

## SOMATIC MANAGEMENT OF PSYCHIATRIC PATIENTS IN THE EMERGENCY DEPARTMENT

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### SUMMARY

*This retrospective study aims to assess a potential difference in the management of patients with a psychiatric history in somatic emergencies. Indeed, the psychiatric population has higher mortality and morbidity rates than the general population. The negative stigmatization of patients with mental health disorders remains one of the factors to consider when studying this morbidity and mortality. In this context, adult patients diagnosed with myocardial infarction, pulmonary embolism, stroke, acute cholecystitis or appendicitis in the emergency department of the Brugmann University Hospital Center during the year 2021 were selected. The presence or absence of a history psychiatric was then recorded for each patient. Different key intervention times, the total length of stay and the occurrence of complications were also studied for 459 patients, 74 of which had a history psychiatric. A significant difference in the time preceding the prescription of the first complementary examination for patients with a psychiatric history was thus highlighted. No other differences in care were demonstrated within the limits of this sample. This difference could be associated with the phenomenon of diagnostic overshadowing. It is the fact of associating the somatic complaints of a patient with his psychiatric pathology. Another potential explanation, present in the literature, could be the discomfort felt by somaticians when dealing with psychiatric patients. Finally, the integration of the experience of psychiatric patients into the training of physicians and the question of the relevance of applying the triage system to psychiatric patients were raised as potential future studies.*

**Key words:** psychiatry – emergencies - length of stay - diagnostic overshadowing

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### INTRODUCTION

Many somatic physicians admit to being intimidated by psychiatric patients (Jespers et al. 2021). However, the higher mortality and morbidity rates of the psychiatric population compared to the general population, as well as its frequent use of emergency services, make the somatic management of these patients inevitable (Conseil National Professionnel de Psychiatrie 2015, Lewis et al. 2023, Marzola et al. 2022). In addition, the significant demand for care in emergency departments for situations relating to mental health confronts doctors with these “difficult patients” (Holland et al. 2021). This study aims to quantify a possible difference in care in the emergency department of a Belgian hospital between patients with a psychiatric history and those without.

In 2018, 15.5% of the Belgian population over the age of 15 took at least one sedative -type medication or antidepressant on prescription (Gisle et al. 2020). In 2020, the estimated rate of severe psychiatric illness in the adult US population was 5.6% (Richesson et al. 2021). In Belgium, a clear increase in psychiatric disorders was observed, in all regions of the country, between 2008 and 2013. In 2013, a third of the Belgian population reported suffering from a mental health problem (Detollenaere et al. 2019, p.57). Psychiatric

problems were, in 2013 and 2018, the most important cause of disability in Belgium (Detollenaere et al. 2019, p.57; Gillis et al. 2020).

The population with a mental health problem requires regular somatic care. Indeed, patients suffering from psychiatric disorders are recognized as having higher mortality and morbidity rates than the general population. Patients with a severe mental disease are almost twice as likely to present a multi-morbidity compared to the general population (Lachowycz et al. 2018). Mortality of schizophrenic patients in particular was 4.5 times that of the general population, all ages, sexes and causes of death (natural and non- natural) combined (Conseil National Professionnel de Psychiatrie 2015). A meta-analysis published in 2019 reports a 1.4 to 2 times increased risk of cardiovascular disease for patients with a diagnosis of mental illness compared to the general population (Firth et al. 2019 ). In 2018, 15.7% of patients hospitalized in Belgian psychiatric wards had somatic issues (Jespers et al. 2021). There are multifactorial etiologies to the differences between the rates of the psychiatric population and those of the general population. They may in particular be linked to the communication disorders presented by certain psychiatric patients, but also to negligence on the part of the healthcare teams in regard to health and care issues for these patients

(Collège national des universitaires en psychiatrie et al. 2016, p.580). In addition, psychiatric pathology remains associated with significant stigmatization on the part of medical teams (Collège national des universitaires en psychiatrie et al. 2016, p.580; Jespers et al. 2021).

Furthermore several studies associate the presence of a psychiatric diagnosis with more frequent use of emergency services (Coates et al. 2018, Firth et al. 2019). The question of the impact of this stigmatization on the management of psychiatric patients' somatic diseases arises. Thus, if the somatician doctors have *a priori vis-a-vis* psychiatric patients, the question of the impact of the knowledge of a patient's psychiatric history on their stay arises.

## SUBJECTS AND METHODS

The aim of this study is to assess a potential difference in the care of psychiatric patients in the emergency department. To illustrate this difference, the time factor was chosen.

The study therefore attempts to respond to various null hypotheses. First, the absence of relationship between the presence of a psychiatric history and a difference in the total length of stay in the emergency department. Second, the absence of a relationship between the presence of a psychiatric history and a difference in the period preceding the treatment of the patient. Key steps in the stay in the emergency department have therefore been selected: taking the vital signs, management by a member of the nursing team, management by a member of the medical team, prescription of the first additional examination, realisation of the first complementary examination, prescription of the first medical imaging, realisation of the first medical imaging, realisation of the complementary diagnostic examination and prescription of the medicinal treatment corresponding to the inclusion diagnosis. Third, the absence of a relationship between the presence of a psychiatric history and the occurrence of a complication (occurring while staying in the emergency room or during the following hospitalisation).

### Data

#### *Inclusion criteria*

Therefore this study compares the management of patients with no psychiatric history to that of patients with a psychiatric history in a Belgian somatic emergency department. To do this, patients were selected retrospectively from the adult population (over 15 years old) who had attended the emergency department of the Brugmann University Hospital Center during the year 2021. In order to eliminate visits motivated by a mental health issue, only patients whose final somatic diagnosis was made were retained. In order to limit the

search to somatic emergency situations, the following diagnoses were retained: myocardial infarction, pulmonary embolism, stroke, acute cholecystitis and appendicitis. Thus an initial database of 603 patients was obtained. This cohort was then split into two groups, depending on whether or not there was a psychiatric history.

#### *Exclusion criteria*

From this initial database were excluded encoding errors (37 patients), patients who were not ultimately taken care of by the emergency department (20 patients), chronic cholecystitis (2 patients) and patients who were admitted to the emergency room via the *service mobile d'urgence et de réanimation* (SMUR), these being already assessed by an emergency doctor before arriving in the service (86 patients). A total of 459 patients were finally retained.

## Statistical analyses

#### *Descriptive statistics*

The average length of stay in the emergency room and of the periods preceding the various nursing and medical interventions were calculated to assess a possible difference between patients with and without a psychiatric history. Then, a correlation matrix for patients with a psychiatric history and another for patients without a psychiatric history were produced. Finally, the rate of occurrence of complications was highlighted for each group.

#### *Inferential Statistics*

In order to compare the time means of groups with and without a psychiatric history, an independent samples t-test was performed for both databases. In this context, a normality test (Shapiro-Wilk test) was carried out for each collected time variable. Then, based on whether or not normality was observed, a Student's t-test and a Mann-Whitney's test were generated. The size of a potential effect of the presence of a psychiatric history on the examined variable has also been calculated. Finally, in order to assess a possible relationship between the presence of a psychiatric history and the occurrence of a somatic complications, a chi-square test was achieved.

## RESULTS

Among the 459 patients in the database, a psychiatric history was found for 74 of them. The diagnostic distribution of patients with a psychiatric history was as follows: 12 myocardial infarctions, 16 pulmonary embolisms, 18 strokes, 18 acute cholecystitis and 10 appendicitis. Among patients with no history, the distribution was 58 myocardial infarctions, 73 pulmonary embolisms, 64 strokes, 76 acute cholecystitis and 114 appendicitis.

The average treatment times collected in this database show a shorter average waiting time for patients with no psychiatric history, except for the average time preceding the realisation of the diagnostic examination and the mean of the total length of stay was longer for patients without a psychiatric history.

In addition, since the distribution of temporal variables did not obey the normal law ( $p$ -value  $< 0.001$  for all variable in Shapiro-Wilk's test), the non-parametric Mann-Whitney's test was carried out. The only statistically significant difference was between the median time preceding the prescription of the first additional examination ( $p$ -value of 0.03). The hypothesis of the absence of a relationship between the presence of a psychiatric history and a difference in time preceding the prescription of the first complementary examination can therefore be rejected within the limits of our database and our study protocol. The presence of a psychiatric history has therefore a weak effect (Rank biserial correlation 0.1597) on the time preceding the prescription of an complementary examination.

The correlation between the time preceding the prescription of the first complementary examination and the time preceding the prescription of the appropriate treatment is 41% (with a  $p$ -value  $< 0.01$ ) for patients with a history and by 26.3% (with a  $p$ -value  $< 0.001$ ) for patients without a psychiatric history. In addition, the correlation between the time interval preceding the prescription of the first complementary examination and the time preceding the prescription of the first medical imaging is 35.9% (with a  $p$ -value  $< 0.01$ ) for patients with history and 35.5% (with a  $p$ -value  $< 0.001$ ) for patients without.

Finally, the frequency of complications was highlighted for each of the two groups. A chi-square test was then performed to estimate a possible relationship between the presence of a psychiatric history and the occurrence of a somatic complication. Once again, no statistically significant link ( $p$ -value = 0.857) could be demonstrated between the risk of occurrence of a somatic complication and the presence of a psychiatric history for this sample.

## DISCUSSION

The presence of a mental disorder or a disorder related to substance abuse is frequently found among patients frequenting the emergency services, more than 4 visits per year (Chastonay & Bodenmann 2021, Slankamenac et al. 2020). While the need to know a patient's history for good overall care is not questioned in this study, the question of a possible negative impact of knowing a psychiatric history on the care provided to these patients arises. Indeed, the examples where the "psychiatric" label has impacted the somatic management of the patient, leading in

particular to diagnostic errors, remain present in the current literature (Liu et al. 2021, Molloy et al. 2023, Perry et al. 2020). The objective of this study is to assess a possible consequence. Since the length of stay in the emergency department is recognized as a quality criterion for the provided care (Clay-Williams et al. 2020), this was chosen for our study.

This study did not show any significant difference in the total length of stay of patients with a psychiatric history compared to the general population. Since the distribution of the studied time variables does not respect the normal law, the comparison of the differences between the time means is not significant. The inferential statistics did not show a significant link between the risk of occurrence of complications and the presence of a psychiatric history. Only a significant difference in the time preceding the prescription of an complementary examination could be demonstrated in this study. This result can be interpreted in two ways: it may be a false positive or the presence of a psychiatric history could be the reason for hesitation in prescribing an additional examination. However, the effect reported by this study remains weak.

Literature reports the persistence of discrimination against patients with a psychiatric disorder while consulting acute care. Perry et al. (2020) highlights the different forms that the stigma of mental health disorders takes, both in the attitude and behavior of health professionals and in organisational behaviour. We find examples of positive attitudes and behaviors from the medical staff towards patients with a mental health issue, such as granting special attention to these patients. In contrast, a negative label negative, such as being "aggressive" or "complicated" patients, is often associated with patients with a mental health condition, impacting the given care (Perry et al. 2020). However, some authors insist on the need to know the presence history psychiatric disorders in emergency department patients. They notably justify this awareness by the higher risk of violence towards caregivers in case of a previous hospitalization psychiatric forced or psychosis (Claudius et al. 2017, Salani et al. 2021).

Hesitation to prescribe a complementary examination could correspond to the phenomenon of diagnostic overshadowing. This is one of the recurring subjects in publications considering somatic management of psychiatric patients (Jespers et al. 2021, Molloy et al. 2023, Perry et al. 2020, van Nieuwenhuizen et al. 2012). It is defined as the risk to associate, to patients with psychiatric disorders, a somatic complaint with the expression of their psychiatric pathology (van Nieuwenhuizen et al. 2012). This phenomenon is found especially in examples of situations where the somatic diagnosis is initially missed. Therefore it can lead to clinical deterioration, to sequelae, or even to the death of the patient (Perry et al. 2020). In Belgium,

the rate of attendance at emergency departments for social, psychological or psychiatric reasons was 1.6% in 2016 and considered as stable for the four years prior (Devos et al. 2019). The complexity of the management of patients presenting with a psychiatric emergency (the term psychiatric emergency being used here as opposed to a somatic emergency) makes the effectiveness of the exclusion of a somatic issue all the more essential (Coates et al. 2018). Martinez et al. (2022) highlights the need for the intervention of a somatician doctor in 23.5% of hospitalized patients in psychiatry after a visit to the emergency room. While referral to a psychiatry department without clinical examination was made in 30.9% of consultations in the emergency department (Martinez et al. 2022). The risk of neglecting a somatic diagnosis in a psychiatric patient is therefore real and it appears necessary to raise awareness of this risk.

Another possible interpretation of this significant time difference would be to associate it with the uneasiness felt by somatic doctors when faced with patients presenting a psychiatric disorder (Jespers et al. 2021). An extended length of stay in the emergency room is associated with a higher mortality (Lee et al. 2022). Literature also reports a longer length of stay in the emergency room for patients with psychiatric disorders, as well as conflicting data for hospitalization time (Jentzsch et al. 2018, Lampros et al. 2020, Pearlmutter et al. 2017, Purushothaman 2021).

In this context, the question of the relevance of the triage system for psychiatric patients with somatic complaints arises. Indeed, the link between priority granted through triage, length of stay in the emergency department and short-term mortality has recently been shown (Wessman et al. 2022). Liu et al. (2021) reported that 41.6% of symptoms initially judged "psychiatric" in an emergency department turned out to be of somatic etiology. The sorting system (triage) being judged by the medical staff as inadequate for psychiatric patients (Perry et al. 2020), a possible future study would be that of the impact of the "psychiatric" label on triage and therefore on care provided to these patients.

The absence of other statistically significant links in this study could be related to the fact that it was performed in a single hospital and for a short period, therefore on a small sample. Similarly, the choice to limit inclusion diagnoses to somatic emergency situations for which the timing of administrated care impact the prognosis limited the number of retained patients. Nevertheless, this initial selection allowed the study of the length of stay only for somatic emergency consultations, without considering psychiatric emergencies contrary to studies found in the literature. In addition, the complication rate having uniquely been recorded for patients hospitalized following their visit to the emergency department, it does not consider

possible complications in the longer term, thus limiting the analysis of the link between the presence of a psychiatric history and a complication.

The excess mortality of psychiatric patients compared to the general population is undeniable. The present study did not show any significant difference in the length of stay for these patients in a somatic emergency department. Similarly, no impact of a psychiatric history on the risk of somatic complications was demonstrated for this cohort. Only the time preceding the first complementary examination for patients with a psychiatric history was demonstrated longer within the limits of this study. Possible explanations found in the literature would be the overshadowing diagnosis or the discomfort felt by somatic doctors when faced with psychiatric disorders. The question of the relevance of the triage system used in the emergency department for psychiatric patients was also raised and would be a potential avenue for future study.

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**Contribution of individual authors:**

All Authors contributed to the literature search and the drafting of the text.

## References

1. Chastonay OJ, Bodenmann P: Grands consommateurs des services d'urgence, un défi pour le système de santé: une mise au point. *J Eur Urgences Réanimation* 2021; 33:135-40. FRENCH. doi:10.1016/j.jeurea.2021.06.001
2. Claudius I, Desai S, Davis E, Henderson S: Case-controlled Analysis of Patient-based Risk Factors for Assault in the Healthcare Workplace. *West J Emerg Med* 2017; 18:1153-8. doi:10.5811/westjem.2017.7.34845
3. Clay-Williams R, Taylor N, Ting HP, Winata T, Arnolda G, Austin E, et al.: The relationships between quality management systems, safety culture and leadership and patient outcomes in Australian Emergency Departments. *Int J Qual Health Care J Int Soc Qual Health Care* 2020; 32(Suppl\_1):43-51. doi:10.1093/intqhc/mzz105
4. Coates D: Service Models for Urgent and Emergency Psychiatric Care An Overview. *J Psychosoc Nurs Ment Health Serv* 2018; 56:9. doi:10.3928/02793695-20180212-01
5. Collège national des universitaires en psychiatrie, Association pour l'enseignement de la sémiologie psychiatrique, Collège universitaire national des enseignants en addictologie: *Référentiel de psychiatrie et addictologie: psychiatrie de l'adulte, psychiatrie de l'enfant et de l'adolescent, addictologie. 2e éd. Tours: Presses universitaires François-Rabelais; 2016. Chapitre 7, Thérapeutiques; p.580. FRENCH*
6. Conseil National Professionnel de Psychiatrie: *Recommandation de bonne pratique en psychiatrie: Comment*

- améliorer la prise en charge somatique des patients ayant une pathologie psychiatrique sévère et chronique. Saint-Denis La Plaine: Haute Autorité de Santé; 2015. FRENCH. [https://www.has-sante.fr/jcms/c\\_2059048/fr/label-de-la-has-comment-ameliorer-la-prise-en-charge-somatique-des-patients-ayant-une-pathologie-psychiatrique-severe-et-chronique](https://www.has-sante.fr/jcms/c_2059048/fr/label-de-la-has-comment-ameliorer-la-prise-en-charge-somatique-des-patients-ayant-une-pathologie-psychiatrique-severe-et-chronique)
7. Detollenaere J, Gisle L, Mistiaen P: Prevalence of mental health problems. In: Mistiaen P, Cornelis J, Detollenaere J, Devriese S, Farfan-Portet MI, Ricour C, editors. *Organisation of mental health care for adults in Belgium*. Health Services Research (HSR). Brussels: Belgian Health Care Knowledge Centre (KCE); 2019. KCE Reports 318. D/2019/10.273/50
  8. Devos C, Cordon A, Lefèvre M, Obyn C, Renard F, Bouckaert N et al.: Performance of the Belgian Health System – Report 2019. Health Services Research (HSR). Brussels: Belgian Health Care Knowledge Centre (KCE); 2019. KCE Reports 313. <https://kce.fgov.be/en/performance-of-the-belgian-health-system-%E2%80%93-report-2019>
  9. Firth J, Siddiqi N, Koyanagi A, Siskind D, Rosenbaum S, Galletly C, et al.: The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *Lancet Psychiatry* 2019; 6:675-712. doi:10.1016/S2215-0366(19)30132-4
  10. Gillis O & Mendes da Costa E: Etat des lieux sur la situation de la Santé mentale aujourd'hui à Bruxelles. Bruxelles: Observatoire de la Santé et du Social de Bruxelles-Capitale; 2020. Figure 7 : Répartition (en %) des causes d'invalidités – salariés – Bruxelles – 2005-2018; p.11. FRENCH. [https://www.ccc-ggc.brussels/sites/default/files/documents/graphics/tableaux-de-bord-de-la-sante-etat-des-lieux\\_sante\\_mentale\\_bruxelles\\_fevrier\\_2020.pdf](https://www.ccc-ggc.brussels/sites/default/files/documents/graphics/tableaux-de-bord-de-la-sante-etat-des-lieux_sante_mentale_bruxelles_fevrier_2020.pdf)
  11. Gisle L, Drieskens S, Demarest S, Van der Heyden J: Santé mentale. Enquête de santé 2018. Bruxelles: Sciensano; 2020. D/2020/14.440/3. FRENCH. [https://www.sciensano.be/sites/default/files/summ\\_mh\\_fr\\_2018.pdf](https://www.sciensano.be/sites/default/files/summ_mh_fr_2018.pdf)
  12. Holland KM, Jones C, Vivolo-Kantor AM, Idaikkadar N, Zwald M, Hoots B, et al.: Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic. *JAMA Psychiatry* 2021; 78:372-9. doi:10.1001/jamapsychiatry.2020.4402
  13. Jentzsch T, Seifert B, Neuhaus V, Moos RM: Predictors for shorter and longer length of hospital stay outliers: a retrospective case-control study of 8247 patients at a university hospital trauma department. *Swiss Med Wkly* 2018; 148:w14650. doi:10.4414/smw.2018.14650
  14. Jaspers V, Christiaens W, Kohn L, Savoye I, Mistiaeni P: Synthèse Soins De Santé Somatiques En Institutions Psychiatriques. Health Services Research (HSR). Brussels: Belgian Health Care Knowledge Centre (KCE); 2021. Report No.: 338Bs. D/2021/10.273/03. FRENCH. [https://www.kce.fgov.be/sites/default/files/2021-12/KCE\\_338B\\_Psychosomatic\\_Synthese\\_0.pdf](https://www.kce.fgov.be/sites/default/files/2021-12/KCE_338B_Psychosomatic_Synthese_0.pdf)
  15. Lachowycz K, Celebi S, Price G, Lugton C, Roche R: Severe mental illness (SMI) and physical health inequalities: briefing. London: Office for Health Improvement and Disparities (UK); 2018. Figure 10: Prevalence of physical health multi-morbidities for severe mental illness (SMI) and patients aged 15 to 74; p.15-16
  16. Lampros A, Montardi C, Journeau L, Geogin-Lavialle S, Hanslik T, Dhote R, et al.: Association des comorbidités psychiatriques avec la durée de séjour des patients en médecine interne d'aval des urgences. *La Revue de Médecine Interne* 2020; 41:360-7. FRENCH. doi:10.1016/j.revmed.2019.12.016
  17. Lee KS, Min HS, Moon JY, Lim D, Kim Y, Ko E, et al.: Patient and hospital characteristics predict prolonged emergency department length of stay and in-hospital mortality: a nationwide analysis in Korea. *BMC Emerg Med* 2022; 22:183. doi:10.1186/s12873-022-00745-y
  18. Lewis J, Weich S, O'Keefe C, Stone T, Hulin J, Bell N, et al.: Use of urgent, emergency and acute care by mental health service users: A record-level cohort study. *PLOS ONE* 2023; 18:e0281667. doi:10.1371/journal.pone.0281667
  19. Liu F, Chen J, Du Y, Jiang W, Gong L, Mu J: Misidentification of Acute Psychiatric Symptoms in the Emergency Room: Clinical Experience in China. *Front Psychiatry* 2020; 11:579484. doi:10.3389/fpsy.2020.579484
  20. Martinez M, Mariat C, Kaczorek M, Lefebvre T, Mas-soubre C, Tazarourte K: Intérêt de l'évaluation somatique systématique chez les patients adultes à présentation psychiatrique en structure des urgences. *Ann Méd-Psychol Rev Psychiatr* 2022; ISSN 0003-4487. FRENCH. doi:10.1016/j.amp.2022.08.011
  21. Marzola E, Duranti E, De-Bacco C, Lupia E, Villari V, Abbate-Daga G: Psychiatric patients at the emergency department: factors associated with length of stay and likelihood of hospitalization. *Intern Emerg Med* 2022; 17:845-55. doi:10.1007/s11739-021-02820-x
  22. Molloy R, Brand G, Munro I, Pope N: Seeing the complete picture: A systematic review of mental health consumer and health professional experiences of diagnostic overshadowing. *J Clin Nurs* 2023; 32:1662-73. doi:10.1111/jocn.16151
  23. Pearlmutter MD, Dwyer KH, Burke LG, Rathlev N, Maranda L, Volturo G: Analysis of Emergency Department Length of Stay for Mental Health Patients at Ten Massachusetts Emergency Departments. *Ann Emerg Med* 2017; 70:193-202.e16. doi:10.1016/j.annemergmed.2016.10.005
  24. Perry A, Lawrence V, Henderson C: Stigmatisation of those with mental health conditions in the acute general hospital setting. A qualitative framework synthesis. *Soc Sci Med* 2020; 255:112974. doi:10.1016/j.socscimed.2020.112974
  25. Purushothaman S: Patient flow from emergency department to inpatient psychiatric unit - a narrative review. *Australas Psychiatry Bull R Aust N Z Coll Psychiatr* 2021; 29:41-6. doi:10.1177/1039856220936629
  26. Richesson D, Hoening JM: Key Substance Use and Mental Health Indicators in the United States : Results from the 2020 National Survey on Drug Use and Health. Rockville: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2021. 156 p. Publication No.: PEP21-07-01-003 <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFR1PDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>
  27. Salani D, Valdes B, De Oliveira GC, King B: Psychiatric Emergencies: Emergency Department Management of Al-

- tered Mental Status. *J Psychosoc Nurs Ment Health Serv* 2021; 59:16-25. doi:10.3928/02793695-20210427-02
28. Slankamenac K, Heidelberger R, Keller DI: Prediction of Recurrent Emergency Department Visits in Patients With Mental Disorders. *Front Psychiatry* 2020; 11:48. doi:10.3389/fpsyt.2020.00048
29. van Nieuwenhuizen A, Henderson C, Kassam A, Graham T, Murray J, Howard LM, et al.: Emergency department staff views and experiences on diagnostic overshadowing related to people with mental illness. *Epidemiol Psychiatr Sci* 2012; 22:255-62. doi:10.1017/S2045796012000571
30. Wessman T, Ärnlöv J, Carlsson AC, Ekelund U, Wändell P, Melander O, et al.: The association between length of stay in the emergency department and short-term mortality. *Intern Emerg Med* 2022; 17:233-40. doi:10.1007/s11739-021-02783-z

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