PSYCHIATRIC EMERGENCIES

(1) SUICIDE AND PARASUICIDE

Try to distinguish:

(a) Active suicidal intent vs release of pent-up emotions or escape from an impossible position.

(b) Presence or absence of psychiatric illness.

NB Those who have taken ODs require full medical evaluation and observation (24 hours) before being psychiatrically assessed.

ASSESSMENT OF SUICIDAL RISK

(a) Direct statement of intent.
(b) Planned or pre-meditated vs impulsive.
(c) Precautions against discovery.
(d) Note or other act anticipating death.
(e) Patient's attitude on recovery.
(f) Presence of psychiatric illness if depressed - ask about hopelessness.

OTHER FACTORS

Suicide	DSH
Older age group	Younger age group
Males predominate	Females predominate
Serious attempt	
Bizarre methods	
Social isolation	Often commit act in company
Chronic physical illness	

Q.1 Do all attempted suicides/DSH need to see a psychiatrist?

Depends on local arrangements.

Q.2 What if patient is drunk?

Assessment of mental state is very difficult when patient is drunk.

Best option is often to arrange assessment when sober (eg, in am). Often is possible to send them home especially if they live with someone.

Q.3 Remember to involve social services and voluntary agencies depending on circumstances.

AA, RELATE, CRUSE, ALCOHOLICS-ANONYMOUS

PROBLEMS WITH NEUROLEPTICS

(1) Dystonic reactions: may occur early and after a small dose of neuroleptic (occ fatal).

Treatment - IM or IV anticholinergics → rapid relief.

(2) Akathisia: motor restlessness; inability to sit still, very distressing.

Treatment - some response to anticholinergics, consider reduction in dose of neuroleptics.

(3) Malignant neuroleptic syndrome: muscle rigidity; hyperpyrexia ↑ ck.

Treatment - admit to medical ward.

G.Lynch
8 July 1992

ALCOHOL PROBLEMS

(1) Simple drunkeness is <u>not</u> a psychiatric problem.

(2) DTs is a medical problem with a definite mortality.

(3) Assessment of mental state is unreliable in drunkeness - if apparently suicidal or depressed, give him some time, a sympathetic interview and arrange for a psychiatric interview when sober.

(4) Become aware of the range of services available to alcoholics in your local area.

(5) Beware suicide in the socially isolated, older chronic alcoholic.

ACUTE ANXIETY

Patient is usually terrified that they are going to die.

<u>Treatment</u>

(1) Simple, calm explanation of the nature of anxiety - reassure that patient is not going to die, go mad, have an MI or CVA.

(2) Breathing exercises.

(3) Arrange for psychiatric evaluation.

(4) ? Drugs - perhaps a short course of benzodiazepines or neuroleptics.

ACTUAL OR POTENTIAL VIOLENCE

(1) Arrange for adequate but unobtrusive help to be readily available.

(2) Interview in a quiet place; if in a room, consider leaving the door open.

(3) Keep arms length away; do not attempt physical examination unless consent explicitly given.

(4) Speak quietly and in a firm distinct manner.

(5) Observe for behavioural cues - posture, speech, motor activity, startle response.

Think - is there any evidence of psychiatric illness? Otherwise violence is a <u>police</u> matter.

<u>Conditions associated with violence</u>

(1) Alcohol and drug intoxication
(2) DTs
(3) Delerium
(4) Acute psychoses
(5) Post ictal state.

<u>Treat the case</u>

If restraint really necessary, at least four people and use the patient's own clothing and restrain limbs.

PSYCHOGERIATRIC EMERGENCIES

(1) Confusion: requires careful medical evaluation, should not be admitted to a psychiatric unit as an emergency. This applies even to a patient who is known to have dementia and presents with increasing confusion.

(2) True dementia presenting as an emergency should be very rare and an admission to a scarce dementia bed may not be the best policy. Involve the on-call social worker to arrange placement, eg emergency R.A.

(3) All elderly people presenting with psychiatric/hysterical symptoms should be carefully evaluated to exclude organic cause.

(4) Beware suicide/DSH in the elderly - evaluate carefully for psychiatric illness.

ACUTELY PSYCHOTIC PATIENTS

Points to remember:

(1) Delusions and hallucinations are not pathogenomic of functional illness - think of organic mental illness, drug intoxication, alcohol withdrawal.

(2) Although they may appear to lack contact with reality, they may be aware of what is happening, lack of respect or empathy may worsen the situation.

(3) In functional illnesses, differentiation between schizophrenic and affective psychoses has important implications for treatment and prognosis. Interview may be very important in establishing diagnosis. Record verbatim examples of speech.

Alleviate tensions and distress by a constant attendance and a calm unhurried manner.

Interview and attempt to establish a diagnosis before using drugs.

If sedation is really necessary, give parenterally for speed of action.

IM haloperidol
IM lorazepam.

THE MENTAL HEALTH ORDER (1986)

Grounds for compulsory admission

(1) The patient suffers from a mental disorder of a nature or degree which warrants his detention in hospital for assessment.

and

(2) Failure to detain would create a substantial likelihood of serious physical harm to self or others.

Mental illness - a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he requires care or medical treatment in his own interests, or those of other people.

NB No person can be detained by reason only of personality disorder, immoral conduct, promiscuity, sexual deviancy or dependency on alcohol or other drugs.

Medical recommendation is generally by the GP (Form 3). Application for admission for assessment is based on the medical recommendation and made either by an approved SW (Form 2) or the nearest relative (Form 1).

Temporary holding power is available to a MO for a patient already admitted to hospital (Form 5).