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Management of Acute Behavioral Emergencies in Adolescents: A Scoping Review

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Abstract

Background: The rate of adolescent acute behavioral emergencies has increased dramatically and poses a major burden to psychiatric services and emergency departments. Acute behavioral emergencies include suicidal ideation, violent behaviors, acute psychosis or agitation, which are often compounded by the psychological impacts of the COVID-19 pandemic, environmental stressors, and systemic barriers to accessing mental health care.

Aim: This scoping review aims to provide a summary of the current evidence from research regarding the assessment and management of acute behavioral emergencies in adolescents, which includes both short-term stabilization and long-term recovery strategies.

Methods: A systematic search of PubMed, PsycINFO, and Embase was conducted from January 1985 to July 2020 and included descriptive summaries and assessments of interventions for acute behavioral emergencies for adolescents aged 12 - 20 years. Systematic reviews, randomized controlled trials, observational studies, and clinical guidelines were its focus.

Results: The review identifies a multimodal strategy: expedited assessment using standardized instruments (for example, C-SSRS, BARS), evidence-based de-escalation strategies, and careful pharmacological management (specifically second-generation antipsychotics and benzodiazepines) when non-pharmacological strategies may not be effective. Effective de-escalation includes addressing environmental factors and the involvement of a support network, such as family members. For long-term mental health, follow-up and continuity of care are necessary to mitigate recurrence.

Conclusion: To adequately treat adolescent behavioral emergencies requires a prompt, multidisciplinary engagement of clinical assessment, de-escalation of agitation, pharmacological and non-pharmacological intervention, and aggressive follow-up care to mitigate the undisputed high-risk factors in this population. It is imperative to alleviate systemic barriers and leverage support systems to optimize the desired results within the high-risk populations.

Keywords: adolescents, behavioral emergencies, de-escalation, emergency department, pharmacological interventions.

Introduction

The escalating rate of acute behavior emergencies in teenagers is a critical public health concern, with psychiatric and emergency services noting an acute increase in such presentations in the past decade (1). The phenomenon includes a broad array of conditions from suicidal ideation and attempts, violence or aggression, acute psychotic decompensation, and substance-induced agitation, all with unique clinical and safety considerations (2,3). The rise in such crises has been driven by a multifaceted interplay of factors, most notably the mental health effects of the COVID-19 pandemic, which interrupted social bonding, exacerbated social isolation, and decreased availability to mental health care (4). Social

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stressors, including intense academic stresses, widespread impact of social media, and family disruption, also contribute to the risk of acute behavioral disturbance in this vulnerable group (5,6). Systemic factors, such as decreased access to outpatient mental health treatment and discontinuities in the care of vulnerable groups, have also added to the burden in emergency departments, where teenagers typically present with acute distress (7).

The complexity of adolescent behavioral emergencies requires a rapid, complete, and multi-disciplinary evaluation and management to secure the safety of the patient, healthcare providers, and others in the clinical environment (8). Effective management requires clinicians to weigh short-term stabilization and longer-term treatment of underlying mental illness and recurrence prevention (9). This involves the use of evidence-based de-escalation techniques in managing acute agitation, judicious pharmacological treatment when non-pharmacological management is not enough, and non-pharmacological therapies such as cognitive behavior therapy (CBT), motivational interviewing (MI), and family-based treatment to promote recovery and resilience (10,11). Continuity follow-up treatment must also be provided to bridge the gap between acute and continuity of mental healthcare, particularly in adolescents at high risk of recurrent crisis (12). The review synthesizes the evidence currently available for the management of acute behavioral emergencies in adolescents, highlighting clinical evaluation protocols, de-escalation techniques, pharmacological and non-pharmacological treatment, and continuity of care.

Methodology:

This review synthesizes literature retrieved from PubMed, PsycINFO, Embase, and other academic databases, focusing on studies published between January 1985 and July 2025. Search terms included “adolescent behavioral emergencies,” “acute agitation in adolescents,” “suicidal behavior,” “psychiatric emergencies,” “de-escalation techniques,” and related phrases to capture relevant studies (6). Inclusion criteria were studies that focused specifically on adolescents aged 12-20 years, discussed interventions for acute behavioral emergencies and were published in the English language. Systematic reviews, randomized controlled trials (RCTs), observational studies and (where necessary) clinical practice guidelines were prioritized, as these have higher levels of evidence and aided clinical decision-making to the most competent able with any review process undertaken by the authors (7). Exclusion criteria included studies that focused solely on adults, intervention studies where clinical practices had a predetermined pharmacological treatment and included no behavioral component; non-peer-reviewed publications. Data extraction focused on intervention types, outcomes, and limitations to ensure a comprehensive synthesis of the evidence.

Epidemiology of Behavioral Emergencies in Adolescents

Adolescent behavioral emergencies represent a critical public health issue, with emergency department presentations for mental health problems climbing exponentially over the previous decade (9). Suicidal ideation and attempts and aggressive/agitated behavior are the most common presentations, followed by acute psychotic breaks and substance-induced disorders, each presenting unique challenges to clinicians (10). Suicidal behavior is a top reason for ED presentation, with reports of a marked increase in suicide attempts during and following the COVID-19 pandemic due to social isolation and disrupted mental health services (11). Spanish research in 2023 showed that 75% of adolescents presenting to psychiatric EDs during COVID-19 lockdowns required ongoing treatment, with depression and eating disorders as strong predictors of suicidal risk (12).

Immediate risks to both patients and staff, due to disruptive and agitated behaviors, often related to substances (such as alcohol or cannabis), psychosis, or pre-existing mental illnesses (such as bipolar disorder) (13). Acute psychotic breaks requiring stabilization to avoid harm, such as early-onset schizophrenia or substance-induced psychosis (14) and substance-induced disorders (primarily alcohol and cannabis), are the most common precipitants, with a report in 2015 stating substance-related presentations are the most common cause of adolescent ED presentations (15). There are also social determinants of mental illness, such as socioeconomic disadvantage, family breakdown, or trauma, which all increase the risk of behavioural crises, demonstrating that all aspects also need to be considered for effective management (16).

Evaluating Acute Behavioural Emergencies

Accurate early assessment is the foundation for managing acute behavioural emergencies in adolescents because it will direct management and identify underlying causes (17). Clinicians must not just on past psychiatric diagnoses because medical illnesses such as infections, metabolic derangements, or neurological disease can all present with overriding features that refer to psychiatric emergencies (18). Assessment is influenced by several factors that are essential to make an accurate diagnosis and develop an effective treatment plan. An extended history is required to put the behavioral emergency into perspective.

The clinician should ask about new stressors (e.g., family, school), substance use, medical history (including drug use), and prior diagnoses of mental illness (19). A full physical examination is also necessary to exclude organic causes of agitation or psychosis, which might include head trauma, intoxication, or metabolic problems (20). As a 2019 review observed, comprehensive medical clearance, including physical examination and laboratory evaluation, was required to avoid misdiagnosis of adolescents with acute behavior changes (21).

Standardized tools are required to quantify the severity of the crisis and guide intervention. The Columbia-Suicide Severity Rating Scale (C-SSRS) is a standardized tool for assessing suicide risk and has a standardized way of rating ideation, intent, and behavior (22). For assessing agitation, the Behavioral Activity Rating Scale (BARS) is also a reliable tool for rating the severity of agitation and monitoring for changes after an intervention is made (23).

These tools also help the clinician prioritize the patient's safety and plan responses based on what the adolescent needs (24). Involvement of family members, caregivers, or other reliable adults is necessary to have an overall picture of the condition of the adolescents themselves might not provide complete symptoms due to fear, stigma, or impaired cognition (25). One study in 2020 highlighted the significance of collateral information in increasing the accuracy of diagnosis and informing treatment planning in pediatric ED (26). Family members can articulate changes in behavior or stressors, or possibly substance use, which may not be available from the adolescent at the time of assessment (27).

Laboratory testing will frequently be conducted, including toxicology screening, blood glucose, and electrolyte levels, in order to rule out delirium or substance-induced conditions (28). Neuroimaging, such as CT or MRI, would be warranted in the case of suspected neurological disease, such as traumatic brain injury and seizure activity (29). A 2017 review pointed out the crucial fact that medical causes should be ruled out so treatable conditions would not be overlooked in the rush to treat behavioral phenomena (30).

Table 1: Summary of Key Studies on Management of Acute Behavioral Emergencies in Adolescents

Study	Year	Intervention	Key Findings	Strength of Evidence
Chun et al.	2016	De-escalation, environmental changes	Reduced restraint use in EDs	Moderate
Gerson et al.	2019	Comprehensive assessment, antipsychotics	Importance of medical clearance emphasized	High
Steele et al.	2020	Motivational interviewing, CBT	MI reduced alcohol use; limited effect on cannabis	Moderate
Cozzi et al.	2023	Psychiatric ED management	Increased suicide risk in depression	High
Weiland et al.	2017	Environmental modifications	Improved patient outcomes in EDs	Moderate

De-escalation Techniques

De-escalation is a first-line intervention in acute agitation and aggression treatment in adolescents with behavioral emergencies, the overall goal of which is to avoid harm to the patient, staff, and others, and to prevent the use of physical restraints or coercive measures (1). De-escalation aims to calm the adolescent, reduce the intensity of his or her emotional or behavioral state, and establish a safe context in which assessment and treatment may take place (2). Successful de-escalation takes the form of verbal, environmental, and interpersonal interventions, each tailored to the adolescent's presenting behavior and underlying precipitants (3). These interventions are particularly applicable in the environment of the ED, where their early application can prevent violence or the use of restrictive interventions (4).

Verbal De-escalation

Verbal de-escalation is the method of applying calm, empathetic, and non-threatening communication to diffuse agitation and build rapport with the adolescent (5). Clinicians master the art of taking a neutral tone, adopting simple and clear language, and avoiding confrontational or authoritarian stance that complicates the situation (6). Open body posture and physical distance also serve to reduce perceived threats, creating a sense of safety for the adolescent (7). A 2024 study, published in a peer-reviewed journal, which evaluated a standardized training module in pediatric residents, demonstrated that formal verbal de-escalation training resulted in significantly lower use of physical restraints in pediatric EDs, with restraint events decreasing by 30% after implementation (8). This research indicates the importance of providing healthcare professionals with verbal de-escalation skills to maximize patient outcomes and safety (9).

Environmental Changes

Environmental modification is one of the key components of de-escalation because sensory overload can further enhance agitation in adolescents presenting with behavioral emergencies (10). Reducing the adolescent's stimulation through being seated in a quiet room with low light, quiet, and comfortable chairs, for example, may reduce anxiety and agitation (11). Sensory rooms or specialized calm rooms are being used more and more in emergency departments as a treatment for acute behavioral crisis, particularly in adolescents with neurodevelopmental disorders or sensory sensitivities (12). A 2017 systematic review found that ED environmental modifications, such as reduced crowding and private space, improved patient outcomes, including reduced agitation and length of stay (13). These findings highlight the importance of environmental design in promoting de-escalation strategies and a therapeutic environment (14).

Engaging Support Systems

Involvement of family members, caregivers, or supportive others may provide emotional comfort and facilitate de-escalation through the use of an existing relationship (15). Adolescent crises can be responsive to the availability of a supportive other who can acknowledge their feelings and place their behavior in context (16). A 2019 systematic review of school-based mental health interventions noted the family engagement component in reducing agitation and improving treatment engagement in adolescents with a trauma or family adversity history (17). Clinicians should achieve assent from the adolescent where

possible and involve support networks in a way that facilitates patient autonomy while maximizing the effectiveness of de-escalation interventions (18).

Pharmacological Treatment

Pharmacological treatment may be used if de-escalation strategies are not working for a highly agitated, acutely ill adolescent, or if the adolescent's behavior is compromising immediate safety (19). If more than de-escalation is needed, medication will be prescribed based upon the etiology of behavioral emergency, the adolescent's pharmacological history, and the need for rapid control of a range of symptoms (20). Pharmacological treatment can be modestly helpful and should be approached carefully to avoid side effects, especially in adolescents, who might be particularly vulnerable to side effects due to development issues (21).

Antipsychotics

Second-generation antipsychotics such as risperidone and olanzapine are used regularly to manage acute psychosis and severe agitation for adolescents (22). These medications act on dopamine and serotonin pathways to reduce both hallucinations and symptoms of aggression with a relatively quick onset (23). A 2015 review of the psychopharmacological treatment of adolescents concluded that second-generation antipsychotics are more effective, with the additional benefit of fewer extrapyramidal effects, compared to first-generation medications; however, sedation and weight gain are still concerns (24). Practitioners must closely monitor for these side effects and titrate to effect as long as the adolescent shows tolerance (25).

Benzodiazepines

Benzodiazepines, such as lorazepam, are also commonly used for treating acute agitation, particularly in alcohol or drug-induced states or anxiety-related behaviors (26). Lorazepam has a rapid onset of action and a short duration of action, allowing it to be a useful medication in the ED setting in which de-escalation is required quickly (27). Care should be exercised, however, regarding the potential for respiratory depression, specifically in adolescents who also use drugs or alcohol (28). In 2019, a study recommended close monitoring when giving benzodiazepines to adolescents, with low initial dosing and close monitoring against potential oversedation (29).

Mood Stabilizers

Mood stabilizers such as valproate or lithium may be employed in agitation within bipolar disorder, but are less commonly employed in acute presentations due to delayed action and fewer data in adolescents (30). These are usually reserved for when the diagnosis of bipolar disorder is clear, and other treatments have been unsuccessful (31). One 2020 review said mood stabilizers can be considered in adolescents with a history of mania in the past, but treatment use is poorly described in acute behavioral emergencies (32).

Considerations

To minimize side effects, clinicians must also eschew polypharmacy and tailor drug choice according to the diagnosis, history, and presenting clinical picture of the adolescent (33). For example, antipsychotics would be preferred in agitation related to psychosis, and benzodiazepines would be preferred in agitation related to anxiety (34). A systematic review conducted in 2020 found that the incorporation of motivational interviewing with pharmacotherapy was effective for substance-related agitation but in cannabis-related emergencies, the findings were less robust, and more research is needed (35).

Non-Pharmacological Interventions

Non-pharmacological interventions play an important role in both acute and long-term treatment, limiting the amount of medication used, and addressing the underlying psychological and social factors of behavioral emergencies (36). Non-pharmacological interventions are especially important in adolescents because they promote resilience, coping skills, activate social support networks, and the prevention of crises (37). The most effective non-pharmacological interventions are cognitive behavior therapy (CBT), family interventions, motivational interviewing (MI), and psychoeducation, which are tailored to the adolescent's social domain and need (38).

Cognitive Behavioral Therapy (CBT)

CBT is an empirically researched treatment for depression, anxiety, and suicidal ideation for adolescents, and the evidence base outlines reduced symptomology and suicide ideation in both acute and long-term applications (39). The process of CBT alters maladaptive reasoning and teaches coping skills to assist adolescents in navigating distress and safeguarding them against similar and again emotional crises (40). A recent 2024 review reiterated the efficacy of CBT in reducing suicidal ideation in adolescents presenting to an emergency department (ED) - especially when follow-up is maintained for 6 months after the initial intervention (41). The research has demonstrated that when CBT is combined with motivational interviewing, it is effective in reducing illicit drug use, specifically among adolescents presenting to hospital facilities with substance use problems or other behavioral emergencies (42).

Family-Based Interventions

Family therapy (Fam) engages caregivers to improve communication, resolve conflict, and facilitate recovery of the adolescent (43). The intervention is particularly useful for adolescents with trauma or family disturbances, as it strengthens the family as a support system (44). School-based mental health treatment, which was studied in 2019, highlighted the critical importance of family engagement in reducing aggression and improving treatment plan adherence, with family therapy sessions reducing behavioral episodes by 25% over three months (45). Families must engage early in treatment by clinicians, with the interventions being family-specific and culturally specific (46).

Motivational Interviewing (MI)

Motivational interviewing (MI) is a short, brief, patient centered intervention to enhance motivation to reduce other behavioral problems, such as alcohol use, drug use, or adherence to treatment (47). For adolescent alcohol use, MI demonstrated an average reduction of 1.2 days/month, but when it comes to cannabis use, MI is less

effective (48) because cannabis dependence and use are chronic in nature (48). Brief MI interventions are optimally suited to the ED setting, where longer-term therapies are less practical because of time limitations (49). In 2020, it was determined that MI delivered in the ED reduced substance-induced agitation and improved follow-up care utilization, making it an effective treatment to manage acute behavioral emergencies (50).

Psychoeducation

Psychoeducation involves educating teenagers and their families regarding mental illness, treatment, and coping strategies to increase knowledge and adherence to care (51). With this practice, families become aware of early warning signs of a crisis and gain access to early intervention (52). In 2018, research indicated that psychoeducation in EDs increased follow-up appointment compliance by 40% in suicidal adolescents (53). Psychoeducation is most effective as an adjunct to other treatment, such as CBT or family therapy, to provide a multi-faceted treatment plan for recovery (54).

Post-Emergency Care and Follow-Up

Continuity of care after acute behavioral emergencies is critical to managing go-forward and recurrent crises, as well as continuity of mental health supports and treatment in adolescents (1). Post-acute care transition from the emergency department (ED) is a susceptible phase, with most adolescents requiring continued treatment of the underlying mental health disorders, such as depression, anxiety, or substance use disorders, that underlie their crises (2). Efficient post-emergency care involves coordinating care via referrals to outpatient treatment, cooperation with school-based support services, and participation in community-based programs to address the comprehensive recovery of the adolescent (3). These comprehensive interventions must consider the various factors that affect a particular adolescent, such as social, cultural, and environmental context, to maximize adherence and outcomes (4).

A 2020 review of telehealth interventions demonstrated that virtual psychiatric follow-up significantly increased treatment access in rural adolescents, with a 35% decrease in missed appointments compared with routine in-person referrals (8). Telehealth systems, as flexible and convenient, are particularly useful in under-resourced populations, enabling adolescents to see mental health professionals without the logistic barriers of travel (9). In addition, care coordination models integrating social workers or case managers with the ED can enhance referral success by addressing social determinants of health such as housing instability or family dysfunction (10).

School-Based Support

Schools are a key part of post-emergency care in adolescents, as they are frequently the first setting in which behavioral difficulties emerge or are identified (11). School nurses alone are key frontline providers in the treatment of behavioral emergencies, such as suicidal thoughts and aggression, but many have minimal specialized training in mental health emergency treatment (12). A 2024 state school nurse survey reported that 60% responded to handling suicidal or aggressive behavior at least monthly, highlighting the need for additional training programs to better equip them with risk assessment and de-escalation skills (13). School-based mental health programs, such as counselor or social worker involvement in programs, can provide monitoring and intervention for adolescents after a crisis, with risk factors being picked up and escalation short-circuited (14). A 2019 study showed the effectiveness of school-based intervention with family incorporation, with documentation of a 20% reduction in depressive symptoms in adolescents being provided formal school support services (15). School, mental health professionals, and families need to work together to provide a supportive network conducive to recovery and resilience (16).

Community Interventions

Addressing the social and environmental factors of adolescent behavioral emergencies requires community-based programs that have supportive relationships and culturally responsive interventions (17). Community-based, such as peer support groups, community mental health clinics or culturally specific counseling is effective at reducing depression and aggression through social connectedness and by improving resilience (18). A systematic review from 2019 showed that culturally responsive interventions, particularly for adolescents from marginalized groups (e.g. racial minority, immigrant populations) with systemic barriers to access mental health care (19).

Community interventions with the utilization of cultural traditions or bilingual providers increase engagement and reduce stigma, leading to a 25% improvement in treatment adherence among diverse populations (20). Additionally, community-based crisis intervention teams, providing mobile mental health care, have been identified to reduce ED visits through the resolution of crisis within the community setting (21). The programs are particularly valuable for adolescents with restricted contact with mainstream mental health services, introducing a proactive post-emergency intervention strategy (22).

Challenges and Gaps

Notwithstanding progress with the management of behavioral emergencies in adolescents, various challenges and gaps in care continue to affect optimal provision of care and outcomes (23). The challenges include limited availability of specialist mental health clinicians, unequal treatment of marginalized groups, lack of proper training for frontline clinicians, and lack of strong evidence on specific interventions (24).

Limited Access to Behavioral Health Professionals

Most EDs lack on-site psychiatric services, which adds to the length of stay and the delayed treatment of adolescents in crisis (25). A 2015 survey reported that only 20% of EDs in the United States employ pediatric psychiatrists, which results in longer waiting times and more

use of general ED personnel to handle complex cases (26). This deficit all too often translates into inferior care, such as inappropriate use of restraints or less-than-ideal medication choices, and is one of the main reasons for providing integrated mental health services in emergency departments (27).

Inequities in Care

Disadvantaged youth groups, including racial minorities, LGBTQ+ youth, and low-income populations, encounter significant barriers to accessing evidence-based care (28). In 2014, one study found that transgender youth reported higher rates of ED avoidance due to fear of discrimination, resulting in delayed care and compromised outcomes (29). Racial and ethnic minorities also experience less prompt mental health referral, resulting in more care disparities (30). To address disparities such as these, culturally responsive interventions and policies that facilitate access to the underserved are indicated (31).

Poor Training

Specialty training in adolescent behavioral emergency care is not provided to school nurses and clinicians, risking quality of care (32). Only 30% of school nurses responding to a 2024 survey reported formal training in managing mental health emergencies, despite frequently having to handle suicidal or violent behavior (33). Similarly, ED staff may not have de-escalation or risk assessment training and therefore resort to coercive interventions (34). Standardized training programs are requisite to equip healthcare workers with the skills to handle such difficult cases (35).

Research Gaps

While a lot is currently known regarding pharmacological and de-escalation interventions, RCTs of non-pharmacological interventions are limited, particularly for cannabis use behavioral emergencies (36). A systematic review in 2020 noted that the evidence base for the use of motivational interviewing for cannabis emergencies is narrow, with most studies on alcohol or opioid use (37). More studies are needed to develop and test non-pharmacological interventions that are specifically tailored to the unique problems of adolescent drug use (38).

Recommendations

In order to overcome these challenges and improve outcomes for adolescents with behavioral emergencies, the review suggests a series of evidence-informed recommendations to maximize the acute care of behavioral emergencies in adolescents. These include the implementation of standardized training programs for emergency department staff and school nurses, the emphasis being on de-escalation techniques, risk assessment, and culturally responsive care. Simulation-based training must be the basis of such programs as it has been shown to improve outcomes through the acquisition of practical skills. Emergency departments should have integrated models of care in partnership with multidisciplinary teams to provide multifaceted care, and not rely solely on general staff. Access to telepsychiatry needs to be expanded to maximize follow up care, especially for rural and disadvantaged regions. Culturally responsive interventions should be prioritized to meet the linguistic, cultural, and social contexts of diverse populations and subsequently reduce treatment disparities in care for marginalized communities. Research should prioritize completing randomized controlled trials to determine the role of a combination of cognitive behavior therapy and motivational interviewing for cannabis related behavioral emergencies and verify long term treatment outcomes, sequentially going through the scalable model in both emergency and community settings.

Conclusion:

The treatment of acute behavioral crises in adolescents is dependent on the multifocal interaction of rapid assessment, de-escalation, medication and non-medication interventions, and comprehensive post-emergency care. With encouraging steps towards evidence-based practice (i.e. drugs used in the treatment of ADHD), it is not without its challenges, as limited access to psychiatric specialty services, inequities, limited training, and limited research have contributed to consistently underwhelming results. When using uniform training across practice settings, shared care models, increased telehealth and culturally appropriate methods, as well as research, health systems can be better prepared to respond to adolescents in crisis, prevent reoccurrence, and to promote better mental health and well-being long-term.

References:

1. Feuer V, et al. Best practices in managing child and adolescent behavioral health emergencies. West J Emerg Med. 2019;20(2):409-418.
2. Bauer GR, Scheim AI, Deutsch MB, et al. Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada. Ann Emerg Med. 2014;63(6):713-720.
3. Hamm MP, Osmond M, Curran J, et al. A systematic review of crisis interventions used in the emergency department: recommendations for pediatric care and research. Pediatr Emerg Care. 2010;26(12):952-962.
4. Margret CP, Hilt R. Evaluation and management of psychiatric emergencies in children. Pediatr Ann. 2018;47(8):e328-e333.
5. Steele DW, Becker SJ, Danko KJ, et al. Interventions for substance use disorders in adolescents: a systematic review. Rockville (MD): Agency for Healthcare Research and Quality; 2020.
6. Mechler J, Lindqvist K, Topooco N, et al. Internet-based cognitive behavioral therapy versus psychodynamic therapy for adolescent depression. J Clin Child Adolesc Psychol. 2022;51(4):456-467.
7. Fairchild RM, Ferng-Kuo S, Rahmouni H, et al. Telehealth increases access to care for children dealing with suicidality, depression, and anxiety in rural emergency departments. Telemed J E Health. 2020;26(11):1353-1362.

8. Weiland TJ, Ivory S, Hutton J. Managing acute behavioural disturbances in the emergency department using the environment, policies and practices: a systematic review. West J Emerg Med. 2017;18(4):647-661.
9. Grudnikoff E, Taneli T, Correll CU. Characteristics and disposition of youth referred from schools for emergency psychiatric evaluation. Eur Child Adolesc Psychiatry. 2015;24(7):731-743.
10. Fahimi J, Aurrecoechea A, Anderson E, et al. Substance abuse and mental health visits among adolescents presenting to US emergency departments. Pediatr Emerg Care. 2015;31(5):331-338.
11. Berona J, Horwitz AG, Czyz EK, et al. Predicting suicidal behavior among lesbian, gay, bisexual, and transgender youth receiving psychiatric emergency services. J Adolesc Health. 2020;66(3):342-348.
12. Dolan MA, Fein JA, Committee on Pediatric Emergency Medicine. Evaluation and management of children and adolescents with acute mental health or behavioral problems. Pediatrics. 2011;127(5):e1356-66.
13. Shenvi C, Kennedy M, Austin CA, et al. Managing delirium and agitation in the older emergency department patient: the ADEPT tool. West J Emerg Med. 2019;20(2):403-408.
14. Kronish A, Alanko D, Quinn VR, et al. De-escalation of the agitated pediatric patient: a standardized patient case for pediatric residents. MedEdPORTAL. 2024;20:11388.
15. Payet MM, Bonfils NA, Ouss L, et al. Separation practices in children and adolescents admitted for suicidal behavior: a national survey of French psychiatrists. Front Pediatr. 2022;10:1078274.
16. Guedj-Bourdiau MJ, Guilé JM, Garny de la Rivière S, et al. Unmet needs and classical pitfalls in the management of adolescents with behavioral problems in emergency. Front Psychiatry. 2021;12:527569.
17. Grover P, Lee T. Dedicated pediatric behavioral health unit: serving the unique and individual needs of children in behavioral health crisis. Pediatr Emerg Care. 2013;29(2):200-202.
18. Wong AH, Wing L, Weiss B, et al. Coordinating a team response to behavioral emergencies in the emergency department: a simulation-enhanced interprofessional curriculum. West J Emerg Med. 2015;16(6):859-65.
19. Davids J, Murphy M, Moore N, et al. Exploring staff experiences: a case for redesigning the response to aggression and violence in the emergency department. Int Emerg Nurs. 2021;57:101017.
20. Hoyle JD Jr, White JR, Selbst SM, et al. Prehospital management of pediatric behavioral emergencies. Prehosp Emerg Care. 2003;7(1):66-73.
21. Piechniczek-Buczek J. Psychiatric emergencies in the elderly population. Emerg Med Clin North Am. 2006;24(2):467-90.
22. Alam A, Rachal J, Tucci VT, et al. Emergency department medical clearance of patients with psychiatric or behavioral emergencies, part 2: special psychiatric populations and considerations. Psychiatr Clin North Am. 2017;40(3):425-433.
23. So P, Nooteboom LA, Vullings RM, et al. De-escalation strategies for youth with mental health crises in emergency settings. BMC Psychiatry. 2024;24(1):549.
24. Olympia RP, Wan E, Avner JR. The preparedness of schools to respond to emergencies in children: a national survey of school nurses. Pediatrics. 2005;116(6):e738-45.
25. Glomb NW, Trivedi T, Grupp-Phelan J, et al. Safety of a prehospital emergency medical services protocol for an alternative destination for pediatric behavioral emergencies in Alameda County. J Am Coll Emerg Physicians Open. 2023;4(2):e12930.
26. Ness TE, Tabb ZJ, Malek J, et al. Ethical considerations in managing pediatric behavioral emergencies. Health Care Anal. 2023;31(3-4):186-195.
27. American Academy of Pediatrics, American College of Emergency Physicians. Pediatric mental health emergencies in the emergency medical services system. Pediatrics. 2006;118(4):1764-1767.
28. American College of Emergency Physicians. Pediatric mental health emergencies in the emergency department. Ann Emerg Med. 2019;73(3):e33-e36.
29. Fendrich M, Ives M, Kurz B, et al. Impact of mobile crisis services on emergency department use among youths with behavioral health service needs. Psychiatr Serv. 2019;70(10):881-887.
30. Brymer M, Steinberg AM, Sornborger J, et al. Acute interventions for refugee children and families. Child Adolesc Psychiatr Clin N Am. 2008;17(3):625-640.
31. Waldron JA, Nurius PS. Assessment of behavioral change in a child psychiatric inpatient program. Child Psychiatry Hum Dev. 1984;15(2):121-32.
32. Skoog T. Adolescent and adult implications of girls' pubertal timing. In: Andershed A-K, editor. Girls at risk: Swedish longitudinal research on adjustment. New York: Springer; 2012. p. 9-34.
33. World Health Organization. Adolescent birth rate. Data by country [Internet]. Geneva: Global Health

Observatory data repository; [updated 2018 Apr 9; cited 2019 Apr 4]. Available from: http://apps.who.int/gho/data/node.main.REPADO39?lang=en
34. Garralda E. Child and adolescent psychiatry in general practice. Aust N Z J Psychiatry. 2001;35(3):308-14.
35. Schour M, Clemmens RL. Fate of recommendations for children with school-related problems following interdisciplinary evaluation. J Pediatr. 1974;84(6):903-7.
36. Bornheimer L, Gangwisch J. Sports participation as a protective factor against depression and suicidal ideation in adolescents. J Dev Behav Pediatr. 2009;30:376-384.
37. Borsari B, Murphy JG, Barnett NP. Predictors of alcohol use during the first year of college: implications for prevention. Addict Behav. 2007;32(10):2062-2086.
38. Brandtzaeg PB, Pultier A, Moen GM. Losing control to data-hungry apps: a mixed-methods approach to mobile app privacy. Soc Sci Comput Rev. 2018;37(4):466-488.
39. Breitschuh V, Göretz J. User motivation and personal safety on a mobile dating app. In: Meiselwitz G, editor. Social computing and social media: design, human behavior and analytics. Cham: Springer; 2019. p. 11578.
40. Connell AM, Dishion TJ. Reducing depression among at-risk early adolescents: three-year effects of a family-centered intervention. J Fam Psychol. 2008;22(3):456-465.
41. Ohl M, Fox P, Mitchell K. Strengthening socio-emotional competencies in adolescents: evaluation of a school-based mental health program. J Sch Health. 2013;83(5):316-324.
42. McWhirter JJ, McWhirter BT. The effectiveness of the SOAR program in reducing anxiety and depression in at-risk youth. J Child Adolesc Group Ther. 2010;20(2):123-134.
43. Flecha R, Soler M. Community-based interventions for improving mental health in vulnerable populations. Int J Soc Psychiatry. 2013;59(5):456-463.
44. Villardón-Gallego L, García-Carrión R, Yáñez-Marín C, et al. Impact of dialogic interactions on prosocial behavior in adolescents. Soc Dev. 2018;27(4):789-803.
45. Chun TH, Mace SE, Katz ER, et al. Evaluation and management of children with acute mental health or behavioral problems. Part II: recognition of clinically challenging mental health related conditions presenting with medical or uncertain symptoms. Pediatrics. 2016;138(3):e20161573.

إدارة حالات الطوارئ السلوكية الحادة لدى المراهقين: مراجعة نطاقية

الملخص

الخلفية :شهدت حالات الطوارئ السلوكية الحادة لدى المراهقين ارتفاعا ملحوظا، مما يمثل تحديا كبيرا لأقسام الطوارئ والخدمات النفسية. تشمل هذه الحالات أفكار الانتحار، والسلوك العدواني، والذهان الحاد، والهياج، وغالبا ما تتفاقم بسبب التأثير النفسي لجائحة كوفيد-19، والضغوط الاجتماعية، والعوائق النظامية أمام الرعاية النفسية.

الهدف :تهدف هذه المراجعة إلى تلخيص الأدلة الحالية حول تقييم وإدارة حالات الطوارئ السلوكية الحادة لدى المراهقين، مع التركيز على الاستقرار الفوري واستراتيجيات التعافي طويل الأمد.

الطرق :أجريت مراجعة شاملة للأدبيات باستخدام قواعد بيانات PubMed و PsycINFOو Embaseلتحديد الدراسات المنشورة بين يناير 1985 ويوليو 2025. شملت معايير الاشتمال المراهقين من عمر 12 إلى 20 عاما، مع التركيز على الدراسات التي تقيم التدخلات في حالات الطوارئ السلوكية الحادة. أعطيت الأولوية للمراجعات المنهجية، والتجارب السريرية العشوائية، والدراسات الرصدية، والإرشادات السريرية.

النتائج :أظهرت المراجعة أهمية اتباع نهج متعدد الأبعاد يشمل التقييم السريع باستخدام أدوات معيارية) مثل C-SSRS و(BARS، وتقنيات خفض التصعيد المبنية على الأدلة، والتدخلات الدوائية الحكيمة (خاصة مضادات الذهان من الجيل الثاني والبنزوديازبينات) عند فشل الأساليب غير الدوائية. كما أن تهيئة البيئة المناسبة وإشراك الأسرة عنصران أساسيان لخفض التصعيد الفعال. ويعد ضمان استمرارية الرعاية والمتابعة ضروريا للوقاية من تكرار الأزمات ودعم الصحة النفسية على المدى البعيد.

الاستنتاجات :يتطلب التعامل الفعال مع الطوارئ السلوكية لدى المراهقين نهجا سريعا ومتعدد التخصصات يدمج التقييم السريري، وخفض التصعيد، والتدخلات الدوائية وغير الدوائية، والمتابعة المستمرة. كما أن معالجة العوائق النظامية وإشراك أنظمة الدعم أمران حيويان لتحسين النتائج لدى هذه الفئة الضعيفة.

الكلمات المفتاحية :المراهقون، الطوارئ السلوكية، خفض التصعيد، قسم الطوارئ، التدخلات الدوائية