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Psychiatric emergencies: A multidimensional overview

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Abstract
Emergency psychiatry aims at the rapid assessment, diagnosis, and management of acute mental health disorders that pose an immediate risk to the patient or community. Common examples of such emergencies include Suicidal behavior, Acute psychosis, Violent and aggressive conduct, Severe anxiety or panic states, Substance intoxication or withdrawal, and Delirium. Medical stabilization is immediately provided, followed by psychiatric assessment with the help of structured instruments such as the Mental Status Examination and risk assessments. Pharmacological and non-pharmacological methods are employed in the stabilization process. Psychotherapy and counseling play an important role in the process of preventing recurrence and improving coping mechanisms, sorting out underlying conflicts, and enhancing insight, thus helping in long-term rehabilitation. This article attempts to mention the emergency psychiatric assessment and management and further discusses the rehabilitative roles played by psychotherapy and counseling.

Keywords: Psychiatric emergencies, suicide, acute psychosis, violence and agitation, substance intoxication and withdrawal, stupor and catatonia, panic attacks, crisis intervention, emergency assessment, triage, mental health services, WHO mhGAP

Introduction
An Emergency can be defined as an unforeseen amalgamation of circumstances or events which calls for an immediate action. A Medical Emergency can be defined as a medical condition or an event which might endanger an individual's life or may cause a great suffering to the individual. However, Psychiatric Emergency can be described as a disturbance in thought, mood or action which can cause a sudden distress to the individual or to others who are important to the individual or sudden disability, thus requiring immediate management. These psychiatric emergencies are also termed as Behavioural Emergencies. Previously, emergency psychiatric cases were mainly handled in psychiatric hospitals but now these occur mostly in general medical emergency departments. This reflects the integration of mental health into general healthcare systems [1, 2].
Globally, the demand for emergency psychiatric services has increased due to rising prevalence of mental illnesses, urbanization, reduced inpatient psychiatric beds, increased substance abuse, and the psychosocial effects of stress and social isolation. Most patients, according to WHO mhGAP, initially come to non-specialist health services, thus, it is important to educate the general practitioners, nurses, and emergency personnel to recognize psychiatric emergencies and take effective measures for stabilization [3].

Global Epidemiology of Emergency Psychiatry
Psychiatric emergencies constitute a considerable proportion of global emergency department visits. WHO mhGAP (2016) has mentioned that acute behavior changes are often the most frequently occurring mental disorders in the emergency settings, including suicidal behavior, acute agitation, violent aggression, psychosis, and delirium [3].

a) Prevalence and Global Trends
- International evidence indicates that psychiatric emergencies account for 10-60% of all emergency visits, depending on the healthcare structure, accessibility of specialized services, and the criteria for diagnosis. A decade-long study in high-income countries has shown a dramatic rise of 40% in psychiatric emergency visits, which has been linked to several factors: reductions in psychiatric beds, increased homelessness, rising drug misuse, and the shift toward community-based management of severe mental illness [1].

- In contrast, low- and middle-income nations face an even more substantial psychiatric load. According to the World Health Organization (WHO) estimate, around 75% of individuals suffering from severe mental disorders are not getting any continuous treatment, and thus, most people get help only when their situation has evolved into a crisis. This unaddressed burden often shows itself through suicidal attempts, acute psychosis, violence, and agitation [3].

b) Contributing Global Factors

- **Increasing Suicide Rates**

Suicide is the very common cause of death that ranks within the first 20 deadliest diseases around the globe. A lot of people who committed suicide had visits to the emergency room or had contact with a primary healthcare provider in the weeks before, which points to missed chances for recognizing the risk.

- **Greater Substance Abuse**

Usage of alcohol and illegal drugs are often the causes of mental health emergencies and their effects like agitation, aggression, confusion, and even psychosis are the results of these substances. Intoxication and withdrawal are the two major reasons for violent behavior that the emergency departments see.

- **Untreated Severe Mental Illness**

Difficult access to psychiatric care causes relapses in conditions like schizophrenia, bipolar disorder, and severe depression that usually led to emergency hospital admissions.

- **Social & Environmental Stressors**

Factors like urbanization, migration, poverty, unemployment, family break-up, and social isolation are the major contributors to emotional crises and mental health breakdowns.

- **Trauma, Conflict, and Disasters**

Those who have suffered from war, natural calamities, or interpersonal violence usually come with a range of symptoms such as acute stress reactions, dissociation, panic states, and psychiatric decompensation [1, 3].

Indian Epidemiology of Emergency Psychiatry

a) Hospital Based Epidemiology in India

A study in 2017 noted that:

- 70% of patients going through a psychiatric emergency were males
- 20% were exhibiting aggressive behavior
- Most frequent diagnoses: Schizophrenia - 33.3%; Alcohol dependence - 25%; Acute mania - 16.7%
- The majority were through referrals from non-psychiatric units.

These results emphasize the fact that psychiatric emergencies occur regularly in general hospital settings where specialized psychiatric care may not always be available immediately [5].

b) Population-Based Patterns in India

A population-based study was performed on the emergency of behavioral issues and recognized it as one of the first epidemiological studies in India. It was conducted in 2010. Their findings were as follows:

- A very high percentage of psychiatric crises went undetected.
- The most frequent emergencies were: Suicidal attempts; Acute psychosis; Alcohol-related agitation; Violence
- There was a marked prevalence of young adult males.

This situation mirrors the public health problems of late detection, the lack of mental health community resources, and the insufficient follow-up [4].

c) Key Contextual Factors in India

- **Severe shortage of Psychiatrists**

India has far fewer psychiatrists per capita than global recommendations, which leads to overcrowded emergency departments and lack of specialists [6].

- **Stigma and Cultural Beliefs**

Mental disorders are still very much stigmatized, which results in families only seeking medical help when the symptoms are no longer manageable or have become dangerous [5].

- **Substance Abuse**

Alcohol abuse is a prominent factor contributing to the emergency psychiatric cases, especially those with aggression and loss of control [4].

- **Lack of Community Mental Health Infrastructure**

India's community mental health is developing but it is still insufficient and the result is the frequent relapses and recurrent crises [6].

- **Medicolegal Overlap**

Suicidal attempts, domestic violence, trauma, and substance-related incidents often require police reporting, which increases emergency referrals and complicates clinical workflows [4].

Life Threatening Psychiatric Emergencies

1. **Suicidal attempt**: Suicide is considered the model psychiatric emergency and the leading cause of death among psychiatric patients. It includes deliberate self-harm, attempted suicide, and suicidal gestures, differing mainly in intent and lethality. Attempted suicide is non-fatal but carries a 2-10% long-term risk of eventual completion. Women attempt suicide more frequently, but completed suicide is significantly more common in men. Suicide ranks among the top causes of death in India, with high rates in younger age groups, especially 15-29 years. Risk factors include age over 40, male sex, being single, previous attempts, depression, suicidal preoccupation, substance dependence, severe physical illness, recent stress, social isolation, and impulsivity. Common methods involve poisoning, hanging, burning, drowning, or jumping in front of vehicles. Suicide and attempted suicide remain punishable offences under IPC Section 309 [2, 8].

2. **Acute psychotic episode with excited behavior and violence**: Acute psychosis presents with sudden onset

of hallucinations, delusions, disorganised behaviour, or agitation. Violence and excited behaviour commonly bring patients to psychiatric emergency services and can cause considerable fear and disruption. These states may result from organic brain disorders like delirium and dementia, psychiatric conditions such as schizophrenia, mania, agitated depression, personality disorders, panic disorder, reactive psychosis, or substance intoxication and withdrawal [2, 8].

3. **Alcohol & drug withdrawal syndrome:** Alcohol or drug-related emergencies include intoxication, withdrawal states, and associated psychiatric complications. These conditions often need urgent evaluation, detoxification, and management of behavioural disturbances [2, 8].

4. **Depressive stupor or catatonic syndrome:** Stupor is a psychiatric emergency defined as a condition of akinesis and mutism with preserved consciousness. Although often associated with psychiatric conditions such as catatonia, most cases are found to have underlying organic cerebral causes. Catatonic stupor may appear with features such as mutism, negativism, posturing, echolalia, or echopraxia, and only the withdrawn type of catatonia presents with stupor. Differentiation between organic and psychogenic stupor is essential and is based on history, onset, physical and neurological examination, and sometimes diagnostic interviews using diazepam or barbiturates. Management begins with essential supportive measures: airway, breathing, circulation, and correction of metabolic abnormalities—followed by treatment directed at the primary cause [2, 8].

5. **Side effects of Psychotropic Medications:** Certain drug-induced conditions present as psychiatric emergencies, notably acute dystonia, akathisia, and neuroleptic malignant syndrome. Acute dystonia causes painful muscle spasms and responds rapidly to promethazine. Akathisia leads to severe restlessness and distress, while neuroleptic malignant syndrome is a potentially life-threatening reaction with rigidity, fever, and autonomic instability. Prompt recognition and treatment are essential [2].

6. **Severe Depression:** Severe depression may present as an emergency when associated with suicidal attempts, intense agitation, or refusal of food, fluids, or medication. Such refusal can lead to dehydration, physical deterioration, or worsening mental state. Feelings of hopelessness may prevent adherence to treatment, requiring urgent intervention to stabilise the patient and ensure safety [2].

7. **Acute stress reaction with dissociative conversion disorder:** An **acute stress reaction** may appear suddenly in response to a severe emotional or traumatic event and can bring a patient to emergency services when the distress becomes overwhelming. In such situations, individuals may also develop dissociative or conversion symptoms, most commonly seen as *pseudoseizures*, which often present in emergency departments because they closely mimic epileptic attacks. These episodes arise from psychological stress and reflect a dissociative mechanism rather than a neurological disorder [2, 8].

8. **Panic disorder with panic attacks**: Patients with panic disorder often arrive in emergency settings due to sudden, intense episodes of fear accompanied by alarming somatic symptoms. The acute distress leads many to believe they have a serious medical illness, requiring rapid reassurance and assessment [2, 8].

Treatment Settings in Emergency Psychiatry

a) General Hospital Emergency Departments

General Hospital Emergency Rooms (GH-ERs) are the first responders to psychiatric emergencies. The patients with acute suicidal ideation, those exhibiting violent behavior, severely agitated ones, and others with altered mental state or psychosis are generally brought here by relatives, ambulance services, or police. Therefore, GH-ERs should be prepared with:

- A secure environment for assessment that does not have any harmful objects
- Professionals who are able to identify psychiatric symptoms through training
- Psychotropic medications that are basic for quick tranquillization
- A medical screening protocol to determine if there is any underlying physical illness
- Psychiatric consultation services available [1, 4].

The research conducted in India in 2017, pointed towards the non-psychiatric emergency units being the primary sources of psychiatric referrals, thereby affirming the overlap between medical and psychiatric emergencies [5].

b) Dedicated Psychiatry Emergency Services

In certain high-income nations, psychiatric emergency services (PES) operate independently or adjacent to hospital ERs. These units feature

- Rooms for seclusion
- Psychiatric personnel trained
- Crisis intervention teams
- Protocols for rapid assessment

But still, these specialized services are hardly found in India. A study in 2011 asserted dedicated PES units significantly reduce duration of stay, improve safety, and provide more structured care, but are largely absent due to resource constraints [1, 6].

c) Observation Units

Short-term psychiatric observation units (24-72 hours)

- Stabilization
- Diagnostic clarification
- Elimination of unnecessary admissions
- Structured supervision

These units are often beneficial for patients presenting with intoxication, delirium, acute stress reaction, and uncertain diagnosis [1].

d) Emergency Mobile Crisis Teams

Mobile crisis teams are rare in India, although they are

common in some countries. The team services include:

- Assessment on the spot
- Crisis counseling
- Referral at once

WHO advises the incorporation of the crisis teams into the community mental health programs to lessen the emergency department load [1, 3].

e) Forensic and Police Settings

Emergency departments are often the first place where policemen take those who show violent, unpredictable or bizarre behavior. A close working relationship between mental health services and police is needed to guarantee

- Transport in a safe way
- Restraint with the right techniques
- Documentations in legal terms [1, 4].

Role of Staff in Emergency Psychiatry Services

Emergency psychiatric care requires a multidisciplinary approach. Crisis situations often involve impaired judgment, aggression, fear, mistrust, and altered reality testing; therefore, staff must function cohesively to ensure safety and stabilization [1].

a) Psychiatrists

Psychiatrists are in charge of clarifying the diagnosis, as well as assessing the risks, and planning the treatment. They evaluate

- Presence of psychosis
- Level of suicidality or homicidality
- Need for medication or restraint
- Capacity for self-care
- Need for admission or observation

They also coordinate with medical staff for further investigations [1].

b) Emergency Physicians

Usually, most psychiatric emergencies are first seen at the general hospital's emergency rooms; therefore, the doctors in emergency departments carry out medical screening examinations to exclude

- Delirium
- Toxicological factors
- Neurological conditions
- Metabolic disarrangements

Prompt medical-psychiatric cause differentiation is of utmost importance [1, 3].

c) Nurses

Psychiatric emergency nurses play a central role in

- Triage
- Monitoring the vital signs
- Behavioral observing
- Helping with de-escalating the situation
- Medication administration
- Safety of the environment.

The World Health Organization (WHO) recommends specialized training in verbal de-escalation and crisis communication for nurses [1, 3].

d) Social Workers

Social workers assist in

- Obtaining collateral history
- Tackling psychosocial issues
- Family involvement coordination
- Community referral facilitation
- Connecting with shelters or rehabilitation centers [1, 5].

e) Security Staff and Police Personnel

Security people are simply a must when the following situations arise

- Violent or aggressive individuals
- Patients with impaired impulse control
- Substance-intoxicated persons
- Individuals with forensic involvement [1, 4]
- Security involvement must always follow clinical direction, as excessive force risks trauma, escalation, and legal liabilities [1].

Ethical and Legal Issues in Emergency Psychiatry

Psychiatric emergencies are often complicated by the involvement of medico-legal issues. The affected individuals might be unable to give their consent to treatment because they are under the influence of drugs, have lost touch with reality, are confused, or are extremely agitated [1].

a) Informed Consent and Capacity

A patient's capacity must be evaluated based on their ability to

- Understand information
- Appreciate consequences
- Reason about treatment
- Communicate a choice

If a patient's capacity is compromised, then by implication, emergency treatment can be provided [1].

b) Confidentiality

Confidentiality, while it is of utmost importance, can still be overridden in certain situations

- When there is a very high possibility that the patient would harm himself or others
- The police are involved because of the law
- There is a third party at risk of harm (e.g., threats of violence) [1].

c) Involuntary Treatment

According to the Indian law, involuntary admission can be ordered by the court if the patient

- Is a danger to himself or to others
- Is not capable of making a decision
- Is in need of help but cannot take care of their basic needs

The Mental Healthcare Act (MHCA) 2017 states that involuntary treatment should be the least restrictive and must be well-documented [7].

d) Use of Restraints

Physical restraints must be:

- Used only when absolutely necessary
- Administered by persons with the proper training
- Applied only when the patient is a threat to himself or others

- Accompanied by documentation that includes time, reason, and monitoring parameters

WHO mhGAP recommends that verbal de-escalation should always be the first strategy before resorting to the use of restraints [1, 3].

e) Police Involvement

Police may be called in if

- A patient is extremely aggressive
- Medico-legal issues are connected
- There are doubts about public safety

Nevertheless, clinical decisions take precedence over police directions in relation to patient care [4].

Evaluation and Triage in Psychiatric Emergencies

The main aim of conducting emergency psychiatric evaluation is to swiftly spot the risk, provide symptomatic relief and, lastly, decide where the patient should go next [1].

a) Nursing Triage

Nurses perform the initial triage

- Assess level of agitation
- Check vital signs
- Identify medical instability
- Ensure safety precautions
- Request previous medical records

The triage should be done in such a way that it differentiates between

- High-risk (urgent intervention needed)
- Urgent
- Non-urgent [1]

b) Psychiatric Triage

Psychiatric triage includes

- Establishing rapport
- Observing mental status: Screen for organicity. Test for higher mental functions, such as consciousness, orientation, attention, concentration, memory, intelligence, abstract thinking, insight and judgement. Particular emphasis should be placed on the presence of ideas of self-harm or suicide, or of harming others
- Assessing orientation, agitation, and psychosis
- Determining level of supervision required
- Identifying need for sedation [, 2]

c) Medical Evaluation

Thorough medical check-up is necessary to eliminate

- Delirium
- Metabolic irregularities
- Toxic substances ingestion
- Disease of the nervous system
- Contagions

Since quite a few medical conditions imitate signs of mental disorder, this phase is very important for precise diagnosis [1].

d) Collateral Information

The information from family, police reports, ambulance narratives, and previous medical records is invaluable. However, collateral sources may be biased due to emotional involvement, denial, or misinterpretation [1].

e) Communication Across Shifts

Consistent information transfer using

- Written documentation
- Verbal handovers
- Updated observation charts

Fragmented communication is a major cause of misdiagnosis and treatment delays [1].

Differentiating Medical and Psychiatric Conditions

One of the most important tasks of an emergency evaluation is to separate psychiatric emergencies from medical emergencies. A lot of medical conditions like hypoxia, hypoglycaemia, infection, epilepsy, and toxic effect may all show up as psychiatric symptoms at the same time [1].

a) Indicators Suggesting Medical Cause

Some of the signs that doctors should be cautious seeing:

- Sudden onset (minutes-hours)
- Age extremes (young or old)
- Abnormal vital signs
- Fluctuating consciousness
- Memory loss or disorientation
- Visual/olfactory hallucinations
- Recent head injury
- Neurological deficits (e.g., unequal pupils)
- Substance ingestion
- Abnormal physical findings [1].

b) Medical Conditions That Are Often Confused with Psychiatric Ones

- Delirium: fluctuating consciousness, disorientation, caused by metabolic or infectious origins
- Substance intoxication/withdrawal: restlessness, hallucinations, seizures
- Hypoglycaemia: confusion, aggression, bizarre behaviour
- Neurological conditions: temporal lobe seizures can cause disposing or aggressive behaviours similar to psychosis [1].

Importance of Medical Screening

As per the guidelines of the WHO mhGAP, it is mandatory that the medical screening of all agitated or confused patients to be conducted before the psychiatric diagnosis is given. Non-adherence to this might lead to:

- Missed diagnosis
- Delayed treatment
- Increased morbidity and mortality [3].

Management of Psychiatric Emergencies

a) Pharmacological Interventions

The primary goal of pharmacological treatment in emergency psychiatry is to quickly stabilize the patient's acute symptoms, such as agitation, psychosis, mood swings, and suicidal thoughts or actions. When selecting medications, factors such as the patient's age, existing health problems, and co-occurring medical conditions must be taken into account [1].

Table 1: Emergency Psychiatric Conditions and First-Line Medications

Condition	First-line Emergency Medication	Dosage/Route
Acute agitation (psychosis/mania)	Haloperidol	2-5 mg IM
Severe psychosis	Olanzapine	10 mg IM
Acute mania	Risperidone	2-4 mg PO/IM
Severe depression with psychotic features	Escitalopram + low-dose antipsychotic	PO
Delirium	Haloperidol	0.5-2 mg IM
Substance-induced agitation	Benzodiazepines (Lorazepam, Diazepam)	1-4 mg IM

- Medical screening should always be performed before pharmacological intervention.
- Start with the lowest effective dose, increase as needed.
- Observe for side effects and drug interactions, especially in elderly or medically ill patients [1].

b) Psychological Interventions

Psychological approaches are integral to emergency stabilization, reducing distress, and preventing escalation.

- **Psychoeducation**
- Explains the psychiatric condition and immediate coping strategies.
- Provides information on early warning signs and follow-up care.
- Evidence supports improved adherence and reduced relapse.

- **Brief Cognitive-Behavioral Techniques**
- Techniques: controlled breathing, grounding exercises, cognitive reframing.
- Effective for acute anxiety, panic, and agitation.

- **Problem-Solving Therapy**
- Structured approach to identify and address immediate stressors.
- Reduces symptom severity even in short sessions.

- **Supportive Counselling**
- Reduces feelings of helplessness and agitation.

- **Family and Caregiver Involvement**
- Education on de-escalation techniques, safety, and monitoring.
- Family participation reduces hospital admissions and improves outcomes [3, 4, 6].

Stigma and Barriers related to Psychiatric Care

In the country India, majority of the mentally ill persons and their families turn to healers, astrologers, or practitioners from the old days first, then finally go for psychiatric care. These practices are the result of very strong cultural beliefs that see the cause of mental illness as either divine punishment, possession, past sins, or black magic. These beliefs are further supported by the fear of being socially judged, by stigma, and by the unwillingness to get associated with psychiatric hospitals, which are often viewed negatively. Since faith healers are easily accessible, inexpensive, and culturally trusted, families usually end up spending a considerable amount of time, like weeks or months, going through the rituals, pujas, exorcisms, or spiritual cleansing. The healer-first approach takes a significant amount of time before the patient can get to receive the evidence-based medical treatment, thus prolonging the duration of untreated mental disorders, and making it more likely for the patients to get to formal health services only when the symptoms turn into psychiatric emergencies, for example, acute psychosis, violent behaviour, or severe suicidal attempts [9].

Conclusion

Emergency psychiatry is crucial in mental-health care, offering quick identification and stabilization of acute crises, such as attempted suicide, acute psychosis, violent behaviour, intoxication or withdrawal from substances, and severe panic or dissociative states. Throughout the world and the nation, psychiatric emergencies are on the rise; thus, well-organized, accessible, multidisciplinary emergency services are needed. Its effective management encompasses thorough triage, prompt medical screening, and appropriate psychiatric evaluation, complemented by pharmacological and psychological interventions. Counselling and rehabilitative planning further help prevent relapse and support long-term recovery.

Yet, persistent stigma remains a major barrier. Many still believe in supernatural causations, continue to depend on faith-healers or "tantrik babas," and avoid seeking care for fear of being labelled mentally ill. Such beliefs cause delays that worsen the crisis and enhance risks. Overcoming such sociocultural barriers through awareness, community engagement, and integration with general healthcare is crucial.

Training, collaboration, and ethical practice are all ways in which emergency psychiatric systems can be strengthened and outcomes can be improved. As mental health needs continue to grow, emergency psychiatry remains the key link between crisis management and the wider continuum of psychiatric care.

Conflict of Interest

Not available

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