# for Non-Psychiatrists

*October 17, 2025*

# Emergency Psychiatry

**Austin Safranek, DO**

**PGY-3**

Broadlawns-UnityPoint Psychiatry Residency

**Eric Parrott, DO**

Psychiatrist

UnityPoint Health – Iowa Lutheran

# DISCLOSURE

**We do not have any financial relationships with ineligible companies to disclose.**

**Dr. Parrott will be discussing the off-label use of a commercial product.**

# Outline

- Case Study
- High-Risk Presentations
- De-escalation Strategies
- Legal/EMTALA Considerations
- Suicidality vs NSSI
- Medical Mimics
- Wrap-Up Pearls
- Q&A

# Learning Objectives

**Recognize** high-risk psychiatric presentations in the emergency department that require immediate intervention, including suicidality, mania, and psychosis.

**Apply** brief assessment strategies and verbal de-escalation techniques to manage acute behavioral crises.

**Navigate** EMTALA requirements and legal considerations when evaluating and stabilizing psychiatric emergencies.

**Differentiate** between suicidal behavior and non-suicidal self-injury (NSSI) and implement appropriate safety planning and follow-up care.

**Identify** medical mimickers of acute psychiatric presentations to avoid misdiagnosis and inappropriate disposition.

# Case Study

# Introduction

**Patient**: 28-year-old male, brought by police after waving a knife at family.

- **Chief Complaint**: "I'm the chosen one. No one can stop me."
- **History of Present Illness**:
  - 5 days without sleep
  - Pressured, nonstop talking
  - Increased spending, risky behavior
  - No known psychiatric history
- **Collateral**: Family reports escalating agitation and bizarre behavior

# ED Assessment

**Vital Signs:** BP 142/88, HR 112, afebrile, $SpO_2$ 98% RA

**Exam / MSE:**

- Appearance: Disheveled, pacing
- Behavior: Non-redirectable, increasingly agitated
- Speech: Rapid, pressured
- Mood/Affect: Euphoric, irritable
- Thought Process: Flight of ideas
- Thought Content: Grandiose delusions, no current suicidal/homicidal intent
- Insight/Judgment: Severely impaired

# Differential Diagnosis

- **Primary psychiatric:**
  - Bipolar disorder, manic episode with psychosis
  - Schizophrenia spectrum disorder
- **Substance-induced:**
  - Stimulant intoxication (methamphetamine, cocaine)
  - Hallucinogen intoxication
  - Steroid induced psychosis
- **Medical/neurologic mimics:**
  - Thyroid storm
  - CNS infection or encephalitis
  - Delirium (less likely given age/vitals)

# Initial ED Work-Up

- **Labs:** CBC, CMP, TSH, electrolytes, tox screen, alcohol level
- **Other tests:** Glucose bedside, urine pregnancy if female, ECG (QTc before meds)
- **Safety Measures:**
  - Security/1:1 sitter
  - Remove dangerous objects
  - Consider restraints only if verbal de-escalation fails
  - Emergency hold request?

# High-risk presentations in the ED

# Danger to Self

- Suicidality
  - High risk = plan + intent + means
  - Recent attempt = strongest predictor
  - Conditional threats: often unmet needs
  - Always assess access to firearms, meds, rope, etc.

# Danger to Self

- Severe Depression with Self-Neglect
  - Refuses food, fluids, medications
  - May appear “quiet” but medically unstable
  - Requires medical + psychiatric admission if unsafe

# Danger to Self

- Eating Disorders with Instability
  - BMI <15 or rapid weight loss
  - Electrolyte derangements (K, Mg, $PO_4$)
  - Risk: arrhythmia, sudden cardiac death
  - Requires medical admission

# Danger to Self & Others

- Psychosis
  - Command hallucinations
  - Paranoid delusions
  - Disorganized/unpredictable behavior

# Danger to Self & Others

- Mania/Agitation
  - DIGFAST mnemonic
  - Unsafe impulsivity, aggression, recklessness
  - Escalates quickly

# Danger to Others

- Homicidality
  - Explicit threats toward identifiable victims
  - Paranoia/persecutory delusions
  - Weapons access = highest risk
  - Duty to protect/warn

# Medical Instability / Misdiagnosis Risk

- Catatonia
  - Mutism, posturing, echolalia/echopraxia
  - Risk: dehydration, aspiration, DVT
  - First-line: lorazepam; avoid antipsychotics

# Medical Instability / Misdiagnosis Risk

- Delirium (esp. elderly)
  - Acute, fluctuating confusion
  - Causes: infection, metabolic, stroke, meds
  - Always assume delirium first in elderly

# Medical Instability / Misdiagnosis Risk

- Substance States
  - Intoxication: stimulants, alcohol, hallucinogens
  - Withdrawal: alcohol, benzos, opioids
  - Mimics mania/psychosis

# Medical Instability / Misdiagnosis Risk

- Postpartum Psychosis
  - Onset: within 2 weeks postpartum
  - Symptoms: confusion, delusions, mood lability
  - Risks: suicide + infanticide
  - Always admit

# Medical Instability / Misdiagnosis Risk

- Self – Others – Stability
  - Self: suicidality, severe depression, eating disorders
  - Others: homicidality, mania, psychosis
  - Stability: catatonia, delirium, substance states, postpartum psychosis

# Assessment & De-escalation in Acute Behavioral Crises

# Why it matters

- Behavioral crises escalate rapidly in the ED
- Verbal de-escalation preserves dignity, reduces restraints
- Quick bedside assessment guides safe interventions

# Rapid Bedside Assessment

- Vitals: always first — hypoxia, hypoglycemia, delirium
- 3 Key Questions:
  - Suicidal or homicidal thoughts?
  - Hearing voices or feeling unsafe/paranoid?
  - Able to care for self if discharged?
- Collateral from EMS/family

# Goals of De-escalation

- Ensure safety for patient, staff, self
- Reduce agitation without coercion
- Preserve dignity
- Build alliance for ongoing care

# Setting the Stage

- Clear exits, safe environment (remove sharps, clutter)
- Maintain calm tone, steady pace
- Respect personal space
- Supportive stance (open posture, hands visible)

# Verbal Techniques

- Use simple, concise language
- Empathic statements: “I can see this is upsetting”
- Active listening + reflection
- Offer choices (restore sense of control)
- Set limits clearly but respectfully

# Tailoring Approach

- Fearful patient → reassurance, validation
- Goal-directed anger → negotiation, offer options
- Overstimulated → reduce stimuli, provide space
- Paranoia/psychosis → avoid confrontation, calm presence

# Body Language Best Practices

- Approach at an angle, not head-on
- Maintain eye contact without staring
- Avoid sudden movements
- Use nodding/mirroring to show engagement

# If De-escalation Fails

- Mania/agitation: haloperidol + lorazepam
- Stimulant intoxication: haloperidol + lorazepam
- Psychotic agitation: antipsychotic (olanzapine preferred)
- Resistant agitation: chlorpromazine (sedating, broad activity)
- Always monitor vitals, $O_2$, QTc

# Quick Review: De-escalation

- Assess quickly (vitals + 3 key questions)
- Stage environment (safe, calm, open posture)
- Use words first (simple, empathic, offer choices)
- Tailor approach to type of agitation
- Escalate meds only if necessary

# EMTALA & Legal Considerations in Psychiatric Emergencies

# EMTALA Basics

- Applies to all ED patients, including psychiatric
- Requires:
  - Medical screening exam (MSE) for all who present
  - Stabilization of emergency medical conditions (includes psychiatric)
  - Appropriate transfer if not stable or specialized services needed

# EMTALA & Psychiatry

- Psychiatric emergency = risk of harm to self/others or grave disability
- Stabilization = patient is protected from immediate harm, not “cured”
- Cannot transfer just to clear ED — must meet EMTALA criteria
- Accepting facility must have capability and capacity

# Involuntary Holds

- State-specific laws govern criteria (danger to self, others, grave disability)
- Involuntary status ≠ automatic admission
- Requires: Documentation of risk
- Review of less restrictive alternatives
- May differ between states

# Conditional Suicidality & Malingering

- Conditional statements: “If you discharge me, I’ll…”
- May reflect unmet needs, not imminent risk
- Document context + rationale for disposition
- Suspect malingering if symptoms inconsistent or external incentives present

# Duty to Protect

- Tarasoff v. Regents (1976): duty to warn identifiable victims
- Today: duty to protect, which may include:
  - Warning potential victim
  - Notifying law enforcement
  - Hospitalizing patient
- Applies when homicidal threat is credible and specific

# Documentation Pearls

- Always include:
  - Patient statements (direct quotes)
  - Collateral information (family, EMS, police)
  - Clinical rationale for risk level & disposition
- Explicitly state: why inpatient vs outpatient
- Document alternatives considered

# Quick Review: Legal Essentials

- EMTALA: screen, stabilize, appropriate transfer
- Involuntary hold: danger to self, others, or grave disability
- Conditional suicidality: document context, rationale
- Duty to protect: act if threat credible + specific
- Documentation: quotes, collateral, reasoning

# Suicidality vs NSSI

# Case #2: Introduction

**Patient:** 19-year-old female, brought in by friends after cutting her forearm with a razor.

- **Chief Complaint:** “I just wanted to feel something.”
- **History of Present Illness:**
  - Reports daily stress from college classes and recent breakup
  - Endorses chronic cutting behavior over 2 years
  - Denies plan or intent to die
  - Reports relief after self-injury, not a wish to end life

# Case #2: ED Assessment

**Vital Signs:** Stable

**Exam / MSE:**

- Superficial linear lacerations on left forearm, no neurovascular compromise
- Affect: Dysphoric but reactive
- Thought Content: Denies suicidal intent, denies plan
- Insight/Judgment: Limited, impulsive coping style

**Collateral:** Friends confirm behavior is longstanding, worsens with stress

# Case #2: Differential Diagnosis

- Nonsuicidal Self-Injury (NSSI)
- Major depressive episode with self-harm behavior
- Borderline personality traits/disorder
- Adjustment disorder
- Substance use (consider but denied)

# Case #2: Differential Diagnosis

- Nonsuicidal Self-Injury (NSSI)
- Major depressive episode with self-harm behavior
- Borderline personality traits/disorder
- Adjustment disorder
- Substance use (consider but denied)

# Case #2: ED Disposition & Teaching Points

- **Not acutely suicidal** → distinguish from imminent suicide risk
- **Management:**
  - Safety planning (identify triggers, alternatives to cutting, emergency contacts)
  - Referral to outpatient psychiatry/therapy
  - Engage support system
- **Key Teaching**: Not all self-injury = suicidality. Accurate differentiation prevents unnecessary hospitalization and focuses on long-term treatment.

# Medical Mimickers of Psychiatric Illness

# Why It Matters

- Psychiatric vs. medical → often indistinguishable at first
- Wrong assumption = wrong treatment (e.g., antipsychotics worsening delirium)
- EMTALA & standard of care require ruling out medical causes first

# Red Flags for Medical Mimics

- Abrupt onset or atypical age
- Fluctuating or waxing/waning course
- Normal prior functioning, no psych history
- Focal neuro findings, abnormal vitals
- Treatment resistance or paradoxical reactions

# Common Medical Mimics

- Infections: UTI, pneumonia, encephalitis, HIV, syphilis
- Endocrine/metabolic: thyroid storm, adrenal crisis, hypoglycemia, electrolyte derangements
- Neurologic: stroke, seizure, Parkinson’s, brain tumors
- Medications/substances: steroids, intoxication, withdrawal, anticonvulsants

# Evaluation Framework

- History & ROS (recent infection, meds, substance use)
- Physical & neuro exam (don’t skip vitals!)
- Core labs: CBC, CMP, TSH, tox screen, glucose
- Other tests as indicated: HIV, syphilis, vitamin levels, CRP/ESR, CT/MRI, LP

# High-Risk Populations

- Elderly (delirium, infection, metabolic)
- Substance use disorders (intoxication, withdrawal)
- Complex medical comorbidities
- Low socioeconomic status (delayed care, malnutrition)

# Quick Review: Medical Mimics

- Red flags: abrupt, fluctuating, abnormal vitals, no psych history
- Common mimics: infection, endocrine, neuro, substances
- Work-up: vitals + exam + labs + imaging as needed
- Always rule out medical before assuming psychiatric

# Final Pearls:
# Emergency Psychiatry

- Self – Others – Stability framework
  - Self → suicidality, severe depression, eating disorders
  - Others → homicidality, mania, psychosis
  - Stability → catatonia, delirium, substance states, postpartum psychosis
- De-escalation first: words > meds > restraints
- Document everything: direct quotes, collateral, rationale
- Always rule out medical before assuming psychiatric

# Questions & Discussion

# References

Anderson, Eric, Kimberly Nordstrom, Michael Wilson, Jennifer Peltzer-Jones, Leslie Zun, Anthony Ng, and Michael Allen. 2017. "American Association for Emergency Psychiatry Task Force on Medical Clearance of Adults Part I: Introduction, Review and Evidence-Based Guidelines." The Western Journal of Emergency Medicine 18 (2): 235–42.

Calabrese, Jordan, and Yasir Al Khalili. 2025. "Psychosis." In StatPearls. Treasure Island (FL): StatPearls Publishing.

Crone, Catherine, Laura J. Fochtmann, Evelyn Attia, Robert Boland, Javier Escobar, Victor Fornari, Neville Golden, et al. 2023. "The American Psychiatric Association Practice Guideline for the Treatment of Patients with Eating Disorders." The American Journal of Psychiatry 180 (2): 167–71.

Dailey, Mark W., and Abdolreza Saadabadi. 2025. "Mania." In StatPearls. Treasure Island (FL): StatPearls Publishing.

Daniels, Jessica. 2009. "Catatonia: Clinical Aspects and Neurobiological Correlates." The Journal of Neuropsychiatry and Clinical Neurosciences 21 (4): 371–80.

Friedman, Susan Hatters, Eric Reed, and Nina E. Ross. 2023. "Postpartum Psychosis." Current Psychiatry Reports 25 (2): 65–72.

Glick, Rachel L., Scott L. Zeller, and Jon S. Berlin. 2020. Emergency Psychiatry: Principles and Practice. Wolters Kluwer.

Gorshkalova, Olga, and Sunil Munakomi. 2025. "Duty to Warn." In StatPearls. Treasure Island (FL): StatPearls Publishing.

In, Referred to. n.d. "Hospitalization of Persons with Mental Illness." Accessed September 15, 2025. https://www.legis.iowa.gov/docs/ico/chapter/229.pdf.

Klonsky, E. David, Sarah E. Victor, and Boaz Y. Saffer. 2014. "Nonsuicidal Self-Injury: What We Know, and What We Need to Know." Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie 59 (11): 565–68.

Kontos, Nicholas, John B. Taylor, and Scott R. Beach. 2018. "The Therapeutic Discharge II: An Approach to Documentation in the Setting of Feigned Suicidal Ideation." General Hospital Psychiatry 51 (March): 30–35.

Lourdes Ramírez Echeverría, María de, Caroline Schoo, and Manju Paul. n.d. "Delirium." Accessed September 15, 2025. https://www.ncbi.nlm.nih.gov/books/NBK470399/.

McKee, Jerry, and Nancy Brahm. 2016. "Medical Mimics: Differential Diagnostic Considerations for Psychiatric Symptoms." The Mental Health Clinician 6 (6): 289–96.

Mulkey, Malissa A., and Cindy L. Munro. 2021. "Calming the Agitated Patient: Providing Strategies to Support Clinicians." Medsurg Nursing: Official Journal of the Academy of Medical-Surgical Nurses 30 (1): 9–13.

Nordstrom, Kimberly, Leslie Zun, Michael Wilson, Victor Stiebel, Anthony Ng, Benjamin Bregman, and Eric Anderson. 2012. "Medical Evaluation and Triage of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Medical Evaluation Workgroup." The Western Journal of Emergency Medicine 13 (1): 3–10.

Oldham, Mark A., and Hochang B. Lee. 2015. "Catatonia Vis-à-Vis Delirium: The Significance of Recognizing Catatonia in Altered Mental Status." General Hospital Psychiatry 37 (6): 554–59.

"Psychiatric Inpatient Hospitalization." n.d. Accessed August 20, 2024. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34183&ver=18&=.

QUALIFYING STATEMENTS. n.d. "VA/DoD CLINICAL PRACTICE GUIDELINE FOR ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE." Accessed September 15, 2025. https://www.healthquality.va.gov/guidelines/MH/srb/VADoD-CPG-Suicide-Risk-Full-CPG-2024_Final_508.pdf.

Resnick, Phillip J., and James Knoll. n.d. "Faking It: How to Detect Malingered Psychosis." Accessed September 15, 2025. https://www.mdedge.com/currentpsychiatry/article/61060/schizophrenia-other-psychotic-disorders/faking-it-how-detect.

Richmond, Janet S., Jon S. Berlin, Avrim B. Fishkind, Garland H. Holloman Jr, Scott L. Zeller, Michael P. Wilson, Muhamad Aly Rifai, and Anthony T. Ng. 2012. "Verbal DE-Escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA DE-Escalation Workgroup." The Western Journal of Emergency Medicine 13 (1): 17–25.

Roppolo, Lynn P., David W. Morris, Fuad Khan, Rohini Downs, Jeffery Metzger, Tiffany Carder, Ambrose H. Wong, and Michael P. Wilson. 2020. "Improving the Management of Acutely Agitated Patients in the Emergency Department through Implementation of Project BETA (Best Practices in the Evaluation and Treatment of Agitation)." Journal of the American College of Emergency Physicians Open 1 (5): 898–907.

Schmalz, Alexander, and Nicolas T. Sawyer. 2020. "The EMTALA Loophole in Psychiatric Care." The Western Journal of Emergency Medicine 21 (2): 244–46.

"State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases." n.d. Accessed September 15, 2025. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf.

Taylor, John B., Scott R. Beach, and Nicholas Kontos. 2017. "The Therapeutic Discharge: An Approach to Dealing with Deceptive Patients." General Hospital Psychiatry 46 (May): 74–78.

Wilson, Jo Ellen, Mark A. Oldham, Andrew Francis, Dina Perkey, Eric Kramer, Shixie Jiang, Jennifer Yoon, et al. 2025. "Catatonia: American Psychiatric Association Resource Document." Journal of the Academy of Consultation-Liaison Psychiatry 66 (4): 277–99.