Review / Derleme

DOI: 10.4274/cayd.galenos.2021.93823
J Pediatr Emerg Intensive Care Med 2022;9:66-73

A Dimension of Child Emergency: Psychiatric Emergency and Nursing Approach

Çocuk Acilin Bir Boyutu: Psikiyatrik Aciller ve Hemşirelik Yaklaşımı

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Abstract

In recent years, there has been a significant increase in applications to pediatric emergency services. Psychiatric emergencies are one of the frequent applications made to pediatric emergency services. Psychiatric emergencies are the first places that children and families will go to, as a situation that applications urgent intervention. However, in cases that do not require emergency intervention, children and families should apply to psychiatry services, while most of the applications are made to emergency services. Psychiatric emergencies constitute 3-12% of the applications made to emergency services. Therefore, in this review, psychiatric emergencies, risk factors, incidence, identification and evaluation of psychiatric emergencies, specific psychiatric emergencies and nursing approach are discussed in this review.

Keywords: Emergency nursing, child, psychiatric emergency services

Öz

Son yıllarda çocuk acil servislerine başvurularda belirgin bir artış görülmektedir. Çocuk acil servislerine yapılan sık başvurulardan biri de psikiyatrik acillerdir. Psikiyatrik aciller, acil müdahale edilmesi gereken bir durum olması sebebiyle çocuk ve ailelerin ilk başvuracakları yerlerdir. Ancak acil müdahale gerektirmeyen durumlarda çocuk ve ailelerin psikiyatri servislerine başvuru yapması gerekirken başvuruların çoğunluğunun acil servislere yapılmaktadır. Psikiyatrik aciller, acil servislere yapılan başvuruların %3-12'sini oluşturmaktadır. Bu nedenle bu derlemede çocukluk çağındaki psikiyatrik aciller, risk faktörleri, insidansı, saptanması, değerlendirilmesi ve hemşirelik yaklaşımı ele alınmıştır.

Anahtar Kelimeler: Acil hemşireliği, çocuk, psikiyatrik acil hizmetleri

Introduction

Psychiatric emergencies are a medical condition occurring suddenly in one or more of the individual's behaviors, thoughts and emotion areas, and requiring immediate intervention.[1,2] Psychiatric emergencies that require urgent intervention may develop due to substance use, drug interaction, poisoning, medical conditions and drug side effects as well as due to stress, chronic mental illnesses and negative situations resulting from psychosocial factors (peer quarrels, loss-grief process).[3] Psychiatric emergencies constitute 3-12% of the applications to the emergency services.[4,5] Since psychiatric emergencies are a situation that requires urgent intervention, patients and their relatives first apply to emergency services.[6,7] Intervention and quality care services have a very important place in these applications.[7-9] The patient and his/her family, who apply to the psychiatric emergency, should be guided early and appropriately, the correct diagnosis should be established on time, and the treatment should be planned and implemented urgently.[10,11] Comprehensive evaluation of the patient when he/she comes to the emergency department will facilitate the emergency that may develop in the next period and his/her compliance with the treatment in the following processes.[12] First of all, the patient and his/her family should be calmed before starting treatment in psychiatric emergencies. Afterwards, the patient should be treated and psychiatric symptoms should be reduced.[13] In addition, healthcare professionals need to have knowledge

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Received/Geliş Tarihi: 30.05.2021 **Accepted/Kabul Tarihi:** 08.11.2021

and skills in many aspects when intervening in psychiatric emergencies.[8,14] Psychiatric emergencies are classified under 3 separate headings. This classification is as follows: Psychiatric emergencies that threaten the life of the individual, including "major depression, suicide attempt, conflict, acute paranoia, alcohol and substance intoxication", psychiatric emergencies that threaten the life of others, including "aggressive, impulsive and homicidal behaviors", and psychiatric emergencies that threaten the flow of life, including "rape, psychosis, grief process, panic attacks, abuse, conversion, anxiety, psychosomatic symptoms, physical or sexual traumas".[13]

Psychiatric Emergencies in Children

Child psychiatric emergencies are those that are perceived as a potential threat to the safety or well-being of the child and his/her family. In these cases, in the event of danger, intense symptoms may occur in the presence of an urgent and sudden negative event.[9,12,13] Children's psychological health and well-being largely depend on their families, schools and the society in which they live. Child psychiatric emergencies mostly arise as a result of a long history of emotional and behavioral difficulties as well as sudden situations.[9,12,13,15]

In many developing regions of the world, children live in extremely difficult social conditions. As a result of disease epidemics, wars, disasters, long-term hospital stays due to diseases and other cultural practices, children have to be separated from their families. Today, children cannot go to school due to extreme poverty, violence and social events (war, battle, migration). All these factors increase the vulnerability of children to psychiatric emergencies. Therefore, a psychiatric condition in the child reflects the family and society system. This situation of the child is defined as an emergency by the parents or other people around their.[15-19]

Considering today's malnutrition and high rates of infectious diseases, pathological conditions are the underlying cause of many psychiatric emergencies in children. For example, acute organic brain syndromes can cause varying degrees of behavioral disorders in children, often requiring immediate psychiatric intervention. In addition, self-harming behavior among adolescents sometimes leads to negative psychosocial events in the person or family.[3,15-19] Parents often accept a child's behavioral problems as an emergency when they can no longer cope with the behavior.

Psychiatric emergencies in children include suicide, depression, psychosomatic disorders, sudden psychotic symptoms, anxiety disorder, severe eating disorders, panic, conversion disorders, non-organic pain, running away from home, sleep disorders, behavioral disorders, dissociative children, substance abuse, thought disorders, abuses, phobias, negligence, hallucinations, substance addiction, acute stress reactions, self-harming and mood disorders.[3,13,18-21]

Risk Factors for Psychiatric Emergencies in Children

Psychiatric emergencies in children are affected by individual, familial, social and school-related factors. Individual factors include "physical and mental disability, chronic physical illness, isolation, impulsive behaviors, poor social skills and separation"; familial factors include "poor parent-child communication, exposure to abuse by caregivers, parental separation, divorce, parental abandonment, and occurrence of illness or death in the family"; school-related factors include "academic failure, problems with peers, peer bullying, failing the class and being expelled from school" and social factors include "low socio-economic level, social discrimination, isolation, bullying and religious beliefs".[3,15-19] In general, a psychiatric disorder that exists in a child occurs as an acute traumatic experience, a medical condition, or a complication of treatment.[16-19]

Incidence of Psychiatric Emergencies in Children

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) guideline prepared by the American Psychiatric Association (APA), it is stated that psychiatric disorders are seen at a rate of 10-15% in childhood and adolescence, and anxiety disorders are the most frequently diagnosed psychiatric disorders.[22-24] According to the national survey data of hospital outpatient medical care, the rate of admissions to the emergency department due to psychiatric conditions increased from 4.4% in 2001 to 7.2% in 2011. In addition, it was reported in this study that psychiatric cases admitted to the emergency department were between the ages of 12 and 17 years.[25]

In developed countries, the rate of children applying to psychiatric emergencies is higher than that in developing countries.[25,26] Zachary and Mannix[27] stated in their study that applications to psychiatric emergencies increased in children. The incidence of psychiatric emergencies in children varies depending on the school calendar. According to the studies, the use of emergency services by children is less in the summer months and generally in the evening hours.[28,29]

The incidence of psychiatric emergencies in children increases with age. Psychiatric problems are seen in 10.2% of pre-school children, 13.2% of pre-adolescent children and 16.5% of adolescents.[30] In addition, it was reported in another study that the majority of psychiatric emergencies occur during adolescence.[26] In the study conducted by Tokgöz et al.,[31] the incidence of psychiatric diseases was reported as 0.7% in children and 4.2% in adolescents. In a study conducted in Turkey, it was reported that 3.3% of the applications

made to the pediatric emergency service were psychiatric emergencies.[32] In the international literature, there are studies evaluating the incidence of children admitted to the pediatric emergency department due to psychiatric emergencies.[26,28-30] However, there are limited studies to determine this incidence in Turkey, and such studies are needed to be conducted.[31,32]

Detection and Evaluation of Psychiatric Emergencies in Children

Psychiatric emergencies in children are determined by parents, school teachers, counselling service, nurses caring for hospitalized children, family physicians, pediatricians, psychologists, other family members, friends and social environment.[33-35]

The clinical presentation of psychiatric problems in children and adolescents is different from adults. While most adults seek help on their own behalf, children rarely do so. In addition, depending on age and development, some children are unable to provide historically and clinically relevant information. Therefore, parents or caregivers are often the primary source of information about the child's condition. However, this does not mean that children should be excluded from the process of obtaining information. In order to make the right decision about the child's behavior, the developmental appropriateness of the behavior should be determined. Moreover, it requires clinical assessment, a detailed history, mental state examination, combining all available data on biological, psychological, and social aspects, diagnosis, and differential diagnosis. In order to transfer this information to the patient and their family, a treatment plan should be created.[33-41]

Assessment

Evaluation of psychiatric emergencies admitted to the pediatric emergency should be done as follows:

- The attribution and causes of the emergency should be recorded from the information source.
- His or her past feelings, thoughts and mood about the child's family, school and living conditions as well as current difficulties should be collected.
- The factors that have caused or may cause the onset and emergence of these problems (genetic, developmental, familial, social, medical) should be determined.
- Existing problems should be identified for the treatment of the child.
- The presence of one or more psychiatric disorders in the child should be determined.
- It should be tried to form an idea about the factor that causes the emergency situation in the child.
- Possible risk situations for the safety of the child and his/her family should be determined.
- The extent to which the disease affects the child's daily life should be evaluated.
- It should be determined whether the child is at risk of harming himself/herself or others.
- Interventions that include situations that create difficulties for the child and that can improve them should be identified.
- The child and his/her family should be evaluated as a whole.
- Strength areas, sources of support and social environment within the family should be defined.
- A safe environment should be created regarding how and where the child's treatment will be carried out.
- It should be determined whether admission to the psychiatry service is necessary.[33-41]

Psychiatric Interview

The specialist who will evaluate the child's mental health should use interview and observation skills to encourage the child to talk. During the interview, this specialist should pay attention to the child's both verbal and non-verbal cues. He/she should attempt to meet with adolescent children privately in a separate room and encourage them to talk freely about their concerns.[1,2,6,33-36] The points that the specialist who communicates with the child should pay attention are as follows;

- The specialist should introduce himself/herself to the child with a short greeting.
- The specialist should explain to the child who he/she is and what he/she wants to do in clear and understandable language.
- The specialist should take into account the age and developmental level of the child when meeting with the child.
- The situation of the child may create a crisis effect. The child may want to talk about the situation, be quiet or withdrawn. Persistent behavior while talking to the child may cause a feeling of being forced into treatment.
- The child may be overwhelmed and frightened by the reaction to his/her actions. Because of this, the child may try to hide the problem. Therefore, specialists should be careful in this regard.
- No matter how bad the behavior is, one should not be accusatory against the child.
- Questions about behavior or feelings when interviewing the child should be simple.

- The child's relationship with family members and participation in solving problems should be observed.
- When meeting with the child, it should be learned how the child feels, thinks or behaves.
- With young children, it may be helpful to first talk about neutral topics to reassure the child. With this approach, the child's speech, emotion and thought patterns are evaluated.
- Adolescents value their privacy and independence and are more likely to share information if they know it will be kept confidential. In line with this information, the child should be contacted.
- Interview time with the child should not be prolonged.[1,2,6,13,33-41]

Evaluation of Mental State

It is important to take the history of psychiatric illness in the evaluation of the child's mental health. The most distinctive point here is to know that acute psychiatric disorders and mental health problems have different treatments. Psychiatric emergencies in children include delirium, aggression, violence, psychosis, depression, conversion, schizophrenia, phobia, bipolar disorder, somatic symptom disorder, eating disorders, anxiety disorders, post-traumatic stress disorder, dissociative disorders, panic disorder, behavioral disorder, intentional self-harm, suicide attempt, child abuse and neglect.[1,2,13,15,33,36,37,40,41] The following should be considered during the mental state examination of children;

- Impairment in consciousness, attention, memory, and orientation
- Neurological and physical diseases
- Neurological symptoms such as slurred speech, ataxia and apraxia
- Crisis assessment
- Inconsistency of thought and speech
- Weak memory
- Thoughts of suicide or murder
- Psychomotor agitation or retardation, restlessness
- Aggressive threats or thoughts
- Perceptual disturbances
- Impulsivity
- Poor judgment and insight
- Limited intelligence
- Withdrawal syndrome
- Hallucinations, delusions
- Drug-substance poisoning
- Depressive or aggressive mood, mood changes[13-15,33-41]

Co-occurring Disorders

In emergency situations, the most prominent acute disorder should be addressed first. For example, the mania state of an adolescent who presents to the emergency room with the diagnoses of mania and attention deficit hyperactivity disorder is first intervened. Primary psychiatric disorders that are not life-threatening should be intervened at a different time in the outpatient setting.[1,2,37,39,41]

Evaluation of Family

An immediate evaluation should focus on high-risk family mental health problems such as suicide, substance abuse, mood disorders, and psychosis. Children with a family history of psychiatric illness are at higher risk.[2,6,31,33,36]

Treatment History

Inventory and evaluation of previous treatments, including pharmacotherapy and psychotherapy, are essential in the treatment of child psychiatric emergencies. Information regarding the child's previous treatment, duration, drug doses, side effects, hypersensitivity, and adherence to treatment should be reviewed in detail.[1,2,12-15,33-40]

Nursing Approach to Pediatric Patients in Psychiatric Emergencies

Nursing interventions in psychiatric emergencies in children are mostly made for the acute stages of the disease or the first periods of the onset of the disease. After the evaluation of the child patient is completed, the nurse should cooperate with the patient and his/her family to make appropriate nursing interventions.[1,2,5,18,41] Nursing approach towards the child admitted to the psychiatric emergency is as follows;

- The nurse should himself/herself to the child and express that he/she is here to help.
- While communicating with the child, the nurse should adjust the tone of voice and make him/her feel that they are there to help.
- When the communication between the nurse and the child begins, the child should be listened and given the opportunity to express his/her feelings as he/she wishes.
- Open-ended questions should be asked during communication with the child.
- When the communication between the nurse and the child begins, the child should be listened and the nurse should make confirmative sentences indicating that he/she is listening. If the child thinks that he/she is not taken into consideration while he/she is trying to explain the events or answering the questions the nurse asks, he/she

may suddenly cut-off communication, show agitation and aggression.

- The nurse should ensure personal safety while communicating with the child.
- Aggression status should be examined in restless and agitated children, and in case of aggression, the child should be kept at a distance.
- After creating a safe environment between the child and the nurse, the patient's vital signs should be evaluated and recorded.
- In many psychiatric conditions, the negative experiences and events experienced by the child can create agitation at a level that "does not even allow you to touch and examine him/her". The nurse should approach the child in a very calm and quiet manner. In such cases, one should not be overly insistent and try to calm the child.
- "Standard first and second examinations" should be done after the child accepts the examination and assistance. While the standard first examination includes the patient's "detailed history, mental state, physical and neurological examination, laboratory and imaging tests", the second examination includes a detailed approach to "an underlying medical illness, acute psychiatric disorder and mental health".
- Among the most overlooked events in psychiatric emergencies, there are physical illnesses that may alter the child's mental state, head trauma, substance abuse, metabolic diseases, cerebrovascular diseases and drug use. For this reason, the necessary medical examinations and procedures should be performed in addition to the psychiatric evaluation of the child.
- The nurse should distinguish between acute psychiatric disorder and acute mental health while evaluating the child. With the knowledge of psychiatric emergencies, pediatric patients can be detected in the early period, their risks can be reduced and treatment can be started in the early period. Late detection of psychiatric emergencies may cause both the disease to be chronic and negative consequences such as suicide.
- During the examination, the nurse should evaluate alcohol use (alcohol smell in the breath), trauma (head and chest trauma), drug use (injection scars), and possible penetrating stab wound (scars on the body). After a short and rapid neurological examination of the child, a physical examination should be performed.[1,2,5,7,11-14,18,41]

Physical Examination

It is stated that the physical examination of the child will be carried out by a physician or a healthcare professional under the supervision of a physician, according to the regulation on "Physical Examination, Genetic Examinations and Determination of Physical Identity in Criminal Procedure".[42] One of the data collection methods regarding the child's condition within the scope of the nursing diagnosis process is physical examination.[43] While performing the physical examination of the child, first "inspection" and then "palpation method" should be used. During the physical examination, the room lighting should be sufficient and the necessary medical supplies should be available. The nurse should inform the child about the physical examination in a language that he/she can understand, and then obtain the child's verbal consent, and both verbal and written consent from the parents. Relatives of the child should not be present in the room during the physical examination. Depending on the child's wishes, another nurse may also attend the physical examination. The nurse should reassure and calm the child during the physical examination. If there is a "suspect for forensic case", the forensic law enforcement officers should be notified regardless of the nature of the case while medical treatment is being administered.[43,44] The child, who is thought to be a forensic case, should be prevented from "taking a bath and changing the clothes on before the examination".[43-45]

In this process, the nurse is the first person to see the child, to communicate with his/her family, and to deal with the laboratory samples.[46] While examining and treating pediatric cases, deficiencies and mistakes may occur from time to time in the detection, collection, documentation, protection and storage of all evidence that can constitute forensic evidence. Particularly documentation of information and evidence that can be considered as evidence is very important in terms of preventing the loss of evidence, the judicial process to hinder and unfair victimization.[47,48]

Physicians and nurses should wear gloves while collecting forensic evidence so that the collected evidence is not contaminated, and they should change their gloves while collecting each different evidence. When collecting evidence, attention should be paid to the child's clothing and traces. In case of penetrating stab wounds, the holes should not be damaged when removing the child's clothes, and if there are suspicious stains, they should be circled and documented with a photograph.[49-51] In order not to lose the evidence in the clothes, the child is provided to undress standing on a wide and white sheet. In cases where the clothes cannot be removed, the clothes should be cut as far as possible from the area of the wound and the procedure should be noted as "clothing was cut".[52,53] All lesions on the skin such as wounds, burns, abrasions, ecchymosis (bruises) and scars should be determined. If there are traces of substance use in the child's body, a blood sample should be taken within the first 48 hours and a urine sample within 120 hours for

the detection of the drug substance. Samples taken should be placed in two sterile containers.[54] The entire lesioned area is measured and camera recording should be made simultaneously. The "color, shape, appearance, location and measurement results" of the lesion on the skin should be recorded.[49,55,56] All evidence obtained should be placed in separate paper bags in a dry condition. If the evidence is wet or damp, it should be left to air dry and delivered to the laboratory where the drying process will be carried out as soon as possible.[55] The person collecting the evidence enumerates each of the paper bags and writes "the name of the accused/victim, the protocol number, gender, date/time of arrival, date of birth, complaints, findings, examinations, wounds, the examination performed, the name of the examining doctor and the name of the nurse who collected it" for recording.[49-51,53,55]

Treatment

After making a rapid evaluation of the child who applied to the emergency department with psychiatric complaints, the physician should intervene by evaluating the previous treatment history for the "child's mood, thought and behavioral disorders". These interventions aim the psychiatric and medical differential diagnosis of the child and includes medical and surgical treatment, pharmacotherapy, psychotherapy, and social therapy.[4]

Pharmacotherapy changes depending on the psychiatric diagnosis of the child. Among the pharmacotherapies recommended in the pediatric emergency department are "lorazepam, risperidone, biperiden, sertraline, aripiprazole, olanzapine, fluoxetine, hydroxyzine, clonazepam, haloperidol, quetiapine, valproic acid, escitalopram, paroxetine, and mirtazapine."[3,57] In the management of pharmacotherapy, the emergency nurse is responsible for "collecting data on drug use, knowing and observing the effects and side effects of drugs, administering the drug (by knowing the dose and route of administration), evaluating the response to the drug, recording it, organizing the treatment program in cooperation with the treatment team, and giving education to the individual and the family on the continuation of drug use after discharge".[58,59] The points that should be paid attention by the pediatric emergency nurse while administering medication to the child patient are as follows:

- Before administering the treatment, the child and family should be informed about the treatment.
- The child's and parents' questions about treatment should be answered clearly.
- The nurse should have knowledge about the "pharmacokinetic and pharmacodynamic effects" of the drugs administered to the child and should administer the treatment accordingly.
- The nurse should administer the drug to the child in line with the "10 right principles".
- The nurse should inform the child and parents about "how the drug to be administered is taken, its effect, side effects, management of side effects and duration of effect".
- Medications in the emergency room should be kept in locked cabinets in rooms where patients cannot reach.
- The child should be observed to ensure that he/she gets the drug during the treatment.
- The nurse should inform the physician if the child vomits the drug and should repeat the administration of the drug in line with the doctor's recommendation.
- The nurse should observe the child's reaction to the drug and inform other members of the team.[60,61]

If "the child's affection, thinking, and impulse control is impaired to such an extent that it harms him/herself and his/her surroundings, his/her lifestyle becomes so confused as to disintegrate his/her psychic structure, the risk of suicide is high and social support is weakened", the physician should contact the child and adolescent psychiatrist after completing the examination. If necessary, hospitalization of the child can be decided. The child's hospitalization is carried out after getting the informed consent of the parents.[57,62,63]

Conclusion

In this review, general information about childhood psychiatric emergencies, risk factors, incidence, detection, evaluation and nursing approach is given. Pediatric emergency services play a vital role in the management of pediatric patients with psychiatric emergencies. Psychiatric conditions in children and adolescents are predicted to be an increasing risk factor globally in the near future. A multidisciplinary approach is very important in the management of psychiatric emergencies in childhood. In order to display this approach, parents, nurses, pediatricians, emergency specialists, psychiatrists and psychologists should be included in this team. After the evaluation of the child patient is completed, especially pediatric, emergency and psychiatry nurses should cooperate with the child and their family.

Ethics

Peer-review: Externally peer-reviewed.

Authorship Contributions

Concept: B.A., İ.K., Design: B.A., İ.K., Literature Search: B.A., İ.K., Writing: B.A., İ.K.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study received no financial support.

References

1. Karlıdere T. Psikiyatrik Aciller. İçinde: Güleç C, Köroğlu E (eds). Psikiyatri Temel Kitabı. Ankara: Hekimler Yayın Birliği, 2007: 544-61.
2. Sadock BJ, Ahmad S, Sadock VA. Klinik Psikiyatri El Kitabı. Tamam L (çeviren) 6.Baskı, Ankara: Güneş Tıp Kitabevleri, 2020: 579-84.
3. Fauman BJ. Other Psychiatric Emergencies. In: Sadock BJ, Sadock VA, Ruiz P (eds). Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 10th ed. Lippincott: Williams and Wilkins; 2017: 2040-55.
4. Kısa C, Aydın OD, Cebeci S, Aydemir Ç, Göka E. Acil psikiyatrik başvuruların ve acil psikiyatrik hizmetlerin değerlendirilmesi. Yeni Symposium. 2001;39:174-80.
5. Kerrison SA, Chapman R. What general emergency nurses want to know about mental health patients presenting to their emergency department. Accid Emerg Nurs. 2007;15:48-55.
6. Şahingöz M, Kendirli K, Yılmaz E, Sönmez EÖ, Satan Y, ve ark. Bir üniversite hastanesindeki psikiyatrik aciller. Selçuk Tıp Derg. 2014;30:153-4.
7. Morphet J, Innes K, Munro I, O'Brien A, Gaskin, CJ, et al. Managing people with mental health presentations in emergency departments–a service exploration of the issues surrounding responsiveness from a mental health care consumer and carer perspective. Australas Emerg Nurs J. 2012;15:148-55.
8. Clarke DE, Brown AM, Hughes L, Motluk L. Education to improve the triage of mental health patients in general hospital emergency departments. Accid Emerg Nurs. 2006;14:210-8.
9. Aker S, Böke Ö, Pekşen Y. Evaluation of psychiatric disorders among admittances to 112 emergency services in Samsun - 2004. Anadolu Psikiyatri Dergisi. 2006;7:211-7.
10. McDonough S, Wynaden D, Finn M, McGowan S, Finn M, et al. Emergency department mental health triage consultancy service: an evaluation of the first year of the service. Accid Emerg Nurs. 2004;12:31-8.
11. Nicholls D, Gaynor N, Shafiei T, Bosanac P, Farrel G. Mental health nursing in emergency departments: the case for a nurse practitioner role. J Clin Nurs. 2011;20:530-6.
12. Bekaroğlu M, Bilici M. Psikiyatrik Aciller. İçinde: Güleç C, Köroğlu E (eds). Psikiyatri Temel Kitabı. 2. Cilt. Ankara: Hekimler Yayın Birliği, 1998: 835-55.
13. Milli Eğitim Bakanlığı. Psikiyatrik Aciller Kitapçığı. Ankara, 2011:1-68.
14. Antai-Otong D. Psychiatric emergencies - How to accurately assess and manage the patient in crisis. 2nd ed. Premier Publishing & Media;2009.
15. Martin A, Volmar FR, Lewis M (eds). Lewis' child and adolescent psychiatry: A comprehensive textbook. 4nd ed., Philadelphia: Lippincott Williams and Wilkins, 2007.
16. Omigbodun OO. Psychosocial issues in a child and adolescent psychiatric clinic population in Nigeria. Soc Psychiatry Psychiatr Epidemiol. 2004;39:667-72.
17. Sorrentino A. Chemical restraints for the agitated, violent, or psychotic pediatric patient in the emergency department: controversies and recommendations. Curr Opin Pediatr. 2004;16:201-15.
18. Shipman K, Taussig H. Mental health treatment of child abuse and neglect: the promise of evidence-based practice. Pediatr Clin North Am. 2009;56:417-28.
19. Omigbodun OO, Olatawura MU. Child rearing practices in Nigeria: implications for mental health. Nigerian Journal of Psychiatry. 2008;6:10-5.
20. Karabekiroğlu K. Çocuk psikiyatrisinde acil durumlar. Erişim adresi: http://www.cocukhayat.com/yazi/acil.html. Erişim tarihi: 15 Şubat 2021.
21. Mutlu C, Kılıcoğlu AG, Güneş H, Adaletli H, Metin H, et al. Characteristics of pediatric psychiatric emergency population in a mental health hospital. Eurasian J Emerg Med. 2015;14:123-30.
22. Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Psychiatric Association: Washington DC, USA;2013.
23. Fleitlich-Bilyk B, Goodman R. Prevalence of child and adolescent psychiatric disorders in southeast Brazil. J Am Acad Child Adolesc Psychiatry. 2004;43:727-34.
24. Goodman R, Ford T, Richards H, Gatward R, Meltzer H. The Development and well-being assessment: Description and initial validation of an integrated assessment of child and adolescent psychopathology. J Child Psychol Psychiatry. 2000;41:645-55.
25. Simon AE, Schoendorf CK. Emergency department visits for mental health conditions among US children, 2001-2011. Clin Pediatr (Philia). 2014;53:1359-66.
26. Taastrøm A, Klahn J, Staal N, Thomsen PH, Johansen A. Children and adolescents in the psychiatric emergency department: A 10-year survey in Copenhagen county. Nord J Psychiatry. 2014;68:385-90.
27. Zachary E. P, Mannix R. Trends in pediatric visits to the emergency department for psychiatric illnesses. Acad Emerg Med. 2014;21:25-30.
28. Lueck C, Kearl L, Lam CN, Cladius I. Do emergency pediatric psychiatric visits for danger to self or others correspond to times of school attendance? Am J Emerg Med. 2015;33:682-4.
29. Ali S, Rosychuk RJ, Dong KA, McGrath PJ, Newton SA. Temporal trends in pediatric mental health visits: using longitudinal data to inform emergency department heath care planning. Pediatr Emerg Care. 2012;28:620-5.
30. Zahn-Waxler C, Klimes-Dougan B, Slattery MJ. Internalizing problems of childhood and adolescence: Prospects, pitfalls and progress in understanding the development of anxiety and depression. Dev Psychopathol. 2000;12:443-66.
31. Tokgöz Y, Güvenir T, Duman M, Yılmaz D. Ergenlerde psikiyatrik aciller. Pediatri Uzmanlık Akademisi Dergisi. 2014;2:1-3.
32. Mönür M, Gülen M, Avci A, Satar S. 112 Ambulansı ile çocuk acile getirilen hastaların değerlendirilmesi. Bakırköy Tıp Dergisi. 2018;14:253-62.
33. Burks HL, Hoekstra M. Psychiatric emergencies in children. Am J Orthopsychiatry. 1964;34:134-7.
34. Carandang C, Gray C, Marval-Ospino H, MacPhee S. Child and Adolescent Psychiatric Emergencies. In: Rey JM (ed). IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions, 2012.
35. Roman SB, Matthews-Wilson A, Dickinson P, Chenard D, Rogers CS. Current pediatric emergency department innovative programs to improve the care of psychiatric patients. Child Adolesc Psychiatr Clin N Am. 2018:7;441-54.
36. Reynolds EK, Gorelik S, Kook M, Kellermeyer K. Acute psychiatric care for pediatric patients. Int Rev Psychiatry. 2020;32:272-83.

37. Gerson R, Havens J, Marr M, Storfer-Isser Amy, Lee M, et al. Utilization patterns at a specialized children's comprehensive psychiatric emergency program. Psychiatr Serv. 2017;68:1104-11.

38. Randall MM, Parlette K, Reibling E, Chen B, Chen M, et al. Young children with psychiatric complaints in the pediatric emergency department. Am J Emerg Med. 2020;46:344-8.

39. Bella T, Adejumo O, Ibeziako P, Omigbodun O. Child Psychiatric Emergencies. In: Rangaswamy T, Vijayakumar L (eds). Emergencies in Psychiatry in Low-and Middle-Income Countries. 2nd ed. New York, NY: Routledge;2017:104-21.

40. Starling J, Bridgland K, Rose D. Psychiatric emergencies in children and adolescents: an emergency department audit. Australas Psychiatry. 2006;14:403-7.

41. Christodulu VK, Lichenstein R, Weist DM, Shafer EM, Simone M. Psychiatric emergencies in children. Pediatr Emerg Care. 2002;18:268-70.

42. Resmi Gazete. (2005, Haziran 1) .Ceza muhakemesinde beden muayenesi, genetik incelemeler ve fizik kimliğin tespiti hakkında yönetmelik. Erişim adresi: https://www.resmigazete.gov.tr/eskiler/2005/06/20050601-13.htm. Erişim tarihi: 15 Ekim 2021.

43. İnanıcı A, Şelimen D. Acil Serviste Adli Olgu Değerlendirilmesi ve Adli Hemşirelik. İçinde: Acil Bakım. 3. Baskı, İstanbul, Yüce Yayım, 2004:169-84.

44. Polat O. Adli Tıp. 2. Baskı, İstanbul, Der Yayınları;2001.

45. Çolak B, İnanıcı MA, Yaycı N. Çocukta cinsel istismar ve adli hemşirelik. Hemşirelik Forumu Dergisi. 2003;6:7-13.

46. Pakiş I. Acil Bakımda Adli Olgu Yaklaşımı. İçinde: Aslan FE, Olgun N (eds). Erişkinlerde Acil Bakım. 1. Baskı, Ankara: Akademisyen Tıp Kitabevi, 2014:181-91.

47. Celbis O, Karaca M, Özdemir B, Isır AB. Cinsel suçlarda muayene. Harran Üniversitesi Tıp Fakültesi Dergisi. 2004;1:48-52.

48. Kent-Wilkinson A. Forensic nursing educational development: an integrated review of the literature. J Psychiatr Ment Health Nurs. 2011;18:236-46.

49. Sözen Ş, Aksoy E. Cinsel saldırılarda hekim sorumluluğu, tıbbi ve huhuki yaklaşım. Klinik Gelişim. 2011;207-16.

50. Can M, Üner B, Sarıkaya Ö, Tok M, Berber G, ve ark. Adli tıpta giysi incelemesinin yeri. Adli Tıp Bülteni. 2005;10:56-61.

51. Lynch VA. Forensic nursing science: global strategies in health and justice. Egyptian Journal of Forensic Sciences. 2011;1:69-76.

52. Koehler SA. Firearm evidence and the roles of the ER nurse and forensic nurse. J Forensic Nurs. 2009;5:46-8.

53. İlçe A, Yıldız D, Baysal G, Özdoğan F, Taş F. Acil servislerde çalışan sağlık bakım personelinin adli olgularda delillerin korunması ve saklanmasına yönelik bilgi ve uygulamalarının incelenmesi. Ulus Travma Acil Cerrahi Derg. 2010;16:546-51.

54. United Nations Office on Drugs and Crime. Guidelines fort he forensic analysis of drugs facilitating sexual assault and other criminal acts. Available from: https://www.unodc.org/documents/scientific/forensic_analys_of_drugs_facilitating_sexual_assault_and_other_criminal_acts.pdf. Accessed: 17 Ekim 2021.

55. McGillivray B. The role of victorian emergency nurses in the collection and preservation of forensic evidence: a review of the literature. Accid Emerg Nurs. 2005;13:95-100.

56. Foresman-Capuzzi J. CSI & U: collection and preservation of evidence in the emergency department. J Emerg Nurs. 2014;40:229-36.

57. Bilginer Ç, Karadeniz S, Aydoğdu S, Şahin DB. Bir üniversite hastanesinin acil servisinde sunulan çocuk ruh sağlığı hizmetleri. Turk J Child Adolesc Ment Health. 2021;28:12-9.

58. Aygin D, Cengiz H. İlaç uygulama hataları ve hemşirenin sorumluluğu. Ş.E.E.A.H. Tıp Bülteni. 2011;45:110-4.

59. Demiralp M. Psikofarmakolojik tedavilerde psikiyatri hemşireliği uygulamaları. Turkiye Klinikleri J Psychiatr Nursing-Special Topics. 2016;2:87-99.

60. Gürhan N. Ruh Sağlığı ve Psikiyatri Hemşireliği. Ankara: Nobel Tıp Kitapevleri, 2016:15-267.

61. Schriver JA, Talmadge R, Chuong R, Hedges JR. Emergency nursing: historical, currentand future roles. Acad Emerg Med. 2003;10:798-804.

62. Kayatekin ZE, Maner F, Abay, Saygılı S, Şener Aİ. Ruh hastalarında homisidal saldırganlık. Düşünen Adam. 1991;4:22-7.

63. Yıldız A. Akut ajitasyon sağaltımında benzodiazepinlerin, tipik ve atipik antipsikotiklerin yeri: bulguların gözden geçirilmesi. Türk Psikiyatri Dergisi. 2003;14:134-44.