Psychiatric Emergencies: Self-Harm, Suicidal, Homicidal Behavior, Addiction, and Substance use

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Psychiatric Emergencies

An emergency involves an immediate danger of harm to one or more people (self-induced or based on a threat to the person's life or development) for which an acute intervention is required. Defining psychiatric emergency depends on whose perspective is taken into consideration. For example, one outpatient medical provider might perceive treatment nonadherence as a psychiatric emergency (passive suicidality), while another provider might see the same behavior as developmentally within the realm of adolescent poor decision-making. As psychologists in medical settings, it is very likely that medical providers will turn to our expertise to assess, intervene, and manage acute or perceived psychiatric emergencies. In receiving a request for consultation, it is important that psychologists differentiate right away between the "urgency" and "emergency" of the consultation question, by considering the continuum of psychiatric acuity. At one end, a youth reporting fleeting thoughts of death, a nurse noticing healed scars on the forearm, a teenager reporting smoking marijuana, etc., constitute urgent psychiatric concerns, while at the other end of the spectrum, behaviors such as an agitated youth throwing things in the clinic waiting room, a youth reporting suicidal ideation and plan during medical admission, or a noticeable altered mental status due to substance ingestion, all constitute psychiatric emergencies. This chapter will address cross-cutting issues of diagnostic assessment and management of acute safety concerns and other psychiatric emergencies, as well as intervention and treatment recommendations across outpatient (specialty and primary care clinics) and inpatient medical settings.

Diagnosis and Medical Basis

Pursuing a detailed diagnostic evaluation, as the acute situation affords, can allow psychologists to reach a conclusion about the current psychiatric diagnoses. Ensuring diagnostic clarity allows the psychologist to put forth a hypothesis about the reasons for the presentation, creates a basis for intervention and alliance building with the youth and family, and can lead to the appropriate treatments and disposition planning.

Differential diagnosis is the process by which clinicians consider the given symptom presentation across the spectrum of competing, although not mutually exclusive psychiatric systems before choosing a single diagnosis that best explains the given presentation (First, 2017). For example, a symptom such as acute decline in

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B. D. Carter, K. A. Kullgren (eds.), *Clinical Handbook of Psychological Consultation in Pediatric Medical Settings*, Issues in Clinical Child Psychology, https://doi.org/10.1007/978-3-030-35598-2_31

mood and associated irritability can be due to depression, social anxiety, trauma, psychosis, or substance use.

Several aspects are important to consider in the process of diagnostic interview such as the availability of information from the youth/family/collateral sources. Clinicians rely on a collaborative, honest communication about the nature or severity of the symptoms with the youth/family/collateral sources. In addition, the ability to observe the youth in the acute situation and understand the context leading to or perpetuating the psychiatric emergency can provide equally valuable information. Finally, it is important to integrate developmental factors and cultural perspectives in establishing the presence or absence of a mental disorder. Especially for psychologists working with youth with medical conditions, it is important to be alert in the differential diagnosis process to the potential that what might appear to be at face value a psychiatric emergency (e.g., agitation or behavioral dysregulation) can be better explained at times by physiological conditions (the presence of a medication impacting the central nervous system or direct effects of a general medical condition). In the context of working with medically involved youth, it is important to think of a psychiatric emergency both as a "casual comorbidity" in which the psychiatric presentation is a direct result of physical illness and can have impact on the course or severity of the physical illness and as a "coincidental comorbidity" in instances in which psychiatric presentations are not related with physiological conditions (Shaw & DeMaso, 2010). Therefore, close collaboration with medical colleagues and clear communication about psychiatric impressions, diagnoses, and formulation can guide the best next clinical steps and management of an emergency in the medical setting.

Agitation

Agitation is an acute behavioral emergency (heightened state of anxiety, emotional arousal, and/or increased motor and/or verbal activity) requiring immediate intervention to control symptoms and decrease the risk of injury to self or others. Actual causes for agitation are hard to identify especially in the crisis moment; hence the differential diagnoses for agitated behaviors should be broad and should include several factors, more often than not in combination: preexisting psychiatric disorders (e.g., attention deficit/hyperactivity symptoms, oppositional and defiant behaviors, conduct concerns, autism-related struggles, intellectual disabilities, etc.), new psychiatric developments (e.g., mania, anxiety, psychosis, trauma), psychosocial concerns (e.g., child protective concerns, acute on chronic lack of access to mental health treatment, academic stressors, etc.), and medical issues (e.g., intoxication, substance withdrawal, delirium, organic brain syndromes, pain, sensory concerns, infectious or metabolic processes, etc.). Attempts to determine the underlying cause of the agitation should be made, nevertheless, as they often guide treatment choices (Chun et al., 2016). The sheer fact of being in a medical setting (clinic, emergency room, hospital room, procedure unit) could be the trigger for agitation even in youth without any identifiable risk factors, as these environments are stimulating, unpredictable, and taxing to psychological and physiological resources of youth and their caregivers (e.g., fear, pain, fatigue, discomfort, novelty, hunger, etc.).

Psychologists should collaborate with physicians to ensure that an appropriate examination has taken place as it can provide important information with regard to potential triggers for the agitation especially for youth who do not have a history of agitation at baseline and/or have intellectual disabilities or autism spectrum disorder diagnoses. For instance, an assessment of the gait, pupil size, general appearance, and a review of recent vital signs can provide important clues regarding the presence of physical or genetic disease, intoxication, and developmental/functional disability (Gerson, Malas, & Mroczkowski, 2018). Having basic knowledge of the existence of such conditions and related presentations will empower the psychologist to work together with the medical teams and advocate for the appropriate medical investigation at the same time as psychological factors are explored.

Suicidality

Suicide is a particular concern for youth as the second leading cause of death among young individuals (19.2 deaths in every 100,000 males aged 15–24 years). As important as it is to assess for risk factors (prior engagement in self-harm or suicide attempts; being a 15–19-year-old female adolescent; history of depression, ADHD, anxiety, alcohol and substance abuse; school failure; family relational struggles; childhood sexual abuse), it is equally important to not assume that the absence of risk factors is evidence of absence of suicidal ideation or plans (Hawton, Saunders, & O'Connor, 2012). Suicide screening procedures have been implemented in medical settings in the last decades, and there are many screening tools available to clinicians across many disciplines (Ambrose & Prager, 2018).

Self-Harm

Nonsuicidal self-injury (NSSI), or self-harm, is a direct and deliberate action (cutting, burning, biting, poisoning) with the intent of destructing bodily tissue and with an undetermined intent to die (Cha et al., 2016). Self-harm is thought of as a maladaptive way to regulate and cope with emotions triggered by stressors, low self-esteem, bullying, and negative body image (O'Reilly, Kiyimba, & Karim, 2016). Assessing for a history of self-harm, quantifying the frequency and triggers, qualifying the means, and assessing for signs and symptoms concerning for additional psychological and psychiatric disorders should be part of the psychologist's routine assessment during a consultation. The presence of major depressive disorder and hopelessness, anxiety disorders, disruptive behavior disorders, or substance use, particularly alcohol and cigarettes, increases the risk for self-harm; hence, the psychologist should be alert to the fact that the NSSI might be a signal for deeper, potentially unrecognized psychiatric struggles, especially as there is mounting evidence in the field that the presence of NSSI is a predictor of future suicide attempt (Cha et al., 2016; Hawton et al., 2012). Repetition of self-harm is also common in adolescents, especially ones presenting with risk factors as outlined above, so safety planning for discharge is an appropriate intervention. Additionally, there are many other known risk factors for NSSI that psychologists should assess for and address in treatment, such as onset of sexual activity, history of sexual abuse, sexual orientation concerns, exposure to others' self-harm/suicide attempts, family adversity (e.g., poor parenting styles and parental divorce), interpersonal difficulties both with peers and adults, social isolation, and bullying. The literature also highlights associations between self-harm and personality styles from perfectionism and low self-esteem to borderline personality traits/disorders and learned behaviors (Cha et al., 2016; Hawton et al., 2012).

Homicidal/Violent Behavior

A broad look at violent behavior in adolescents between 2004 and 2008 showed that about a third of youths engaged in at least one violent behavior (e.g., a serious fight at school or work, group-against-group fight, or an attack on others with the intent to seriously hurt them) (SAMHSA, 2010). The differential diagnosis for NSSI and violent behaviors should move beyond pure psychiatric explanations, especially when encountering youth in medical settings, as the potential of harm to others and agitation can also present in youth with developmental disabilities, physiological/medical causes, or both. Youth with developmental disabilities are likely to exhibit tantrums, aggression, or self-injury as part of the regular repertoire of behaviors (estimated prevalence of aggression in youth with autism is about 35%) or when triggered by being in the hospital/clinic (Carroll et al., 2014). While behavioral treatment of aggression can be challenging in the acute setting, preemptive planning before the clinic visit or hospital admission with families and medical teams can reduce the impact of lack of structure, loss of routine, novelty of staff and medical cares, pain reactions, and sensory overload. In addition, via collaboration with parents and providers who know the child (e.g., teachers,

applied behavior analysis specialists), context can be provided for the "function" of an aggressive behavior and its triggers. Collaboration with psychiatry colleagues in their expertise for psychiatric medication management is also highly recommended (Gerson et al., 2018).

In assessing the risk for violence, psychologists should focus on exploring possible risk factors which can include both static (i.e., age, sex, and history of abuse) and dynamic/modifiable factors that can be altered and, therefore, can be targets for intervention (e.g., substance abuse, lack of psychiatric treatment). While the presence of substance abuse and psychosis has been reported to increase the risk of violence, mental illness is estimated to be a very small contributor to the overall violence in the United States (Saxton, Resnick, & Noffsinger, 2018). Determination about whether there is duty to warn and protect as evidenced by the Tarasoff ruling (Adi & Mathbout, 2018), thoughtful documentation of a risk assessment (with or without use of instruments) guiding decision-making, and the elaboration of a discharge plan that addresses clinical presentation aiming at treatment and risk reduction are also within the scope of the consulting psychologist (Copelan, 2006; Saxton et al., 2018).

Substance Abuse and Addiction

Substance use is among the most common psychiatric disorders of adolescence and is associated with substantial morbidity and mortality. Heavy use, abuse, and dependence are the strongest predictors of continued substance use disorders in adulthood and of psychosocial impairment such as school failure, early parenthood, high-risk sexual behavior, and legal problems (Hicks et al., 2014). Mental illness comorbidity both precedes and develops as a consequence of substance use, with disruptive behavior and mood disorders (depression and bipolar disorders) as the most frequent psychiatric diagnoses (Hersh, Curry, & Kaminer, 2014). Medically ill youth, while at similar risk for using substances compared to their healthy counterparts (Snyder, Truong, & Law, 2016), are likely to experience more adverse effects from substances by the impact on their medical condition via organ dysfunction, medication interactions, invalidation of lab tests, and associated risky behaviors that can adversely affect their health, such as nonadherence.

Obtaining an adequate history of substance use, qualifying and quantifying substances of choice, and assessing for signs and symptoms concerning for psychological and physiological dependence with or without the use of well-established tools should be part of the psychologist's routine assessment during a consultation (Knight, Sherritt, Shrier, Harris, & Chang, 2002; Sterling et al., 2015). A negative urine drug screen in the presence of a suspicious history is not particularly meaningful as many recreational drugs such as hallucinogens and synthetic cannabinoids are not detected on a standard toxicology screen (Rocker & Oestreicher, 2018).

Formulation

A developmental biopsychosocial formulation gives a multidimensional picture of the youth and family that goes beyond diagnostic labels and beyond a simple medical-model explanation. The formulation allows the psychologist to put forward hypotheses about underlying causes and precipitants of the psychiatric emergency, about factors leading to the continuation of the crisis, while at the same time allowing for reflection on strengths and ameliorating factors that could be used in developing a comprehensive and supportive treatment plan (Winters, Hanson, & Stoyanova, 2007). In the process of responding to psychiatric emergencies, psychologists can use case formulation to succinctly highlight the major issues in a manner that is useful for the multidisciplinary approach, via clear and simple terminology, by answering the questions "what is this case about?," "why is this happening for this youth?," "what can be done (immediately and in the long run)?," and "how?" Creating a youth-/family-centered formulation can be a powerful intervention in itself in building alliance with youth and caregivers and by increasing

empathy, understanding, and effective communication with medical and nursing staff. Painting a developmental, cultural, biopsychosocial multifaceted picture of the youth in crisis can reduce stigma and increase understanding, which in turn can decrease negative affect in staff toward the youth/family and positively impact collaboration with medical providers in managing and avoiding future psychiatric crises (Jellinek & McDermott, 2004).

One of the major approaches to case formulation is the biopsychosocial model (Winters et al., 2007). As relevant, it is important to also include developmental and cultural factors in the formulation, as many times developmental stages and milestones and cultural values and practices are informing the clinical presentation, especially in the context of working with medically complex youth. Another model for case formulation is the "four Ps" which puts forward hypotheses about underlying *predisposing* aspects (e.g., genetics, life events, temperament), *precipitants* of the current problems (e.g., specific triggers), factors leading to the *perpetuation* of the presenting problem, and the individual and systems strengths conceptualized as *protective* factors that could be used in developing a treatment plan (Winters et al., 2007).

Engagement

Never has the statement "treat others how you want to be treated" rang more true than in times of emergency/crisis. To engage youth and families, it is important to think about the entire interaction from the beginning to the end. In a medical setting, youth and families are meeting many new providers, so it is important to introduce yourself and explain your role when engaging in the care of the young patient. This will, in turn, invite the opportunity to clarify the relationship and names of caregivers, as well as how they prefer to be addressed. Never assume the adults accompanying the youth are the parents. Also, asking the youth for the preferred way to be addressed is important for the beginning stages of engagement, especially with respect and awareness toward gender identity.

Another early starting point for alliance building and engaging the youth/family is asking about families' expectations and their understanding about what the reason for the psychologist's presence is in the management and treatment of the youth. In addition, another basic strategy to engage caregivers and older adolescents is to acknowledge the areas in which they are more knowledgeable than the clinicians. Starting from a place of empowerment rather than coming in as the expert can begin to create the alliance. Because youth and families meet various providers, are answering many questions, and have to retell the event several times, it is helpful to ask the youth/caregiver where they want to start. It is best to offer the youth/caregiver a choice of how/where/when we start: "I understand you have talked to a lot of different people. I want to make good use of your time. Do you want to start by telling me what is important to know or would it be helpful if I tell you what I understand from reading your chart and talking to the members of your team; you can correct anything I have wrong and/or fill in information I might be missing."

At times, the psychiatric crisis has started well before the youth arrives in the medical setting, and hence, caregivers are blindsided by the emergency. As a psychologist in the medical setting, it is important to recognize that youth/families might not want mental health involvement in their treatment; therefore, close collaboration with the medical team for integrating recommendations in the overall treatment plan of the youth and for delivering the recommendations to the families can reduce resistance and increase participation in the psychiatric treatment. In contrast, there might be times when the psychologist may need to advocate for the youth/family's needs and educate the medical providers and the rest of the multidisciplinary treatment team. Difficult conversations and interactions can be productive in the midst of a psychiatric emergency if engagement and alliances are part of the framework. At times, the psychologists' best intervention is

building the therapeutic relationship that allows an opportunity to "plant a seed" via support and psychoeducation with the knowledge that other providers are going on to "nurture and water" that seed toward behavior change. This intervention is not only relevant in the work with the youth/family but also in collaborating with providers as part of systemic changes. Psychologists in medical settings can make the difference in engaging both the youth/family and the medical team in the management, reduction, and treatment of psychiatric emergencies.

In psychiatric emergencies, clinicians can override the parent/guardian/young adult's consent for psychiatric evaluation and treatment. Ideally, when assessing and managing psychiatric emergencies, psychologists should maintain the delicate balance between respecting youth/family's confidentiality and engaging external supports (e.g., family, mental health systems), as collaboration will lead to a more positive and productive experience for all involved, including providers. Having transparent open conversations that invite youth and caregivers to ask questions and offer potentially opposing perspectives allows for the youth and family to join the providers in the decision-making process. Families are often scared, feel out of control, and may even be blaming themselves for their child being in the midst of a psychiatric crisis. Understanding caregivers' experience allows providers to remain compassionate partners with them through the process, one moment at a time. Engaging families and youth will also allow for more collaboration with other providers outside the hospital, via consented collateral contacts, as understanding how the youth and/or family present in other settings gives more context to the psychiatric emergency. Talking with collaterals is best practice for managing the psychiatric crisis and planning for next steps.

In summary, when considering engaging the family in assessing and managing psychiatric emergencies, it is important that the psychologist acts in authentic, transparent, knowledgeable, yet humble, and flexible ways. Even in the most challenging situations, a relationship can be initiated and an alliance formed to help the youth through the psychiatric emergency and moving toward next steps.

Intervention

In the medical setting, providing youth in psychiatric emergencies with a safe environment is paramount for everybody, no matter what causes it (e.g., NSSI, agitation, suicidality, altered mental status, etc.). A first general intervention in any psychiatric emergency ensures a safe environment by providing the youth with a separate room/removed space from which unnecessary and potentially unsafe objects have been removed: cords, sharp objects (e.g., glass, aluminum cans), medications (either that the youth/families have with them or left in the room by the medical staff), objects that can be thrown, and, in extreme emergency cases, even pieces of furniture. Additionally, it is important that the youth is constantly observed for safety. Determining the most appropriate person to observe the patient largely depends on the resources available in the setting (clinical assistant, care companion). Careful thought should be given before a family member is asked to fulfill this role, especially for the most high-risk cases of suicide attempts, self-harm, and violence to others in the context of interpersonal/family dynamics. For the patient who is at risk of hurting others by becoming aggressive and/or attempts to elope, consider collaboration with hospital security (Lelonek et al., 2018). Guidelines for working with agitated patients in medical settings have been developed with focus on the safety of the individual and the treating staff, managing emotions and regaining control of behavior, utilizing age-appropriate and the least-restrictive methods possible, and recognizing that coercive interventions may exacerbate the agitation. Some of the principles of de-escalation are respect for personal space, not being provocative, establishing verbal contact, being concise, identifying desires and feelings, listening closely to what the patient is saying, agreeing or agreeing to disagree, setting clear limits, offering choices and optimism,

and debriefing the patient, family, and staff (Chun et al., 2016; Marzullo, 2014; Richmond et al., 2012).

At an interpersonal level, psychologists should facilitate safety planning for the youth in collaboration with the youth and caregivers, with focus on the trigger for the psychiatric emergency (NSSI, substance intoxication, suicidal thoughts, etc.) and as informed by a biopsychosocial case formulation that was agreed upon by the youth and caregivers. The core of safety planning involves identifying (1) triggers and warning signs both internally for the individual and externally for the family/caregivers, (2) concrete/spelled out coping skills, (3) natural supports and (4) additional professional resources and agencies in the community that are already in place and can be contacted for help, and (5) ways to make the environment safe at home and on the way from the hospital to home (Suicide Prevention Resource Center, 2018). Creating a visual (pictorial/nonverbal) safety plan with the youth/family can address unique communication and learning styles in a developmentally sensitive manner (e.g., Likert scale, traffic light, the "Zones of Regulation") (Kuypers, 2018). Finally, behavior management plans and daily schedules should be utilized for youth who are boarding for psychiatric placement or who are hospitalized on the medical units. Close collaboration with other hospital specialists and tapping into additional resources in the medical setting (child life specialists, augmentative communication specialists, social workers, etc.) is crucial. Two very important additional steps are to inform the youth's medical team (physicians, nurses) about the behavioral interventions and plans as a means to provide consistency and predictability and reduce behavioral escalations, and to document useful interventions in the medical records for future admissions/clinic visits.

For suicidal youth, the family-based crisis intervention (FBCI) has been used successfully in the emergency room and outpatient settings and has been shown to prevent the need for psychiatric hospitalization (Wharff et al., 2017). The FBCI is a single visit structured intervention that utilizes elements of cognitive-behavioral, narrative, and family systems therapy along with safety planning. The visit is broken into three meetings: one with the youth separately, another with the family/caregivers separately, and the final meeting with youth and family/caregivers together. The goal of the three meetings is to operationalize a "joint crisis narrative" that allows improvement in intrafamilial communication, collaborative safety planning, and effecting changes that enable the youth to feel and remain safe at home.

When working with youth presenting with substance abuse, motivational interviewing is a well-established empirically based treatment. Over the years, motivational interviewing has evolved to be an intervention that can be used for a variety of psychiatric presentations in which the focus is on behavior change, such as nonadherence to medical treatments, reducing NNSI, etc. Motivational interviewing allows clinicians to build an alliance with the youth and work with their resistance to behavior change by creating an opportunity to observe the discrepancy between youth's behavior and their wishes/self-image while supporting youth's belief that successful behavior changes can take place (SAMHSA, 2018). The screening, brief intervention, and referral to treatment (Sterling et al., 2015) is another evidence-based practice that can be used to prevent the development of a substance use disorder and/or prevent the progression of substance-related disorders with adolescents across settings such as schools or primary cares (D'Amico et al., 2018).

Finally, when addressing psychiatric emergencies, psychologists should be knowledgeable about levels of psychiatric care and how to access such supports for youth in need, in collaboration with case managers and health insurances. The levels of care in the mental health-care system range from the most intensive services (inpatient psychiatric units and residential treatment programs) to less intensive services (outpatient partial hospitalization/day programs, intensive evening programs), to outpatient therapy. Based on the psychiatric emergency, the diagnostic evaluation, case formulation, and the youth/family needs and input, the youth might need to

be connected with various behavioral health treatments once the crisis is stabilized and treatment planning starts. For youth who require safety and stabilization at an inpatient psychiatric unit, the ideal situation is that the youth and the guardian are in agreement with this plan. When the legal guardian does not agree with the psychiatric admission despite the assessment of acute safety concerns, the clinician can invoke the state's laws defining the standards for involuntary treatment. Each practicing psychologist should be knowledgeable about the legal coordinates of practicing in their state with regard to age of consent for psychiatric treatment and involuntary psychiatric treatment (Testa & West, 2010). Ideally, it is best to collaborate with family and understand their hesitation with the plan (e.g., stigma of mental health, cultural and/or religious beliefs). Empathic listening and validation of guardians' concerns/questions/hesitancies, yet a transparent and collaborative approach, as well as some extra time for processing the information, are helpful in gaining buy-in from the guardians.

Adaptation

Engaging families and youth in the process of evaluating and managing psychiatric emergencies as much as possible allows for opportunity to continue with intervention once the crisis has stabilized. Working in clinics, pediatricians' offices, or on the medical floors creates challenges for psychologists with regard to youth/family's time availability, access to private space, ability to respect privacy, individual/family stage of readiness for change and their availability (emotional and cognitive) for psychiatric treatment, developmental needs, cultural and contextual needs and values, etc. Therefore, psychologists have to work within the flexibility and fidelity framework (Kendall & Beidas, 2007) and combine empirically supported treatment principles, clinical expertise, and individual client characteristics in their treatment interventions. Psychological treatment in the medical setting should be pragmatic and preventative, with focus on immediate impact and concrete opportunities for behavior change and alignment with youth/family's needs. In contrast with the outpatient psychotherapeutic work, for psychologists working in medical settings, less is more: in the context of the inherent time limitations, providing a few interventions with observable/measurable positive outcome can lead to further behavior change through attitude change, strengthening of working alliance, knowledge about the benefit of behavioral health, and empowerment for further access of treatment in the community, outside of the hospital setting.

Resources/Support

Detailed knowledge about available resources, both clinical expertise and environmental resources that can facilitate and enhance the psychological interventions in psychiatric emergencies, is key. Utilizing clinical expertise to assess and intervene during a psychiatric emergency can be enhanced by utilizing standardized assessment and intervention tools many of which are readily available online. While other chapters of this book address collaborating with psychosocial teams and psychiatry colleagues in medical settings, it is important to highlight other providers like nursing, behavior response teams, care companions, physical and occupational therapists, etc., that can enhance the care of the patient through collaboration on environmental interventions (e.g., reducing sensory overload in the room, room safety proofing, maintenance of daily schedule and behavioral plans). Additional resources and interventions should focus on ensuring the ability to communicate in one's own language and fostering communication by collaborating with language interpreters and augmentative communication specialists; supporting families and ensuring family-centered care through partnering with chaplaincy, cultural brokers, and social work; ensuring safety (e.g., consulting with child protection teams, security, legal counsel); and devising appropriate and realistic disposition planning through work with resource specialists and case managers.

Along with understanding the resources available within the work setting, it is important to

understand resources available in the psychologist's geographic area of practice, especially when addressing psychiatric emergencies, as it is important that psychologists understand how/when youth can be hospitalized involuntarily for psychiatric or substance-related treatment.

In-Hospital Consultation and Outpatient Consultation

The role of a psychologist in the medical setting might vary based on the actual setting of the work. Providing consultation in an inpatient medical setting vs. in an outpatient specialty or primary care clinic presents unique advantages and challenges for the psychologist to navigate in order to best address the needs of youth, caregivers, and medical providers. Independent on the setting, the psychologists' role is likely to involve effective collaboration, communication, and coordination of care. Other common goals in working with medically involved youth in outpatient settings include promoting emotional wellness, providing early identification of mental health problems and interventions, integrating culturally sensitive and evidence-based mental health services, and increasing comfort, knowledge, and abilities in diagnosing and responding to mental health problems (DeMaso et al., 2009).

Case Example

Dan is a 13-year-old white male with autism spectrum disorder, anxiety, and a medical history of seizure disorder. He is a freshman in high school in a regular classroom and has an individualized educational plan to assist him with social pragmatics and speech therapy. Dan has had a difficult time transitioning to high school and has been increasingly anxious. He presented to a previously scheduled neurology clinic after he had a behavioral outburst at school and a challenging morning during which his parents had a difficult time getting him to school. He had an anxiety attack during class and was escorted to a quiet room where he engaged in light head banging. He was redirected with support from the school nurse. In the clinic, he was given a screening instrument to assess for depression which revealed moderately/severe range for depression. An emergency consultation was arranged by Dan's neurologist with the clinic's psychologist for a safety assessment. While being assessed by the psychologist, Dan reported worsening mood and anxiety symptoms over the past month. He described difficulties with sleep and appetite due to constant anxious thoughts about having to attend school every day. He feels he "does not fit" and, therefore, does not see a future for himself. Dan disclosed cutting the past 2 weeks and feeling increasingly hopeless. When asked about suicide, he was vague, "I wish I was not around sometimes." When asked about whether he had a plan to end his life, he reported "I don't know, but one can always find ideas online." He stated he did not feel comfortable telling his parents how he felt because "they don't get it." Due to significant concerns for worsening depression and safety, after the psychologist discussed with Dan and his parents the clinical impressions and recommendations, a plan was made to transfer him to the emergency department (ED) for psychiatric assessment, management, and disposition. The psychologist called the ED to alert the staff of the arrival of a youth in psychiatric crisis. The clinic nurse, psychologist, security, and the family all escorted Dan to the ED.

In the ED, Dan was assessed briefly by nursing in the triage area and moved to an ED bedspace. After appropriate safety measures were taken (e.g., removing unnecessary objects and cables from the room, belonging search for safety, a one-to-one constant observer, etc.), he was evaluated by an emergency psychiatry clinician. During the evaluation, Dan became agitated requiring a brief physical hold by security staff and requiring administration of medication (lorazepam), which he took orally. As a result, it was deemed that Dan could not be safely discharged to the community and required higher level of psychiatric care. Due to the lack of available psychiatric beds, and since Dan waited in the ED for 48 hours, the medical team decided to

transfer Dan to a medical unit to continue boarding for an inpatient psychiatry unit placement. Dan transferred to the medical unit in good behavioral control. Again, similar safety measures were taken for the room. Over the next few days that Dan remained in the hospital, he was seen daily by the consultation-liaison (CL) psychologist for ongoing assessment, brief interventions, and continued work for a safe disposition plan. Since the one time in the ED, Dan did not have any further episodes of acute agitation, did not require any restraints, and did not need emergent psychiatric medications. He expressed remorse for his behavior in the ED and was able to process with the CL psychologist and his parents the precipitant to both his acute agitation and to his presentation to the hospital. CL psychologist, Dan, and his parents created a safety scale which was utilized daily to assess his psychiatric acuity and safety. In addition, the psychologist worked with Dan on concrete cognitive and behavioral skill building (e.g., understanding the connection between thoughts, actions, body reactions, and feelings, learning relaxation strategies and cognitive techniques to identify and challenge automatic/irrational thoughts). Finally, the psychologist provided brief family work to help clear communication and guide some of the interactions between the parents and Dan, to reduce stress in the home. The CL psychologist communicated with Dan's school, primary care physician (PCP), and neurologist throughout his boarding process and also collaborated with the unit's child life specialist to create structure and routine during his days with the goal of appropriate behavioral activation and emotion regulation.

After 5 days boarding on the medical unit, Dan stabilized psychiatrically. Dan continued to experience significant anxiety and depressive symptoms, mainly related to school stressors. A plan was made with Dan and his parents to attend a partial hospitalization program where he could get intense psychological therapy together with a psychotropic medication evaluation. Prior to discharge, the CL psychologist engaged parents, Dan, school, and PCP in safety planning which included coping tools and signs and symptoms that Dan should return to the nearest ED for psychiatric re-evaluation.

Appendix: Attachments: Resources

https://www.samhsa.gov/

"The Substance Abuse and Mental Health Services Administration is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation."

https://www.integration.samhsa.gov/about-us/about-cihs

"The SAMHSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings."

Alcohol and substance abuse screening tools

https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf

https://www.samhsa.gov/sbirt

Motivational interviewing tools

https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing

Depression screening tools

http://www.cqaimh.org/pdf/tool_phq9.pdf

https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml

Safety planning tools

www.sprc.org

https://www.zonesofregulation.com/index.html

References

Adi, A., & Mathbout, M. (2018). The duty to protect: Four decades after tarasoff. *The American Journal of Psychiatry Residents' Journal, 13*, 6. https://doi.org/10.1176/appi.ajp-rj.2018.130402

Ambrose, A. J. H., & Prager, L. M. (2018). Suicide evaluation in the pediatric emergency setting. *Child and Adolescent Psychiatric Clinics of North America, 27*(3), 387–397. https://doi.org/10.1016/j.chc.2018.03.003

Carroll, D., Hallett, V., McDougle, C. J., Aman, M. G., McCracken, J. T., Tierney, E., … Scahill, L. (2014). Examination of aggression and self-injury in children with autism spectrum disorders and serious behavioral problems. *Child and Adolescent Psychiatric Clinics of North America, 23*(1), 57–72. https://doi.org/10.1016/j.chc.2013.08.002

Cha, C. B., Augenstein, T. M., Frost, K. H., Gallagher, K., D'Angelo, E. J., & Nock, M. K. (2016). Using implicit and explicit measures to predict nonsuicidal self-injury among adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry, 55*(1), 62–68. https://doi.org/10.1016/j.jaac.2015.10.008

Chun, T. H., Mace, S. E., Katz, E. R., & American Academy of Pediatrics; Committee on Pediatric Emergency Medicine; American College of Emergency Physicians; Pediatric Emergency Medicine Committee. (2016). Executive summary: Evaluation and management of children and adolescents with acute mental health or behavioral problems. Part I: Common clinical challenges of patients with mental health and/or behavioral emergencies. *Pediatrics, 138*(3), e20161571. https://doi.org/10.1542/peds.2016-1571

Copelan, R. (2006). Assessing the potential for violent behavior in children and adolescents. *Pediatrics in Review, 27*(5), e36–e41.

D'Amico, E. J., Parast, L., Shadel, W. G., Meredith, L. S., Seelam, R., & Stein, B. D. (2018). Brief motivational interviewing intervention to reduce alcohol and marijuana use for at-risk adolescents in primary care. *Journal of Consulting and Clinical Psychology, 86*(9), 775–786. https://doi.org/10.1037/ccp0000332

DeMaso, D. R., Martini, D. R., Cahen, L. A., Bukstein, O., Walter, H. J., Benson, S., … Medicus, J. (2009). Practice parameter for the psychiatric assessment and management of physically ill children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(2), 213–233. https://doi.org/10.1097/CHI.0b013e3181908bf4

First, M. B. (2017). *The DSM-TM handbook of differential diagnosis*. Washington, DC: American Psychiatric Association Publishing.

Gerson, R., Malas, N., & Mroczkowski, M. M. (2018). Crisis in the Emergency Department: The evaluation and management of acute agitation in children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 27*(3), 367–386. https://doi.org/10.1016/j.chc.2018.02.002

Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *Lancet, 379*(9834), 2373–2382. https://doi.org/10.1016/S0140-6736(12)60322-5

Hersh, J., Curry, J. F., & Kaminer, Y. (2014). What is the impact of comorbid depression on adolescent substance abuse treatment? *Substance Abuse, 35*(4), 364–375. https://doi.org/10.1080/08897077.2014.956164

Hicks, B. M., Johnson, W., Durbin, C. E., Blonigen, D. M., Iacono, W. G., & McGue, M. (2014). Delineating selection and mediation effects among childhood personality and environmental risk factors in the development of adolescent substance abuse. *Journal of Abnormal Child Psychology, 42*(5), 845–859. https://doi.org/10.1007/s10802-013-9831-z

Jellinek, M. S., & McDermott, J. F. (2004). Formulation: Putting the diagnosis into a therapeutic context and treatment plan. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(7), 913–916. https://doi.org/10.1097/01.chi.0000125090.35109.57

Kendall, P., & Beidas, R. S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology: Research and Practice, 38*(1), 13–20.

Knight, J., Sherritt, L., Shrier, L., Harris, S. H., & Chang, G. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *The Archives of Pediatrics & Adolescent Medicine, 156*, 607–614.

Kuypers, L. (2018). Retrieved September 19, 2018, from http://www.zonesofregulation.com/index.html

Lelonek, G., Crook, D., Tully, M., Trufelli, K., Blitz, L., & Rogers, S. C. (2018). Multidisciplinary approach to enhancing safety and care for pediatric behavioral health patients in acute medical settings. *Child Adolesc Psychiatric Clin N Am, 27*, 491–500.

Marzullo, L. R. (2014). Pharmacologic management of the agitated child. *Pediatric Emergency Care, 30*(4), 269–275;. ; quiz 276–268. https://doi.org/10.1097/PEC.0000000000000112

O'Reilly, M., Kiyimba, N., & Karim, K. (2016). "This is a question we have to ask everyone": Asking young people about self-harm and suicide. *Journal of Psychiatric and Mental Health Nursing, 23*(8), 479–488. https://doi.org/10.1111/jpm.12323

Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Jr., Zeller, S. L., Wilson, M. P., … Ng, A. T. (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. https://doi.org/10.5811/westjem.2011.9.6864

Rocker, J. A., & Oestreicher, J. (2018). Focused medical assessment of pediatric behavioral emergencies. *Child and Adolescent Psychiatric Clinics of North America, 27*(3), 399–411. https://doi.org/10.1016/j.chc.2018.02.003

Saxton, A., Resnick, P., & Noffsinger, S. (2018). Chief complaint: Homicidal. Assessing violence risk. Current Psychiatry, 17(5):26–35.

Shaw, R. J., & DeMaso, D. R. (2010). *Textbook of pediatric psychosomatic medicine*. Arlington, VA: American Psychiatric Publishing.

Snyder, L. L., Truong, Y. K., & Law, J. R. (2016). Evaluating substance use and insulin misuse in adolescents with type 1 diabetes. *The Diabetes Educator, 42*(5), 529–537. https://doi.org/10.1177/0145721716659149

Sterling, S., Kline-Simon, A. H., Satre, D. D., Jones, A., Mertens, J., Wong, A., & Weisner, C. (2015). Implementation of screening, brief intervention, and referral to treatment for adolescents in pediatric primary care: A cluster randomized trial. *JAMA Pediatrics, 169*(11), e153145. https://doi.org/10.1001/jamapediatrics.2015.3145

Substance Abuse and Mental Health Services Administration. (2018). *Motivational interviewing*. Retrieved from https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). The National Survey on Drug Use and Health report: Violent behaviors and family income among adolescents. Rockville, MD.

Suicide Prevention Resource Center. (2018). *Suicide prevention resource center*. Retrieved September 19, 2018, from http://www.sprc.org/

Testa, M., & West, S. G. (2010). Civil commitment in the United States. *Psychiatry (Edgmont), 7*(10), 30–40.

Wharff, E. A., Ginnis, K. B., Ross, A. M., White, E. M., White, M. T., & Forbes, P. W. (2017). Family-based crisis intervention with suicidal. Adolescents: A randomized clinical trial. *Pediatric Emergency Care, 35*, 170. https://doi.org/10.1097/PEC.0000000000001076

Winters, N. C., Hanson, G., & Stoyanova, V. (2007). The case formulation in child and adolescent psychiatry. *Child and Adolescent Psychiatric Clinics of North America, 16*(1), 111–132. , ix. https://doi.org/10.1016/j.chc.2006.07.010