American College of Emergency Physicians

POLICY STATEMENT

Adult Psychiatric Emergencies

The American College of Emergency Physicians (ACEP) supports a comprehensive approach to psychiatric emergencies. Psychiatric emergencies can include suicidal and homicidal behavior, psychosis, agitation, anxiety, substance use disorders, depression, mania, and a host of related and overlapping medical problems, such as delirium and dementia. All patients deserve access to emergency care for psychiatric crises. Emergency departments (EDs) are a critical component of a comprehensive safety net for psychiatric emergencies, and emergency physicians have an obligation to advocate for high-quality psychiatric emergency care.

In support of these principles, ACEP believes:

- Open access to high quality care for psychiatric emergencies is an essential component of a comprehensive medical safety net.

- Local communities, state and federal governments, private insurers, hospitals, and healthcare systems should be held accountable to invest adequate resources to assure psychiatric services meet the acute needs of patients in crisis.

- Hospitals and community psychiatric facilities should provide emergency psychiatric care comparable to the care provided for other medical emergencies.

- All EDs should be prepared to accept and stabilize the full range of psychiatric emergencies by providing evidence-based training for physicians and nurses, harm-mitigated facility space, adequate supplies and equipment, and coordination with those providing specialty and continuity of care, including psychiatry, social services, and community psychiatric facilities.

- Screening of patients presenting to the ED to detect acute and life-threatening signs and symptoms of suicide is supported by evidence and should be accompanied by treatment for high-risk individuals. All routine screening should be evidence-based, properly resourced, and not detract from the primary mission of the ED.
• Routine medical screening or “clearance” of all patients with psychiatric emergencies in EDs before they can be seen at community psychiatric facilities is not supported by the evidence. Focused screening may be appropriate in selected cases, and the approach should be coordinated across the community. Any medical testing should be guided by the history and physical examination.

• Boarding of patients with psychiatric emergencies in the ED is unacceptable, does not provide for a therapeutic alliance, and is a rapidly growing symptom of a systemic problem. Physicians, hospitals, community agencies, patient advocacy groups, and local, state and federal governments must work together to find timely solutions to this pressing problem.

• Medically appropriate and humane interventions are necessary to treat acutely agitated patients who are a threat to themselves, staff, the public, or who threaten to disrupt the care of other patients in the ED. All EDs should be adequately prepared for this care.

• The initiation of medically appropriate acute psychiatric and behavioral therapies in the ED is important to ensure timely care and should be coordinated with physicians and psychiatric clinicians to preserve continuity of care.

• Emergent psychiatric care should be age and gender-appropriate and tailored to the specific psychosocial conditions of each patient.

• As an integral component of disaster planning, hospitals and EDs should prepare for the emergent psychiatric consequences that disasters and public health crises can bring.

• Emergency physicians, medical associations, and other stakeholders should collaborate to create national consensus guidelines for the care of psychiatric emergencies.

• Research in psychiatric emergencies should be supported at all organizational levels, and emergency departments should be considered as potential sites for the conduct of appropriate studies.