenatal environment influences fetal brain development. While this example focuses on child development, the principle applies to adults as well, as when biologic changes occur after psychosocial traumas. Extended periods of psychologic strain can lead to changes in brain physiology, and continued periods of uncontrollable environmental stress may change brain functioning, leading to chronic depression or anxiety. Enduring psychosocial trauma leads to biologic changes unless the individual has made an effective adaptation to the cause of the strain.

It is hoped that the success of the Human Genome Project (HGP) will lead to better information and research about the effect of genetic makeup on mental illness. Even without the HGP, there is evidence to support a genetic component to some disorders. Whether the disorder will be manifested (phenotype) depends on environmental and psychologic factors. Genetic makeup may predispose some individuals to anxiety or mood disorders, while others can handle adversity with little or no sequelae. Severe environmental or psychologic factors can influence basic genetic predisposition.

Regardless of the type of facility (e.g., ED, private practice office), professionals should determine the cause of a psychiatric condition in order to provide the most appropriate plan for treatment and discharge. It is certainly correct to focus on the more specific and accurate diagnostic terms when approaching psychiatric illnesses and emergencies. However, that degree of precision may not be practically achieved when the goal is to provide immediate care, stabilize the patient's psychiatric condition, and refer to appropriate follow-up care. If follow-up care becomes more of a long-term process, the healthcare provider can develop as much precision as necessary to effectively treat the patient. An emergency setting does not usually require that degree of precision; instead, defining the psychologic trauma as either organic or functional may be helpful when referring a patient after stabilization.

MANAGEMENT OF PSYCHIATRIC EMERGENCIES

Management of psychiatric emergencies in the ED is largely in the form of pharmacotherapy, due to the risks for violence and self-harm. Long-term treatment and follow-up will be required for many patients, and appropriate referral to outpatient facilities is often necessary. However, the management approach varies widely among the different types of mental illness that present in an emergency setting. The ACEP has encouraged clinicians to make every effort to establish whether the potential for violence can be managed at a verbal or behavioral level prior to turning to pharmacotherapy, with its risk of undesirable side effects [5; 79].

AGITATION

In many cases, agitation is the most treatable manifestation of a psychiatric emergency. Furthermore, treatment of agitation and/or aggression can facilitate the opportunity for a more thorough analysis and diagnosis. Agitated patients should be thoroughly examined for both physical and psychologic causes for the agitation. Organic conditions that may cause agitation range from infections, such as HIV or urinary tract infections in the elderly, to substance abuse [57; 58]. Many of these patients will require pharmacologic intervention to calm them quickly and effectively. The recommendation is to start with a low dose of the medication and slowly increase the amount if the required benefit is not achieved.

When managing the risk of violence and aggression, the National Institute for Health and Care Excellence recommends using a multidisciplinary team that includes a psychiatrist and a specialist pharmacist to develop and document an individualized pharmacologic strategy for using routine and, when needed, medication to calm, relax, tranquillize, or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

(https://guideline.gov/summaries/summary/49322. Last accessed February 13, 2017.)

Level of Evidence: Expert Opinion/Consensus Statement

For the acutely agitated, undifferentiated patient in the ED, benzodiazepines (e.g., lorazepam or midazolam) or first-generation antipsychotics (e.g., haloperidol) have been suggested as effective therapy for initial drug treatment; ketamine may also be considered [5; 79]. Recommended initial therapy consists of combination haloperidol and lorazepam [78]. The addition of benztropine or diphenhydramine may reduce the risk of extrapyramidal symptoms. Second-generation antipsychotics, such as ziprasidone and olanzapine, may also be used for initial drug treatment and have fewer short term side effects than haloperidol [59]. Agitated but cooperative patients may be treated with a combination of lorazepam and risperidone [79]. For the patient with known psychiatric illness for which antipsychotics are indicated, the ACEP has recommended treatment with an antipsychotic (typical or atypical) as effective monotherapy both for management of agitation and initial drug therapy.

In addition or as an alternative to pharmacologic intervention, agitated patients require a safe and quiet room to limit stressors; this is especially true of intoxicated patients, in whom medication (e.g., benzodiazepines) may enhance respiratory depression, or when agitation is secondary to alcohol intoxication [72]. Family members or friends who do not cause upset should join the patient in a calm room to reassure safety and provide support. If family or friends are not a viable option, it is necessary to have a nonthreatening staff person sit quietly with the patient to ensure that he or she does not become frightened or agitated again. Conversations should be respectful and supportive, as condescending or controlling statements may stimulate agitation or combativeness. Members of law enforcement or a facility security department may also be required to protect the patient and others from the agitated and potentially aggressive behavior.

SUICIDE

Patients who present in the ED as a result of injuries that may have been self-inflicted should be thoroughly evaluated. A psychosocial assessment of suicidal patients should not be delayed until after medical treatment is complete, unless life-saving medical treatment is needed or the patient is unconscious or otherwise incapable of being assessed [60]. If treatment is delayed, the patient should be offered an environment that is safe, supportive, and quiet. These patients should be constantly supervised. The initial assessment should determine if the patient has any underlying medical or psychiatric conditions that should be addressed. Patients experiencing distress due to anxiety or depression may benefit from administration of alprazolam [61].

Although patients with suicidal ideation, gestures, or attempts benefit from treatment with a combination of pharmacologic and psychosocial interventions, acute treatment in the ED is generally limited to symptom alleviation and prevention of further injury. The APA has recommended that patients experiencing acute depressive episodes receive antidepressant therapy unless somatic therapy is planned [62]. It is advised that clinicians select an antidepressant with a low risk of overdose, such as a selective serotonin reuptake inhibitor (SSRI) or other newer antidepressant, and prescribe conservative doses. According to the APA, benzodiazepines may be the best choice for the treatment of agitation, panic attacks, or psychic anxiety [62]. Other possible pharmacologic options include some second-generation antipsychotics and some anticonvulsants, such as gabapentin or valproic acid. The FDA warns that valproic acid/valproate/divalproex should not be given during pregnancy, due to decreased IQ in children whose mothers took these anticonvulsants while pregnant [73]. For psychotic patients, particularly those with schizophrenia, treatment with clozapine may be effective [62].

Patients who have been diagnosed as suicidal should be provided with both verbal and written explanations of their care plan, including medications and instructions for follow-up care. If possible, this information should be provided in their native language to ensure comprehension and adherence. Possible delays in the actions of antidepressant medications should also be discussed [62].

DELIRIUM AND DEMENTIA

Delirium and dementia are considered organic conditions, meaning that these conditions generally stem from biologic and/or physiologic causes. Patients with either disorder will require follow-up care. Because these patients can become agitated and combative, it is important to administer a fast-acting sedative. Perphenazine and haloperidol may be used to treat agitated individuals, including children and the elderly [61]. Examples of medications used in the treatment of patients with dementia are donepezil and rivastigmine [61].

The American Psychiatric Association recommends that nonemergency antipsychotic medication should only be used for the treatment of agitation or psychosis in patients with dementia when symptoms are severe, are dangerous, and/or cause significant distress to the patient.

(https://guideline.gov/summaries/summary/50334. Last accessed February 13, 2017.)

Level of Evidence: 1B (Recommendation based on moderate confidence that the evidence reflects the true effect)

It is important not to assume that a patient's confusion is due to long-term dementia or other mental handicap [74]. The most common causes of delirium are infections, medications, or drug withdrawal. A well-documented cause of delirium/dementia symptoms in the elderly patient is urinary tract infection, especially in women, and these infections are often "silent" in older individuals (i.e., no discomfort or other symptoms). It is important to ascertain if the patient has a history of dementia symptoms or if the confusion and/or unusual behaviors are acute. The family/caregivers can provide a patient history.

The ED is an especially important resource for immediate treatment of the delirious patient, and roughly 15% to 20% of patients presenting in the ED will be delirious [74]. An outpatient clinic may or may not have the resources and professional staff to appropriately treat this medical emergency. Inpatient settings should have the necessary resources for treating patients experiencing delirium and should be the treatment location of choice. Delirium, if appropriately treated, should be expected to resolve completely; dementia may be managed pharmacologically, but the patient will not regain full cognitive functioning.

After the delirious or demented patient is stabilized, a referral for continued short-term treatment or long-term therapy should be made. A delirious patient who returns to a normal mental state should be referred to a physician who can further investigate the cause of the delirium and continue treating it. Depending on the expected reason for the dementia, the demented patient should be referred to the appropriate specialist.

FUNCTIONAL DISORDERS

Patients with functional disorders, for which no physiologic or anatomic cause can be identified, may be seen in EDs, outpatient facilities, and inpatient facilities. Initial treatment of a patient who is experiencing agitation, disorientation, confusion, severe withdrawal, suicidal or homicidal behavior, or other potentially life-threatening behaviors should be immediate and effective to avoid harm to the patient or others. If a facility is unable to appropriately intervene, it is imperative to direct or transfer the agitated person to the closest available facility that is able to manage the problem.

Those with functional illnesses also may require medication to calm them, particularly patients with a history of psychiatric illnesses for which they may or may not be receiving treatment [63]. If a patient is currently receiving treatment for a psychiatric condition, assessment should address medication compliance. Re-establishing the medication may result in recovery of behavioral control and resolve the emergency.

Patients with certain personality disorders who may show agitation, including those with borderline, narcissistic, and antisocial personality disorders, may present in the ED. However, these patients are often taken to the ED by family, friends, or law enforcement rather than presenting for voluntary treatment. Medications can be used to address the symptoms of agitation [63].

HOMICIDAL PATIENTS

Homicidal patients represent a different and unique challenge. As with any psychiatric patient, the professional staff should determine if imminent danger is present. Individuals with antisocial personality disorders are a special case as their behavior is, by definition, criminal. Children diagnosed with conduct disorder manifest assaultive or homicidal behavior and can be as dangerous as adults. Any patient believed to be a danger to others should be isolated and, if necessary, sedated and/or restrained. Discharge planning may include involuntary hospitalization. Law enforcement personnel may also be involved if a victim is identified.

MANAGING INTENSE EMOTIONS

There are effective, nonpharmacologic methods that can be used in the ED to help establish trust and calm patients experiencing a psychologic emergency. Although interactions in the ED can be a frightening and agitating experience for all parties, it is critical that staff remain aware of their own mood, attitude, and emotions at each interaction and keep them in control. The Substance Abuse and Mental Health Services Administration offers the following guide on managing intense emotions [77]:

- Communicate calmly; use the acronym SOLER.
  - **S**it squarely or stand using the L-stance (shoulder 90 degrees to the patient's shoulder)
  - **O**pen posture
  - **L**ean forward
  - **E**ye contact
  - **R**elax
- Communicate warmth.
  - Use a soft tone.
  - Smile.
  - Use open and welcoming gestures.
  - Allow the patient to dictate the distance between you.

- Establish a relationship.
  - Introduce yourself if he/she does not know you.
  - Ask the patient what he/she would like to be called.
  - Do not shorten a name or use a first name without permission.
  - In some cultures, it is important to always address the patient as Mr. or Mrs.
- Use concrete questions to help the patient focus.
  - Use closed-end questions.
  - Explain why you are asking the question.
- Come to an agreement on something.
  - Establish a point of agreement that will help solidify your relationship and gain their trust.
  - Active listening will help you find a point of agreement.
- Speak to the patient with respect.
  - Use words like "please" and "thank you."
  - Do not make global statements about the patient's character.
  - Lavish praise is not believable.
  - Use positive language.

If the patient becomes agitated, he or she may:

- Challenge or question authority
  - Answer the question calmly.
  - Repeat your statement calmly.
- Refuse to follow directions
  - Do not assert control; let the patient gain control of self.
  - Remain professional.
  - Restructure your request in another way.
  - Give the patient time to think about your request.
- Lose control and become verbally agitated
  - Reply calmly.
  - State that you may need assistance to help them.
- Become threatening
  - If the patient becomes threatening or intimidating and does not respond to your attempts to calm them, seek immediate assistance.

APPROPRIATE DISCHARGE PLANNING

In a large group practice or ED, it is beneficial to have an on-call mental health professional available to advise regarding psychiatric emergencies, mental health referrals, and discharge planning. This is more easily found in urban areas with psychiatric residency programs, where on-call duty is built into the training program. Facilities without available psychiatric residency programs should arrange a practical on-call procedure with local mental health professionals. The extent to which state law and hospital rules allow mental health professionals who are not physicians to provide emergency on-call mental health services affects the availability of these services in hospital settings.

The discharge of patients seen in EDs and other facilities should include the consideration of hospitalization or outpatient treatment after the patient is stabilized. Hospitalization is necessary for patients exhibiting imminent danger to themselves or others. Inpatient treatment for other patients may be provided on a voluntary basis. Patients who do not acquiesce will be discharged home.

The goal of the professional staff is to stabilize the patient and refer to someone for follow-up treatment. A decision about the most appropriate and effective way of treating psychiatric patients should be made on an individual basis.

As discussed, each state or commonwealth has its own laws pertaining to involuntary hospitalization. Healthcare professionals working with and around psychiatric patients should know the applicable laws or have quick access to that information. Usually, the signatory officer for an order of involuntary hospitalization is a physician or clinical psychologist. The signatory officer should interview the patient and, exercising professional opinion, determine that imminent danger is present and hospitalization is necessary to protect the patient from self-harm. Some states or commonwealths require two signatures. One signature initiates the order to hospitalize the patient, and the other is from the physician at the receiving hospital. Of course, both must agree that imminent danger is present.

Inpatient treatment can be quite beneficial for patients who are starting a new medication or require close observation to monitor efficacy and adherence to treatments. Those who do not respond to medication may need inpatient treatment to determine the best combination of drugs and dosages, particularly if they cannot function effectively on an outpatient basis. Patients who are withdrawn because of the psychiatric condition may be hospitalized to provide more intense treatment, including involvement with other people. When the inpatient is able to function, he or she can be discharged for outpatient follow-up treatment.

Suicidal patients will usually require close supervision after discharge. It may not be possible for family and friends to meet that demand. Therefore, these patients will likely need inpatient treatment to establish better control over their thinking and behavior before returning home. When a patient does return home, responsible adults should be present to supervise activities of daily living, manage the correct usage of all medications, and ensure safety from wandering away or engaging in other activities that might be potentially dangerous. The degree of cognitive impairment helps determine the amount of danger present. Mild cognitive impairment may allow the patient to live with minimal supervision, while severe cognitive impairment will require close supervision.

OFFICE EMERGENCIES

Office emergencies can be challenging, as offices frequently do not have the range of resources present even in small EDs. Large group practices should establish procedures to protect professional and administrative staff from an agitated or acting-out patient. The procedures should also instruct the staff on how to protect others who may be present in the facility, especially those in the waiting room or offices.

Facilities with a speaker system can announce an emergency requiring assistance by using an innocuous message. The message should not frighten others or increase the agitation of the person who is causing the announcement. It should also provide the location by code where help is needed. Protection of the professional staff may include a hidden button that, when operated, notifies the administrative staff that help is needed and where the problem is occurring. The staff, especially front desk staff, should have a similar procedure to signal the need for help. A written policy should be reviewed and practiced by everyone on a regular basis to be certain that any emergency can be managed without having to refer back to the policy. The policy and procedures should include how and when to call for law enforcement.

Protecting staff and others from potentially dangerous patients involves physical means as well as warning systems. The administrative staff should be protected by separating their work area from the waiting room. Patients may make appointments or complete insurance claims without entering the separate administrative area. A locked door between the waiting room and the rest of the office may also provide some protection. Only authorized people should be able to open the door, providing another obstacle for patients who are agitated and acting out.

When in the therapy side of the office, a helpful, but more expensive, choice is a small quiet room. These are routinely found in inpatient psychiatric facilities but are less common in outpatient settings. The quiet room should be built similarly to those seen in hospital settings. When in this room, the patient should be protected from his or her own behavior. If any furniture is present, it should be soft. There should also be a way to monitor the person in the quiet room. Some facilities utilize video cameras with appropriately discreet monitors; others have a small window in the door to allow the responsible employee(s) to observe the patient without having to enter the room. Using a quiet room to help calm and control an agitated or acting-out patient helps protect the staff from being hurt but requires frequent monitoring to ensure that the patient is also safe.

Independent practices usually do not have the staff or other resources to implement strategies that may be found in large group practices. Nonetheless, independent practitioners should also plan for the possibility of a psychiatric emergency occurring in their office. Some independent practices have receptionists, at least on a part-time basis, and, in these settings, the communication between the professional and the receptionist is critical. Without violating any confidentiality rules, the receptionist should know any patient(s) whom the professional considers potentially dangerous. As with other types of practices, it is important to formulate plans and policies addressing how to specifically manage patients if agitated or acting-out behavior is observed. The most likely first step is to contact the psychologist or other provider. The professional should then decide how to best manage the situation. This, of course, will be affected by circumstances such as the presence or absence of others in the office, the location of the office, and its proximity to other businesses. The goal should be to protect innocent people from the behavior of a patient who presents a dangerous situation. At the very least, the office should be designed in such a way that there is a physical barrier between the waiting room and the administrative and therapy area(s).

Individual practices without an administrative staff or other professionals working in the office are at particular risk in the case of a psychiatric emergency. Again, a locked door that separates the therapy offices from the waiting room and a safe exit from the offices should be installed. Some may invest in a video camera system to monitor who enters the waiting room and what is occurring. Practitioners should decide how to best protect themselves and any patients with them if an emergency occurs.

Only medical professionals are able to administer medication to calm a patient; therefore, other methods are necessary in mental health practices. Every practice, whether group or independent, should determine the type of patients they are best able to treat and plan how to manage the emergencies that their patients may present. Even when patients who are likely to be dangerous are not included in the practice, staff members should be aware that emergencies may occur and it is their responsibility to manage them.

LEGAL ISSUES

A psychiatric emergency may raise legal issues, and legislation can affect the provision of care. The Tarasoff Rule, passed in 1985, influences how medical and mental health professionals are required to address violent or homicidal threats [64]. The rule was instigated by the case of a young man who told his psychologist, in the confidence of psychotherapy, that he was going to kill a young woman. The psychologist reported the threat to campus security. The young man was interviewed but not detained. He stopped seeing the psychologist and subsequently killed the young woman. The young woman's parents filed a lawsuit against the psychologist saying that he had not done enough to protect their daughter. The courts agreed that the psychologist's response was insufficient.

The Tarasoff Rule requires mental health professionals to: notify law enforcement when they become aware of a threat against someone else; inform the identified target; and provide both law enforcement and the target with the name of the threatening person. It has been recommended that professionals seek legal counsel regarding the requirements in specific states about notifying others of a patient's threat.

State and local laws may vary regarding notification of child abuse and elder abuse. Specific information about abuse should be sought from the jurisdiction in which the professional practices.

CONCLUSION

Emergency rooms were initially designed to treat acute medical conditions and stabilize patients before transfer to the appropriate treatment resource. In larger, urban areas, emergency rooms have evolved into EDs that provide more extensive services. Unfortunately, EDs have also become a place to seek treatment for many people who do not have a family physician. As a result, the number of emergency visits has increased, although the reasons for the visits often are not emergencies. Thus, nonemergent visits are causing a huge backlog of real emergency patients and increasing the amount of money spent on health care. Misuse of EDs also complicates the diagnosis and treatment of people with psychiatric emergencies. As the emergency staff becomes overwhelmed with demands, they are less capable of providing the necessary time and attention to understand the psychiatric problems that bring some patients to the EDs.

Psychiatric conditions are comprised of many symptoms. There is considerable overlap in the presence of particular symptoms in different psychiatric diagnoses. The effective and accurate diagnosis of psychiatric conditions requires assessment beyond the presence or absence of symptoms; it involves examining the psychosocial and biologic aspects of a patient's life as well. Common psychiatric emergencies carry many similar characteristics, including agitation, disorientation, confusion, fear, and acting out. These symptoms are experienced by patients with both organic mental disorders, such as delirium and dementia, and functional mental disorders, including intense anxiety, major depression, and certain personality disorders. Management of psychiatric emergencies, both organic and functional, may involve fast-acting sedative medication, physical restraint, careful diagnosis, and stabilizing treatment before discharge planning.

A psychiatric emergency can present a serious threat to the professional staff, administrative staff, patients, and others who are present during the emergency. It is important to calm psychiatric patients in order to protect them from harming themselves or others. Usually, the most effective way to calm the person is by using a fast-acting medication. It is also helpful to have a quiet and safe place for psychiatric patients to wait before receiving treatment. A thorough physical and mental examination is necessary to determine the most appropriate discharge plan. Discharge from the ED may lead either to inpatient treatment or outpatient follow-up. Discharge planning for facilities other than EDs should also consider the range of options from inpatient treatment to outpatient follow-up.

Whether it is an ED or another facility, policies and procedures should be in place to protect both the patient and staff in the case of a psychiatric emergency. Law enforcement is a valuable resource, as most mental health professionals have no training or expertise in physically managing people who are acting out. EDs, large group practices, and small independent practices should establish systems of warning others about a developing emergency.

Emergencies that involve the threat of imminent danger, such as suicide, homicide, and the inability to avoid common danger, can occur in well-staffed EDs as well as in an individual practitioner's office. A patient who is believed to be an imminent danger should be evaluated to determine the degree of risk. In the opinion of the professional evaluating the patient (e.g., physician, clinical psychologist), a decision should be made regarding the appropriateness of involuntary hospitalization. In addition, a patient who is believed to constitute a real threat to others forfeits confidentiality, and the professional has an obligation to inform both law enforcement and the identified victim(s) of the threat.

Although individual practices may not focus on people who are likely to experience an emergency, the potential is still present, and a plan is necessary to prevent harm to others when it occurs.

RESOURCES

American Foundation for Suicide Prevention
120 Wall Street, 29th Floor
New York, NY 10005
(888) 333-2377
http://www.afsp.org
Provides extensive information about suicide prevention. Part of its mission is to address the impact of suicide on a survivor's life.

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
(703) 907-7300
http://www.psychiatry.org
Provides information about psychiatric practice, education, research, advocacy, and career development.

American Psychological Association
750 First Street NE
Washington, DC 20002
(800) 374-2721
http://www.apa.org
The professional and scientific organization for psychologists. Part of the website is for members only and part is open to consumers.

American Society of Addiction Medicine
5515 Security Lane, Suite 700
North Bethesda, MD 20852
(301) 656-3920
http://www.asam.org
Provides medical training and education for physicians and medical students on state of the art science in addiction medicine.

Association for Behavioral and Cognitive Therapies
305 7th Avenue, 16th Floor
New York, NY 10001
(212) 647-1890
http://www.abct.org
An interdisciplinary organization for those interested in behavioral and cognitive therapy.

National Association of Social Workers
750 First Street NE, Suite 800
Washington, DC 20002
(202) 408-8600
http://www.naswdc.org
The professional organization for social workers.

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(703) 739-9333
http://www.nasmhpd.org
Provides names and email addresses for state mental health program directors, from state agencies to directors of specific hospitals or programs. It also provides current information on important mental health laws in each state or commonwealth.

National Empowerment Center
599 Canal Street
Lawrence, MA 01840
(800) 769-3728
http://www.power2u.org
Offers support to individuals with mental illness.

National Institute of Mental Health
6001 Executive Boulevard
Room 6200, MSC 9663
Bethesda, MD 20892
(866) 615-6464
https://www.nimh.nih.gov
A government website with a variety of resources pertaining to mental health issues, policy and research topics, and funding opportunities.

National Institute on Alcohol Abuse and Alcoholism
(301) 443-3860
https://www.niaaa.nih.gov
Provides information and publications pertaining to alcohol use and abuse. Sources for grant funding are included.

National Institute on Drug Abuse
6001 Executive Boulevard
Room 5213, MSC 9561
Bethesda, MD 20892
(301) 443-1124
https://www.drugabuse.gov
A government website with a wide range of topics pertaining to drug abuse and treatment of addiction. Sections are provided for professionals, researchers, and consumers.

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
(877) 726-4727
https://www.samhsa.gov
Government resource providing information about substance abuse and mental illness information for a wide range of ages and circumstances.

Training Institute for Suicide Assessment and Clinical Interviewing
http://www.suicideassessment.com
Provides training to all professionals who may assess or treat suicidal patients. This website is not for people who are suicidal and seeking help.

U.S. Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152
(202) 307-1000
https://www.dea.gov
Government agency that provides valuable information about prescription and illegal drugs and law enforcement efforts to interdict illegal drug use.

U.S. National Library of Medicine
8600 Rockville Pike
Bethesda, MD 20894
(301) 594-5983
https://www.nlm.nih.gov
A vast source of publications in medicine, psychology, and education.

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