Management of acute psychiatric emergencies: Approaches and challenges in emergency departments

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Abstract---**Background:** The prevalence of psychiatric emergencies increases significantly during public disasters, highlighting the need for effective management strategies. Disasters, including pandemics and epidemics, exacerbate mental health conditions and strain healthcare systems. Despite established models for psychiatric emergency management, there remains a crucial need to ensure accessibility and effectiveness in such high-stress scenarios. **Aims:** This article aims to review and propose strategies for managing psychiatric emergencies in the context of public disasters. It focuses on evaluating the impact of crises on mental health and the capacity of healthcare systems to address these needs effectively. **Methods:** A comprehensive review of literature was conducted, examining psychiatric emergencies in disaster settings, including pandemics and natural disasters. The review involved analyzing current management models, assessing their effectiveness, and identifying gaps in healthcare provision. **Results:** The study finds that the prevalence of mental disorders during disasters is significantly higher compared to normal conditions. Key challenges include inadequate infrastructure, limited staff, and the need for specialized psychiatric interventions. Effective strategies include enhanced triage systems, increased availability of outpatient and inpatient care, and the use of telepsychiatry where applicable. **Conclusion:** Effective management of psychiatric emergencies during public disasters requires a well-coordinated approach involving improved infrastructure, trained personnel, and comprehensive care strategies. Implementing robust triage and referral systems, providing psychological first aid, and utilizing telepsychiatry can significantly enhance care. Ensuring mental health support for both affected individuals and healthcare workers is crucial for mitigating the impacts of disasters.

Keywords---Psychiatric emergencies, public disasters, mental health, crisis management, telepsychiatry, healthcare infrastructure.

Introduction

The incidence of mental health issues within the general populace during a public disaster tends to be elevated. In such crises, the frequency of individuals presenting with psychiatric emergencies or crises may rise, yet the requisite support systems could be compromised if not adequately planned for. Despite the existence of various models to manage psychiatric emergencies, overarching principles remain consistent, particularly concerning the accessibility of these services to the affected individuals. This article aims to review and provide recommendations for managing psychiatric emergencies in the context of public disasters, encompassing calamities, physical and medical crises, epidemics, and pandemics. To grasp the impact of medical emergencies on public health, large-scale human disasters serve as a pertinent example [1]. These encompass disasters, physical and medical crises, epidemics, and pandemics, including the ongoing COVID-19 outbreak [2–4]. Investigating the interaction between natural disasters and human behavior is essential for comprehending both the management of their impacts and their effects on mental health [3, 5].

Consequently, the prevalence of mental disorders during disaster scenarios is two to three times higher compared to normal conditions, ranging from 8.6% to 57.3% among the affected population [6, 7]. Moreover, the impacted community may exhibit numerous subsyndromal symptoms. While many acute reactions and disorders may resolve on their own, some may necessitate specialized intervention [7]. However, a significant concern related to natural disasters is their effect on mental health [2, 3, 8], including the exacerbation of symptoms and an increase in psychiatric emergencies [1, 9, 10]. Psychiatric conditions, such as posttraumatic stress disorder, anxiety, and depression, often affect both disaster survivors and healthcare professionals involved during the crisis [6, 9, 11, 12]. Besides the long-term repercussions of disasters, the strategies employed to address health emergencies during the acute phase are vital in mitigating their immediate and prolonged impacts.

These issues can affect hospitals multiple times within a given period. A reduction in staff and an increase in patient volume may temporarily strain hospital capacity, potentially leading to avoidable adverse outcomes [1]. As an initial step, hospitals may need to close their doors and redirect patients. Although hospitals generally have a duty to accommodate incoming patients, outbreaks and staff shortages may necessitate diverting ambulances to alternative facilities. Despite such delays, the goal remains to prevent negative outcomes utilizing all available medical and nursing resources [1–3]. Medical emergencies involve situations where an individual faces imminent death and thus require urgent intervention. Changes in a patient's behavior that pose risks to themselves or others and necessitate immediate therapeutic action (within minutes or a few hours) to avert harm are termed psychiatric emergencies. Common emergency scenarios include severe self-neglect, self-harm, suicidal behavior, depressive or manic episodes, aggressive psychomotor agitation, significantly impaired judgment, intoxication, or withdrawal from psychoactive substances [13, 14].

In crises, the number of patients experiencing outbreaks or crises may increase, and the necessary support systems may be impaired if not prearranged [2, 3, 10].

Despite various models for addressing psychiatric emergencies, general principles remain consistent, especially concerning the accessibility of these services to the affected population [10]. This review seeks to propose strategies for managing psychiatric emergencies in disaster contexts, including the examination of attitudes towards public policies and conduct codes for healthcare professionals.

Assurances to the Affected Population:

The individuals impacted by a disaster should receive comprehensive health care, including psychiatric and mental health services. According to Ho et al. [15], during the COVID-19 pandemic, it is crucial to implement specific strategies to manage high-risk populations experiencing stress, such as individuals under quarantine. They also emphasize the importance of incorporating screening tools to evaluate the mental health effects of the outbreak on those exhibiting frequent COVID-19 symptoms and individuals with a history of psychiatric issues [15]. Beyond the support provided by emergency services specialists—which includes observation facilities—there must be guaranteed access to outpatient treatment for those affected. This ensures care for less severe cases and helps prevent future episodes or crises [16]. Additionally, adequate hospitalization facilities must be ensured for the management of acute cases [2, 3]. Mobile prehospital emergency care units should be available, with personnel trained specifically to handle psychiatric emergencies [2, 17, 18]. All these services should be supported by psychiatrists [10, 19]. Additional resources should be provided to the population for both screening acute cases and offering support and prevention [16, 17, 20], including:

- Established mechanisms for triage and referral [17]
- Psychosocial evaluation and identification of vulnerable groups [2, 17, 20]
- Effective communication strategies for the affected individuals [3, 17, 20]
- Assessment of psychopathology and psychophysiological responses to fear, focusing on psychiatric emergencies [17, 20]
- Evaluation of the cultural context influencing mental health [17, 20]
- Provision of psychological first aid [20]
- Attention to the mental well-being of healthcare and support workers [17, 20]
- Services to differentiate between normal distress and pathological stress [20]
- Digital access to pertinent mental health information, support, and intervention [3, 12]

Telepsychiatry can serve as a supportive tool in providing care to areas with limited access. However, considerations regarding its cost-effectiveness, the availability of necessary equipment, and associated legal factors are essential. It is important to note that telepsychiatry should be used primarily to address gaps in stable patient care and to prevent crises, rather than for managing ongoing psychiatric emergencies.

Structure of Care:

Psychiatric emergencies can arise unpredictably and in any setting, underscoring the need for a well-prepared environment, which may not always be readily available to healthcare professionals [10, 19, 21, 22]. The primary concern in managing psychomotor agitation should be the safety of both the patient and those around them. Healthcare providers, including doctors and team members, should avoid placing themselves in potentially hazardous situations, such as attending to a patient in a confined space with no accessible exit or without appropriate personal safety equipment [13, 23, 24].

An adequate physical infrastructure is crucial for managing patients in emergency situations. Psychiatric patients should be treated in designated areas designed specifically for mental health care, considering the unique characteristics of psychiatric presentations. The facility must provide sufficient space for nursing staff to administer specialized care, including well-ventilated rooms and accessible restrooms [13, 21, 25, 26]. Adequate lighting and orientation aids, such as clocks and calendars, should be provided to assist patients who may be disoriented [26]. In the waiting area, furniture should be arranged to ensure organization, and the office should have easily accessible entry and exit points for both patients and healthcare professionals [21]. Ensuring patient comfort and minimizing external stimuli is essential. Harsh noises, bright colors, and extreme temperatures can exacerbate psychiatric symptoms. It is important to maintain a calming environment in the psychiatric emergency department, with well-designed facilities for both entry and exit. Rooms should be quiet and private, and waiting times should be minimized to the greatest extent possible [21, 24–28].

The emergency room designated for psychiatric care should be equipped with chairs and a table for patients and their families, an examination table, and a sink for handwashing [13, 26, 29]. The exit route should be positioned behind the attending professional and kept completely unobstructed to allow for swift evacuation in the event of an unmanageable threat [29, 30]. It is critical to consider that patients in crisis may exhibit unpredictable behavior, necessitating the removal of potentially dangerous objects from the room [24, 28]. Given that psychiatric emergencies can often be linked to organic causes, it is vital that emergency equipment such as oxygen tanks, orotracheal intubation tools, suction devices, vaporizers, nebulizers, carts, and defibrillator trays are readily accessible [26]. On-site laboratory testing capabilities, including capillary blood glucose tests, oximetry, and ECGs, should also be available [24]. Materials for physical restraint, including appropriate restraints, must be present [13, 21, 26, 30].

Observation areas should be equipped with beds that have elevated headrests and fixed bars for potential restraints. Patients under observation should not remain on stretchers [26]. The layout should be organized to facilitate continuous observation with clear lines of sight, eliminating all blind spots [25]. All behavioral intervention services should be provided in spaces designed to minimize patient agitation [25]. To mitigate the risk of infectious disease transmission, such as H1N1, COVID-19, or tuberculosis, healthcare professionals working with psychiatric patients must be equipped with protective measures. This includes

isolation areas, containment protocols, and personal protective equipment, regardless of whether they are in an emergency room setting. During an epidemic, managing behaviorally aggressive or hostile patients presents a challenge, as it may be unclear if the patient is infected. Thus, all patients exhibiting agitation should be treated as potential cases of infection.

Consideration should be given to establishing observation areas and dedicated wards for individuals with mental illness during an epidemic to contain disease transmission and manage emergency situations, such as agitation. Healthcare teams must be consistently equipped and prepared for prompt intervention. Additionally, individuals with mental illness may struggle to understand and adhere to preventive measures such as frequent hand washing, mask-wearing, and physical distancing. It is crucial that the patient population does not exceed the available bed capacity, as overcrowding can heighten tension between patients and staff [25]. When engaging with patients displaying agitated or violent behaviors, efforts should be made to manage their treatment in a less restrictive environment [25]. This includes utilizing a specialized observation unit that provides adequate space, equipment, security, and trained staff [13, 25, 30, 31]. The Psychiatric Intensive Care Unit (PICU) has demonstrated superior outcomes compared to even specialized psychiatric departments dedicated to acute care [32].

Staff:

The healthcare team should be well-trained and adhere to established protocols for managing major psychiatric emergencies. These protocols outline each step in patient management and delineate the responsibilities of each team member [13, 26]. Physicians in intensive care settings must be adept at multitasking and managing rapid changes in patient conditions [28]. It is crucial for these professionals to handle and even thrive in situations involving agitated patients. This requires specific temperamental traits, and doctors are encouraged to evaluate their own suitability for such work [28]. Agitated patients may provoke and test the clinician's authority, competence, or credentials. Some patients, seeking to deflect from their own vulnerabilities, may be particularly attuned to detecting and exploiting the clinician's perceived weaknesses [28].

Everyone involved in this type of service must adopt a professional role, including wearing appropriate attire such as lab coats or non-provocative, neutral-colored clothing, and badges. Avoiding drop earrings, necklaces, or long hair is recommended to minimize the risk of being targeted by aggressive patients [13, 21, 33]. Sudden movements and prolonged direct eye contact should be avoided as they may be perceived as threats. Maintaining an adequate distance from agitated patients is essential to ensure the safety of both the team and the patient [21, 33]. In situations involving infectious disease outbreaks, emergency professionals may experience interpersonal isolation and fear of transmitting the virus to their families. Medical teams have reported that protective gear, such as N95 masks, can impede communication between team members and with patients. During the 2015 MERS-CoV outbreak in Korea, stigma and hardship directly impacted the mental health of healthcare professionals working in public

hospitals [34, 35]. Psychological adaptation was observed among personnel who had access to well-structured and adequately equipped environments [34].

Medical workers in Wuhan during the COVID-19 outbreak faced high infection risks, insufficient protection, overwork, frustration, discrimination, isolation, and exhaustion. They also experienced negative emotions and a lack of contact with their families [2, 18, 34, 36]. This situation has led to mental health issues such as stress, anxiety, depressive symptoms, insomnia, denial, anger, and fear [34, 37]. These problems not only impair medical workers' attention, comprehension, and decision-making abilities—potentially hindering the fight against COVID-19— but also have long-term effects on their overall well-being [2, 18, 34, 36]. This situation may also result in an anticipated increase in cases of posttraumatic stress disorder (PTSD). Therefore, it is essential to provide adequate equipment, establish comprehensive protocols, and offer psychological and psychiatric support to maintain team functionality and improve patient care.

Assessment:

When patients and their families present to the emergency department with psychiatric emergencies, it is crucial to swiftly and effectively assess the situation to implement the most appropriate treatment. The protocol for managing psychomotor agitation can be adapted for other emergencies, as the core objectives are screening and assessing the severity of the situation [13, 21, 24, 30, 38, 39]. This protocol generally includes:
a. Objective and subjective anamnesis.
b. Physical and neurological examination.
c. Psychiatric examination.
d. Differential diagnosis.
e. Rapid tranquilization.
f. Referral and guidance.

In some cases, it may be challenging to complete all these steps immediately upon patient arrival. Given the importance of time in emergencies, we recommend addressing the following four fundamental questions [13, 29]:
A. What is happening?
Identify the behavioral changes of concern. It is vital to discern acute changes in behavior that may pose risks to the patient or others and to rule out any organic causes.
B. For how long?
Determine whether the observed changes in behavior are recent or have been ongoing. Assess if there have been significant or acute behavioral changes. Even in patients with a history of agitation, the current situation might be urgent, and sudden behavioral changes may be due to organic factors.
C. Why today?
Investigate the reasons for seeking help at this particular moment. Crucial triggering factors might be perceived as circumstantial or irrelevant, or they may not have been disclosed by the patient or their relatives.
D. What is the diagnostic hypothesis or provisional diagnosis?
Initiate the differential diagnosis process to determine the most suitable approach. In emergency settings, syndromic diagnoses, such as psychotic

disorders or mood disorders, are typically used, as rapid decision-making is required, and a detailed diagnosis may not be feasible.

Approach to the Main Situation
General Support for Stress:

As previously emphasized, it is crucial for the population to have prompt access to screening and efficient referral systems during and following a disaster. Patients should then receive targeted care that addresses potential pre-existing mental disorders and conditions that heighten vulnerability to stress. This is particularly pertinent for individuals exhibiting atypical responses to the calamity, such as:

- Survivor's guilt,
- Onset of mental illness,
- Stress associated with caregiving for individuals with physical or mental health conditions,
- Fear of losing control over overwhelming emotions,
- Substance use,
- Suicidal ideation and death wishes.

Emotional validation can help provide context and justification for these intense feelings. Several interventions are recommended for addressing abnormal responses to a disaster:

- **Psychological First Aid:** Survivors may display a range of physical, emotional, and cognitive symptoms. During a disaster, patients might struggle to think and act rationally. Psychological first aid, which can be administered by minimally trained non-professionals within the community, is designed to provide immediate support [7, 40].
- **Crisis-Focused Intervention/Psychotherapy:** This intervention aims to stabilize patients, halt the escalation of distress, alleviate acute symptoms, restore functionality, and establish therapeutic goals. It is particularly useful for managing sensations of entrapment commonly observed in psychiatric emergencies [41].
- **Debriefing:** Defined as group discussions conducted within 48–72 hours after an event, often termed 'psychological debriefings' [7], these sessions encourage participants to share both factual and emotional aspects of their disaster experience. The rationale is that immediate processing allows individuals to cognitively restructure the event, reducing its traumatic impact [7, 11].
- **Cognitive Behavioral Intervention (CBT):** CBT has proven effective in diminishing subsequent psychopathology following disaster exposure [7, 11]. In emergencies, CBT should be implemented in brief sessions and may include psychoeducation, breathing and relaxation exercises, cognitive restructuring, and techniques such as imagery or in vivo exposure to address traumatic experiences [42].
- **Community-Based Interventions:** These interventions encompass structuring daily activities to mitigate displacement, promoting family and cultural rituals, conducting group discussions, validating survivors' emotions and guilt, providing factual information, educating parents and

teachers, engaging children in informal educational activities such as drawing and singing, and involving adults in disaster relief activities. Reopening schools as soon as possible is crucial for normalizing daily activities for children, even if it involves informal education, sleep hygiene instruction, and substance use education. Community-based interventions may also include art therapy, group discussions, drama, daily routine planning, and various activities such as prayers, yoga, relaxation, and sports. Managing the stress of social workers is also vital, as is involving willing survivors in spiritual activities and community rebuilding efforts [7].

- **Psychopharmacology:** The use of psychotropic medications is generally discouraged in disaster settings due to beliefs that "disaster reactions are typically normal responses to abnormal situations" and "most symptoms are self-limiting." Prophylactic use of psychotropic drugs is rarely supported by evidence [7]. Exceptions exist for cases where a mental disorder has been diagnosed or exacerbated by the disaster, in which case treatment should be tailored to the specific diagnosis.

Delirium:

Delirium is a syndrome characterized by mental confusion, impaired consciousness, cognitive dysfunction, and attention deficits. It has an abrupt onset and a fluctuating course, often indicating a rapid decline in brain function due to underlying physical illnesses, commonly with systemic involvement. Delirium is associated with significant morbidity and a high risk of mortality [43, 44].

Management of Delirium:
1. **Underlying Condition:** Treatment should focus on resolving the underlying condition causing delirium.
2. **Non-Pharmacological Interventions:** Include environmental modifications and supportive care.
3. **Pharmacological Interventions:** Should be used cautiously and tailored to individual needs.
4. **Diagnosis and Monitoring:** Early diagnosis relies on the training of healthcare professionals. Continuous monitoring is necessary post-discharge [21, 43, 44].

In public emergencies, healthcare services must be equipped to quickly identify and diagnose delirium and initiate treatment promptly. Protocols should be established for handling such cases, considering potential causes like trauma, electrolyte imbalances, complications from existing conditions, medications, substance abuse, and infections (e.g., kidney, lung). Delirium often signifies greater severity in infectious disease scenarios [10].

Agitation

Psychomotor agitation, often resulting from mental disorders, requires immediate attention. Key management strategies include:
1. **Protection:** Ensure the safety of the patient and others.

2. **Communication:** Employ verbal de-escalation techniques.
3. **Medication:** Administer cautiously, following principles of rapid tranquilization.
4. **Physical Restraint:** Use as a last resort [13, 24, 28].

De-Escalation Techniques: According to the American Association of Emergency Psychiatry, effective de-escalation involves:
1. Respecting personal space.
2. Avoiding provocations.
3. Establishing verbal contact.
4. Being concise and clear.
5. Identifying and acknowledging the patient's needs and feelings.
6. Listening attentively.
7. Agreeing on reasonable terms.
8. Setting clear boundaries.
9. Offering choices and optimism.
10. Debriefing after the intervention [28].

Medications and Restraint: Should be administered in a controlled environment like an emergency room. Medications should be used to achieve rapid but not excessive sedation, with minimal side effects. Physical restraint should be used if other measures fail. Regular monitoring of vital signs and consciousness is essential [13, 21].

Considerations: Agitated patients may also suffer from physical illnesses, necessitating general medical support. For infectious disease outbreaks, protective measures must be taken to prevent contagion. Psychotropic medications, including antipsychotics and benzodiazepines, have risks such as increased pneumonia risk and respiratory issues. Medications should be used judiciously, considering side effects and drug interactions [45].

Suicide Risk:
Disasters often increase the risk of suicide due to changes in economic, psychosocial, and health-related factors [19, 21, 38, 39]. This risk extends to healthcare workers facing overwhelming challenges [47–50].

Approach to Suicidal Behavior:
1. **Risk Assessment:** Evaluate risk and protective factors using safety plans [38, 39, 51, 52].
2. **Observation:** High-risk individuals require close monitoring, either in an emergency department, hospital, or supported home care if a robust support network is available [10].
3. **Comprehensive Evaluation:** Use psychometric tools as part of a broader assessment that includes identifying risk factors (e.g., previous attempts, mental illness, substance abuse) and protective factors (e.g., social support, coping skills) [38, 39, 54].

Integrated Care: Address general health issues and psychiatric emergencies concurrently, particularly in cases involving trauma or intoxication [38, 39].

Opportunities for Improvement:
- **Physical Distance, Not Social Distance:** Maintain connections despite physical separation.
- **Tele–Mental Health:** Expand access to mental health services remotely.
- **Distance-Based Suicide Prevention:** Implement preventive measures through media and digital platforms [55-56].

Conclusion

The management of psychiatric emergencies during public disasters presents unique challenges that require a multifaceted approach. The increased incidence of mental health issues during such crises underscores the need for specialized and accessible psychiatric care. The review highlights that the prevalence of psychiatric disorders can be two to three times higher during disasters, with conditions such as PTSD, anxiety, and depression being prevalent among both survivors and healthcare professionals. Effective management strategies must address the limitations in current healthcare systems. Ensuring adequate infrastructure is critical; psychiatric emergency departments should be equipped with facilities designed for mental health care, including safe spaces, adequate lighting, and well-organized waiting areas. Training healthcare professionals to handle psychiatric emergencies effectively is also essential. The importance of psychological first aid, crisis-focused interventions, and community-based support systems is emphasized. Furthermore, telepsychiatry can play a significant role in providing support to underserved areas, though considerations around its cost-effectiveness and legal implications are necessary. Implementing robust triage and referral systems can facilitate timely care and prevent the exacerbation of psychiatric conditions. Healthcare workers' well-being must also be addressed, as they are prone to stress and mental health issues themselves during crises. Providing adequate support and resources for healthcare workers is essential to maintaining their effectiveness and well-being. In summary, improving psychiatric emergency management during public disasters involves enhancing infrastructure, training personnel, implementing effective care strategies, and supporting both patients and healthcare providers. This comprehensive approach is crucial for mitigating the immediate and long-term impacts of psychiatric emergencies in disaster settings.

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إدارة الطوارئ النفسية الحادة: الأساليب والتحديات في أقسام الطوارئ

الملخص:

الخلفية :تزداد حالات الطوارئ النفسية بشكل ملحوظ خلال الكوارث العامة، مما يبرز الحاجة إلى استراتيجيات إدارة فعالة. الكوارث، بما في ذلك الأوبئة والأمراض المعدية، تؤدي إلى تفاقم الحالات الصحية العقلية وتؤثر على نظم الرعاية الصحية. على الرغم من وجود نماذج راسخة لإدارة الطوارئ النفسية، إلا أنه لا يزال هناك حاجة ملحة لضمان الوصول إلى الرعاية وفعاليتها في مثل هذه السيناريوهات ذات الضغط العالي.

الأهداف :يهدف هذا المقال إلى استعراض واقتراح استراتيجيات لإدارة الطوارئ النفسية في سياق الكوارث العامة. يركز على تقييم تأثير الأزمات على الصحة العقلية وقدرة نظم الرعاية الصحية على تلبية هذه الاحتياجات بفعالية.

الطرق :تم إجراء مراجعة شاملة للأدبيات، حيث تم فحص الطوارئ النفسية في سياقات الكوارث، بما في ذلك الأوبئة والكوارث الطبيعية. شملت المراجعة تحليل النماذج الحالية للإدارة، وتقييم فعاليتها، وتحديد الثغرات في توفير الرعاية الصحية.

النتائج :توصلت الدراسة إلى أن انتشار الاضطرابات النفسية خلال الكوارث أعلى بشكل ملحوظ مقارنةً بالحالات العادية. تشمل التحديات الرئيسية البنية التحتية غير الكافية، والموظفين المحدودين، والحاجة إلى تدخلات نفسية متخصصة. تشمل الاستراتيجيات الفعالة تحسين نظم الفرز، وزيادة توفر الرعاية العيادية والإقامة، واستخدام الطب النفسي عن بُعد حيثما يكون ذلك ممكنًا.

الخلاصة :تتطلب الإدارة الفعالة للطوارئ النفسية خلال الكوارث العامة نهجًا منسقًا يشمل تحسين البنية التحتية، وتدريب الأفراد، واستراتيجيات الرعاية الشاملة. يمكن أن يسهم تنفيذ نظم فرز وإحالة قوية، وتقديم الإسعافات النفسية الأولية، واستخدام الطب النفسي عن بُعد بشكل كبير في تحسين الرعاية. ضمان دعم الصحة العقلية للأفراد المتأثرين والعاملين في مجال الرعاية الصحية أمر بالغ الأهمية للتخفيف من آثار الكوارث.

الكلمات المفتاحية :الطوارئ النفسية، الكوارث العامة، الصحة العقلية، إدارة الأزمات، الطب النفسي عن بُعد، بنية الرعاية الصحية.