

# Treatment of Psychiatric Patients in Emergency Settings

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## ABSTRACT

*Urgent mental health presentations in United States emergency departments are rising in number and are a significant percentage of all emergency department visits. As federal law requires these cases to be evaluated and stabilized, or admitted for inpatient care, they can present a considerable challenge to emergency care facilities with limited resources. In response to this demand, emergency psychiatry has evolved into a subspecialty in which practitioners seek to rapidly stabilize those in psychiatric crisis in a non-coercive and collaborative manner, and ensure appropriate and safe dispositions. This article discusses different emergency care settings and models as well as the types of interventions used with patients suffering from acute symptoms of suicidal ideation, agitation, psychosis, mania, intoxication, anxiety, and other presentations.*

## INTRODUCTION

Whether due to the long-term effects of deinstitutionalization, inadequate community resources, the large numbers of uninsured individuals, or other causes, it is inarguable that emergency department presentations of psychiatric problems are on the rise.<sup>1</sup> As a result, the treatment of psychiatric emergencies—acute disturbances of thought, mood, or behavior that require immediate intervention<sup>2</sup>—has progressed to a subspecialty in its own right. Practitioners of emergency psychiatry can help resolve suicidal feelings, quell agitation, lessen the severity of psychosis and mania, and assist in the stabilization of the troublesome symptoms of many mental health crises.

## FOCUS POINTS

- The number of psychiatric emergencies in the United States is rising, and multiple approaches have evolved for their assessment and treatment.
- Emergency psychiatry treatment goals include rapid stabilization and caring for patients in a non-coercive therapeutic alliance.
- Emergency psychiatry clinicians can intervene successfully and promptly in patients with suicidal ideation, acute agitation, psychosis, mania, anxiety, and other presentations.

Psychiatric emergencies, while perhaps not as obvious to lay people as trauma or cardiac arrest situations, are nevertheless appropriate for emergency department treatment. The most severe psychiatric conditions that are dealt with in emergency settings—those in which patients are acutely dangerous to themselves or others—are considered “emergency medical conditions” per the Emergency Medical Treatment and Labor Act, and thus must either be stabilized or admitted for inpatient hospitalization. Such patients are not considered stable until they are both protected and prevented from harming themselves and/or others.<sup>3</sup>

Along with the increasing numbers of psychiatric “crises” (another term describing a psychiatric emergency), many different treatment approaches have evolved. This article briefly reviews prevalence data on psychiatric emergencies, and discusses the varied models of delivering urgent psychiatric interventions, the major treatment goals for emergency psychiatric conditions, and the most prominent types of crisis psychiatric presentations.

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## PREVALENCE OF PSYCHIATRIC EMERGENCIES

Between 1992 and 2001 there were 53 million mental health-related emergency department contacts in the United States, an increase from 4.9% to 6.3% of all emergency department visits, and an upswing from 17.1–23.6 visits per 1,000 of the US population during this period.<sup>4</sup> One study<sup>5</sup> estimated that 135,000 emergency psychiatric assessments are made each year in New York State hospitals alone. Due to frequently inadequate alternatives, emergency departments and psychiatric emergency services (PESs) have become the primary acute care settings where patients seek mental health care in the US.

## MODELS OF EMERGENCY PSYCHIATRIC DELIVERY

As demands for urgent mental health care have increased, varied emergency psychiatry service delivery models have developed to meet regional needs. Such factors as the total numbers of psychiatric patients seen, the geographic catchment area of the emergency setting, the availability of psychiatrists and other mental health professionals, local philosophy of mental health treatment and mental health laws, and economic constraints all play a role in determining which model is implemented. Frequently, as the quantity of patient contacts change, a system may convert from one model into another.

Though there are numerous hybrid or idiosyncratic versions, there are three basic models of emergency psychiatry delivery in fixed settings: the psychiatric consultant seeing patients in the medical emergency department; a separate section of the medical emergency department dedicated to mental health patients, with specially-trained and dedicated staff; and the stand-alone PES, a facility separate from a medical emergency department that is solely for treatment of acute mental health patients.

### Consultant in Medical Emergency Department

The first method, where a mental health professional consults on patients in a medical emergency department, is the most common model in the US. Though optimally a psychiatrist consulting, in many systems the consultants are psychologists, advanced registered nurse practitioners, social workers, or licensed marriage/family therapists. Some facilities even employ psychiatric technicians or others with less than master's level training, although this has been described as an "insufficient" level of care for those in psychiatric crisis.<sup>6</sup>

This model's advantages are that it is the lowest-cost and easiest to implement in a medical emergency department; all patients are primarily treated and given a medical screening exam by an emergency medicine physician, so physical

concerns are evaluated and organic causes of psychiatric symptoms can be ruled out prior to consultation; and mental health patients are treated in the same setting as all patients in the emergency department, with less opportunity for stigma and delays in treatment than segregation might cause.

However, there are potentially many disadvantages to the model as well. Diagnosis and interventions must usually await the consultant's arrival, which may take several hours, during which time the patient may be receiving little or no treatment. Once present, the consultant's decision is usually restricted to the choice either to admit for psychiatric hospitalization or to discharge, with little chance to observe a patient sufficiently to see if improvement or decline in status might change the disposition; the emergency department setting is likely not conducive to extended psychiatric treatment and observation.

The physical setting of the emergency department—with its noise, bustle, and possibility of surrounding patients agonizing in severe pain or needing life-saving interventions—may not be the most supportive or healing environment for those in mental health crisis. Emergency department environments with easy access to instruments and various equipment may not be a safe environment for suicidal patients. Additionally, suicidal patients in general emergency departments are often placed in restraints if 1:1 observation is not available.

Further, many emergency department staff may be under-trained in mental illness, with some even disdainful of the mentally ill (whom some do not see as "real" emergencies). This can lead, in busy emergency departments, to staff callousness and disregard for psychiatric patients, resulting in poorer care and pressure to move them out quickly to open up bed space.

While advancing a more multidisciplinary approach to treatment, the use of non-psychiatrist consultants restricts the ability to recommend medications or to comfortably diagnose conditions such as delirium. Situations may also arise in which such consultants are seen as lesser authorities by emergency medicine physicians, and may thus have difficulty challenging the physician's decisions. This can even happen with the common practice of using psychiatry residents to do emergency department psychiatric consults, as the physicians-in-training may be justifiably anxious about countermanding an emergency department attending's opinion.

Some emergency departments' mental health consultation is provided by a visiting team from an area inpatient psychiatric facility. As such teams' employers stand to benefit financially by increased admissions, the impartiality of dispositions by such teams may come into question.

### Dedicated Mental Health Wing of Medical Emergency Department

This model improves on the mere consultant in the emergency department model by providing a separate, often more

nurturing and calming environment. Frequently staffed by nurses or others with extra training in mental health, this unit may allow for more focused and appropriate care for individuals in crisis, and thus avoid some of the pitfalls that may confront the psychiatric patient in the general emergency room. Since its location is within a medical emergency department, patients can receive full medical history and physicals as part of their evaluation. Additionally, because of the separate setting, there may be less urgency to move patients out and therefore permit time for medications and interventions to have effect prior to disposition decisions.

However, this model has its drawbacks. The distribution of patients to a separate space permits their marginalization and potential stigma as “different” or “crazy”; some facilities have even been known to dress crisis patients in different colored gowns (eg, bright red) to identify them as psychiatric. Given the limited space of the physical plant of many emergency departments, on especially busy days there may be demands to overflow non-psychiatric patients into the mental health wing, or float staff away from the mental health section. Too often these sections are little more than holding areas or “dumping” sites with little actual psychiatric treatment, and seen as a way of taking the patients out of the main part of the emergency department until placements are made.

## The PES Model

The PES is typically a stand-alone program dedicated solely to the treatment of individuals in mental health crisis. Such facilities can either be locked, unlocked, or a combination of the two, and located in-hospital or community based. The former would ideally be situated near a medical emergency department.<sup>7</sup>

A typical PES is staffed around the clock with psychiatric nurses and other mental health professionals, with psychiatrists either onsite or readily available. With such staffing, diagnosis and treatment can proceed far more promptly than in the models which await a consultant’s arrival. Once in a PES, a patient’s psychiatric treatment can begin without delay, with the potential for patients to stabilize quickly.

Where the first two models most often practice emergency psychiatry in a method described as the “Triage Model,” with “rapid evaluation, containment and referral,”<sup>8</sup> a typical PES follows the “Treatment Model,” where in addition to Triage Model capability many patients can also be treated to the point of stabilization onsite.<sup>9</sup> This is possible because many PESs have extended observation capability, allowing them to treat patients for up to 24 hours or even longer. This can often be sufficient time for many patients to stabilize and thus avoid inpatient hospitalization.

Stabilization within a PES rather than an unnecessary inpatient stay is beneficial to the patient, who has a path to recovery which is more timely and focused, and to the mental health

system, by lowering costs while preserving inpatient bed availability. A PES with extended observation capacity can dramatically lower inpatient admission rates over a program using the Triage Model; one study revealed a drop in admissions from 52% to just 36%.<sup>10</sup>

A PES also can be very advantageous for area medical emergency departments in decompression of overcrowding, allowing psychiatric patients to be transferred for their evaluations and treatment rather than waiting for consultants to arrive at a facility or an inpatient bed to become available. Many PES programs can also accept ambulances, police deliveries, and self-referrals directly, allowing crisis patients to avoid medical emergency departments completely. In a time when concern about overcrowding in medical emergency facilities has been at the forefront,<sup>11</sup> establishment of a regional PES is a potential outlet for diverting the urgent mental health population for appropriate care.

Chief among the drawbacks of a PES is that it is more expensive than the other models, with the cost of 24/7 staffing and of maintaining its own physical plant. Because of this, a PES usually only makes fiscal sense to facilities or communities seeing large numbers of acute psychiatric patients per month. In systems of this size, however, a PES can more than justify its value by minimizing unnecessary inpatient admissions and shortening lengths of stay.

## TREATMENT GOALS OF EMERGENCY PSYCHIATRY

### Exclude Medical Etiologies for Symptoms

As many medical conditions can present with symptoms that appear similar to endogenous psychoses, mania, or other acute psychiatric states, it is essential that medical etiologies be ruled out prior to commencing psychiatric treatment (Table 1). Differentiating between delirium and psychosis is especially important; misdiagnosing delirium as a psychosis and treating it as such can be life threatening.

TABLE 1

### TREATMENT GOALS OF EMERGENCY PSYCHIATRY

- Exclude medical etiologies for symptoms
- Rapid stabilization of acute crisis
- Avoid coercion
- Treat in the least restrictive setting
- Form a therapeutic alliance
- Appropriate disposition and aftercare plan

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There is a considerable segment of patients presenting to medical emergency departments with psychiatric complaints who have co-existing medical illnesses or have an undiagnosed medical condition.<sup>12</sup> Failure to recognize these conditions have led to serious morbidity,<sup>13,14</sup> including encephalitis.<sup>15</sup>

A good history and visual evaluation by a qualified medical professional, along with vital signs, are frequently sufficient to make a determination that urgent medical rather than psychiatric intervention is indicated. In patients with no known previous history or new-onset symptoms, head computerized tomography and laboratory data also might be indicated. Patients who appear medically unstable need to be treated and cleared by medical emergency physicians before psychiatric evaluation can proceed.

### Rapid Stabilization of the Acute Crisis

Once a patient's medical stability has been ensured, stabilization of the acute crisis should proceed (Table 1). Frequently, this will involve medications. Prompt crisis counseling can also assist with stabilization. Those patients who are not able to be stabilized in the emergency setting will need inpatient admission to resolve the acute condition. A discussion of stabilization approaches to distinct crises will follow later in this article.

### Avoid Coercion, Treat in the Least Restrictive Setting, Form a Therapeutic Alliance

Practitioners in the emergency setting are often the first contact a patient will have with mental health care (Table 1). A bad experience on this initial mental health contact may lead to long-term problems in which consumers might fear, distrust, or dislike psychiatrists and other providers. Such issues might interfere with their desire to obtain help, continue in treatment, or take their medications. During the early phases of acute mental illness, even brief interactions can have enduring implications for a patient's ability to function and recover.

In realizing this, it is very important that crisis professionals work with patients in a supportive, caring, and interpersonal manner, creating with the patient what is known as a therapeutic alliance.

A therapeutic alliance might be most simply described as a collaborative relationship between a patient and the clinician. Rather than the mental health professional attempting to have a "higher rank" or ordering the patient what to do, a therapeutic alliance instead means striving for bonding and empathy with patients, and treating them as partners. This can lead to working together with patients and sharing responsibility for achieving treatment goals in the acute setting, often resulting in better outcomes. One study<sup>16</sup> showed the better the early therapeutic alliance, the lower the possibility of a patient becoming violent during psychiatric hospitalizations.

Working with a therapeutic alliance mindset also means avoiding coercion, which is the use of force or threats to make

patients do things against their will. In emergency psychiatry, this includes the use of oral medications with informed consent as opposed to forcible injections; verbal de-escalation of agitated individuals instead of physical restraints; and little or no infringement on a patient's rights when possible. Treating in the least restrictive level of care is another means of avoiding coercion.

The more restrictive the level of care, the more there is propensity for a coercive experience and thus less opportunity for a therapeutic alliance. The most restrictive mental health levels of care are physical restraints and/or seclusion rooms; then involuntary inpatient units and locked clinical settings; followed by voluntary, unlocked inpatient care. The least restrictive settings are outpatient clinics where patients are free to come and go as they wish. As most patients will do best both in the short and long terms in the appropriate level of care which is least restrictive, the goal in emergency psychiatry of avoiding hospital admissions where possible is a worthy one.

### Appropriate Disposition and Aftercare Plan

In emergency psychiatry, the mental health professional's duties are not complete merely with cessation of the presenting crisis (Table 1). It is essential that a patient be provided with an appropriate care plan for post-discharge, including appointments (when possible) with outpatient providers, referral to mental health clinics and/or substance abuse treatment programs, and instructions on what to do if crisis symptoms recur. Frequently, assistance with housing may be a part of the aftercare plan, as might coordination of arrangements with loved ones or caregivers.

Appropriate aftercare planning can be of great benefit to the long-term stability of patients and help prevent recidivism. Individuals who do not have an outpatient appointment after a discharge have been shown to be two times more likely to be psychiatrically hospitalized in a year than patients who went to at least one outpatient appointment.<sup>17</sup>

## TYPES OF PSYCHIATRIC EMERGENCIES

With millions of emergency psychiatric interventions in the US annually, there are countless types of crisis presentations; the most prevalent are highlighted in this section and Table 2. Insofar as diagnosis and treatment of each condition is worthy of extensive texts on their own, this article focuses only briefly on specific concepts relating to their interventions in the emergency setting.

### Suicide Attempt/Ideation

Perhaps the most commonly seen psychiatric emergency, and one unfortunately increasing in number, involves suicidal thoughts or behavior. In the period between 1992 and 2001, US

emergency room encounters for suicide attempt and self-injury increased by 47%, from 0.8–1.5 visits per 1,000 US residents.<sup>18</sup>

Patients may arrive in emergency settings after surviving a suicide attempt, being stopped from making a suicide attempt, in the wake of suicidal threats, or after reporting suicidal ideation.

Though suicidality in itself can be a justification for psychiatric hospitalization, inpatient care may be avoided when suicide risk is mitigated. According to the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors,<sup>19</sup> release from an emergency setting may be possible without inpatient admission after a suicide attempt or suicidal ideation when: the suicidality is a reaction to precipitating events (eg, exam failure, relationship problems) especially if the patient's view of the situation has now changed; the plan and intent have low lethality; the patient has a stable and supportive living situation; and the patient is able to cooperate with follow-up recommendations.

These guidelines also suggest that in cases in which a patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available then the individual may benefit more from outpatient treatment than hospitalization.<sup>19</sup>

Other presentations—such as malingering or contingent suicidal ideation for secondary gain, and suicidal ideation in context of substance intoxication or withdrawal which dissipates with detoxification—may frequently be dischargeable from the emergency setting.

Even in the most severe and demonstrative suicidal situations, the guidelines do not state that a patient “must always” be admitted, instead giving leeway to crisis clinicians with such categories as “admission generally indicated” and “admission may be necessary.”<sup>19</sup> Here, a well-qualified and experienced crisis clinician should be able to review information; obtain collateral data from family, friends, caregivers, and other concerned parties; listen well; note stressors and risk factors; and work therapeutically with patients. Only after this should a clinician make a compassionate decision on a treatment plan, including

**TABLE 2**

**TYPES OF PSYCHIATRIC EMERGENCIES**

- Suicide attempt/ideation
- Agitation, violent or disruptive behavior
- Psychosis leading to dangerous behavior/thoughts
- Mania
- Intoxication states
- Anxiety
- Other presentations and exclusions

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whether a patient will need inpatient care. Again, the philosophy of seeking the least-restrictive but most appropriate level of care is essential, while always ensuring patient safety first.

**Agitation, Violent or Disruptive Behavior**

Agitation might be best and most concisely described as “excessive verbal and/or motor behavior.”<sup>20</sup> Agitation in psychiatric conditions can be a major concern in emergency settings, with the potential for violence and harm to the patient, staff, or others. Of psychiatric emergency visits in the US, it is estimated that perhaps 20% to 50% might involve patients at risk for agitation.<sup>21</sup> Up to 10% of patients seen in psychiatric emergency settings may be agitated or violent during their evaluation.<sup>22</sup> As many as 1.7 million medical emergency department contacts per year might involve agitated patients.<sup>23</sup>

Traditionally, many emergency settings' response to serious agitation would be restraining such patients and forcibly sedating them with powerful medications. There are many drawbacks to this approach: it is very coercive to patients; oversedated patients cannot participate in treatment, nor can dispositions be determined for them while they are obtunded; and many of the medications used in these situations can have severe and/or unpleasant side effects which will be quite disturbing to patients, and interfere with opportunities for therapeutic alliance.

The emergency psychiatry approach to this condition begins with training staff on the prevention and management of assaultive behavior and non-violent crisis intervention to avert severe agitation in the first place. When patients do become agitated, verbal de-escalation and calming techniques should always be attempted prior to resorting to restraint; when possible, medications should be offered voluntarily to patients rather than forcibly injected.

Unlike the traditional medical approach of heavy sedation, emergency psychiatrists prefer merely calming the agitated patient. According to an Expert Consensus Guidelines survey of emergency psychiatrists, the goal of emergency interventions in agitation is calming the patient without sedation, or mild sedation to the point of drowsiness but not sleep.<sup>24</sup> A patient who is calm rather than unconscious can participate in care and work together with the crisis clinician towards an appropriate treatment disposition, which is of benefit to the patient and also to the emergency setting. A sleeping patient may just be taking up space that can be used by others.

**Psychosis Leading to Dangerous Behavior or Thoughts**

Pronounced symptoms of psychosis such as auditory hallucinations, paranoia, and disorganization can be quite common in patients with diseases such as schizophrenia; for some, unfortunately, such symptoms are daily and unremit-

ting. Such psychosis in and of itself may not be cause for emergency intervention. However, when the psychosis leads a patient to dangerous behavior or thoughts (eg, command auditory hallucinations telling a patient to harm others or self; confusion leading a patient to wander into busy traffic with no concern for his own safety), such symptoms are of major concern and are responsible for a large number of visits to emergency settings.<sup>25</sup>

The importance of intervention in these situations cannot be understated. Suicide may account for as many as 13% of the deaths of people with schizophrenia.<sup>26</sup> In a study<sup>27</sup> of patients who reported having command hallucinations telling them to harm others in the previous year, 22% reported having acted on those commands.

In acute psychosis where patients are dangerous to themselves or others, or unable to care for themselves, the primary goal is keeping patients safe while promptly lessening the disturbing symptoms. Timely administration of antipsychotics is indicated, preferably oral versions given with informed consent.

The predominant view of antipsychotics has been that they typically take many days to weeks to be efficacious. Yet, emergency psychiatrists have long spoken anecdotally about patients with disturbing, dangerous symptoms of psychosis frequently clearing quickly in the emergency setting. Newer research now supports this contention; recent studies<sup>28,29</sup> note substantial improvement in psychosis in <24 hours, perhaps as soon as 2–4 hours with antipsychotics.

## Mania

Patients with acute bipolar mania, with its symptoms of high energy, insomnia, impulsiveness, and grandiosity, often can display poor judgment which will lead to dangerous behavior or inability to care for themselves. Typically, patients with full-blown mania will need inpatient stabilization, but hypomanic symptoms may at times be lessened sufficiently with medications in the emergency setting to permit their discharge to lower levels of care. Since patients with bipolar disorder can frequently be high functioning with symptom resolution, therapeutic alliance is very important in the emergency setting, as long-term compliance with medication and treatment can assist in reaching a full recovery.<sup>30</sup>

## Intoxication States

Pure intoxication on alcohol or other substances reaching the level of emergency intervention may need only detoxification by emergency medical personnel without the assistance of mental health clinicians. However, if intoxication leads an individual to make suicidal or homicidal threats, or exacerbates the symptoms of a chronic mental illness, crisis clinicians may become involved. This remains a large number, however; primary diagnosis of substance abuse was responsible for 27%

of psychiatric-related emergency department visits in the US from 1992–2000.<sup>31</sup> Further, patients with comorbid major psychiatric diagnoses and substance abuse diagnoses are over-represented in those who are frequent recidivists to PES.<sup>32</sup>

In patients with comorbid disorders, it can be difficult to discern which symptoms are caused by underlying psychiatric illness and which are due to the intoxication. When possible, allowing patients to detoxify sufficiently prior to making a full evaluation, diagnosis and disposition decision is preferred.

While most intoxication states are usually not difficult to diagnose, intoxications from cocaine, and amphetamines in particular, can mimic the delusions, paranoia, hallucinations and agitation from decompensated psychotic illnesses. In such cases, or in those cases which the cause of the acute symptoms of psychosis is unknown, the use of benzodiazepines to calm patients is indicated. Patients whose symptoms are due to stimulants will then have the opportunity to detoxify calmly without risking the side effects of antipsychotics; frequently, such patients will awaken clear and non-psychotic.

## Anxiety

Though rarely an emergency in the sense of dangerousness to self or others, severe anxiety is nonetheless a common presenting problem in emergency departments. It should be noted, however, that subjectively the suffering may be so intense that the patient feels it is a profound emergency. Anxiety-related presentations accounted for 16% of emergency department mental health visits from 1992–2001.<sup>33</sup>

Often a mental health clinician can quell anxiety states with brief supportive psychological interventions and relaxation techniques.<sup>34</sup> More pronounced cases may benefit from anti-anxiety medications such as benzodiazepines.

## Other Common Presentations and Exclusions

Such situations as symptoms of dysphoria, family and life stresses, relationship difficulties, or housing issues usually do not rise to the crisis level but are nonetheless commonly seen in the emergency setting. Once individuals with these concerns are determined to not have an emergency medical condition—which, as in all emergency setting mental health presentations, should include an assessment of suicide risk and dangerousness to others—they should be provided access to social services, counseling, or appropriate referrals to a less acute level of care.

Cases of delirium and agitated dementias are at times referred to mental health clinicians. However, these are most often medical or neurologic conditions which should be treated by emergency medicine physicians, and likely would not benefit from acute psychiatric interventions.

## CONCLUSION

The number of people seeking mental health care in emergency settings continues to rise. As many of these cases involve patients who are a danger to themselves or others, these are legitimate emergency medical conditions which require urgent stabilization.

This increasing demand has led the practice of emergency psychiatry to become a vital subspecialty in emergency settings. By combining the compassionate and interpersonal therapeutics of psychiatry with the fast-paced assessment and treatment approach of emergency medicine, emergency psychiatry clinicians can make positive and prompt interventions for those individuals suffering from acute mental health disturbances.

In communities where the numbers of behavioral emergencies are elevated and growing, moving to a model of a stand-alone psychiatric urgent care facility such as a PES may be cost effective, decreasing inpatient psychiatric bed utilization and helping to decompress overcrowded medical emergency departments. **PP**

## REFERENCES

- Hazlett SB, McCarthy ML, Londner MS, Onyike CU. Epidemiology of adult psychiatric visits to US emergency departments. *Acad Emerg Med.* 2004;11(2):193-195.
- Barton GM. *Task Force Report on Psychiatric Emergency Care Issues.* Washington, DC: American Psychiatric Association; 1983.
- Department of Health and Human Services. Centers for Medicare and Medicaid Services. CMS Manual System. Appendix V. Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines. Available at: [www.cms.hhs.gov/manuals/downloads/som107ap\\_v\\_emerg.pdf](http://www.cms.hhs.gov/manuals/downloads/som107ap_v_emerg.pdf). Accessed April 22, 2010.
- Larkin GL, Claassen CA, Emond JA, Pelletier AJ, Camargo CA. Trends in U.S. emergency department visits for mental health conditions, 1992 to 2001. *Psychiatr Serv.* 2005;56(6):671-677.
- Dawes SS, Bloniarz PA, Mumpower JL, Shern D, Stewart TR, Way BB. Supporting psychiatric assessments in emergency rooms. Albany, NY: University at Albany, Center for Technology in Government, 1995. Available at: [www.ctg.albany.edu/publications/reports/supp\\_psych\\_assess/supp\\_psych\\_assess.pdf](http://www.ctg.albany.edu/publications/reports/supp_psych_assess/supp_psych_assess.pdf). Accessed April 22, 2010.
- Fishkind AB, Berlin JS. Structure and function of psychiatric emergency services. In: Glick RL, Berlin JS, Fishkind AB, Zeller SL, eds. *Emergency Psychiatry: Principles and Practice.* Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins; 2008:9-23.
- Allen MH, Forster P, Zealberg J, et al. Task force on psychiatric emergency services report and recommendations regarding psychiatric emergency and crisis services. Washington, DC: American Psychiatric Association; 2002. Available at: [http://archive.psych.org/edu/other\\_res/lib\\_archives/tfr/tfr200201.pdf](http://archive.psych.org/edu/other_res/lib_archives/tfr/tfr200201.pdf). Accessed April 22, 2010.
- Gerson S, Bassuk E. Psychiatric emergencies: an overview. *Am J Psychiatry.* 1980;137(1):1-11.
- Allen MH. Definitive treatment in the psychiatric emergency service. *Psychiatr Q.* 1996;67(4):247-262.
- Gillig PM, Hillard JR, Bell J, Combs HE, Martin C, Deddens JA. The psychiatric emergency service holding area: effect on utilization of inpatient resources. *Am J Psychiatry.* 1989;146(3):369-372.
- Trzeciak S, Rivers EP. Emergency department overcrowding in the United States: an emerging threat to patient safety and public health. *Emerg Med J.* 2003;20(5):402-405.
- Carlson RJ, Nayar N, Sur M. Physical disorders among emergency psychiatry patients. *Can J Psychiatry.* 1981;26(1):65-67.
- Hall RC, Popkin MK, Devaud RA, Faillace LA, Stickney SK. Physical illness presenting as psychiatric disease. *Arch Gen Psychiatry.* 1978;35(11):1315-1320.
- Hall RC, Gardner ER, Popkin MK, Lecann AF, Stickney SK. Unrecognized physical illness prompting psychiatric admission: a prospective study. *Am J Psychiatry.* 1981;138(5):629-635.
- Vincent A, Bien CG. Anti-NMDA-receptor encephalitis: a cause of psychiatric, seizure, and movement disorders in young adults. *Lancet Neurol.* 2008;7(12):1074-1075.
- Beauford JE, McNeil DE, Binder RL. Utility of the initial therapeutic alliance in evaluating psychiatric patients' risk of violence. *Am J Psychiatry.* 1997;154(9):1272-1276.
- Nelson EA, Maruish ME, Axler JL. Effects of discharge planning and compliance with outpatient appointments on readmission rates. *Psychiatr Serv.* 2000;51(7):885-889.
- Larkin GL, Smith RP, Beautrais AL. Trends in US emergency department visits for suicide attempts, 1992-2001. *Crisis.* 2008;29(2):73-80.
- Suicidal behaviors. In: *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2004.* Washington, DC: American Psychiatric Association, 2004:31.
- Citrome L. Atypical antipsychotics for acute agitation. New intramuscular options offer advantages. *Postgrad Med.* 2002;112(6):85-88,94-96.
- Marco CA, Vaughan J. Emergency management of agitation in schizophrenia. *Am J Emerg Med.* 2005;23(6):767-776.
- Huf G, Alexander J, Allen MH. Haloperidol plus promethazine for psychosis induced aggression. *Cochrane Database Sys Rev.* 2005;(1):CD005146.
- Allen MH, Currier GW. Use of restraints and pharmacotherapy in academic psychiatric emergency services. *Gen Hosp Psychiatry.* 2004;26(1):42-49.
- Allen MH, Currier GW, Carpenter D, Ross RW, Docherty JP, Expert Consensus Panel for Behavioral Emergencies 2005. The expert consensus guideline series. Treatment of behavioral emergencies 2005. *J Psychiatr Pract.* 2005;11(suppl 1):5-108.
- Pandya A, Larkin GL, Randles R, Beautrais AL, Smith RP. Epidemiological trends in psychosis-related emergency department visits in the United States, 1992-2001. *Schizophr Res.* 2009;110(1-3):28-32.
- Pompili M, Amador XF, Girardi P, et al. Suicide risk in schizophrenia: learning from the past to change the future. *Ann Gen Psychiatry.* 2007;6:10.
- McNeil DE, Eisner JP, Binder RL. The relationship between command hallucinations and violence. *Psychiatr Serv.* 2000;51(10):1288-1292.
- Agid O, Kapur S, Warrington L, Loebel A, Siu C. Early onset of antipsychotic response in the treatment of acutely agitated patients with psychotic disorders. *Schizophr Res.* 2008;102(1-3):241-248.
- Kapur S, Arenovich T, Agid O, Zipursky R, Lindborg S, Jones B. Evidence for onset of antipsychotic effects within the first 24 hours of treatment. *Am J Psychiatry.* 2005;162(5):939-946.
- Jain R. Managing bipolar disorder from urgent situations to maintenance therapy. *J Clin Psychiatry.* 2008;69(3):e7.
- Hazlett SB, McCarthy ML, Londner MS, Onyike CU. Epidemiology of adult psychiatric visits to US emergency departments. *Acad Emerg Med.* 2004;11(2):193-195.
- Chaput YJ, Lebel MJ. Demographic and clinical profiles of patients who make multiple visits to psychiatric emergency services. *Psychiatr Serv.* 2007;58(3):335-341.
- Smith RP, Larkin GL, Southwick SM. Trends in U.S. emergency department visits for anxiety-related mental health conditions, 1992-2001. *J Clin Psychiatry.* 2008;69(2):286-294.
- Pasic J, Zarkowski P. Anxiety. In: Glick RL, Berlin JS, Fishkind AB, Zeller SL, eds. *Emergency Psychiatry: Principles and Practice.* Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins; 2008:201-211.