A guide to psychiatric assessment and management in the emergency department

ARTICLE

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SUMMARY

This article provides the general psychiatrist with a pragmatic guide to working confidently and productively in the emergency department (ED). The focus is on effectively navigating the distinctive physical environment, personnel, systems, time pressures, legal boundaries, special challenges and broad scope of practice applicable to this setting to maximally support both patients and staff. It brings to the reader's attention special considerations at all stages of workflow, including pre-assessment preparations, the assessment process and ongoing planning. It considers common requests and the application of mental health law (in England and Wales) associated with both capacity assessment and involuntary care. Finally, it explores unique challenges associated with risk assessment, physical health advocacy and management of conflict in the ED setting. The specific systems described are those of the UK's National Health Service, but the principles involved are universal.

LEARNING OBJECTIVES

After reading this article, you will be able to:

- adapt the process of mental health assessment to accommodate the environment and purpose of an emergency department (ED)
- recognise contributions a psychiatrist can make in the ED independently of direct patient contact
- appreciate some of the nuances of mental health law in England and Wales that are especially pertinent to the ED setting.

KEYWORDS

Liaison psychiatry; mental health services; mental health law; emergency psychiatry; general adult psychiatry.

Demand for 24 h access to a senior psychiatrist in the emergency department (ED) is growing, increasingly warranting involvement of psychiatrists who are not well accustomed to the functional nuances and unique challenges of this setting. This occurs as problems arising from mental health conditions account for a significant and escalating portion of ED attendances internationally (Barratt 2016; Theriault 2020). In addition, people with psychiatric illness are more likely to present to an ED for physical healthcare (Dorning 2016) and to attend the ED with high frequency (Gentil 2021).

The value of a psychiatrist's biopsychosocial approach in the ED should not be underestimated. Mental ill health can complicate medical assessment and management. Physical ill health can contribute to behavioural disturbance, social barriers and risk associated with poor mental health. A concerted multidisciplinary effort can minimise synergistic decline of both and maximise overall department efficiency.

We assume that the general psychiatrist is familiar with the management of psychiatric emergencies forming part of a psychiatrist's role in the ED. The focus here is on functioning within the distinctive ED 'habitat' that forms part of a broader healthcare ecosystem. In Box 1, we list some skills that are required for psychiatrists to work effectively in the ED. Although readers requiring guidance on special patient populations may need to consult further resources, we offer a flavour of psychiatry in the ED that is relevant to all groups. While the article refers to liaison psychiatry in the UK's National Health Service (NHS), the

BOX 1 Skills required for psychiatrists to work effectively in the emergency department

- Ability to work in parallel with emergency physicians
- Ability to work within the time pressures of the department
- Ability to make decisions based on incomplete information
- Ability to tolerate ambiguity and uncertainty
- Ability to constructively discuss differences in opinion

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BOX 2 Key details informing the purpose, urgency and practicalities of assessment in the emergency department

- Patient identifying information and location
- Time of arrival
- Area of current residence
- Initial presenting complaint
- Reason for referral to psychiatry
- Specific request, e.g. formal assessment, medication advice, participation in multidisciplinary team (MDT) discussion
- Medical status, e.g. critically unwell, undergoing investigations but able to engage, ready for discharge
- Medical plan
- Level of arousal, e.g. agitated or disruptive, settled, unconscious
- Psychiatric history
- Details and outcome of any initial psychiatric liaison nurse (PLN) assessment

BOX 3 Common emergency department (ED) referrals to liaison psychiatry

Likely to warrant full psychiatric assessment in the ED:

- acute suicidality or self-harm
- severe self-neglect with evidence of current mental illness
- public disturbance or violence with evidence of current mental illness
- behaviour suggestive of mania or acute psychosis
- severe agitation associated with current mental illness
- mental illness interfering with medical assessment or treatment
- advice regarding cessation, continuation or recommencement of psychotropic medication
- substance withdrawal syndromes (where there is not a substance misuse service separate from psychiatry)

Likely to be redirectable with a triage assessment or discussion with referrer:

- insomnia
- panic attack
- intoxication or antisocial behaviour without evidence of mental illness
- mood disturbance triggered by social stressor(s) without apparent risk to self or others
- safeguarding concerns relating to chronic mental illness
- historical mental health concerns
- repeat prescription requests

principles are relevant to many other systems and countries.

Psychiatric assessment and discharge planning in the ED

Pre-assessment

Psychiatrists commonly receive a referral via a psychiatric liaison nurse (PLN), but direct engagement with the initial referrer is often valuable. Taking time to clarify details included in Box 2 can ultimately save time and help to establish a collaborative working relationship with ED personnel. Where the referrer's request is non-specific or unrealistic under the circumstances, direct discussion can also facilitate agreement on the nature and timing of psychiatric input from the outset. Although we focus in this section on assessment, beyond this the mental health liaison team (MHLT) has much to contribute to the management and subjective experience of patients in the ED. We therefore recommend an open-minded and supportive approach to all referrers.

Referrals from triage are now encouraged (Brown 2020). Occasionally this provides an opportunity for the MHLT to signpost patients to alternative services that better suit their needs, including their general practitioner (GP), community mental health services or a local crisis assessment unit. Where there is a clear need for mental health assessment in the ED, referral from triage allows for swifter flow through the department and supports parallel working between mental health and ED teams. In our experience, 'first contact' by a member of the MHLT at triage can facilitate an understanding of the situation and enable early contribution of expertise to management of the case within the ED. The latter includes planning of special observations or a security search and advocacy for concomitant medical review in cases where the need has been overshadowed by the person's mental state. Examples of common referrals are given in Box 3. It is important to take heed of local ED procedures and community resources that affect which referrals warrant psychiatric assessment in the ED setting and which may be reasonably redirected.

Once the referral has been received and clarified, collateral information from electronic record systems can be sought with the specific goals of the assessment in mind. A detailed understanding of the patient's psychiatric history is not always required to address the urgent task at hand. For patients in crisis, understanding previous engagement and any difficulties with previous treatments allows for targeted discussion within the assessment to better inform the plan. For patients who attend the ED

frequently, records should be checked for an individualised care plan. Familiarity with this will help ensure a consistent and constructive approach to both assessment and management.

Assessment

It is considered essential by both the Psychiatric Liaison Accreditation Network (Baugh 2022) and the Royal College of Emergency Medicine (RCEM) (RCEM 2021) to have available in the ED a customised mental health assessment room. This should have two doors that open both ways and cannot be locked from the inside, an observation window, a panic button, a risk-assessed ceiling, no ligature points or potential weapons, and calming decor. Regrettably, this will not be available in every ED or at all times. Where a patient is to be observed or assessed in a more traditional cubicle or the resuscitation area, a brief risk assessment of the space should be carried out beforehand (RCEM 2021).

It is to everyone's advantage that psychiatric assessment proceeds as soon as the patient is capable of engaging and a suitable space has been secured. Parallel working between acute hospital and liaison psychiatry staff is now considered a fundamental standard by the Royal Colleges of Psychiatrists, Emergency Medicine, Nursing and Physicians (Brown 2020). Although critical illness, reduced consciousness or severe intoxication might delay a complete interview, it is neither practical nor sensible to await 'medical clearance' or 'medical optimisation' to begin assessment. In some places, the value of parallel working is understood in theory better than it is practised. A key role of a psychiatrist in the ED is to model for the wider team a collaborative working style.

There are many reasons why psychiatric input should not be delayed. First, there are no widely agreed criteria for deeming a patient medically 'cleared' or 'optimised'. Second, the key target of seeing, treating and planning the ongoing care of patients within 4 h of arrival in the ED is incorporated into the NHS constitution (Department of Health & Social Care 2025). Declining to become involved until the patient is 'medically cleared' is likely to anger pressured ED staff, result in rushed and inadequate physical health assessments and compromise effective collaboration. Third, delay undermines parity of esteem for mental health (Brown 2020). Where the patient cannot yet be interviewed, a collateral history of mental health concerns and communication of relevant background will be invaluable early contributions. Further, early MHLT involvement can prevent escalation of the patient's distress in the unsettling environment of the ED, minimising associated disruption and aiding cooperation with medical investigations. Box 4 describes a fictitious case illustrating that the value of psychiatric input is maximised when integrated with medical input rather than added as an afterthought following segregated review.

BOX 4 Case vignette: integrated psychiatric and medical input

A 48-year-old male with a known diagnosis of bipolar affective disorder presented to the emergency department (ED) with his visibly upset wife. She reported a 2 week history of elevation in his mood and energy levels, which she recognised as signs of manic relapse. She repeatedly requested urgent mental health assessment. The behaviour made it difficult for the assigned ED clinicians to perform a detailed history and physical examination. Apart from a mildly deranged renal function attributed to reduced oral intake, basic blood tests were unremarkable. He was promptly referred to the on-call psychiatrist.

On mental health assessment he was considered hypomanic with retention of some insight. He reluctantly admitted to having titrated his dose of lithium over the past week in an effort to avert relapse, which he knew had historically been associated with extremely distressing experiences for his wife. During the assessment she calmed as her own concerns were explored and it appeared that her husband was getting the help he needed. She interacted more patiently with his assigned nurse, who in turn engaged more compassionately.

The psychiatrist alerted the assessing ED physician to the new concern. The physician undertook a more detailed and targeted physical examination and additional investigations, revealing mild ataxia and hyperreflexia, sinus node dysfunction and a lithium level of 1.4 mmol/L. It was agreed that the patient should be transferred to the adjacent short-stay medical unit for monitoring, cardiology opinion and intravenous fluid therapy. The psychiatrist provided an interim plan to withhold lithium and refer for crisis team follow-up. The mental health liaison team continued to review the patient following transfer, assessing progression of his mental state and associated risks and providing carefully tailored lithium education prior to confirming the discharge plan.

During assessment in the ED, it is not uncommon for multiple unresolved problems to become apparent and to tempt detailed exploration. It is best to keep this question in mind: 'Why has this patient presented with this problem at this point in time?' Further issues not requiring urgent attention should be flagged for the relevant in-patient or community team. Figure 1 gives a template for a full psychiatric assessment in the ED, which can and should be adapted for more targeted assessments and well-known patients.

It is worth remembering that assessment shapes more than the immediate plan. The patient's first

Liaison Psychiatry Assessment

Completed by Dr XXX

Date/Time/Location:

CIRCUMSTANCES OF PRESENTATION

- Details obtained from the referrer, triage notes +/– the ambulance proforma
- Delineate parallel medical assessment and treatment

COLLATERAL HISTORY

- Pre-hospital behaviours delineated in the ambulance proforma
- Information received directly from paramedics or police who brought the patient to the ED
- Observations of ED staff
- Recent perspective of the patient's CMHT*
- Concerns of friends, family and/or staff at residential accommodation

HISTORY OF PRESENTING PSYCHIATRIC COMPLAINT (patient interview)†

PSYCHIATRIC HISTORY†

MEDICAL HISTORY†

MEDICATIONS†

ADVERSE REACTIONS†

FORENSIC HISTORY†

DRUGS and ALCOHOL†

SOCIAL HISTORY†

MSE†

CAPACITY†

RISK

- Assessment of risk to self, risk from others and risk to others, including children – with particular attention to immediate and medium-term risks

IMPRESSION and CURRENT ISSUES

Example:
Chronic schizophrenia currently stable on haloperidol but lost to outpatient follow-up
New extrapyramidal side-effects

DISCUSSED WITH OTHER MEMBER(S) OF MHLT: XXXX and XXXX

PLAN:

In hospital:

- Suitability of current location (area of ED, cubicle type)
- Suggested observations level (if 1:1, may specify minimum qualification of supervisor)
- Caution regarding specific risks, e.g. previous violence towards hospital staff or self-harm within ED
- Suggested action if this patient attempts to leave ED before discharged
- Suggested management of acute agitation, including suitable PRN medication
- +/– Management of substance withdrawal

Post-hospital:

- Advice and resources given to the patient during the assessment, e.g. crisis line number, details of local psychological services or social groups
- Plan for psychiatric admission (including legal status) or out-patient follow-up
- Specific requests for GP
- Plan for regular psychotropic medications: ?continue pre-existing, ?same dose, ?new

*If the patient is 'out of area', notes may be requested out of hours by telephoning other MHLTs or crisis telephone lines.
†As per standard psychiatric assessment, although abbreviated formats should be considered for more targeted assessments and well-known patients.

FIG 1 Example emergency department (ED) liaison psychiatry assessment proforma. CMHT, community mental health team; MSE, mental state examination; MHLT, mental health liaison team; PRN, *pro re nata* (when required; as necessary); GP, general practitioner.

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account of events leading to presentation is naturally the most authentic, unadulterated by progressive fatigue, forgetting and evolution of emotion. Documentation of it will become an invaluable resource for the treating mental health team and is likely to influence ongoing formulation and management. For many patients, a long relationship with mental health services begins in an ED cubicle. Subjective experience of this encounter may determine ongoing engagement with services, with potential consequences for the trajectory of illness. Hence, it is important that despite the constraints of the noisy, crowded, chaotic ED environment, the psychiatrist aims to conduct the initial psychiatric assessment in the most therapeutic manner possible.

In-hospital and post-hospital planning

Components of care taken for granted in specialised psychiatric settings may not be as reflexively considered by staff in the ED. This includes consideration of patient location and access to potential ligatures, regular observations independent of vital sign monitoring, precautions against risk to others, appropriate response if the patient absconds (leaves before they are discharged) and least restrictive management of agitation. Particularly where such factors are crucial, the plan may need to be highly specific.

In post-hospital planning, the psychiatrist has responsibility as a gatekeeper of in-patient and community mental health services. The available resources can be viewed as sitting on a spectrum ranging from least specialised and intensive (e.g. follow-up with a GP) to most specialised and intensive (e.g. in-patient admission under mental health legislation). Options falling between these extremes will vary depending on locality. They commonly include community mental health team (CMHT) follow-up, crisis team follow-up, temporary accommodation at a crisis house and voluntary admission to a traditional in-patient unit. Methods of referral to the range of services will also vary locally. Members of the multidisciplinary MHLT are likely to be helpful guides.

A template in-hospital and post-hospital plan is included in Fig. 1.

It is useful to come to the assessment 'armed' with information relevant to the patient's address, which may not be in the same locality as the hospital. For those likely to be discharged, this should preferably include a relevant crisis line telephone number to be given the patient. Patients not previously known to mental health services may benefit from explanation of how these are locally structured and what they can expect after discharge from the ED.

A natural effect of parallel working is that plans will often be dynamic, evolving with the patient's progress. Given the acute shortage of in-patient psychiatry beds, patients may remain in the ED long after a decision to admit has been made. The medium-term management of mentally unwell patients in the ED requires close liaison between the MHLT and the ED team. Verbal handover to the patient's nurse and/or treating doctor at each review provides opportunities for both sides to ask clarifying questions and develop a shared understanding, fostering collaborative relationships that are fundamental to effective liaison psychiatry. ED clinicians may engage more thoroughly with the physical health needs of a behaviourally 'difficult' patient if feeling supported by the MHLT. In some cases, these interactions also provide powerful opportunities to correct misperceptions about the patient's mental illness, helping to reduce the widespread stigmatisation disturbingly common in healthcare settings (Clarke 2014).

Capacity assessment in the ED

Although readers may work within different legal frameworks, in the following sections we reference those currently in use in England and Wales for illustrative purposes. In England and Wales, criteria for assessment of capacity to consent to either medical or psychiatric care in the ED do not differ from other settings and are statutorily defined by the Mental Capacity Act 2005 (MCA) (Department for Constitutional Affairs 2007). Beale et al (2024a, 2024b) and Owen et al (2023) provide pragmatic guides. We focus here on situations in which a psychiatrist may be asked to contribute to the assessment of capacity for urgent medical care, commonly for a patient who has self-harmed and is refusing investigations and/or treatment.

As in other settings, assessment is often complex and involves an uncomfortable degree of uncertainty. Adding to difficulty in the ED, a decision may be required quickly to preserve life and it is usually not feasible to arrange a formal multidisciplinary meeting. There may be a low threshold to seek support from a psychiatrist, assumed to be experienced and adept at assessment of capacity. We acknowledge that this can be a source of frustration for psychiatrists, as all medical professionals are capable of assessing capacity and the decision must ultimately be made by the team enacting it. Indeed, in some cases the referring clinician might already have formed their own view of capacity and the request seems actually for moral support or added legal 'protection'. A psychiatrist certainly cannot be expected to take responsibility

for medical treatment decisions in the ED, nor to resolve ethical issues entwined within complex cases. However, a supportive rather than a critical approach will surely best serve the patient, colleagues and the healthcare system more broadly. Initial exploratory discussion with the referrer will help to uncover what is really being sought. In some cases, it will wholly provide it.

As described by Herschkopf (2021), there is value in involving a psychiatrist beyond direct assessment of capacity. For example, a psychiatrist can facilitate an assessment by providing education in the form of case-based discussion of relevant sections of law, by helping to recognise and rectify factors compromising capacity or by providing a diagnostic opinion to clarify a 'disorder of mind or brain' (MCA, section 2(1)). A psychiatrist can also help clinicians to become conscious of countertransference, including how their emotional reaction to the patient may be influencing their assessment and indeed the referral. In all cases, it is advisable to document the nature of any contribution.

Sometimes it will be appropriate for a psychiatrist to contribute directly to assessment of capacity to consent to medical treatment. It is perhaps unfair to expect medical colleagues to be as discerning of subtle means by which psychiatric symptoms impair decision-making. The ability to 'use or weigh' information relevant to a decision (MCA, section 3(1)) can be particularly tricky to assess. For example, a patient with a diagnosis of emotionally unstable personality disorder (EUPD) who presents following self-harm might be able to articulate the benefits and risks associated with receiving life-saving treatment and communicate refusal of treatment. Exploration of the circumstances of the self-harm, astute mental state examination and access to the patient's psychiatric history, including pattern of presentations, will inevitably provide helpful context. These might suggest that severe emotion dysregulation is precluding use of the acknowledged information in the decision, which instead appears to be driven by the overwhelming sense of hopelessness characterising a transient crisis. In these cases, joint assessment with the doctor offering medical care is desirable. Therapeutic engagement within the assessment may have the added benefit of enhancing both capacity and cooperation (Beale 2024b).

Importantly, in England and Wales the steps that must be taken to form a 'reasonable belief' of incapacity and those that must be taken to enhance capacity in the process of assessment are commensurate with the urgency of the decision (Department for Constitutional Affairs 2007: paras 4.44 and 4.45). This becomes particularly relevant when the patient refusing emergency medical intervention is either not able or not willing to engage completely in assessment of capacity but where delaying intervention is likely to cause further deterioration or reduce the effectiveness of treatment.

Involuntary care in the ED

Holding without consent

In the ED, a psychiatrist's grasp of law permitting detainment without the patient's consent may be rigorously tested. This is because a broad variety of circumstances present themselves, often evolving over minutes or hours and necessitating change in approach. Where a psychiatrist has completed an assessment, pre-emptive guidance about what staff should do if the patient attempts to leave the ED before formal discharge is desirable. This helps to avoid a situation in which a vulnerable patient without the capacity to decide to leave does so without intervention because staff do not fully appreciate either the risks involved or their legal and ethical obligations. In other scenarios, multidisciplinary staff, including security officers, may seek to quell uncertainty about the right course of action or to know precisely the law justifying their restrictive actions. In our experience, reassurance gained from the brief advice of a psychiatrist can have a palpable effect on the composure of staff at the scene. Box 5 provides a fictitious example.

Nuances of current mental health law in England and Wales frequently pertinent in the ED include the following. Sections 5(2) and 5(4) of the Mental Health Act 1983 (MHA) cannot be used in the ED (they relate respectively to a doctor's and a nurse's power to hold for the purpose of MHA assessment). Although they may be used in adjacent short-stay units where the patient is briefly 'admitted' to hospital, a patient cannot be admitted for the sole purpose of a section 5(2). The only mental health legislation allowing detention in the ED is section 136 of the MHA (a police officer's power to transfer to a place of safety someone who appears to have a mental disorder and to be in urgent need of care or control). In this case an MHA assessment must be completed within 24 h, starting from the time of first arrival. A transfer between places of safety can be facilitated only when it is considered in the patient's best interest and not on grounds of convenience or patient flow. Similarly, one 12 h extension is permitted only to allow the patient to become assessable. Police are required to remain present until expiry unless hospital staff agree to take on responsibility for the patient's safety (RCEM 2017).

Holding a patient in the ED either while awaiting an MHA assessment or while awaiting a mental health bed required to complete an application for

BOX 5 Case vignette: collegial reassurance and advice

A 32-year-old homeless woman with a history of major depression was conveyed to the emergency department (ED) by police after being found seated on the ledge of a bridge, overlooking traffic and appearing teary. She did not object to attending, although engaged minimally. On arrival, a foundation doctor[a] reviewed her, managed a right metacarpal fracture sustained in an altercation the day before, noted her affect to be flat and attention poor and referred her to the mental health liaison team for discharge planning. While awaiting their assessment she packed her belongings and indicated that she would be leaving. The doctor was not able to engage her in discussion and panicked. As the ED consultants were busy attending to a full resuscitation bay, the mental health liaison team was contacted for urgent advice.

The psychiatrist advised the doctor to call the security team and arranged for expedited attendance of a senior psychiatric liaison nurse (PLN). The PLN established that the woman planned to return to the bridge and appeared to have difficulty processing information during discussion about mental health follow-up. It was communicated to the foundation doctor that the patient did not demonstrate capacity to discharge herself and a Mental Health Act assessment was promptly arranged. When the woman attempted to leave again, the security team questioned the legal basis for physical restraint. The foundation doctor was able to assure them that the Mental Capacity Act 2005 was being utilised, her new calm and confidence helping to contain the frantic atmosphere at the scene.

a. A doctor in 2 year postgraduate medical training undertaking a series of rotations in different specialties.

detention under section 2 of the MHA is permitted under the MCA or under the common law doctrine of necessity, depending on the circumstances. (Even after two medical recommendations are made, the application cannot be completed by an Approved Mental Health Professional (AMHP) until an in-patient bed is identified.) Common law is likely to be employed where the risk of harm is exclusively to others or where the patient has the capacity to decide to leave but is of 'unsound mind' (*Black v Forsey* [1987]). Although the MCA (outside of its Deprivation of Liberty Safeguards (DOLS)) and common law permit only restriction of liberty, there is neither a statutory definition of deprivation of liberty nor any case law demonstrating precisely where the line between restriction and deprivation is crossed in the ED setting. Alex Ruck Keene's analogy of 'legal ice' is useful here. Taking immediately necessary and proportionate action to protect a patient's life or the safety of others in an emergency is in accordance with the European Convention on Human Rights and likely to rest on 'thick legal ice'. That is, it is likely to be legally justifiable even if the legal basis is not defined by clinicians at the time. However, the ice will thin as time passes (Ruck Keene 2021). Once immediate action has been taken, it is imperative to ensure that an appropriate legal framework is actively pursued, to escalate any delays in the process and to continually reassess the necessity and proportionality of the restrictions.

Emergency medical treatment

Enforcing medical intervention can be pragmatically very challenging. It will sometimes require sedation and intubation in an intensive care setting and a spate of associated risks that would not have developed had the patient acquiesced. It may be necessary to resist pressure to take the lead on such decisions. Instead, a psychiatrist's biopsychosocial approach can help inform the medical team's views of what care is in the patient's best interests. For example, cognisance of the psychological impact of a previous traumatic experience of being restrained may raise the threshold for taking this approach.

To psychiatrists' dismay, a presumption that any indicated medical treatments can be given without consent under mental health legislation is not uncommon. A psychiatrist in the ED might find a colleague seeking assurance that a non-consenting psychiatric patient is 'sectioned' before proceeding with treatment. Such misconceptions highlight contributions that psychiatrists can make outside of patient assessment.

Rapid tranquillisation

Where intramuscular pharmacological intervention is warranted, National Institute for Health and Care Excellence (NICE) guidelines currently recommend either lorazepam or a combination of haloperidol and promethazine (NICE 2015). More specialised national (Patel 2018) and international (Roppolo 2020) guidelines draw attention to special circumstances such as pregnancy, intoxication and withdrawal states and stipulate that agents are ideally targeted at the likely aetiology. We suggest an open dialogue between the ED physician and the psychiatrist when advice is requested, although ultimately in the ED it is the former who must manage physical complications and be comfortable with the balance of benefit and risk in each choice. In some cases, redirection to intensive care or anaesthetic teams will be appropriate, although a psychiatrist's opinion on the cause of agitation will nonetheless guide colleagues' choice of agents.

An understanding of the term 'acute behavioural disturbance' (ABD) in use by emergency services

staff, including police, will be helpful, although we suggest refraining from adopting it. ABD essentially denotes a state of extreme behavioural disturbance associated with adrenergic overdrive. Prompt intervention is considered important to prevent excessive motor activity and sympathetic stimulation from generating severe metabolic derangements and cardiovascular collapse (RCEM 2023). However, like the older term 'agitated delirium', the term ABD is controversial. The Royal College of Psychiatrists' (RCPsych's) position statement casts doubt on its helpfulness (RCPsych 2022). A recent Delphi study attests that it is not distinct from agitation but rather an extreme form of it (Humphries 2023). Both propose that attention to 'red flags' suggestive of a physical health emergency would be preferable to maintaining a separate diagnostic category. Our recommendation is certainly to consider the assessment and management of agitation as a transdiagnostic concept rather than to reify ABD as a separate entity. We also wish to emphasise that as well as being a consequence of extreme agitation, a physical health emergency can cause or contribute to agitation of any severity. In the ED, cases at both ends of the spectrum often benefit from concomitant medical and psychiatric involvement.

As the RCEM recommends either ketamine or droperidol as first-line agents where their criteria for ABD are met (RCEM 2023), these may be encountered on the drug charts of some referred patients. Ketamine is favoured for its dissociative properties and rapid onset (RCEM 2023) and should only be administered in the ED by a level 2 sedation-trained clinician (RCEM 2022). We do not suggest that a psychiatrist should ever advise on its administration in the ED. However, familiarity with the drug can be valuable in the aftermath of its use. Of particular note, 'emergence phenomena' are common and may include a 'dream-like' state, a floating sensation, illusions and visual hallucinations (Electronic Medicines Compendium 2024) which could potentially be confused with features of the patient's underlying mental state. Its other psychiatric effects have been helpfully summarised by Evanoff et al (2023).

Challenging scenarios

Suicidality contingent on social needs

Psychiatrists often encounter patients in the ED who present with suicidal ideas that are expressed in the form 'I will kill myself if you don't provide me with *x*'. The latter might include housing of the patient's choice or a particular intervention to relieve pain. This usually comes up when discharge from the department is discussed. Often these patients do have demographic factors that indicate a high risk of dying by suicide. It is important not to dismiss the patient's statements but to take them as indicators of distress and unmet need. One also needs to be aware of one's own psychological and emotional reactions to the patient and other drivers for discharge, such as bed pressures. The dilemma for the psychiatrist is about managing discharge when the demands of the patient are usually not within the remit of psychiatry, and other agencies say that they have done their best and that the demands are unrealistic.

In such cases, we recommend following the excellent recommendations of Bundy et al (2014). They suggest documenting such decisions in six steps: (1) define and document the clinical situation – summarise the dilemma; (2) assess and document current suicide risk – consider risk factors, protective factors, acute stressors that elevate the risk and access to means; (3) document modified dynamic factors – what you have done to manage the dynamic risk factors so far; (4) document why continued care in the ED is inappropriate – patient's uncooperativeness with treatment, why being in the ED might interfere with a more appropriate care plan in the community, etc.; (5) document discharge discussion with the patient – safety planning, follow-up plans, any onward referrals; (6) document consultation discussion with a colleague.

High-intensity ED use

Psychiatrists working in the ED often come across patients who attend the department frequently. An exact definition of 'frequent attendance' or 'high-intensity use' is elusive. Although different definitions are used depending on the context, 'five attendances in a 12 month period' is one that may be clinically useful. Such patients are usually well-known to both emergency medicine and liaison psychiatry staff and may attract negative views and pejorative labels such as 'frequent flyers'. Not all those attending frequently will have mental health needs. However, a significant number will have a combination of social adversity, substance use disorder, mental disorders or personality disorders and health anxiety.

It is important that an individual formulation of the patient's needs and the reasons for frequent attendance are considered. It is never justified to withhold or delay care and attention in a punitive way. A few years ago, there was a vogue in the UK to treat some cases of high-intensity use of emergency services as misuse of public services and to involve the police. There has been resistance to such approaches from patients and professionals and

current official guidance strictly discourages punitive measures (House 2023). Most EDs have a dedicated group of professionals from emergency medicine, liaison psychiatry, psychology, substance misuse services, homelessness services, social services and others that take a lead on frequent attendances. These multidisciplinary teams often draw up individualised care plans, ideally with the agreement of the patient. When seeing a patient who frequently attends the ED, it is worth checking for this in the notes. Some services may also offer case management, with one professional taking the lead in coordinating and managing care (Budhwani 2022).

Feigning and deception

In emergency medicine, as in most other medical specialties, the practice is to take symptoms presented at face value and to investigate and treat them. In some cases, the question 'Is the patient feigning symptoms and trying to deceive the medical practitioner?' is raised. This could apply to physical, psychological or cognitive symptoms. The first point to make is that lack of an obvious medical explanation should not lead to suspicion of feigning. Functional symptoms, including functional neurological symptoms, are common in the ED. Even when functional symptoms are excluded, there are differing views about suspecting and acting on feigned symptoms.

Beach et al (2017) encourage psychiatrists to 'think dirty'. They use this maxim to advise taking nothing at face value and being alert to the presence of deception and hidden motives. They encourage budding psychiatrists to be explicitly taught to ask the question 'What other motivations might be underlying these symptoms or this behaviour?'. The opposite viewpoint is presented by Thomson & Albert (2024), who draw attention to the problem of incorrectly assuming that patients are feigning symptoms when they are not. This leads to harms such as exclusion from medical services and punitive reactions from staff.

We feel that second-guessing the motivations of all patients presenting to the ED with mental health concerns is unlikely to be helpful. On the other hand, there may be patients with a well-documented history of feigned symptoms from multiple sources. In these cases, recognising the pattern is essential in avoiding unnecessary investigations and interventions and iatrogenic harm.

Comorbid substance misuse

The complications that dual diagnosis presents to psychiatric care across all settings are beyond the scope of the current article. Suffice to say, intoxication and withdrawal states frequently complicate assessment. A psychiatrist in the ED needs to be familiar with syndromes associated with intoxication and withdrawal and remain attentive to the possibility of one contributing to an emergency psychiatric presentation such as florid psychosis or suicidality. It should also be remembered that intoxication and withdrawal can occur concomitantly.

In the case of an intoxicated or withdrawing suicidal or agitated patient, consideration should ideally be given to short-term (in-hospital) and longer-term (discharge) risks. This may necessitate a staged assessment, the former warranting early review and the latter depending on assessment of mental state after intoxication or withdrawal symptoms resolve. Early involvement may help to minimise the disturbance such patients cause in the ED, facilitate advocacy for any overshadowed medical needs and ultimately reduce resistance to delaying full assessment.

Advocating for physical health needs

Where a psychiatrist expects a more thorough medical work-up than thought warranted by the treating ED physician, a request for further tests might be perceived as 'push back' rather than genuine concern for the patient. An impasse can occur in which each party believes that the other is evading responsibility, stagnating care to nobody's benefit. Key to avoiding this deadlock and associated frustration is collegial discussion, centred on the specific circumstances of the patient and framed around overlap in our goals. It is helpful to appreciate that although patients very often present with multiple ailments, ED physicians must ultimately identify the single most suitable disposition for each. Rather than resolving all issues extraneous to an accepting team's specialty, they have a responsibility to identify current issues and to ensure that the patient is sufficiently stable for transfer (Wilson 2023).

An appropriate physical work-up will depend on the patient's current presentation, previous history and likely disposition from the ED. It will also aim to strike a balance between the detection of causative or contributory organic disease and the minimisation of physical and psychological harm caused by over-investigation (Butler 2022) and prolonged ED stays. Although it is widely agreed that a history and physical examination including vital signs should be performed for all patients presenting with psychiatric symptoms (Chennapan 2018; Thrasher 2019; Wilson 2023), the yield of further tests is more contentious. We outline in Box 6 some suggested prompts for further medical

BOX 6 Medical evaluation of psychiatric presentations to the emergency department

Suggested prompts for further medical evaluation:

- All patients aged >65
- First-onset psychiatric symptoms in middle-aged adults
- Abnormal vital signs
- Decreased consciousness
- Cognitive deficits
- History or examination findings suggestive of medical illness
- Focal neurological findings or evidence of head injury
- Significant substance use or intoxication
- Immunosuppressed state
- Rapid onset of symptoms
- Visual hallucinations

(Loosely based on literature reviews by Chennapan et al (2018), Thrasher et al (2019) and Wilson et al (2023).)

evaluation, which are loosely based on three recent reviews with practice recommendations (Chennapan 2018; Thrasher 2019; Wilson 2023). The SMART form recommended by Thrasher et al (2019) and available online (smartmedicalclearance.org) provides more detailed guidance, and there is evidence for use outside of the USA (Festini 2024). However, we suggest that the more rigid approach of a form should first be endorsed by local ED and psychiatric in-patient teams and should not preclude discretionary deviation based on senior clinical judgement. Box 6 relates to patients presenting with psychiatric symptoms. We suggest extra caution and conversation where the primary presenting complaint recorded at triage or in ambulance notes is physical.

As suggested by Wilson et al (2023), an understanding and record of the work-up that has been completed, any identified medical issues and suggested ongoing management will be infinitely more useful than confirmation of 'medical clearance'. In other cases where an issue requiring medical or surgical admission is identified, a psychiatrist may nonetheless be required to help assess and manage psychiatric symptoms concurrently.

Conflict mediation

In the ED, constant influx of diverse presentations invariably pressures limited resources, including space, time and staff. The environment is inevitably fast-paced, volatile and often emotion-laden. Incivility and conflict can ensue between specialties with differing opinions on diagnosis or disposition, between patients and staff with differing objectives and between patients and loved ones with differing perspectives. As Giederman & Marco (2023) and Foster (2024) highlight, attention to the issue of workplace incivility may help to reduce its inevitable impact on healthcare team functioning, morale, clinical decision-making and patient outcomes. Evidence and illustrative examples are included on the Civility Saves Lives website (www.civilitysaveslives.com).

Occasionally a referral from the ED relates to a highly emotionally charged situation, with loose or no connection to a mental health problem. In this situation, an empathetic discussion with the referrer or a brief attendance at the scene can be surprisingly effective. A psychiatrist's discerning emotional radar and well-developed communication skills may well help to defuse conflict before it stifles patient care. However, psychiatrists themselves are of course not immune to the stressors underlying workplace incivility. Where exchanges with staff become tense or discourteous, it may be useful to suggest a discussion removed from the main floor and to remain cognisant of the cumulative impact of minor interactions.

Conclusions

In the ED, it is necessary to be opportunistic with space, time and communication. Psychiatric assessment will often need to be staged, with interim planning that evolves with patient progress and regular liaison and troubleshooting with multidisciplinary staff. Contributions independent of any direct patient contact can be just as valuable. These include advocacy, diplomacy, education, responsible gatekeeping of resources, modelling of constructive communication and support with complex emotional reactions, often with impact beyond the case at hand. It may be necessary to guide staff on what the liaison psychiatry team can offer, which may not be the same as what is asked of it. Embracing a collaborative working style ultimately drives synergistic gains in physical and mental health. This is a concept at the heart of liaison psychiatry but is perhaps especially crucial in a critical care setting, where the presentations are frequently a combination of undifferentiated, severe, unstable and intrinsically emotive. The events, decisions and communications that transpire in the ED can have a lasting impact that is just as dramatic. Hence, this setting presents the psychiatrist with unique challenges but commensurate rewards.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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Author contributions

E.Z. designed the structure of the article, provided a first draft with guidance from G.R. and contributed to editing. G.R. conceived of the idea for the article and contributed to its structural design, drafting and editing.

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Declaration of interest

None.

MCQ answers
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Case

Black v Forsey [1987] SLT 681.

MCQs

Select the single best option for each question stem

1 Which of the following is most likely to be accepted as an appropriate referral for full psychiatric assessment in the ED?

a 29-year-old female presenting with insomnia prior to a high-stakes examination
b 19-year-old male presenting with recurrent panic attacks
c 64-year-old male presenting with low mood 2 days after the death of his spouse
d 26-year-old female with an established diagnosis of emotionally unstable personality disorder presenting with self-harm by cutting
e 42-year-old male with a history of schizophrenia presenting with chest pain.

2 A mental health assessment in the ED should commence:

a once it has been documented that the patient is 'medically cleared'
b once blood test results are available
c once the patient is able to meaningfully engage with an assessor
d once brain imaging has been either performed or declared unnecessary
e any time as long as it is complete within 4 h of the patient's arrival.

3 In England and Wales, the legal framework that may be used to hold a patient in the ED without their consent after a decision to detain under Section 2 of the Mental Health Act 1983 has been made by two doctors and an Approved Mental Health Professional (AMHP) but before an in-patient bed is identified is:

a section 2 of the Mental Health Act 1983
b section 5(2) of the Mental Health Act 1983
c section 5(4) of the Mental Health Act 1983
d Deprivation of Liberty Safeguards
e the Mental Capacity Act 2005.

4 Which of the following is not consistent with 'emergence phenomena' in a patient who received intramuscular ketamine prior to mental health assessment in the ED?

a waxy flexibility
b visual hallucinations
c illusions
d a 'dream-like' state
e a floating sensation.

5 Investigative blood work and/or imaging in a patient who presents to the ED with signs of psychosis should most certainly be prompted by:

a age <25 years
b abrupt onset of symptoms over 24 h
c heart rate 95 beats per minute
d no known family history of psychosis
e severe agitation.