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Special Feature Article

Proposal for a Psychiatric Emergency Medical Care System

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Abstract

Psychiatry is an essential part of emergency medicine. However, unless there is a nearby psychiatrist available for consultation, connecting emergency medical care to psychiatric care is challenging due to differences between the two medical care systems.

The psychiatric emergency medical care system divides emergencies into two types: hard emergencies, which are triggered by a police officer's report of a patient; and soft emergencies, which are not triggered by a police officer's report. In hard emergencies, which are equivalent to tertiary psychiatric emergencies, the decision to treat a patient is often left to the police officer's discretion. Depending on the decision of the police officer, the patient may not be connected to psychiatric care, which is a major difference from general emergency medical care. On the other hand, soft emergencies are equivalent to primary and secondary psychiatric emergencies. They are similar to general emergency medical care as patients can be seen at their request; however, the number of psychiatric facilities that provide such care is small and patients may not receive useful advice from the psychiatric emergency information center, which serves as a consultation service for psychiatric emergencies. As a result, many patients with soft emergencies visit general emergency medical facilities where psychiatrists are not available, placing a burden on general emergency medical facilities.

In this article, we discuss the problems of hard and soft emergencies, and propose that the psychiatric emergency medical care system be converted to an ER-type emergency

system that treats patients regardless of their level of urgency or severity of illness. In addition, we suggest the importance of information exchange between the psychiatry department and the emergency department, since both departments have different views on the decision to accept a patient from the telephone call to the direct consultation, the handling of suicide attempts and self-injury, the timing of consultation in case of overdose, and the need for multiple medications in the case of an emergency.

It is necessary to modify the psychiatric emergency care system to facilitate access to medical care for psychiatric emergency patients and to seek better collaboration between psychiatry and emergency departments.

Keywords: ER, police report, collaboration, stupor

Introduction

Emergency medical care serves as a safety net ensuring the public's security.¹³⁾ Within this system, the number of emergency transports for patients with mental disorders continues to rise, yet there are few psychiatric facilities available to receive them. Consequently, some patients cannot be transported due to a lack of receiving facilities, while others are transported to distant medical institutions, severing them from their community. Furthermore, even when emergency medical care facilities accept emergently transported patients requiring psychiatric treatment, they often cannot promptly connect them to psychiatric care or determine an appropriate treatment plan. Consequently, many emergency medical

care facilities do not accept patients with mental disorders from the outset.

As mentioned above, one factor contributing to the difficulty in transporting patients with mental disorders, who are often not accepted for emergency care, is the complexity of the psychiatric emergency medical care system. In practice, even emergency physicians, who deal with emergency medical care in general, may not fully understand the psychiatric emergency medical care system. The complexity of this system relates to the fact that psychiatric care is based on Act on Mental Health and Welfare for the Mentally Disabled. However, physicians not specializing in psychiatry may lack sufficient knowledge of this act. Furthermore, the act itself is complex, placing a significant burden on frontline staff to understand and implement it.

Therefore, making the psychiatric emergency medical care system more accessible is a practical challenge, and this paper proposes measures to achieve it.

I. Issues in Psychiatric Emergency Care

1. History of psychiatric emergency care

Psychiatric emergency services have been rapidly developed since the late 1990s. Japan's psychiatric emergency care originated with the establishment of the emergency hospitalization system when Mental Health and Welfare Act was enacted in July 1988. In October 1995, "Psychiatric Emergency Medical Care System Development Project" was created, targeting tertiary psychiatric emergency services, and Psychiatric Emergency Information Center was established.¹⁹⁾ In 2005, "Psychiatric Emergency Medical Care Center Project" targeting primary and secondary psychiatric emergency care commenced. Subsequently, "Psychiatric Emergency Medical Care System Development Project" and "Psychiatric Emergency Medical Care Center Project" were reorganized, leading to the launch of "Psychiatric Emergency Medical Care System Development Project" in 2008. This strengthened the psychiatric emergency medical care system, particularly for patients with physical comorbidities, and tailored to regional circumstances. Legislatively, Act on

Mental Health and Welfare for the Mentally Disabled of 2010 established a duty of effort for prefectures to develop psychiatric emergency medical care systems (Article 19-3 of Act on Mental Health and Welfare for the Mentally Disabled). This took effect in 2012, forming the current psychiatric medical care framework. Regarding remuneration, the psychiatric acute care ward hospitalization fee was established in 1996, psychiatric emergency hospitalization fee in 2002, and psychiatric emergency and physical comorbidity hospitalization fee in 2008.

2. Issues with psychiatric emergency medical care system from perspective of emergency medical care providers

The Japanese Society of Psychiatric Emergency Medicine identifies key challenges in the psychiatric emergency medical care system, including: "Management of patients with physical complications," "Status of Psychiatric Emergency Information Center establishment," "Standardization of hospital-clinic collaboration," "Management of dementia patients," "Management of alcohol and substance-related disorders," and "The framework of the transfer system."¹⁵⁾²¹⁾ Simultaneously, disparities exist across regions regarding these challenges. However, the primary challenge for emergency medical personnel within

the psychiatric emergency medical care system is “the difficulty in transferring patients from emergency medical care to psychiatric care.” Therefore, the following sections discuss the respective problems of hard and soft psychiatric emergency medical care from the perspective of emergency medical personnel.

3. Problems with hard emergency care

Hard emergency care is classified as tertiary psychiatric emergency care, involving involuntary hospitalization if the patient poses a risk of self-harm or harm to others.¹⁴⁾ The challenge here is that decisions about patient management are entrusted to non-medical personnel, namely police officers. Even if a patient is severely mentally ill, they cannot be connected to psychiatric care unless the police report the incident to the local government. For example, a patient in a stupor state is psychiatrically severe but unlikely to be reported to the police because they pose no risk of self-harm or harm to others. Mental disorders leading to self-harm or harm to others are expected to primarily involve patients exhibiting visible agitation or restlessness. While this system has low sensitivity but high specificity, it results in many patients being missed, raising questions about its appropriateness as an emergency medical care system.

Police intervention is appropriate in cases where contextual social harm caused by mental disorders results in serious disadvantages to oneself or others.²¹⁾ However, when medical professionals determine that a patient exhibits symptoms leading to risks of self-harm or harm to others due to a mental disorder and file a police report, in order to utilize hard emergency care because the severity of the illness is marked, it is desirable that hard emergency care can be utilized even if contextual social harm is limited.

Furthermore, while medical professionals consider both the severity of the illness and patient's incidental nature, it is extremely difficult for police officers to assess the severity of the illness. Therefore, leaving the patient's treatment to the police's judgment risks causing medical harm to the patient. This situation arises at the emergency scene when medical personnel report to the police that the patient requires hard emergency transport, but the patient has calmed down by the time the police arrive. In such cases, the police officers leave without reporting the patient or providing protection. However, it is not uncommon for the patient to engage in self-harm or harm to others again after the police leave. At the emergency scene, medical personnel are then forced to take measures such as sedating the patient with medication. Cases have

been reported in which patients who were calm at the time of examination and therefore admitted under Involuntary Hospitalization for Medical Care and Protection, rather than involuntary admission by prefectural order, subsequently engaged in self-harm or harm to others again.⁵⁾ This not only makes establishing a therapeutic relationship difficult and prolongs hospitalization, but also significantly increases the likelihood of interrupted medical care after discharge.⁵⁾ This finding indicates that when administrative agencies avoid involuntary admission by prefectural order from a human rights perspective, it may ultimately harm the patient's long-term interests and potentially lead to outcomes contrary to human rights protection.⁵⁾

Medical personnel may have to wait with the patient for extended periods until police officers arrive. Particularly when an emergency scene is reported to police, if medical staff must focus entirely on the patient until officers arrive, the emergency department becomes congested, making it difficult to accept new patients. Police officers responding to patients sometimes confuse the Act on Mental Health and Welfare for Persons with Mental Disorders or Disabilities with the Police Officer Duties Act. Reporting a patient is based on Article 23 of the Act on

Mental Health and Welfare for Persons with Mental Disorders or Disabilities, but protection is based on Article 3 of the Police Officer Duties Act. While it is legally possible to report a patient without initiating protection, there have been instances in which officers believed that “patient reporting presupposes protection; without it, patients cannot be reported.” Furthermore, no feedback system currently exists to address patient disadvantages resulting from officers failing to report. An officer’s attitude may stem from public health centers potentially failing to respond to police reports. In fiscal year 2020, there were 25,175 application reports nationwide, of which 17,392 were police reports. Among the application reports, public health centers determined that medical examination was unnecessary in 14,778 cases, with 8,485 of these originating from police reports.¹⁷⁾ While there is variation among municipalities, many local governments have insufficient police-reporting functions. Comparing all 47 prefectures, the proportion of overall application reports that reached psychiatric examination after public health center investigation ranged from 75% in Gunma Prefecture (highest) to 5% in Tokushima Prefecture (lowest), with a median of 45% (interquartile range: 35–57). Focusing solely on police reports, the highest rate was 98% in

Hiroshima Prefecture, the lowest was 4% in Tokushima Prefecture, and the median was 45% (interquartile range: 20–57). Based on these facts, it can be considered that over half of police reports are deemed invalid by public health centers. Following the 2016 Sagami-hara disability facility attack, the government established the: “Team for Verifying the Incident at the Sagami-hara Disability Support Facility and Examining Measures to Prevent Recurrence.” The team reported measures to prevent recurrence, stating that “it is necessary to analyze factors contributing to the variation in the proportion of police reports that lead to compulsory medical examinations or compulsory hospitalizations.”¹²⁾ This regional variation is considered to be largely due to police officers, who are not medical professionals, finding it difficult to make appropriate judgments, and public health centers not responding to many police reports.

4. Issues with soft emergency care

Soft emergency care refers to primary and secondary psychiatric emergency care, similar to general emergency medical care. It also covers some patients who were not reported by police officers and, thus, could not access hard emergency care. The problem with soft emergency care is the scarcity of psychiatric medical facilities equipped

to handle it. Consequently, patients requiring soft emergency care often end up at general emergency medical care facilities. Furthermore, even when on-site physicians at these facilities determine that a patient needs psychiatric evaluation, few have systems in place for prompt consultation with a psychiatrist. Even facilities with full-time psychiatrists may struggle to contact them during holidays or nights, making it impossible to decide on patient management. For such situations, the Psychiatric Emergency Services program established the Psychiatric Emergency Information Center as a consultation point. It is intended to triage inquiries from patients and medical staff and coordinate outpatient visits and hospital admissions,¹⁴⁾¹⁸⁾ but actual use sometimes reveals that concrete responses are not provided.⁶⁾ According to 2012 data from the Psychiatric Medical Telephone Consultation Service, within the scope of cases handled by the Psychiatric Emergency Information Center, no municipality “handles all psychiatric emergency cases 24/7, 365 days a year, from outpatient-level care to involuntary hospitalization.” Only one municipality “handles all psychiatric emergency cases 24 hours a day on holidays and 365 days a year at night, from outpatient-level psychiatric emergency medical care consultations

to involuntary hospitalization procedures.”¹⁶⁾ Furthermore, as of 2022, some municipalities still do not have a Psychiatric Emergency Information Center. Reports indicate that the functional development of Psychiatric Emergency Information Centers is insufficient and that they are not fulfilling their intended roles adequately,²⁾ and there are also reports that Psychiatric Emergency Information Centers are not functioning effectively in providing soft emergency care.⁷⁾

II. Strategies for Solving the Problem of Difficulty Connecting to Psychiatric Emergency Care Systems

1. Necessary steps for resolving issues in hard and soft emergency care

The following sections discuss strategies for resolving problems within the current psychiatric emergency care system. First, we outline the challenges specific to hard and soft emergency care. As mentioned above, a key challenge in hard emergency care is the need to correct the current practice of entrusting patient management to non-medical personnel (police officers) to avoid causing medical harm to patients. This requires amending Act on Mental Health and Welfare for the Mentally Disabled and establishing a system where medical professionals alone can complete the entire process from initial

consultation to treatment for severely ill psychiatric patients. However, the challenge for soft emergency care is to lower the barriers to patient access and increase the number of facilities handling psychiatric emergency patients, preventing general emergency medical care facilities from becoming overwhelmed.

2. Specific solutions for problem resolution

Hard and soft emergency care can be seen as classifications of severity. This is similar to the primary, secondary, and tertiary classifications used in emergency medical care, but all are administrative classifications, not medical ones. This severity classification was developed by Osaka University, which played a pioneering role in Japan's emergency medical care. In 1967, Osaka University Hospital established a Special Emergency Department, creating a self-contained emergency system that selectively admitted only severely injured trauma patients. This later became the catalyst for the creation of Japan's emergency medical care system, which classifies and treats emergency patients according to severity levels as primary, secondary, or tertiary care recipients.²²⁾ Tertiary emergency medical care facilities were designated as Emergency Medical Centers (EMCs), and this

subsequently led to the development of Japan's emergency medical care. However, EMCs sometimes struggled to accept patients who initially appeared minor at the dispatch stage but were actually tertiary-level cases. Additionally, some facilities excluded emergency patients requiring psychiatric, ophthalmologic, or dermatologic care. Internationally, treating only tertiary emergency patients aligns more with specialized medical care than with emergency medicine.

Subsequently, in 1983, Fukui Prefectural Hospital pioneered the Emergency Room (ER) model of emergency care, which has now been adopted by many facilities. The ER-type system examines all patients regardless of severity or urgency. It covers not only mild and moderate cases previously excluded from tertiary emergency medical care facilities but also psychiatric, ophthalmological, and dermatological emergency patients. This approach was seen as advantageous for reducing patient gaps and lowering barriers to access.

In this paper, the author proposes adopting the ER-style emergency care model for psychiatric emergency medical care. This would eliminate the distinction between hard and soft emergency cases, allowing medical professionals to determine appropriate

care for all patients, from minor to severe conditions, based on their clinical judgment. This approach prevents the exclusion of patients who are psychiatrically severe, such as stupor patients, yet do not qualify as hard emergency cases requiring police reports. By disregarding urgency levels, it also lowers the barrier to patient access. For patients posing pre-hospital risks to others, cooperation from both fire and police services is necessary, a challenge common to all emergency medical care systems. Regarding patients' illegal acts, if medical intervention is required, responsibility transfers to the police after treatment. If no medical intervention is needed, the police are requested to take charge. Ideally, the system should allow frontline medical personnel to complete psychiatric emergency care to the greatest extent possible. In the United States, a leader in ER care, emergency physicians rule out organic disorders in psychiatric emergency patients and admit them to psychiatric wards if there is a suspected risk of self-harm or harm to others.⁴⁾ However, due to the current specialization and fragmentation of medical technology, it is difficult for emergency medicine departments alone to handle all emergency patients. For psychiatric emergencies, similar to emergencies requiring specialized equipment and capabilities in pediatrics,

obstetrics and gynecology, and severe trauma, establishing psychiatric emergency centers is necessary. It is considered appropriate for healthcare providers working in these settings to possess knowledge and skills in both emergency medical care and at least one other specialty area, similar to providers in pediatrics, obstetrics and gynecology, and severe trauma emergency medical care.

While some argue that implementing ER-style emergency care will lead to an influx of minor cases and overcrowd the emergency department, congestion in emergency departments is not caused by an influx of minor cases.⁸⁾ Such congestion stems from multiple factors, among which the prolonged retention of patients in the emergency department (termed “boarding”) due to a lack of available inpatient beds has been reported.⁸⁾ As solutions, it has been suggested to reduce emergency department demand at the micro level through patient education, and increase hospital capacity at the macro level. In psychiatry, providing standardized care to enhance capacity has also been suggested.⁸⁾ Given the current difficulty in connecting patients to psychiatric care, psychiatric patients in the emergency department contribute to crowding, and this will likely continue. Emergency department crowding has also been reported to adversely affect

patient deterioration, mortality rates, patient satisfaction, and quality of care. Therefore, addressing emergency department crowding requires a comprehensive strategy that encompasses not only emergency medical care facilities but also the entire healthcare system, including the general public.⁸⁾

III. Challenges in Collaboration Between Emergency Medicine Departments and Psychiatry

Beyond the previous discussions, when multiple departments are involved, differing perspectives can lead to disagreements about patient management. Therefore, the following sections will outline issues from the emergency medical care provider's perspective regarding collaboration between emergency medicine departments and psychiatry.

1. Regarding psychiatric telephone consultations

Emergency physicians and psychiatrists have different criteria for determining whether a telephone consultation or face-to-face examination is necessary. Therefore, sharing information regarding this assessment is essential. This issue arises because emergency medical care primarily relies on face-to-face examinations, whereas psychiatric primary emergency care is

mainly telephone-based and does not always require prompt face-to-face evaluation.⁷⁾ It is not uncommon for patients deemed by psychiatric telephone consultation not to require a face-to-face examination to subsequently present at an emergency medical care facility. Emergency medical care providers consult psychiatrists considering the possibility of urgent symptoms requiring care, but sometimes they cannot reach the psychiatrist who handled the phone call, or even if they do, the psychiatrist may not respond. In psychiatric care, examining patients outside of regular hours can sometimes worsen symptoms, and so not examining them at this time may be more therapeutically effective. However, emergency medical care providers lack this knowledge and expertise. Psychiatrists who provide telephone consultations should respond to inquiries about their care and share details of their treatment. This transparency is necessary to educate other departments.

2. Suicide attempts and self-harm

Regarding suicide attempts and self-harm, particularly self-harm, emergency physicians and psychiatrists may have differing perspectives on suicide-related behaviors. An exchange of opinions on equal footing is essential. Patients who attempt suicide or engage

in self-harm are frequently encountered in emergency settings. It goes without saying that psychiatric treatment is essential, particularly for suicide attempters. However, regarding self-harm, staff in emergency medical care settings sometimes view patients with non-fatal drug overdoses or wrist-cutting as engaging in “attention-seeking behavior” or “self-harm for the sake of attention,” adopting a dismissive perspective. From a psychiatrist's perspective, repeated suicide attempts may exhibit specific characteristics as a psychological feature. Reports suggest that such behavior is not fundamentally death-seeking but rather an unconscious attempt to assert one's legitimacy or purity to others and seek assistance.³⁾ In practice, patients with minor wrist-cutting injuries may not receive adequate consultation from psychiatrists and sometimes complete their treatment solely with emergency physicians. When psychiatrists do intervene, they often establish a treatment contract, demanding: “Promise me you won't do it again,” before discharging the patient. However, it is not uncommon for patients to self-harm again after returning home and subsequently revisit the emergency department. In such cases, if the psychiatrist negatively evaluates the patient for breaking the contract, the

patient may subsequently avoid psychiatric outpatient care, leading to treatment discontinuation.

A suicide attempt is defined as “an act performed with the intent to end one's conscious state.”¹⁰⁾ In contrast, self-harm is defined as “an act of intentionally inflicting direct injury upon one's own body without suicidal intent, with the expectation of non-fatality, and often repeated habitually,” and is considered to be performed with the intent to alleviate emotional distress or recover from a dissociative state.¹⁰⁾ In the emergency setting, it is easier to understand repeated suicide-related behaviors as repeated self-harm based on this definition. Even for patients with minor drug intoxication or self-harm such as wrist cutting, understanding it as an attempt to alleviate distress often leads to smoother treatment progress. While some psychiatrists may not distinguish between suicide attempts and self-harm, in the emergency medical care setting, efforts to differentiate between the two are considered necessary.

Two reasons make differentiating suicide attempts from self-harm crucial.¹¹⁾ First, the questions asked during this differentiation process are useful for refining suicide risk assessment. Second, applying the same interventions to self-harm as to suicide attempts, such as behavioral

restrictions or involuntary hospitalization, can prevent patients from coping with their emotional distress. Consequently, this may paradoxically increase the suicide risk or lead to discontinuation of treatment after discharge.¹¹⁾ Furthermore, 96% of self-harm occurs in private, often without disclosure to others, and reports indicate that the majority of those who repeatedly self-harm do so to alleviate emotional distress, such as anger or despair.²⁰⁾ Therefore, viewing self-harm as merely attention-seeking behavior may be scientifically erroneous.

According to Matsumoto, self-harm presents two problems.¹¹⁾ One is that the pain relief from self-harm is temporary; without fundamental and constructive solutions to the difficulties, the situation may actually worsen in the long term. The other is that self-harm acts, when repeated, lead to tolerance and escalation.¹¹⁾ This indicates that self-harm shares mechanisms similar to addiction. Therefore, leaving self-harm untreated increases the risk of accidental death due to escalated self-harm. It is appropriate to view self-harm itself as a target of psychiatric treatment. Psychiatrists adopting this perspective in their practice are likely to realize better treatment outcomes.

Furthermore, distinguishing between suicide attempts and self-harm in emergency medical care settings

facilitates patient management planning. If it can be broadly estimated that suicide attempters require psychiatric inpatient treatment after physical care, while self-harm patients require psychiatric outpatient treatment after physical care, and so post-treatment plans become easier to determine. This is crucial in emergency medical care, where rapid bed control is essential. Matsumoto¹¹⁾ reports that for suicide attempters, preventing subsequent suicide attempts is paramount. This requires ensuring the patient's physical safety, restricting access to suicide means and methods, and then treating the underlying mental disorders and adjusting environmental factors that led to suicide attempts. Psychiatric inpatient treatment is appropriate for this. Conversely, for self-harm, restricting access to means or physically isolating the patient through hospitalization can create a confrontational therapeutic relationship, increasing the risk of treatment discontinuation.¹¹⁾ Rather than immediately stopping the self-harm, it is crucial to maintain a relationship where the patient can honestly report self-harming behaviors while collaboratively exploring ways to avoid self-harm with the patient.¹¹⁾ Outpatient treatment is likely appropriate in these cases.

Emergency physicians most frequently see patients who have attempted suicide or engaged in self-harm. To provide the best possible care for the patient, it is desirable for psychiatrists to listen to the opinions of emergency physicians on an equal footing and collaborate in treatment.

3. Regarding the effects of psychotropic drugs

The author believes that it is beneficial for psychiatrists consulted by the emergency medicine department to examine patients who have developed impaired consciousness due to overdose immediately after transport in the initial treatment room. In Japan, acute drug intoxication caused by overdose of psychotropic drugs is a common means of suicide attempt.¹⁾ Knowing the toxic effects of drugs prescribed by physicians beforehand is a critical factor influencing prescribing practices. Therefore, having a psychiatrist, requested by the emergency medicine department to evaluate a patient with acute drug intoxication, examine the patient in the initial treatment room shortly after transport is considered useful for future prescribing plans. Some suggest waiting until consciousness is regained before calling a psychiatrist. However, in such cases, the patient is seen in a state which is similar to routine outpatient care,

making it difficult to assess the influence of prescribed medications.

4. Regarding multiple medications

When the author treats patients with acute drug poisoning in the emergency department, there are times when they wish to confirm the reasons for prescribing multiple medications with the attending physician. Particularly related to the previous point, in overdose cases involving patients prescribed multiple medications, the intended purpose of prescriptions is often difficult to ascertain. Consider this example: A patient diagnosed with insomnia and prescribed five types of benzodiazepine receptor agonists (BzRAs) was transported to the emergency department unconscious after ingesting large amounts of alcohol and prescription drugs. The psychiatric diagnosis was alcohol use disorder, and the insomnia was caused by pharmacologic insomnia due to alcohol withdrawal. According to the patient, they had complained to their primary physician about being unable to sleep, and the medications were gradually increased. It is likely that the primary physician carefully increased the medications step by step while communicating with the patient. However, from an outsider's perspective, it was difficult to understand the rationale behind the prescription

increases or intended purpose of the prescriptions. Generally, addressing multiple medication prescriptions requires constructive third-party intervention, and reports indicate that pharmacist-initiated consultation is effective.⁹⁾ While psychiatric prescriptions may sometimes be determined solely through physician-patient interaction, emergency medical care is team-based, and patients are often managed collaboratively by all involved healthcare professionals, regardless of whether the issue is correction of polypharmacy.

Conclusion

This paper discussed issues within the psychiatric emergency medical care system and outlined possible solutions. It focused on differences in perspective between emergency medicine departments and psychiatry, organizing the associated challenges from the standpoint of emergency medical care professionals. Psychiatry and emergency medicine departments share a close relationship. We believe that it is crucial to further deepen mutual understanding and explore ways to build a better collaboration system.

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