Care of the Psychiatric Patient in the Emergency Department

INTRODUCTION

According to the Agency for Healthcare Research and Quality (2010), mental disorders and/ or substance abuse are related to one of every eight emergency department cases in the U.S. This translates into nearly 12 million visits to hospital emergency departments in a year. It is important therefore that best practices in the care of psychiatric patients in the emergency department be identified, documented and disseminated to both improve care of psychiatric patients in the emergency setting and also to provide for increased staff safety. It is also important that gaps in the research literature related to the care of psychiatric patients in the emergency care setting be identified.

STAFF ATTITUDES AND CONCERNS

For a myriad of reasons, emergency department caregivers in general do not feel comfortable in providing care for emergency psychiatric patients. In many instances, this results in psychiatric patients receiving inadequate care. While the roots of these attitudes are numerous, studies (Clarke, Hughes, Brown & Motluk 2005; Gordon, 2012; Kerrison & Chapman, 2007; McAllister, Creedy, Moyle, & Farrugia, 2002; Purves & Sands, 2009; Stuhlmiller, Tolchard, DeCrespigny, Kalucy, & King, 2004; Valdez 2009; Wand & Happell, 2001) have shown several contributing factors:

- Societal attitudes and personal biases,
- Inadequate educational preparation,
- Organizational climate,
- Safety concerns,
- Crowding,
- Caregiver lack of confidence in skills and expertise, and
- Lack of guidelines.

While many of the studies reported in the literature were conducted in Australia, New Zealand, United Kingdom and Canada, the findings are consistent with those carried out in the United States.

Stefan (2006) notes the ambivalence on the part of emergency care providers as to whether persons with psychiatric crises belong in the emergency department. This attitude, she concludes, has led to significant delays in the development of standards of care for treating psychiatric emergencies. She further notes that there is no apparent agreement on what constitutes a psychiatric emergency or how psychiatric assessment should be conducted in the emergency department. In addition, she points out lack of agreement on what should be included in medical clearance or cognitive assessment. Finally she notes that there is no standard or agreement regarding admission or discharge criteria for the patient with a psychiatric emergency. She sees this as a result of the care of psychiatric patients not being considered part of real emergency services and further states that emergency care providers regard psychiatric patients as problems or nuisances.

Stefan's observations are borne out in the literature. Findings suggest that stigma associated with mental illness may be as strong in health care providers as it is in the general population (Brinn, 2000; Putman, 2008; Reed & Fitzgerald, 2005; Ross & Goldner, 2009).

Emergency nurses and non-psychiatric physicians commonly perceived themselves as lacking knowledge, skills and expertise to provide appropriate care and treatment to psychiatric emergency patients (Clarke et al, 2005; Gordon, 2012; Kerrison & Chapman, 2007; Wand & Happell, 2005). Lack of educational preparation in the care of psychiatric patients is frequently cited as an important contributing factor.

Within the psychiatric emergency patient population, there are two sub-populations that pose particular challenges to the emergency care providers. The two populations consist of those patients presenting with 1) intentional self-harm including suicide (Doyle, Keough, & Morrison, 2007; Egan, Sarma, & 'Neill, 2012; McAllister, 2002; Pallikkathayil & Morgan, 1988; Olfson, Marcus, & Bridge,) or those presenting with 2) substance use / abuse (Spence et al, 2008; Bystrek, 2010; ACEP 2008; Agency for Healthcare Research and Quality (AHRQ) 2010). There is a frequent overlap of these two issues and substance abuse is a known risk factor for suicide.

Emergency care providers are often required to assess and manage the care of patients who self-harm. Many describe a lack of knowledge and expertise as to how best to accomplish that. Additional challenges noted in providing care to these patients included triage risk assessment, frustration with patients who present with repeated suicidal behavior, insufficient resources, lack of available time to provide care, concern with ensuring ongoing patient safety, lack of psychiatric in-patient beds resulting in long lengths of stay, and a feeling of helplessness at the perceived failure of the mental health system (Doyle, 2007). According to other studies (Egan, 2012; McAllister, 2002a; Suokas, Suominen, & Lonnqvist, 2009; Palliikkathayil, & Morgan, 1988) a lack of specific knowledge and skill along with general negative attitudes toward suicide attempters contributes to the concern that psychiatric patients in general and in particular those with expressed suicidal thoughts or actions do not receive adequate care in the emergency department. Most of these studies noted that emergency care providers, both nursing and medicine, had inadequate education in the care of psychiatric emergencies. A consistent recommendation resulting from these studies is for increased education and professional development.   McAllister, Creedy, Moyle & Farrugia (2002b) found four dimensions to explain the variations in nurses' attitudes toward self-harm: perceived confidence in assessment and referral, ability to deal effectively with patients, empathic approach, and ability to cope effectively with legal and hospital regulations that guide practice.

Substance use and abuse is a confounding factor in many emergency department visits. A survey done by the American College of Emergency Physicians (ACEP) eludes to the fact that substance abuse or dual diagnosis patient services are frequently not available. Bystrek (2010) noted a gap in the literature related to detecting substance abusers who present to the emergency department. While the presence of patients who abuse alcohol, opioids, or other illicit substances is well known to emergency department staff, there is little in the literature that addresses the multiple issues involved with the care of these patients in the emergency department. Bystrek's study confirmed that emergency staff overall have little, if any, education specifically related to substance abuse, that they are more familiar with alcohol than with other substances of abuse, that substance-abusing patients are managed inadequately, and that there is a shortage of services to treat this patient

group which is therefore an impediment to adequate management. Spence et al (2008) studied men with a history of substance abuse and suicidal behavior who were frequent users of the emergency department. Emergency staff were also study participants and shared their feeling about caring for this population. Staff reported that caring for patients who were both alcohol abusers and suicidal was stressful especially as related to the chronicity of the illness and noted perceived lack of progress as a major source of frustration. According to the National Institute on Drug Abuse (NIDA), in 2009 there was an increase of 98.4% in emergency department visits involving non-medical use of pharmaceuticals (either alone or in combination with another drug) since 2004. The largest increases were attributed to oxycodone products and benzodiazepines. In that year (2009), almost one million emergency department visits involved the use of an illicit drug. The numbers speak to a problem that is growing exponentially and research is needed to influence emergency practice.

PATIENT ATTITUDES AND CONCERNS

It is important to consider the patient's perspective related to receiving psychiatric care services in the emergency department. Allen and colleagues (2003) investigated the consumer (patient) perspective and present several recommendations. Areas in which both the consumers and psychiatric clinicians agreed included the desirability of verbal interventions, collaborative approach to care, use of oral medications with input from the patient regarding medication experiences and preferences. Most of the consumer participants had had negative experiences in the general emergency department and recommended that there be alternatives to the general ED, for example specialized psychiatric emergency services. The patients also recommended increased training of emergency department staff, increased use of peer support services, increased collaboration between patients and providers, and improved discharge planning and follow-up. Other studies have pointed to issues of concern with the triage process, the noise of the ED, long waits for treatment, and lack of privacy. Clarke, Dusome & Hughes (2007) found that psychiatric patients felt that they were not a priority and they perceived a lack of expertise in the emergency department regarding mental health. They felt labeled and believed they were triaged as psychiatric patients regardless of their presenting complaints. For these reasons however, this group of patients stated that they did not want a separate psychiatric emergency department. Participants recommended that emergency departments be staffed with psychiatric emergency nurses and psychiatric nurse practitioners.

SUMMARY AND RECOMMENDATIONS

It is clear from the literature that psychiatric patients are a significant percentage of the emergency department patient population, and it is equally evident that emergency nurses and physicians lack the educational preparation to provide satisfactory care in many instances. The educational issue is only one factor in the care of psychiatric patients in the emergency department however. Other variables need also to be considered such as stigma, negative attitude of staff, safety concerns, lack of practice guidelines, and organizational/ environmental features such as crowding and staffing.

Recommendations include:
1. Increasing the content related to care of psychiatric patients in nursing and medical education, postgraduate courses, and continuing education/professional development programs,

2. Developing a psychiatric nursing position in emergency departments – preferably a psychiatric-mental health nurse practitioner/advanced practice nurse,
3. Increasing the use of peer counselors for psychiatric patients, and
4. Arranging a defined space in the emergency department for psychiatric patients to decrease extraneous stimulation and afford a degree of privacy.

TRIAGE OF PSYCHIATRIC PATIENTS IN THE EMERGENCY DEPARTMENT

The development of the ESI Scale for the triage of patients presenting to the emergency department has proven to be beneficial to the triage process and the appropriate assignation of triage priorities. In the Emergency Severity Index (ESI) Version 4 Implementation Handbook 2012 published by the Agency for Healthcare Quality and Research (2011) there is a brief reference to psychiatric patients when considering which patients would be labeled level 2 (high risk). Possible presenting complaints, or behaviors, are included in the discussion of determinants of Level 2 categorization. ESI, however, was developed for all patients presenting to the emergency department, so the nuances of triage of psychiatric patients is not explored. As is noted in the Implementation Handbook, the reliability of triage assignment is important because the result of under-triage may be deterioration in the patient's condition while waiting to be seen. On the other hand, over-triage may result in the misuse or misallocation of scarce resources.

Both Canada and Australia have developed acuity systems for the triage of patients with mental health related symptoms (Bullard, Unger, Spence, & Grafstein, 2008, Mental Health and Drug and Alcohol Office, 2009). The Australasian Triage Scale (ATS) and the accompanying Mental Health Triage Scale (MHTS) (2009) is more specifically constructed for the acuity designation of mental health presentations than either the ESI approach or the Canadian Emergency Department Triage and Acuity Scale (CTAS).

According to the Australian reference guide, the higher the potential for something to go wrong, the higher the triage rating should be. It lists the following factors as those that should be considered: risk of aggression, risk of suicide / self -harm, risk of leaving, and risk of a physical problem / medical diagnosis. Unlike ESI, but similar to many other triage scales, the Australasian mental health triage scale includes time parameters within which the patient should be evaluated. A 5 level scale is a continuum of levels of risk with Level 1 as definite danger to self or others and level 5 as non-urgent, no acute distress and no behavioral disturbance. General management principles are also included that include supervision, action, and considerations for each acuity level.

The Canadian Triage and Acuity Scale (Bullard, 2008) is more broadly based, but does include a section on the triage of mental health complaints. Along with the presenting complaint, there is a table of potential descriptors in that category and the appropriate CTAS triage level. For example the presenting complaint of anxiety or situational crisis might have the descriptor severe anxiety or agitation that has the accompanying CTAS level designation as II. The same presenting complaint but with the descriptor of mild anxiety or agitation would have the CTAS level designation of IV. For consistency in the use of descriptors, each of the terms used is defined in an accompanying table.

It should be noted that an underlying assumption of the Australasian triage tool and CTAS is to categorize how long the patient can be allowed to wait without increasing the risk of a poor

outcome. The ESI does not define or assign a time interval for patients to be evaluated according to each of the triage categories.

Since these varied approaches to triage of mental health patients have now been in use for several years, it is important for research to explore if one or the other method of categorizing the urgency of emergency psychiatric patients is more useful in meeting the needs of both the patient and the emergency department. (See examples of CTAS and Australasian scales in Appendix A)

Some early work on this topic concluded that for psychiatric patients, the common components of triage and initial assessments such as vital signs, basic history, physical exam, laboratory tests and toxicology screens were of low yield in the subsequent treatment of psychiatric patients in the emergency setting (Olshaker, Browne, Jerrard, Prendergast, Stair, 1997). However, more recently, White (2010) cites the need for medically related diagnoses to be ruled out before determining that the behavioral symptoms present are only related to a psychiatric illness. She explains that studies have shown that some emergency patients with behavioral symptoms have been ultimately diagnosed with a wide range of concomitant medical disorders that may be responsible for the presentation either wholly or in part. This would suggest that the usual components of a medical evaluation are necessary in the care of patients presenting to emergency departments with symptoms of psychiatric disturbance. White further cautions triage nurses to not plant the seed of a "psych" label in colleagues' minds thus perhaps influencing the assessment and treatment of the patient as a result of a misdiagnosis.

A mental health triage assessment tool is described by Ayliffe, Lagace, & Muldoon (2005) as one that is on the reverse side of their usual triage assessment form. Given the recent conversion in most emergency departments to electronic health records, this innovation may not still be applicable, but the content of the mental health assessment tool still bears merit. The format of the tool includes presenting complaint(s), to whom the patient will be assigned, and the triage code. For example the complaint 'active hallucinations' is to be seen by the ER physician and is a triage code Urgent. Mood disturbance without suicidal behavior is assigned to the crisis intervention worker and the triage code is semi-urgent. Such a system provides guidance for the triage nurse and improves the flow and function of the department.

The use of a far less complex tool developed to assess changes in behavioral activity in agitated patients was explored by Schumacher, Gleason, Holloman, and McLeod (2010). Entitled the Behavioral Activity Rating Scale (BARS), it consists of a single item describing the patient's activity on a 7 point scale. It was thought that such a scale would be more useful in the rapid paced emergency department. The advantage that the BARS tool has is that in addition to predicting which patients will need psychiatric management interventions such as sedating medications or restraint, it can also be used as a serial means of observing and documenting changes in patient's behavior and also improve communication between emergency care providers.

One of the high risk psychiatric triage challenges is that of suicide assessment. There are many risk factors to be considered as well as a broad range of presentations. Suicide assessment at triage is one of the topics most discussed in the literature related to triage assessment of psychiatric emergencies. While many of the risk factors are well known and documented, attempts to devise a tool to be used at triage or during the patient's emergency department visit have not been found to be helpful predictors. In addition to asking the patient about suicidal ideation and intent, risk

factors that have been identified and triage nurses should evaluate include age (less than 19 and over 45), male gender, depression, substance use, previous suicide attempt, psychiatric diagnosis, previous psychiatric inpatient admission, social isolation, lack of support system, unmarried, recent significant loss, chronic debilitating illness, chronic pain, access to agents to inflict harm (Cooper, Kapur, Dunning, Guthrie, Appleby, & Mackway-Jones, 2006; Giordano, 2009; Mahal, Chee, Lee, Nguyen, & Woo, 2009).

According to Simon (2011), there is no suicide assessment method that has been empirically tested for reliability and validity, however he also states that if the suicide assessment methodology is faulty, the patient's treatment and safety management may be adversely affected. Given the high stakes, getting the suicide assessment right is critically important.

SUMMARY AND RECOMMENDATIONS

The ESI approach to triage of psychiatric patients is lacking in detail and guidance to triage nurses who are usually non-psychiatric nurses. Other countries have recognized this lack in their triage methods and have sought to rectify it with more detailed psychiatric triage guidelines.

Recommendations include:

1. Research to improve the ESI process for psychiatric patients in the emergency department and to provide definition to the categorization of mental health emergencies.
2. Research is needed to compare the usefulness, reliability and validity of ESI vs. Canadian Triage and Acuity Scale (CTAS) vs. the Australasian Triage Scale / Mental Health Triage Scale (ATS/MHTS) in the triage of patients presenting with psychiatric complaints.
3. Guidelines related to the triage of persons with psychiatric presentations should be developed to accompany ESI Implementation Handbook.
4. Additional education in the care of psychiatric patients is needed for non-psychiatric emergency department care providers to include critical measures of psychiatric assessment.
5. Guidelines for the initial assessment of suicide risk at triage should be developed.

EMERGENCY DEPARTMENT MANAGEMENT OF PSYCHIATRIC PATIENTS

Several articles referred to the triage area as possibly not providing the needed privacy or being the most conducive area of the emergency department for a mental health / psychiatric assessment (Ayliffe, 2005; Clarke et al 2006; Mitchell & Dennis 2006). It has been suggested that after the initial role of triage (sorting / prioritizing), more in depth mental health assessments could be more effectively conducted once the patient is in the treatment area (Mitchell & Dennis 2006). This would be a more thorough initial psychiatric assessment and include the categories of the more usual mental status examination (MSE) such as appearance, behavior, attitude, mood and affect, speech, thought process, thought content, perceptions, cognition, insight and judgment.   Such an initial evaluation would be beneficial in identifying possible medical causes for the psychiatric symptoms as well as serving as a basis for the plan of care for the patient.

Medical Clearance

There has been considerable discussion in the literature about what constitutes "medical clearance" of patients who present to the emergency department with a psychiatric emergency. Because some

physiologic illnesses can have psychiatric symptoms as the reason for the emergency department visit, it is important to rule out medical etiologies of psychiatric symptoms. In a statement discussing the medical clearance exam which has been accepted by the emergency medicine community and can be accessed at www.acep.org/advocacy/massachusetts-medical-clearance-guidelines/, it is stated that medical clearance reflects short term medical stability and indicates that as far as it is possible to know, there is not a medical cause for the patient's presenting psychiatric complaints. It does not however, confirm that there are no ongoing medical issues. The criteria developed suggest a minimum inclusion of several aspects to the medical clearance for persons deemed to be at low risk: age between 15 and 55 years, no acute medical complaints, no new psychiatric or physical symptoms, no evidence of a pattern of substance abuse, and a normal physical examination which includes normal vital signs with oxygen saturation if available), normal (age appropriate) assessment of gait, strength and fluency of speech, memory and concentration. For patients who do not meet the above criteria, additional diagnostic testing is to be determined based on the patient's clinical presentation and physical findings (ACEP, 2009). These guidelines are consistent with the findings cited in the literature that extensive diagnostic testing is of low yield (Olshaker, 1997).

Violence / Agitation / Restraints

Agitation can be caused by a variety of conditions, both medical and psychiatric. Assessment of patients who present to emergency departments in an agitated state should include a brief history and vital signs if possible in order to identify any medical problems that could potentially be life threatening. Two critical assessments that should be done as soon as possible are finger stick blood glucose and oxygenation level. De-escalation techniques should be employed to decrease the patient's agitation (Nordstrom, Zun, Wilson, Stiebel, Ng, Bregman, & Anderson, 2012). History is critically important in determining whether the source of the agitation is likely related to a general medical condition such as hypoglycemia, hypoxia, or neurologic problem vs. an exacerbation of psychiatric illness. Identifying the underlying etiology is key to treating agitation in the emergency setting. According to Nordstrom, if "the patient has no previous history of psychiatric disease (or is younger or older than a typical patient with psychiatric disease), then the agitation should be presumed to be from a general medical condition until proven otherwise" (2012, p.8).

Alcohol and other mind-altering drugs are frequently the reason for agitation and violence in the emergency department. Withdrawal from alcohol and or benzodiazepines can also be a cause of agitation and are of medical concern as well (Nordstrom, 2012). According to the Emergency Nurses Association (2011) Violence Survey, the most frequent source of violence against emergency nurses is patients (97.1%) with alcohol intoxication as a factor in more than half (55%), other drugs also contribute to violent behavior (46%) and psychiatric diagnoses are an issue in 43%. It is important for all emergency department staff to have training in verbal de-escalation techniques in keeping with Center for Medicare and Medicaid Services (CMS) guidelines. In the situation of an agitated patient, verbal de-escalation should be tried before any type of restraint or seclusion is instituted (Knox & Holloman, 2011). De-escalation is a critical strategy in preventing the agitated patient from becoming violent (Strout, 2010).

It is of note that the use of seclusion, restraint, or forced medication intended to calm the agitated patient has the potential for injurious side effects, both physical and psychological, although it is recognized that there are times when their use is unavoidable. The Centers for Medicare and Medical Services (CMS) have guidelines for the use of seclusion, restraint and medication used as

restraint that is also endorsed by the Joint Commission (Knox & Holloman, 2011). All emergency department personnel should be familiar with these guidelines. Noting that the literature on verbal de-escalation is limited, Richmond, et al (2012) serving as an expert consensus panel developed guidelines for the following components of care of the agitated emergency psychiatric patient:

- Physical space should be designed for safety,
- Staff should be appropriate for the job,
- An adequate number of trained staff must be available,
- Objective scales should be used to assess agitation, and
- Clinicians should self-monitor and feel safe when approaching a patient.

Firm limits should be established in order to protect the staff and other patients, while giving the patient choices when possible. Restraints may be necessary of limits are violated.

Beyond Triage: Emergency Department Care of the Psychiatric Patient

A frequently mentioned addition to the emergency department staff that is consistently cited as a positive influence on patient care and increasing staff awareness of psychiatric patient needs as well as improving staff members' confidence in providing care to psychiatric patients is the emergency psychiatric nurse. Because the literature is international, it is difficult to discern the preparation and specific role(s) of these nurses, but it is evident that their presence is well received (Clarke, 2005; McDonough, 2004; McDonough, Wynaden, Finn, McGowna, Chapman, & Gray, 2003;McEvoy, 1998; Ryrie, Roberts, & Taylor, 1997; Wand, 2004; Wand & Happell, 2001; Wand, White, Patching, Dixon, & Green, 2011; Wynaden, Chapman, McGowan, McDonough, Finn, & Hood, 2003). In addition to assisting with the evaluation and care of the psychiatric patients, they, in many instances, are involved with the education of the nursing staff.

Length of Stay

A critical issue in emergency departments is that of (over) crowding. The frequently long lengths of stay for psychiatric patients in the emergency department is considered to be a significant contributor to this difficult circumstance (American College of Emergency Physicians, 2008; Slade et al, 2007; Waseem et al, 2011; Little et al, 2011). Several studies have documented the increased length of stay of emergency patients with psychiatric complaints vs. those patients who present with medical problems (Little, 2011; Slade et al, 2010, Nicks & Manthey, 2012; Chang et al 2011; Kropp et al, 2005; Park, Parl, Siefert, Abraham, Fry, & Silvert, 2009).

As a first step in identifying opportunities to improve emergency department length of stay, Chang et al (2011) studied contributing factors to long lengths of stay for psychiatric patients in the emergency department. Three approaches to care were noted: care by the emergency physician with request for psychiatric consultation and needed, a separate psychiatric emergency service (PES), and psychiatric evaluation of the patient by a master's level psychiatric clinician after initial examination by an emergency physician.

There was significant variability between the 5 hospitals that participated in the study, but the need for inpatient admission was the factor that had the greatest influence on length of stay. Wait times were predicated on time after the decision to admit had been made (Weiss et al, 2012).

Several suggestions made as a result of the study include changing policies related to inpatient admission of intoxicated patients, and developing observation units that are separate from the emergency department, thus helping to alleviate emergency department crowding. The authors note that the results of the study highlight the interrelatedness of the various elements of the mental health system.

Specifically, an extended length of stay for pediatric psychiatric emergency patients has been demonstrated and may be more detrimental to this population than in adults (Case, Case, Olfson, Linakis, & Laska, 2011). Dolan & Fein et al (2011) describe the emergency department as having possible deleterious effects on the care of children because the emergency department is not an environment that is conducive to calming agitated patients, it lacks privacy in many instances which can have a negative effect on pediatric patients and their families.

SUMMARY AND RECOMMENDATIONS

There are numerous and substantive issues in the care of psychiatric patients in the emergency department. These include timely access to mental health professionals, location within the emergency department, safety of the patient, staff, and other patients. The issue of the appropriate components of medical clearance seems to be resolved with guidelines published on the American College of Emergency Physician's website and elsewhere. Although a considerable amount of work has been published regarding the management of agitated, aggressive and/or violent patients in the emergency department, it has mostly been the result of consensus panels while the actual research is sparse. Concerns remain regarding the appropriate care of agitated, aggressive or violent patients who place an additional burden on emergency department staff who may be ill prepared educationally and experientially to care for these patients. In addition, the emergency department environment either structurally or organizationally, may hamper efforts to provide quality care to emergency psychiatric patients.

The most significant issues raised in the literature that have a negative effect on the rest of the emergency department are the ever increasing numbers of patients seeking psychiatric care in emergency departments as well as their extended length of stay. One possible bright spot in the research is the usefulness of adding psychiatric emergency nurses (psychiatric nurse practitioners) to the emergency department staff. These clinicians not only improve the care of patients, but they help the other emergency care providers gain skill and confidence in the care of psychiatric patients.

Recommendations include:
1. Research to explore various models of care for psychiatric patients in the emergency department,
2. Research to demonstrate the effect of psychiatric patients' length of stay on emergency department crowding,
3. Research to investigate the feasibility (including cost/benefit analysis) of holding units not within the emergency department for intoxicated patients or psychiatric patients or both,
4. Research to illustrate the effect of having an advanced practice psychiatric nurse present in the emergency department,

5. Research to determine best practices for the care of the agitated, aggressive or violent psychiatric patient in the emergency department, and
6. Develop criteria for admission vs. discharge of emergency psychiatric patients.
7. Study the length of stay disparity between general medical emergency patients and psychiatric emergency patients.

DISPOSITION, HAND-OFF, FOLLOW-UP CARE

In the care of psychiatric patients in the emergency department, accurate communication between providers is essential. Cooper, Murphy, Jordan, and Mackway-Jones (2008) describe the results of a study that looked at communication between emergency care providers, psychiatric consultants, and the patient's primary care provider (PCP). Given that the PCP is the patient's primary care provider, the need for communication is obvious. However, the study revealed that in only 62% of the cases of patient who had been seen in the emergency department for an episode of self-harm was there communication with the patient's PCP. The vast majority of these communications were from the psychiatric consult staff and not the emergency physician. In only 3 of 93 patients did the emergency staff communicate with the PCP. It would seem this failure of communication /hand-off for follow-up could be a contributing factor in the frequent repeat visits of psychiatric patients to the emergency department for recurrent symptoms. Although communication should flow both from the primary care physician who is referring a patient to the emergency physician and vice-versa, Harris, Giles, & O'Toole, 2002) found communication from the emergency department to the primary care provider was less than 30% (including telephone and written communication). It can be hoped that with electronic health records, this communication will improve to the benefit of patients. There is little doubt that the lack of communication between providers negatively affects patient care.

The decision as to whether to admit a psychiatric patient frequently falls to the emergency physician in geographic areas where access to mental health professionals is minimal. Unfortunately there are no evidence-based criteria to aid in this decision. Obtaining a psychiatric consult to assist with this decision often results in extended lengths of stay for psychiatric patients. Douglass, Luo, & Baraff, (2011) explored whether emergency physicians could identify patients who could be safely discharged without a psychiatric consultation. The results showed that there was only a 76% agreement between emergency medicine and psychiatry regarding patients' final disposition. The authors recommended increased education of emergency providers to improve the percent of agreement between the two specialties.

In a chart review, Boudreaux et al (2009) found that there was no common standard that was evident for documenting aspects of care for patients with psychiatric emergencies. In spite of careful attention to establishing a tool to be used in abstracting chart information, there was a lack of agreement regarding descriptions and the definitions of wording on the charts. Interpretation of documentation from one provider to another can be faulty. One particularly noticeable area where documentation was insufficient was that of agitated psychiatric patient's response to medication. This affects subsequent care if this information is unknown to the next provider. White (2010) also noted that confusion related to the terms used resulted in difficulties in the hand-off to the next care provider.

SUMMARY AND RECOMMENDATIONS

Communication between the emergency physician and the patient's primary care provider or psychiatric care provider was shown to be inadequate. There was the suggestion that this lack of communication may contribute to recidivism in some patients. The issue of long waits in the emergency department for psychiatric patients and the (over)crowding of emergency departments led to the exploration of whether emergency physicians would make the same admission / discharge decisions as psychiatrists. While there was only a fair degree of agreement, it was suggested that since the care of psychiatric patients in the emergency department is a factor in system wide through-put problems, with additional psychiatric education emergency physicians would be able to make appropriate discharge decisions for psychiatric patients. This would shorten the length of stay for those patients perceived to be able to be discharged with follow-up in the community.

The lack of a common language to describe psychiatric assessment findings and treatment was identified in the study by Boudreaux at al. In time this might be improved by the use of electronic health records (EHR), but the development of the terms and descriptors used in EHR programs should be evidence-based.

Recommendations include:

1. Additional research is warranted to explore the consequences (such as recidivism) of communication deficits between providers.
2. Increased education and practice regarding the assessment, diagnosis, treatment and disposition of psychiatric emergency patients should be included in psychiatric residency programs and in continuing medical education.
3. Develop a common language to describe psychiatric symptoms to improve continuity of care.

PEDIATRIC AND ADOLESCENT PSYCHIATRIC EMERGENCY PATIENTS

Patients seeking care for psychiatric emergencies are not limited to adults. For a number of reasons, there has been an increase in the number of children and adolescents seeking psychiatric care in emergency departments. It is estimated that 10% of children in the US have diagnosable mental illness and more than 13 million children need mental health or substance abuse services (Dolan & Fein, et al, 2011).

According to the Institute of Medicine (2007) the evaluation of children with mental health presentations in the emergency department is inadequate and relates this to inadequate levels of education and training of ED physicians and nurses, the emergency department environment, long wait times for patients needing mental health care, and a lack of inpatient resources. In a joint Clinical and Practice Management statement the American Academy of Pediatrics and the American College of Emergency Physicians acknowledge that pediatric mental health concerns are commonly unaddressed in the emergency department. They acknowledge the fact that the care of these children is a challenge to an "already overburdened ED safety net" (ACEP, 2012). In addition there is concern that in the pediatric and adolescent population psychiatric crises may not be identified because trauma may actually be related to a suicide attempt and somatic symptoms may be associated with depression, PTSD, abuse or suicidal ideation (Dolan & Fein, 2011). These authors

urge the conduct of research that is related to the identification and management of pediatric mental health emergencies as they view that as critical for establishing best practices for the care of these children in the emergency department and the community (Dolan & Fein, 2011; Newton et al, 2011).

The lack of inpatient beds for children and adolescents with psychiatric emergencies is described in a study by Mansbach, Wharff, Austin, Ginnis, & Wods (2003) who also note that there may be a racial, insurance type and seriousness of psychiatric illness related to the length of time children were boarded in the ED or the pediatric medical ward vs. being admitted to a psychiatric facility. This was found to be especially true for patients who expressed homicidal ideation who were boarded on the medical service 2/3 of the time. This may be related to the scarcity of inpatient psychiatric beds for children and adolescents so that those facilities can be more selective in admission decisions with regard to insurance and manifested behaviors of patients. While some of the same issues of concern exist for children and adolescents who seek psychiatric care in the ED as for adults, there are also some important differences that should be considered: if the experience of the child or adolescent in the emergency department is a traumatic experience (or if the patient has a high level of stress or previous trauma) neurohormones can become elevated and lead to permanent changes in their developing brain structures. Lifelong behavioral and mental health problems may be attributed to the changes that ensue (Dolan & Fein, 2011).

SUMMARY AND RECOMMENDATIONS

In any discussion of care of patients with psychiatric emergencies in the emergency department, the care of children and adolescents with psychiatric complaints must be included. Studies have shown that mental health issues in this population are frequently not identified or adequately addressed. The scarcity of inpatient psychiatric facilities that can accommodate child and adolescent patients lead to extended lengths of stay for pediatric patients in the emergency department or admission to a pediatric medical ward where psychiatric care is not adequately provided. This situation may lead to life-long mental health issues for pediatric psychiatric patients, especially those who have experienced high levels of stress or trauma from any cause.

Recommendations include:

1. Increased education for emergency care providers regarding the identification and management of pediatric mental health emergencies,
2. Inclusion of pediatric subjects in psychiatric emergency research,
3. Develop improved communication between primary care providers, school health providers, and psychiatric providers (if patient is in treatment) and the emergency department provider regarding care of children with mental health problems,
4. Identify best practices for the care of pediatric / adolescent patients with psychiatric emergencies,
5. Explore issues of cultural, racial and socioeconomic disparities in the care of children and adolescents with psychiatric emergencies, and
6. Advocate for increased awareness of and support for the issues identified in the care of pediatric patients with psychiatric emergencies.

PRACTICE RECOMMENDATIONS SUMMARY

1. Improve emergency care providers' comfort level and attitude toward the care of psychiatric patients in the emergency department including increased educational content related to care of psychiatric patients in nursing and medical education, postgraduate courses, residency programs, clinical orientation programs, and continuing education / professional development programs.
2. Use ACEP guidelines for medical clearance of emergency psychiatric patients.
3. All emergency department providers and staff should be educated in de-escalation techniques.
4. Use de-escalation techniques with agitated patients – seclusion and restraints should only be used as a last resort to protect the safety of the patient, staff and others.
5. Use published and accepted withdrawal protocols for alcohol and opiates.
6. In the instance that behaviors of psychiatric patients are different from their usual symptoms or illness manifestations or there is a new onset of psychiatric symptoms in persons without a psychiatric history - medical etiology for the symptoms must be ruled out first. Do not assume the problem is psychiatric in nature.
7. If a psychiatric patient has medical complaints, do not assume the symptoms / complaints are psychiatrically related until medical causes have been investigated and ruled out.
8. Develop a psychiatric nursing position in emergency departments – preferably a psychiatric-mental health nurse practitioner / advanced practice nurse. Define role expectations.
9. Explore / consider the use of peer counselors for psychiatric patients.
10. To the extent possible, arrange a defined space in the emergency department for psychiatric patients to decrease extraneous stimulation and afford a degree of privacy.
11. If such a space is available, it must be designed for safety (no dangerous objects, easy and have direct egress for staff, etc.).
12. Give patients choices whenever possible / practical.
13. Incorporate universal suicide screening in assessment.
14. Follow CMS guidelines for use of restraint / seclusion.
15. Institute measures to improve communication between all providers involved in the care of each psychiatric patient treated in the emergency department.
16. Develop a common language to describe psychiatric symptoms to improve continuity of care.
17. Identify best practices for the care of pediatric / adolescent patients with psychiatric emergencies.
18. Increase education for emergency care providers regarding the identification and management of pediatric mental health emergencies
19. Develop improved communication between primary care providers, school health providers, and psychiatric providers (if patient is in treatment) and the emergency department provider regarding care of children with mental health problems
20. Advocate for increased awareness of and support for the issues identified in the care of pediatric patients with psychiatric emergencies.

SUMMARY OF RESEARCH NEEDS

1. Research to develop evidence-based standards for the care of psychiatric patients in the emergency department.
2. Research to improve the ESI triage process for psychiatric patients in the emergency department and to provide definition to the categorization of mental health emergencies.
3. Research to compare the usefulness, reliability and validity of Emergency Severity Index (ESI) vs. Canadian Triage and Acuity Scale (CTAS) vs. the Australasian Triage Scale / Mental Health Triage Scale (ATS/MHTS) in the triage of patients presenting with psychiatric complaints
4. Evidence-based guidelines related to the triage of persons with psychiatric presentations should be developed to accompany ESI Implementation Handbook
5. Research on which to base guidelines for the initial assessment of suicide risk.
6. Research to develop evidence-based guidelines for the care of patients with substance abuse issues including drug related behaviors, withdrawal issues, and drug seeking.
7. Research the usefulness of "peer support services" in the care of psychiatric patients in the emergency department.
8. Research to explore various models of care for psychiatric patients in the emergency department.
9. Research to demonstrate the effect of psychiatric patients' length of stay on emergency department crowding.
10. Research to identify factors related to psychiatric patients' long lengths of stay and strategies to decrease.
11. Research to investigate the feasibility (including cost/benefit analysis) of holding units not within the emergency department for intoxicated patients or psychiatric patients or both.
12. Research to illustrate the effect of having an advanced practice psychiatric nurse present in the emergency department.
13. Research to determine best practices for the care of the agitated, aggressive or violent psychiatric patient in the emergency department.
14. Research in order to develop evidence-based criteria for admission vs. discharge of emergency psychiatric patients.
15. Study the length of stay disparity between general medical emergency patients and psychiatric emergency patients.
16. 12. Research is warranted to explore the consequences (such as recidivism) of communication deficits between providers.
17. 13. Pediatric subjects must be included in psychiatric emergency research.
18. Explore issues of cultural, racial and socioeconomic disparities in the care of children and adolescents with psychiatric emergencies.
19. Explore the usefulness of telemedicine for psychiatric consultation, including decreasing length of stay and assisting with admission / discharge decisions.

Appendix A

Canadian Triage and Acuity Scale

CEDIS presenting complaint	Description	CTAS level
Depression, suicidal or deliberate self harm	Attempted suicide or clear suicide plan	II
	Active suicidal intent	II
	Uncertain flight or safety risk	II
	Suicidal ideation, no plan	III
	Depressed, no suicidal ideation	IV
Anxiety or situational crisis	Severe anxiety or agitation	II
	Uncertain flight or safety risk	II
	Moderate anxiety or agitation	III
	Mild anxiety or agitation	IV
Hallucinations or delusions	Acute psychosis	II
	Severe anxiety or agitation	II
	Uncertain flight or safety risk	II
	Moderate anxiety or agitation, or with paranoia	III
	Mild agitation, stable	IV
	Mild anxiety or agitation, chronic hallucinations	V
Insomnia	Acute	IV
	Chronic	V
Violent or homicidal behavior	Imminent harm to self or others, or specific plans	I
	Uncertain flight or safety risk	II
	Violent or homicidal ideation, no plan	III
Social problem	Abuse physical, mental, high emotional stress	III
	Unable to cope	IV
Bizarre behavior	Chronic, nonurgent condition	V
	Uncontrolled	I
	Uncertain flight or safety risk	II
	Controlled	III
	Harmless behavior	IV
	Chronic, nonurgent condition	V
CEDIS = Canadian Emergency Department Information System; CTAS = Canadian Emergency Department Triage and Acuity Scale.		

Mental health complaints and second order modifiers

Rationale: The 2004 adult CTAS revisions introduced a series of second order modifiers to support the CEDIS mental health complaints. Adoption initially, however, was felt to be inconsistent owing,

in part, to a lack of clear definitions and limited content in the CTAS educational package. A multidisciplinary work has been created to address some of these deficiencies; further research is planned to support this work. Table 4 outlines the revised mental health complaints.

Table 4. Mental health complaints and second order modifiers
Bullard, M.J., Unger, B., Spence, J., Grafstein, E. and the CTAS National Working Group (2008). Revisions to the Canadian emergency department and acuity. *Canadian Journal of Emergency Medicine*, 10(2): 136-142.

Australasian Mental Health Triage Scale

Triage Category	
Category 2-Emergency	Patient is violent, aggressive, suicidal, a danger to self and/or others, has/may have a police escort
Category 3-Urgent	Patient is very distressed or psychotic, likely to become aggressive and is a danger to self and/or others, patient is experiencing a situational crisis and is very distressed
Category 4-Semi-Urgent	Semi-urgent Patient has a long standing, semi-urgent mental disorder/problem. May have a supporting agent present (e.g. community mental health nurse)
Category 5-Non-Urgent	Patient has a long standing non-acute mental disorder/problem. No supportive agency present

Happell, B., Summers, M., & Pinikahana, J. (2003). Measuring the effectiveness of the national mental health triage scale in an emergency department. *International Journal of Mental Health Nursing*, *12*(4):288-292. doi:10.1046/j.1447-0349.2003.t01-7-.x

Australasian Mental Health Triage Scale
South Eastern Sydney Area Health Service Mental Health Triage Scale Version

Triage Code	Description	Treatment Acuity	Typical Presentation
1	Definite danger to self or others	Immediate	OBSERVED: violent behavior, possession of weapon, self-destructive behavior in ED
2	Probable risk of danger to self or others Severe behavioral disturbance	Emergency Within 10 minutes	OBSERVED: Extreme agitation/restlessness, physically/verbally aggressive, confused/unable to cooperate, requires restraint REPORTED: attempt at self harm/threat of self harm, threat of harm to others
3	Possible danger to self or others Moderate Behavior disturbances, severe distress	Urgent Within 30 minutes	OBSERVED: agitation/restlessness, bizarre/disorganized behavior, intrusive behavior, confusion, withdrawn and uncommunicative, ambivalence about treatment REPORTED: suicide ideation, presence of psychotic symptoms: hallucinations, delusions, paranoid ideas, thought disorder, bizarre/agitated behavior, presence of affective disturbance: severe symptoms of depression/anxiety, elevated or irritable mood.
4	Moderate distress	Semi-urgent within 60 minutes	OBSERVED: no agitation/restlessness, irritability without aggression, cooperative, gives coherent history REPORTED: symptoms of anxiety or depression without suicidal ideation
5	No danger to self or others No acute distress No behavioral disturbance	Non-urgent within 120 minutes	OBSERVED: Cooperative, communicative, compliant with instructions REPORTED: known patient with chronic psychotic symptoms, known patient with chronic unexplained somatic complaints, request for medication, minor adverse effect of medication, financial/social/accommodation/relationship problems

Broadbent, M., Moxham, L., & Dwyer, T. (2007). The development and use of mental health triage scales in Australia. *International Journal of Mental Health Nursing*, *16*(6):413-21. doi:10.1111/j.1447-0349.2007.00496.x

References

American College of Emergency Physicians (2008). *ACEP Psychiatric and Substance Abuse Survey 2008*. Irving, TX: Author. Available at http://acep.org/uploadedFiles/ACEP/Advocacy/federal_issues?PsychiatricBoardingSummary.pdf

American College of Emergency Physicians (2012). *Pediatric mental health emergencies in the emergency medical services system*. Irving, TX: Author. Available at http://www.acep.org/Content.aspx?id=29624

American College of Emergency Physicians (2009). Massachusetts Medical Clearance Guidelines. Available at http://www.acep.org/advocacy/massachusetts-medical-clearance-guidelines

Allen, M.H., Carpenter, D., Sheets, J.L., Miccio, S., & Ross, R. (2003). What do consumers say they want and need during a psychiatric emergency? *Journal of Psychiatric Practice, 9*(1):39-58.

Bender, D., Pande, N., & Ludwig, M. (2008). A literature review: Psychiatric boarding. U.S. Department of Health and Human Services. Available at http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf

Boudreaux, E.D., Niro, K., Sullivan, A., Rosenbaum, C.D., Allen, M., & Camargo, C.A. (2011). Current practices for mental health follow-up after psychiatric emergency department/psychiatric emergency service visits: a national survey of academic emergency departments. *General Hospital Psychiatry*, *33*(6): 631-633. doi:10.1016/j.henhosppsych.2011.05.020

Brinn, F. (2000). Patients with mental illness: general nurses' attitudes and expectations. *Nursing Standard*, *14*(27): 32-36.

Broadbent, M., Creaton, A., Moxham, L., & Dwyer, T. (2010a). Review of triage reform: the case for national consensus on a single triage scale for clients with a mental illness in Australian emergency departments. *Journal of Clinical Nursing*, *19*(5-6): 712-715. doi:10.1111/j.1365-2702.2009.02988.x

Broadbent, M., Moxham, L., & Dwyer, T. (2010b). Issues associated with the triage of clients with a mental illness in Australian emergency departments. *Australasian Emergency Nursing Journal, 13*(4):117-123. doi:10.1016/j.aenj.2010.08.087

Bullard, M.J., Unger, B., Spence, J., Grafstein, E., & the CTAS National Working Group (2008). Revisions to the Canadian emergency department triage and acuity scale (CTAS) adult guidelines. *Canadian Journal of Emergency Medicine*, *10*(2):136-142.

Bystrek, D.J. (2010). Emergency department doctors' and nurses' knowledge and attitudes concerning substance use and users. *Journal of Trauma Nursing*, *17*(2):119-120. doi:10.1097/JTN.0b013e3181e737ce

Case, S.D., Case, B.G., Olfson, M., Linakis, J.G., & Laska, E.M. (2011). Length of stay of pediatric mental health emergency department visits in the United States. *Journal of the American Academy of Child and Adolescent Psychiatry*, *50*(11):1110-1119. doi:10.1016/j.jaac.2011.08.011

Chang, G., Weiss, A.P., Orav, E.J., Jones, J.A., Finn, C.T., Gitlin, D.F., Haimovici, F.,…, & Rauch, S.L. (2011). Hospital variability in emergency department length of stay for adult patients receiving psychiatric consultation: a prospective study. *Annals of Emergency Medicine*, *58*(2):127-136e1. doi:10.1016/j.annemergmed.2010.12.003

Clarke, D.E., Hughes, L., Brown, A.M., & Motluk, L. (2005). Psychiatric emergency nurses in the emergency department: the success of the Winnipeg, Canada, experience. *Journal of Emergency Nursing*, *31*(4):351-356.

doi:10.1016/j.jen.2005.03.008

Clarke, D.E, Brown, A.M., Hughes, L., & Motluk, L. (2006). Education to improve the triage of mental health patients in general hospital emergency departments. *Accident and Emergency Nursing*,*14*(4):210-218. doi:10.1016/j.aaen.2006.08.005

Clarke, D.E., Dusome, D., & Hughes, L. (2007). Emergency department from the mental health client's perspective. *International Journal of Mental Health Nursing*, *16*(2):126-131. doi:10.1111/j.1447-0349.2007.00455.x

Cooper, J., Kapur, N., Dunning, J., Guthrie, E., Appleby, L., & Mackway-Jones, K. (2006). A clinical tool for assessing risk after self-harm. *Annals of Emergency Medicine, 48*(4):459-466. doi:10.1016/j.annemergmed.2006.07.944

Cooper, J., Murphy, E., Jordan, R. & Mackway-Jones, K. (2008). Communication between secondary and primary care following self-harm: Are National Institute of Clinical Excellence (NICE) guidelines being met? *Annals of General Psychiatry, 7*:21. doi:10.1186/1744-859X-7-21.

Dolan, M.A., & Fein, J.A. (2011). Pediatric and adolescent mental health emergencies in the emergency medical services system. *Pediatrics, 127*(5):e1356-e1366. doi:10.1542/peds.2011-0522.

Douglass, A.M., Luo, J., & Baraff, L.J. (2011). Emergency medicine and psychiatry agreement on diagnosis and disposition of emergency department patients with behavioral emergencies. *Academic Emergency Medicine*, *18*(4):368-373. doi:10.1111/j.1553-2712.2011.01024.x

Doyle, L., Keogh, B., & Morrissey, J. (2007). Caring for patients with suicidal behaviour: an exploratory study. *British Journal of Nursing*, *16*(19):1218-1222.

Egan, R., Sarma, K.M., & O'Neill, M. (2012). Factors influencing perceived effectiveness in dealing with self-harming patients in a sample of emergency department staff. *The Journal of Emergency Medicine, 43*(6):1084-1090. doi:10.1016/j.jemermed.2012.01.049

Emergency Nurses Association. (2010). Substance abuse (alcohol/drug) and the emergency care setting. Position statement. Des Plaines, IL: Author. Available at http://www.ena.org/SiteCollectionDocuments/Position%20Statements/SUBSTANCE%20ABUSE.pdf

Gilboy, N, Tanabe, P. Travers, D. & Rosenau, A.M., (2011). Emergency Severity Index (ESI): A triage tool for emergency department care, Version 4 Implementation handbook 2012 edition. AHRQ Publication No. 12-0014. Rockville, MD. Agency for Healthcare Research and Quality, November 2011.

Giordano, R. & Stichler, J.F. (2009). Improving suicide assessment in the emergency department. *Journal of Emergency Nursing*, *35*(1):22-26. doi:10.1016/j.jen.2007.11.003

Gordon, J.T. (2012). Emergency department junior medical staff's knowledge, skills and confidence with psychiatric patients: a survey. *The Psychiatrist*, *36*:186-188. doi:10.1192/pb.bp.111.035188

Harris, M.F., Giles, A., & O'Toole, B.I. (2002). Communication across the divide. A trial of structured communication between general practice and emergency departments. *Australian Family Physician*, *31*(2):197-200.

Kerrison, S.A., & Chapman, R. (2007). What general emergency nurses want to know about mental health patients presenting to their emergency department. *Accident and Emergency Nursing*, *15*(1):48-55.

doi:10.1016/j.aaen.2006.09.003

Knox, D.K. & Holloman, G.H. (2012) Use and avoidance of seclusion and restraint: Consensus statement of the American association for emergency psychiatry project BETA seclusion and restraint workgroup. *Western Journal of Emergency Medicine, 13*(1):35-40. doi:10.5811/westjem.2011.9.6867

Kropp, S., Andreis, C., te Wildt, B., Reulbach, U., Ohlmeier, M., Auffarth, I., & Ziegenbein, M. (2005). Psychiatric patients turnaround times in the emergency department. *Clinical Practice and Epidemiology in Mental Health*, *1*:27. doi: 10.1186/1745-0179-1-27

Institute of Medicine (2007). *Emergency care for children: Growing pains.* Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services. Washington, DC: National Academies Press. Available at www.nap.edu

Little, D.R., Clasen, M.E., Hendricks, J.L., & Walker, I.A. (2011). Impact of closure of mental health center: emergency department utilization and length of stay among patients with severe mental illness. *Journal of Health Care for the Poor and Underserve, 22*(2):469-472. doi:10.1353/hpu.2011.0057

Mahal, S.K., Chee, C.B., Lee, J.C.Y., Nguyen, T., & Woo, B.K.P. (2009). Improving the quality of suicide risk assessments in the psychiatric emergency setting: physician documentation of process indicators. *The Journal of the American Osteopathic Association*, *109*(7):354-358.

Mansbach, J.M., Wharff, E., Austin, S.B., Ginnis, K., & Woods, E.R. (2003). Which psychiatric patients board on the medical service? *Pediatrics*, *111*(6 Pt 1):e693-698.

McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002a). Study of Queensland emergency department nurses' actions and formal and informal procedures for clients who self-harm. *International Journal of Nursing Practice*, *8*(4):184-190. doi:10.1046/j.1440-172X.2002.00359.x

McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002b). Nurses' attitudes towards clients who self-harm. *Journal of Advanced Nursing*, *40*(5):578-586.

McDonough, S., Wynaden, D., Finn, M., McGowan, S., Chapman, R., & Gray, S. (2003). Emergency department mental health triage and consultancy service: an advanced practice role for mental health nurses. *Contemporary Nurse*, *14*(2):138-144.

McEvoy, P. (1998). Psychiatry at the front line: CPNs working outside regular hours in an inner-city A&E department. *Journal of Psychiatric and Mental Health Nursing*, *5*(6):445-450. doi:10.1046/j.1365-2850.1998.560445.x

Mental Health and Drug and Alcohol Office. (2009). *Mental health for emergency departments – a reference guide.* NSW Department of Health, Sydney. Available at http://www0.health.nsw.gov.au/resources/mhdao/pdf/mhemergency.pdf

Mitchell, A.J. & Dennis, M. (2006). Self-harm and attempted suicide in adults: 10 practical questions and answers for emergency department staff. *Emergency Medicine Journal, 23*(4):251-255. doi: 10.1136/emj.2005.027250

National Institutes of Health, National Institute on Drug Abuse. (2011). *Drug facts: Drug related hospital emergency room visits*. Bethesda, MD: Author. Available at http://www.drugabuse.gov/sites/default/files/hospitalvisits.pdf

Newton, A.S., Ali, S., Hamm, M.P., Haines, C., Rosychuk, R.J., Warron, L., Johnson, D.W., & Klassen, T.P. (2011). Exploring differences in the clinical management of pediatric mental health in the emergency department. *Pediatric Emergency Care, 27*(4):275-283. doi:10.1097/PEC.0b013e31821314ca

Nicks, B.A. & Manthey, D.M. (2012). The impact of psychiatric boarding in emergency departments. *Emergency Medicine International*, *Volume 2012,* article ID 360308, 5 pages. doi:10.1155/2012/360308

Nordstrom, K., Zun, L.S., Wilson, M.P., Stiebel, V., Ng, A.T., Bregman, B., Anderson, E.L. (2012). Medical evaluation and triage of the agitated patient: Consensus statement of the American Association for emergency psychiatry project BETA medical evaluation workgroup. *Western Journal of Emergency Medicine, 13*(1): 3-10. doi:10.5811/westjem.2011.9.6863

Olfson, M., Marcus, S.C., & Bridge, J.A. (2012). Emergency treatment of deliberate self-harm. *Archives of General Psychiatry*, *69*(1):80-88. doi:10.1001/archgenpsychiatry.2011.108

Olshaker, J.S., Browne, B., Jerrard, D.A., Prendergast, H. (1997). Medical clearance and screening of psychiatric patients in the emergency department. *Academic Emergency Medicine*, *4*(2):124-128.

Pallikkathayil, L., & Morgan, S.A. (1988). Emergency department nurses' encounters with suicide attempters: a qualitative investigation. *Scholarly Inquiry for Nursing Practice*, *2*(3):237-259.

Park, J.M., Park, L.T., Siefert, C.J., Abraham, M.E., Fry, C.R., & Silvert, M.S. (2009). Factors associated with extended length of stay for patients presenting to an urban psychiatric emergency service: a case-control study. *The Journal of Behavioral Health Services and Research, 36*(3):300-308. doi:10.1007/s11414-008-9160-0

Purves, D., & Sands, N. (2009). Crisis and triage clinicians' attitudes toward working with people with personality disorder. *Perspectives in Psychiatric Care*, *45*(3):208-15. doi:10.1111/j.1744-6163.2009.00223.x

Putman, S. (2008). Mental illness: Diagnostic title or derogatory term (attitudes toward mental illness). Developing a learning resource for use within a clinical call center. A systematic review on attitudes towards mental illness. *Journal of Psychiatric and Mental Health Nursing*, *15*(8):684-693. doi:10.1111/j.1365-2850.2008.01288.x

Reed, F. & Fitzgerald, L. (205). The mixed attitudes of nurses to caring for people with mental illness in a rural general hospital. *International Journal of Mental Health Nursing, 14*(4):249-257. doi:10.1111/j.1440-0979.2005.00389.x

Richmond, J.S., Berlin, J.S., Fishkind, A.B., Holloman, G.H., Zeller, S.L., Wilson, M.P., Rifai, M.A., Ng, A.T. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American association for emergency psychiatry BETA project de-escalation workgroup. *Western Journal of Emergency Medicine*, *13*(1):17-25. doi:10.5811/westjem.2011.9.6864

Ross, C.A. & Goldner, E.M. (2009) Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6): 558-567. doi:10.1111/j.1365-2850.2009.01399.x

Ryrie, I., Roberts, M., & Taylor, R. (1997). Liaison psychiatric nursing in an inner city accident and emergency department. *Journal of Psychiatric and Mental Health Nursing*, *4*(2): 131-136.

Shumacher, J.A., Gleason, S.H., Holloman, G.H., & Mcleod, W. (2010). Using a single-item rating scale as a psychiatric behavioral management triage tool in the emergency department. *Journal of Emergency Nursing*,

36(5):434-438. doi:10.1016/j.jen.2010.01.013

Simon, R.I. (2011). Improving suicide risk assessment. *Psychiatric times*. Accessed at
http://www.psychiatrictimes.com/articles/improving-suicide-risk-assessment

Slade, E.B., Dixon, L.B., & Semmel, S. (2010). Trends in the duration of emergency department visits, 2001-
2006. *Psychiatric Services*, *61*(9):878-884. doi:10.1176/appi.ps.61.9.878

Slade, M., Taber, D., Clarke, M.M., Johnson, C., Kapoor, D., Leikin, J.B.,…, Zun, L. (2007). Best practices for the
treatment of patients with mental and substance use illnesses in the emergency department. *Disease-a-
Month, 53*(11-12):536-580. doi:10.1016/j.disamonth.2007.10.001

Spence, J.M., Bergmans, Y., Strike, C., Links, P.S., Ball, J.S., Rhodes, A.E., Watson, W.J., Eynan, R., & Rufo, C.
(2008). Experiences of substance-using males who present frequently to the emergency department.
Canadian Journal of Emergency Medicine, *10*(4):339-346.

Suokas, J., Suominen, K., & Lonnqvist, J. (2009). The attitudes of emergency staff toward attempted suicide
patients: a comparative study before and after establishment of a psychiatric consultation service. *Crisis*,
30(3):161-165. doi:10.1027/0227-5910.30.3.161

Stefan, S. (2006). *Emergency department treatment of the psychiatric patient: Policy issues and legal
requirements*. New York: Oxford Press.

Strout, T.D. (2010). Perspectives on the experience on being physically restrained: An integrative review of
the qualitative literature. *International Journal of Mental Health Nursing*, *19*(6):416-427. doi:
10.111/j.1447-0349.2010.00694-x

Stuhlmiller, C.M., Tolchard, B., Thomas, L.J., de Crespigny, C.F., Kalucy, R.S., & King, D. (2004). Increasing
confidence of emergency department staff in responding to mental health issues: an educational initiative.
Australian Emergency Nursing Journal, *7*(1):9-17.

Valdez, A.M. (2009). So much to learn, so little time: educational priorities for the future of emergency
nursing. *Advanced Emergency Nursing Journal, 31*(4):337-353.

Wand, T. & Happell, B. (2001). The mental health nurse: contributing to improved outcomes for patients in
the emergency department. *Accident and Emergency Nursing*, *9*(3):166-176.

Wand, T., White, K., Patching, J., Dixon, J., & Green, T. (2011). An emergency department-based mental health
nurse practitioner outpatient service: part 2, staff evaluation. *International Journal of Mental Health
Nursing*, *20*(6):401-408. doi:10.1111/j.1447-0349.2011.00743.x

Waseem, M., Prasankumar, R., Pagan, K., & Leber, M (2011). A retrospective look at length of stay for pediatric
psychiatric patients in an urban emergency department. *Pediatric Emergency Care*, *27*(3):170-173.
doi:10.1097/PEC.0b013e31820d644b

Weiss, A.P., Chang, G., Rauch, S.L., Smallwood, J.A., Schechter, M., Kosowsky, J.,Hazen, E., Haimovici, F., Gitlin,
D.F., Finn, C.T., & Orav, E.J. (2012). Patient and practice-related determinants of emergency department
length of stay for patients with psychiatric illness. *Annals of Emergency Medicine*, *60*(2):162-171.e5.
doi:10.1016/j.annemergmed.2012.01.037

White, A. (2010). Managing behavioral emergencies: Striving toward evidence-based practice. *Journal of
Emergency Nursing*, *36*(5):455-459. doi:10.1016/j.jen.2008.12.013

Wilson, M.P., Pepper, D., Currier, G.W., Holloman, G.H., & Feifel, D. (2012). The psychopharmacology of agitation: Consensus statement of the American association for emergency psychiatry project BETA psychopharmacology workgroup. *Western Journal of Emergency Medicine*, *13*(1):26-34. doi:10.5811/westjem.2011.9.6866

Wright, E.R., Linde, B., Rau, N.L., Gayman, M., Viggiano, T. (2003). The effect of organizational climate on the clinical care of patients with mental health problems. *Journal of Emergency Nursing*, *29*(4):314-321. doi:10.1067/men.2003.103

Wynaden, D., Chapman, R., McGowan, S., McDonough, S., Finn, M., & Hood, S. (2003). Emergency department mental health triage consultancy service: a qualitative evaluation. *Accident and Emergency Nursing*, *11*(3):158-65. doi:10.1016/S0965-2302(02)00237-0

Authors

Authored by
  Anne Manton, PhD, APRN, FAEN, FAAN

Reviewed by Institute of Emergency Nursing Research (IENR) Advisory Council
  Kathy Baker, PhD, RN, NE-BC
  Margaret Carman, DNP, MSN, RN, CEN, ACNP-BC
  Paul Clark, PhD, MA, RN
  Deborah Henderson, PhD, MA, RN
  Kathleen Zavotsky, MS, RN, CEN, ACNS-BC, CCRN

ENA Board of Directors Liaison
  Gail Lenehan, EdD, MSN, RB, FAEN, FAAN

ENA Staff Liaisons
  Lisa Wolf, PhD, RN, CEN, FAEN, Director of the IENR
  Altair Delao, MPH, Senior Associate, IENR
  Cydne Perhats, MPH, Senior Associate, IENR

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