THE GROWING TREND OF PSYCHIATRIC EMERGENCIES IN THE MODERN WORLD

Comment [A1]: Greetings
With respect, these comments are suggested.
In the title of the article, the first letter of the words should be written in capital letters and the rest should be written in small letters.
The Growing Trend…

ABSTRACT

Psychiatric emergencies represent critical situations wherein individuals face acute mental health crises that necessitate immediate intervention to ensure their safety and well-being. These emergencies can occur and develop in various forms, and the most popular variants include suicidal ideation, severe psychotic episodes, overwhelming anxiety, or acute intoxication. The growing prevalence of psychiatric emergencies in the modern world raises concerns about the complex interplay of societal, environmental, and individual factors contributing to mental health crises. One important aspect of psychiatric emergencies is the heightened vulnerability of individuals in the face of contemporary stressors. Economic uncertainties, political instability, and rapid societal changes can exacerbate pre-existing mental health conditions or trigger acute episodes. Similarly, the influence of technology and social media introduces novel challenges, affecting interpersonal relationships, self-perception, and the amplification of mental health stressors. Environmental factors, including climate change and urbanization, add another layer of complexity to the landscape of psychiatric emergencies. Disruptions to the environment can influence mental health, and the consequences may be more pronounced in vulnerable populations. Moreover, access to mental health resources remains uneven, contributing to disparities in the prevalence of emergencies among different demographic groups. This study aims to elucidate the multifaceted factors influencing this growing trend, exploring the implications for individuals, communities, and healthcare systems. In addressing the implications of this trend, this review aims to inform strategies for early intervention, prevention, and the improvement of mental health services. It emphasizes the importance of community-based

Comment [A2]: Psychiatric emergencies are different in countries with different environmental social conditions and in time periods.
In what region was this research done under what environmental conditions and in what time frame?

initiatives, destigmatization efforts, and the integration of mental health awareness into public health campaigns.

Keywords: psychiatric emergencies, psychiatry, anxiety disorder, depression, suicidal ideation, emergency

INTRODUCTION

Psychiatric emergencies are defined as 'abrupt disruptions in thought, behavior, mood, or social interactions demanding immediate intervention'. The urgency is determined by the patient, their family, or their social unit, all with the shared goal of preventing imminent harm to the patient or others.(1)

Addressing these critical situations requires a rapid yet thorough assessment. However, in several settings, the availability of specialized mental healthcare workers, such as psychiatrists, is not always guaranteed. As a result, the responsibility often falls on hospital physicians, general practitioners (GPs), or other health professionals, including paramedics, to conduct the initial evaluation and make decisions about the necessary course of action.(2)

In certain instances, an individual consultation by a trained professional or the initiation of psychiatric treatment within the community may prove to be sufficient for the patient and subsequently, their attendants.(3) However, some situations demand more intensive treatment, leading to immediate referrals to inpatient services. Ideally, this transition occurs voluntarily, with patients actively participating in their care. Nevertheless, in cases where less intrusive options are unavailable, involuntary admissions (IAs) become necessary. These involuntary admissions are implemented when psychiatric treatment is deemed essential, typically due to the potential harm posed by the patient's psychiatric condition, even when the patient refuses such intervention.(4)

Comment [A3]: In the abstract, it is necessary to describe the purpose, techniques and methods used, main findings and important conclusions.
What was your research method? yourfindings…

Comment [A4]: .

Comment [A5]: The period is after the parentheses.
action (2).

Comment [A6]: The purpose of your research is to investigate the growing trend of psychiatric emergencies.
It is suggested to highlight the prevalence and growth of psychiatric emergencies.

Comment [A7]: Throughout the article, the methods of treatment and intervention in psychiatric emergencies are highlighted.
The growing trend is highlighted and emphasized with figures.

In usual psychiatry practices, community-based treatment is generally preferred over hospitalization. However, in the context of psychiatric emergencies (PE) within the community, the physicians in charge often find themselves working alone, faced with the responsibility of even managing and evaluating urgent and serious situations that demand quick assessments and resolution. In such scenarios, these physicians encounter internal and external pressures, compounded by time constraints.(5)

Physicians operating in the community may experience external pressures from various sources, including third parties such as relatives or law enforcement, urging them to pursue involuntary admissions (IA). (6)The patient's immediate environment might contribute to the preference for IA due to feelings of desperation, doubts about their ability to care for the patient, and associated burdens. However, the extent to which involving the patient's relatives in the decision-making process facilitates or hinders IA remains unclear.(7)(8)

Although situational factors such as police involvement during the decision-making process have been recognized as important, they have received limited systematic study. Furthermore, scant information exists regarding the characteristics and determinants of the clinical decision-making processes during psychiatric emergencies in the community setting. This gap highlights the need for further exploration and understanding in this complex area of psychiatric practice.(9)

DEALING WITH SOME OF THE MAJOR PSYCHIATRIC EMERGENCIES IN THE MODERN DAY PRACTICE

As emphasized previously, ensuring a quick and smooth access to screening and efficient referral mechanisms for the population is imperative during and following a disaster.

Subsequent to these initial steps, individuals should receive targeted care, particularly addressing pre-existing mental disorders and circumstances that amplify vulnerability to stress. (10)

Comment [A8]: Referencing with numbers should be corrected in this way.
(7, 8)

Comment [A9]: After the introduction, it is suggested to explain the statistical population in a paragraph of the research method.
What kind of research is a review?
Searched from which databases and in what time frame?
Research entry and exit criteria?

Comment [A10]: Edit based on the first comment.

Comment [A11]: Here, it was necessary to explain the types of psychiatric emergencies based on their prevalence and importance.

This is particularly crucial for those individuals who demonstrate abnormal responses to the challenges posed by that particular emergency.

Some of the major types of psychiatric emergencies have been described as follows:

Psychosis:

During an emergency situation, individuals with psychotic disorders often become overlooked, presenting a unique set of challenges. (11)

These disorders compromise critical thinking abilities, hindering adherence to disaster measures. Moreover, individuals with psychotic disorders are particularly susceptible to stigma and neglect. Prioritizing their treatment is essential, with a focus on guidance and the use of antipsychotics. Emergency cases demand special attention, especially those involving the refractoriness of psychotic symptoms accompanied by agitation or aggression, suicidal behavior, severe physical damage, or a risk to others.(12)

Patients with schizophrenia exhibit behavior that requires particular consideration, as this mental illness is correlated with a heightened prevalence of comorbid conditions such as type II diabetes, chronic pulmonary disease, and hypertension/coronary heart disease.(13)

Withdrawal Syndrome:

Patients face heightened vulnerability to substance withdrawal syndrome when discontinuing substances and medications. An all-encompassing care protocol should include provisions for basic life support and specialized services catering to the management of withdrawal symptoms. Following the resolution of patient withdrawal, a personalized therapeutic strategy for addressing addiction should be implemented.(14)

Individuals undergoing isolation or hospitalization, whether due to physical or mental illness and concurrent cigarette use, necessitate assistance for nicotine abstinence. Health services should be

adequately equipped to provide support for nicotine abstinence, employing methods such as nicotine replacement patches.(15)

In instances of "Severe Dependence Emergencies," where substance use directly endangers the patient's life, scenarios such as severe physical impairment, malnutrition, kidney and liver failure, psychotic symptoms, and suicidal behavior may necessitate immediate hospitalization. The healthcare system must be well-prepared to furnish comprehensive support to individuals facing these critical situations.(16)

"Substance-Induced Disorders" are emergencies in their own right, representing severe complications stemming from substance abuse. The treatment approach for these disorders should prioritize discontinuation of the substance and address specific symptoms. An active and targeted approach is crucial for effectively managing substance-induced mental disorders.(17)

Suicidal Ideation:

There are several studies that have highlighted elevated suicide rates, even among medical professionals. This unique population demands dedicated support and prevention services.

Addressing suicidal behavior, including ideation or attempts, requires a therapeutic approach that involves the assessment of risk and protective factors, leading to intervention measures, commonly referred to as a safety plan. (18)

Cases with a high risk of suicide demand a strict observation, requiring individuals to stay in the emergency department, undergo hospitalization, or receive home care, with the latter option contingent on a robust community support network. This includes constant monitoring by a family member or designated person, swift access to mental health care for complications, and the patient's acceptance of the caregiver.(19)

While brief psychometric tools can be part of the assessment for suicide risk, they should not serve as the sole source of information due to their moderate predictive value. Clinicians are advised to conduct a comprehensive assessment that goes beyond psychometry. (20)(21)

In emergency service centers, patients at risk of suicide should initially receive general health care. Acknowledging that many suicide attempts are linked to severe trauma or intoxication, it is imperative not to neglect these emergencies when evaluating psychiatric emergencies, emphasizing the need for a holistic assessment.(22)

THE IMPACT OF THERAPEUTIC INTERVENTIONS AND THE ATTITUDE OF HEALTHCARE PROFESSIONALS

Comment [A12]: Edit based on the first comment.

The journey of mental health treatment, whether in outpatient settings, hospital wards, or intensive care, can evoke fear, distorted beliefs, and even negative memories from previous encounters for many patients.

Despite maintaining regular medication routines, a significant percentage (25–50%) may not perceive beneficial changes and may view treatment as coercive, ultimately leading to medication discontinuation in a substantial portion of patients (40–70%).(27)

In emergency treatment scenarios, patients may present themselves voluntarily or involuntarily. The voluntary approach entails empathy and verbal persuasion. However, when the patient's life is at risk, or poses a risk to others, involuntary admission becomes necessary, even against their will. (28)(29)(30)

The use of physical restraint, a component of emergency psychiatric treatment, exacerbates stigma for patients and significantly influences their adherence to medical treatment. This complex interplay of factors highlights the multifaceted challenges individuals face in the realm of mental health emergencies.(31)

The attitudes of healthcare professionals and the prevailing culture within the workplace play important roles in perpetuating stereotypes and hindering the quality of care.

In healthcare settings, particularly in the emergency room and psychiatric emergency units, professionals often maintain regular contact with individuals experiencing severe and chronic symptoms. Paradoxically, this continuous contact may inadvertently reinforce stereotypical beliefs rather than dispelling them. Furthermore, the nature of this connection is inherently biased, given the power imbalance between healthcare professionals and patients, potentially negating any positive impact of such contact.(32)

Nevertheless, the adverse effects of these biases appear to diminish among professionals with greater experience and age. This underscores the notion that experience acts as a mitigating factor, reducing stigma, while inexperience tends to perpetuate negative beliefs.

In the context of psychiatric emergencies, whether treated on an outpatient basis, in an infirmary, or in emergency care units, the collective experience of the healthcare team, coupled with their treatment approach, holds the potential to diminish negative and stigmatizing attitudes, thereby fostering better support for the patients they serve. (33)

Efforts should focus on reducing stigma surrounding mental health issues, enhancing mental health literacy, and promoting community-based support systems. The integration of mental health awareness into public health initiatives and the expansion of mental health services can contribute to early intervention and prevention.

Additionally, recognizing the unique challenges posed by psychiatric emergencies and tailoring interventions to diverse populations is essential. This includes addressing disparities in access to

mental health care, considering the impact of technology on mental well-being, and acknowledging the intersectionality of socioeconomic factors.

Ultimately, as we navigate the complexities of the modern world, fostering a collective commitment to mental health awareness, destigmatization, and comprehensive care will be instrumental in mitigating the impact of psychiatric emergencies and promoting the well-being of individuals and communities alike.

CONCLUSION

In summary, the escalating trend of psychiatric emergencies in the modern world underscores the critical need for comprehensive and proactive approaches to mental health care. The complex interplay of societal stressors, technological advancements, and environmental factors contributes to the rising prevalence of mental health crises. It is important that mental health professionals, policymakers, and communities collaborate to develop strategies that address the root causes of these emergencies and provide timely, accessible, and culturally sensitive interventions.

Comment [A13]: It is suggested to discuss your findings in this section and explain the causes and factors affecting the growth of psychiatric emergencies. Highlight the alignment or inconsistency of the findings of other researchers in relation to your research.

Comment [A14]: What were the limitations of your research?
What suggestions do you have for other researchers interested in this topic?
Add these parts in a paragraph.

REFERENCES

1. Wheat S, Dschida D, Talen MR. Psychiatric Emergencies. Prim Care. 2016 Jun;43(2):341–54.
2. Moetteli S, Heinrich R, Jaeger M, Amodio C, Roehmer J, Maatz A, et al. Psychiatric Emergencies in the Community: Characteristics and Outcome in Switzerland. Adm Policy Ment Health. 2021;48(6):1055–64.

3. Yalçın M, Baş A, Bilici R, Özdemir YÖ, Beştepe EE, Kurnaz S, et al. Psychiatric emergency visit trends and characteristics in a mental health epicenter in Istanbul during COVID-19 lockdown. Soc Psychiatry Psychiatr Epidemiol. 2021;56(12):2299–310.

4. da Silva AG, Baldaçara L, Cavalcante DA, Fasanella NA, Palha AP. The Impact of Mental Illness Stigma on Psychiatric Emergencies. Front Psychiatry. 2020;11:573.

5. Baldaçara L, da Silva AG, Pereira LA, Malloy-Diniz L, Tung TC. The Management of Psychiatric Emergencies in Situations of Public Calamity. Front Psychiatry. 2021 Jan 28;12:556792.

6. Morreale MK, Wake LA. Psychiatric Medications and Hypertension. Curr Hypertens Rep. 2020 Sep 7;22(11):86.

7. Widdershoven G, Berghmans R. Coercion and pressure in psychiatry: lessons from Ulysses. J Med Ethics. 2007 Oct;33(10):560–3.

8. Saya A, Brugnoli C, Piazzi G, Liberato D, Di Ciaccia G, Niolu C, et al. Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry Around the World: A Narrative Review. Front Psychiatry. 2019 Apr 29;10:271.

9. Chandrasekhar K. Involuntary Hospitalization: The Conflict Zone of Psychiatry and Law (Revisiting Section 19 of Mental Health Act 1987). Indian J Psychol Med. 2018;40(4):301–4.

10. Salleh MohdR. Life Event, Stress and Illness. Malays J Med Sci MJMS. 2008 Oct;15(4):9–18.

11. Calabrese J, Al Khalili Y. Psychosis. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 [cited 2023 Dec 13]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK546579/

12. Arciniegas DB. Psychosis. Contin Minneap Minn. 2015 Jun;21(3 Behavioral Neurology and Neuropsychiatry):715–36.

13. Miller NS. Psychiatric Comorbidity. Alcohol Health Res World. 1994;18(4):261–4.

14. Gupta M, Gokarakonda SB, Attia FN. Withdrawal Syndromes. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 [cited 2023 Dec 13]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK459239/

15. Withdrawal Management. In: Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings [Internet]. World Health Organization; 2009 [cited 2023 Dec 13]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK310652/

16. Newman RK, Stobart Gallagher MA, Gomez AE. Alcohol Withdrawal. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 [cited 2023 Dec 13]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK441882/

17. Lerner A, Klein M. Dependence, withdrawal and rebound of CNS drugs: an update and regulatory considerations for new drugs development. Brain Commun. 2019 Oct 16;1(1):fcz025.

18. Baldaçara L, Grudtner RR, da S. Leite V, Porto DM, Robis KP, Fidalgo TM, et al. Brazilian Psychiatric Association guidelines for the management of suicidal behavior. Part 2. Screening, intervention, and prevention. Braz J Psychiatry. 2020 Dec 9;43:538–49.

19. Boudreaux ED, Miller I, Goldstein AB, Sullivan AF, Allen MH, Manton AP, et al. The Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE): method and design considerations. Contemp Clin Trials. 2013 Sep;36(1):14–24.

20. Rössler W. Stress, burnout, and job dissatisfaction in mental health workers. Eur Arch Psychiatry Clin Neurosci. 2012 Nov;262 Suppl 2:S65-69.

21. Conejero I, Berrouiguet S, Ducasse D, Leboyer M, Jardon V, Olié E, et al. [Suicidal behavior in light of COVID-19 outbreak: Clinical challenges and treatment perspectives]. L'Encephale. 2020 Jun;46(3S):S66–72.

22. Betz ME, Boudreaux ED. Managing Suicidal Patients in the Emergency Department. Ann Emerg Med. 2016 Feb;67(2):276–82.

23. Garriga M, Pacchiarotti I, Kasper S, Zeller SL, Allen MH, Vázquez G, et al. Assessment and management of agitation in psychiatry: Expert consensus. World J Biol Psychiatry Off J World Fed Soc Biol Psychiatry. 2016;17(2):86–128.

24. Richmond JS, Berlin JS, Fishkind AB, Holloman GH, Zeller SL, Wilson MP, et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. West J Emerg Med. 2012 Feb;13(1):17–25.

25. Baldaçara L, Diaz AP, Leite V, Pereira LA, Dos Santos RM, Gomes Júnior V de P, et al. Brazilian guidelines for the management of psychomotor agitation. Part 2. Pharmacological approach. Rev Bras Psiquiatr Sao Paulo Braz 1999. 2019;41(4):324–35.

26. Ryff CD. Psychological Well-Being Revisited: Advances in Science and Practice. Psychother Psychosom. 2014;83(1):10–28.

27. Martínez-Hernáez Á, Pié-Balaguer A, Serrano-Miguel M, Morales-Sáez N, García-Santesmases A, Bekele D, et al. The collaborative management of antipsychotic medication and its obstacles: A qualitative study. Soc Sci Med 1982. 2020 Jan 23;247:112811.

28. Verbeke E, Vanheule S, Cauwe J, Truijens F, Froyen B. Coercion and power in psychiatry: A qualitative study with ex-patients. Soc Sci Med 1982. 2019 Feb;223:89–96.

29. Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, et al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med. 2005 Sep 22;353(12):1209–23.

30. Dardas LA, Simmons LA. The stigma of mental illness in Arab families: a concept analysis. J Psychiatr Ment Health Nurs. 2015 Nov;22(9):668–79.

31. Ye J, Wang C, Xiao A, Xia Z, Yu L, Lin J, et al. Physical restraint in mental health nursing: A concept analysis. Int J Nurs Sci. 2019 Apr 20;6(3):343–8.

32. Knaak S, Mantler E, Szeto A. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthc Manage Forum. 2017 Mar;30(2):111–6.

33. Subu MA, Wati DF, Netrida N, Priscilla V, Dias JM, Abraham MS, et al. Types of stigma experienced by patients with mental illness and mental health nurses in Indonesia: a qualitative content analysis. Int J Ment Health Syst. 2021 Oct 18;15:77.

Comment [A15]: The names of the months should be removed in all references.