Psychiatric Emergencies

Santina Wheat, MD, MPH*, Dorothy Dschida, MD,
Mary R. Talen, PhD

KEYWORDS

• Suicide • Homicide • Mania • Psychosis • Agitation • Psychiatric emergency

KEY POINTS

- Psychiatric emergencies, such as mania, psychosis, and suicidal or homicidal ideation, present as an acute disturbance of thought, behavior, or mood that require prompt intervention to prevent imminent danger.
- The first priority in a psychiatric emergency is ensuring the safety of the patient and those surrounding.
- Initial assessment should consist of a thorough history and physical examination, to rule out underlying medical causes, while simultaneously establishing a safe environment for patient and clinician.
- It is imperative to debrief with the patient, family, and the health care team following the treatment of a psychiatric emergency.
- There are important legal considerations, particularly concerning involuntary admission, surrounding psychiatric emergencies.

INTRODUCTION

A psychiatric emergency is defined by the American Psychiatric Association as "an acute disturbance in thought, behavior, mood, or social relationship, which requires immediate intervention as defined by the patient, family, or social unit." Such emergencies require immediate intervention to save the patient and/or others from imminent danger. Patients who present with a psychiatric emergency typically have a diagnosis of mania, acute psychosis, suicidal ideation, or homicidal ideation. The causes of these extreme disturbances in patients' behaviors can be multifaceted and caused by substance use, medical illness, mood disorder, or extreme anxiety and trauma. Ninety percent of patients who have been suicidal also have a psychiatric diagnosis, such as major depression, substance abuse, or schizophrenia. It is also estimated that up to 50% of patients with psychiatric emergencies have a coexisting medical disease. Thus, medical screening is important in identifying physical conditions that may be the cause of, or contributing factors to, the psychiatric emergency.[1]

Northwestern McGaw Family Medicine Residency Program, Erie Family Heath Center, 2750 West North Avenue, Chicago, IL 60647, USA
* Corresponding author.
E-mail address: swheat@eriefamilyhealth.org

Prim Care Clin Office Pract 43 (2016) 341–354
http://dx.doi.org/10.1016/j.pop.2016.01.009 **primarycare.theclinics.com**
0095-4543/16/$ – see front matter

Psychiatric emergencies are frequent in hospital and outpatient settings. The reported percentage of emergency department visits that are psychiatric emergencies varies from 6% to 25%.[1,2] Additionally, 10% of primary care visits are for psychiatric emergencies.[2] More importantly, medical providers are the front line in assessing patients who are at risk for suicide. However, primary care providers have not adequately detected the level of risk of patients with suicidal thoughts and behaviors.[3] Although suicidal ideation is present in 2% to 7% of all primary care patients, primary care providers have low rates of inquiry, detection, and intervention.[4–8] It is estimated that 50% of patients who committed suicide had been seen by their primary care physician within 1 month of their death,[1,4] and 20% of adults who die by suicide visited their primary care physician within 24 hours of their death.[9] Consequently, medical providers, including nursing and support staff, need to be trained in the assessment, treatment, and management of these patients.

SCREENING/DIAGNOSIS: PSYCHIATRIC AND MEDICAL ASSESSMENTS

The most important first step in the management of a psychiatric emergency is the initial evaluation. An evaluation should take place in a quiet, private room where the safety of the patient, provider, staff, and other individuals can be maintained. Whenever there is a patient who is extremely agitated, aggressive, or suicidal, the health care team needs to be aware and alert. Patients who need a crisis intervention in a psychiatric emergency typically fall into three main categories: (1) acute psychosis and mania, (2) suicidal and depressed patients, and (3) aggressive and homicidal patients. For each type of psychiatric crisis, the screening and management process may differ and require specific types of interventions.

Acute Psychosis and Mania

Patients with acute psychosis and manic behaviors present with eccentric and exaggerated behaviors; unusual, disorganized, and paranoid thinking; and intense or inappropriate emotional expressions. It is particularly important in the initial evaluation of patients with mania and acute psychosis to screen for organic diseases that may be causing these symptoms. These medical conditions may include delirium, infections, metabolic/endocrine disorders, medications, substance abuse/withdrawal, and central nervous system disorders (**Table 1**).[1] This step is crucial to ensure correct diagnosis and to exclude toxic substances or a medical disorder as the cause.[10,11]

Assessing the past medical history of the patient may assist in the detection of a physical condition versus a purely psychiatric disorder (**Boxes 1** and **2**).[1] If the mania or psychosis is caused by a medical condition, the treatment is different. For example, delirium is an acute state of confusion or disturbance of consciousness caused by a medical illness, and this diagnosis changes the goals and medical management. The four key elements that distinguish delirium from acute psychosis include (1) time course, (2) disturbance of consciousness, (3) change of cognition, and (4) evidence of medical cause.[1]

After safety is established for patient and staff, the next step of the evaluation is to obtain a history of the incident; ask for a description of what happened during a crisis event. This information should be obtained from the patient; family; friends; or even individuals who observed the patient, such as bystanders, police, or neighbors. Providers should also review prior hospital records, if possible.[1,4,10,11] Obtaining information from family members and others involved in the life of the patient is particularly important, especially when the patient is cognitively impaired, agitated, paranoid, or having difficulty contributing to the history for other reasons.[4]