

Psychiatric emergencies, a primary care perspective

Psychiatric emergencies can be stressful and dangerous. Advice and pitfalls of sedation are discussed, as well as when to refer or certify.



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According to the World Health Organisation (WHO), five of the top ten most disabling medical conditions are psychiatric in nature. Unipolar depression is fourth on the list (37%), then alcohol dependence (11%), bipolar mood disorder (10%), schizophrenia (9%) and obsessive compulsive disorder (7%). The WHO predicts that psychiatric disorders will increase and that it will be the leading cause of disease (and disability) by 2020. In South Africa, AIDS and violence would be at the top of the list of causes of mortality. Other recent big surveys suggest that seven of the top ten most disabling conditions in the West are possibly psychiatric in origin. And, more importantly, all of these disorders can, at origin or during the course of the illness, present as a psychiatric emergency.

Any emergency needs to be adequately assessed and a specific psychiatric diagnosis needs to be made.

CASE HISTORY

John was a 99-year-old retired company chairman. He suffered from vascular dementia, but had lived independently with his elderly wife who looked after him. John's wife died and following this he decompensated badly and was found to be paranoid, aggressive and assaultive. He stopped eating and drinking and his general practitioner could not contain him in a

home setting. John was admitted to a State hospital from where he was later transferred to a private psychiatric hospital. He remained unco-operative and eventually had to be forcefully sedated. The attending psychiatrist was concerned that if John were certified and ended up in a State hospital, he would be at risk of being attacked by other patients.

DIAGNOSIS

The above clinical case would be an example of a psychiatric emergency. Any emergency needs to be adequately assessed and a specific psychiatric diagnosis needs to be made. We have moved quite a long way from calling people mad or neurotic. We now use the *Diagnostic and Statistical Manual IV* of the American Psychiatric Association. We diagnose along five axes, and in the above case the diagnosis would be something along these lines:

- Axis I: psychiatric diagnosis
John: depression, dementia, delirium or psychosis
- Axis II: personality disorders, e.g. anti-social personality disorder (psychopath), borderline personality disorder, etc.; developmental disorders (including mental retardation)
John: obsessive compulsive personality disorder
- Axis III: medical conditions
John: stroke, chronic obstructive airway disease and atrial fibrillation
- Axis IV: severity of psychosocial stressors
John: death of his spouse (rates extreme)
- Axis V: global assessment of functioning
John: his function was poor, but when

Table 1. Working classification of psychiatric emergencies

Dramatic emergencies	Not so dramatic emergencies
Suicidal patient Psychotic disorders Major depressive disorder Alcohol withdrawal Bipolar mood disorder Substance use disorders Borderline personality disorder Homicidal patient Assaultive/aggressive patient	Other depressive disorders Alcohol dependence Panic attacks Delirium Caregiver burn-out

his wife died, he decompensated totally and needed full-time nursing and medical care (rates 30 — inability to function in most areas).

CAUSES OF PSYCHIATRIC EMERGENCIES

As is the case in other areas of primary care, one should approach and treat psychiatric emergencies bio-psycho-socially, with a preventative angle (BPSP approach). Table I shows a personal working classification of psychiatric emergencies, e.g. dramatic and not so dramatic.

DRAMATIC PSYCHIATRIC EMERGENCIES

Suicidal patient

One might meet a patient who presents with a suicide attempt at home, bleeding or heavily sedated from an overdose, at your rooms, or in the emergency room where the patient was taken for resuscitation. A suicide threat should be treated with caution and respect, since 5% of suicide threats end in a real attempt. Suicide occurs across all ages and populations, with some peaks in adolescence and old age. In some countries two-thirds of all suicide attempts are made by females, whereas the ratio is probably reversed for completed suicides.

Triggers for attempting suicide differ for different ages. In teenagers

the trigger is often relationships or the lack thereof, problems at school or parental expectations. In middle-age the concerns are divorce and separation. The elderly are more likely to give financial or health-related reasons for their attempts. Most completed suiciders had some contact with a health professional in the preceding 1 - 2 weeks.

Some individuals are at high risk for suicide. Elderly white males have a high risk, which increases if alcoholism, unemployment, or major physical illnesses with pain or disability are factors. Note should be taken of individuals who have previously attempted suicide, who have a family history of suicide, who have had recent losses or marked psychosocial stressors, and who are isolated, alienated with poor psychosocial support. Similarly, one should be concerned about patients with depression and associated memory impairment, marked insomnia, self-neglect, and hopelessness. Substance abusers with a poor work record, poor physical health, previous suicide attempts, or lack of support systems should alert the GP. Young schizophrenic males in remission who were previously high achievers, are particularly vulnerable.

Nearly all people who commit suicide had a diagnosable mental illness at the time of their death — depression (50%), alcoholism

(30%). The rest have diagnoses among schizophrenia, the anxiety disorders and drug dependence. The majority of postmortems after suicide confirmed alcohol or other drugs in the blood. When assessing or enquiring about potential suicidality, a conservative and gentle approach should be taken. There are a few questions that one can ask that make it easier to get the cooperation of the patient, and to get a true reflection of possible suicidal intent. Ask the patient whether there is something that he is looking forward to in life. If his answer is 'no', ask him whether life is worth living. If his answer is again negative, one can ask if he is having thoughts of suicidal death. One would then proceed to ask whether he has active thoughts of suicide, and if so, what methods does he consider. If the answers to the last questions were all positive, one is dealing with a patient who has a high suicide risk, bearing in mind the above high-risk categories. High-risk patients should be assessed by a mental health professional, and if in doubt it may be wise to admit, counsel and observe them, even if this requires an involuntary admission.

Psychosis

The classic diagnostic features of psychosis would be delusions, hallucinations and behavioural disturbances, and it would be quite obvious to the family members and the support system. One per cent of the population suffers from schizophrenia. However, there are also other conditions where the patient would present with psychosis, e.g. manic psychosis, organic causes, substance use disorders and delirium. An actively psychotic patient needs acute management. By assessing the patient and obtaining collateral from the family you should be able to make a provisional diagnosis. Most of these patients need referral to a psychiatrist. If,

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however, they are unwilling, they could be certified. This can either be done by a family member getting a reception order from the local magistrate's court, or one can do an emergency certification under section 12 of the current Mental Health Act.

Sedation is necessary for a psychotic emergency. Currently there is no ideal medication to sedate patients, but intramuscular or sublingual lorazepam, up to 4 mg, usually sedates the patient sufficiently to be assessed. Many doctors still only have access to diazepam, which can be used intravenously, since the oral route may take too long and the intramuscular route is unreliable. The addition of antipsychotics to the benzodiazepines is often necessary. Generally available drugs are haloperidol, chlorpromazine and thioridazine (caution because of cardiac irregularities). Intravenous etomidate, although very popular, should also be used with care, since it can cause hypotension, cardiac arrhythmia and aggravates epilepsy. Probably the ideal drugs would be the second-generation antipsychotics (olanzapine, risperidone, etc.), once they are available in injectable form. At the moment the best and most practical drug for this situation would be a combination of intramuscular lorazepam and haloperidol.

Major depressive disorder

Major depressive disorder (MDD) is currently the most disabling condition in the First World, and the fourth most disabling condition in the world. Ten per cent of untreated patients commit suicide. The diagnosis of MDD is usually quite simple. One should ask direct questions about the patient's mood — are you feeling depressed, unhappy, down in the dumps or tearful? Ask about neurovegetative symptoms such as changes in sleep pattern, appetite, weight, concentration, libido, and motivation.

If patients arrive in an emergency setting, it is usually because the symptoms are getting worse (becoming stuporose or psychotic), or the patient is not responding to the current treatment or is having side-effects to current treatment, or is becoming suicidal or aggressive. All of the above would necessitate a decision about admitting the patient for further evaluation, review of diagnosis and medication, and planning of longer-term strategies.

Depression in the postpartum period is often misdiagnosed and needs an article on its own. However it is important to remember that electroconvulsive therapy is often the treatment method of choice in this condition.

Alcohol

Alcohol intoxication

The symptoms of alcohol intoxication are the smell of alcohol, a flushed face, disinhibition, tachycardia, emotional lability and ataxia. This situation is not easy to handle, and the best advice is not to get involved in the crisis, but to let the family members handle it. Situations that need to be managed carefully are those where individuals become destructive to themselves or to others. These patients are managed as one would manage a violent and aggressive patient, with attempts at calming and settling procedures.

If one has to intervene, intramuscular lorazepam can be given, provided the patient can be monitored. An effort should be made to decrease external stimulation and to provide orientation and reality testing.

Alcohol withdrawal

Alcohol withdrawal is one of the commonest emergencies and should be treated by a primary care physician. A small percentage of people still die because they are not

properly assessed and managed, and so this condition should be treated with respect.

Classically, the patient would be an alcoholic who has abruptly stopped drinking and then presents 24 - 72 hours later with symptoms of gastrointestinal distress, anxiety, irritability, autonomic instability (tachycardia, hypertension, sweating), and tremor. If the symptoms are severe (delirium tremens) there is clouding of consciousness, difficulty in sustaining attention, disorientation, the possibility of grand mal seizures, hallucinations, behavioural disturbance, and fever. The hallucinations are mainly visual in nature and it is not uncommon for patients to experience 'little pink elephants'.

This emergency should once again be treated via the BPS approach.

Consider whether it is necessary to admit the patient or to get the family involved. Refer the patient to a psychologist, psychiatrist or a rehabilitation centre.

Biological treatment

Patients who are in a mild to moderate withdrawal can be treated at home with oral diazepam, 20 - 40 mg daily for a few days and tapered over 3 - 5 days. Patients need to be both well fed and well hydrated, and thiamine should be administered before glucose is given. This would to some extent prevent Wernicke's encephalopathy. The patient's nutrition should be evaluated and multivitamins and vitamin

B can be added to this treatment.

Severe withdrawal (delirium tremens) occurs in about 5% of cases. This should be managed in a hospital. The same treatment principles as outlined above should be followed. The pharmacotherapy is directed toward reducing CNS irritability and restoring physiological homeostasis. This often requires use of fluids, continued use of diazepam, and, in selected cases, the use of antipsychotics (haloperidol, etc.).

Psychological treatment

Patients and their families should be educated and motivated to become involved in the treatment process — which in most instances is lifelong. A good relationship with the patient and an optimistic attitude about the benefits of abstinence can motivate patients to be either treated as outpatients with the help of Alcoholics Anonymous, or in a formal treatment centre. One tends to have a ‘heart sink’ feeling when confronted with an alcoholic. However, it is often one’s motivation, together with the intervention of family members, which can help a patient to make the final decision to stop drinking.

Social treatment

Consider whether it is necessary to admit the patient or to get the family involved. Refer the patient to a psychologist, psychiatrist or a rehabilitation centre. Alcoholics Anonymous should certainly be included in the management. Their Twelve Steps Programme is accepted world-wide, and is a very powerful tool since it works with group support and group pressure.

Bipolar mood disorder

One per cent of the population suffers from bipolar mood disorder (BPMD), a condition which as a psychiatric emergency would usually present with mania or severe depression. The symptoms of

mania are classically elevated mood, expansiveness, grandiose or religious ideation or delusions, psychomotor hyperactivity, lots of energy, insomnia and talking and moving incessantly. Patients might present with a very contagious sense of humour and be found to be difficult to contain verbally or socially. Manic patients should be referred to a psychiatrist, and they need admission to a psychiatric unit, either voluntarily or involuntarily. The longer mania remains, the poorer the prognosis — a manic attack is neurotoxic in its own right. Patients can be sedated with lorazepam and haloperidol.

Substance use disorders (cocaine, opiates, cannabis)

Substance intoxication often presents with bizarre symptoms, but can present with any psychiatric symptom or syndrome like psychosis, depression or mania. The clue is usually an atypical picture, with a history of substance abuse and autonomic instability, and possible pupil dilatation. It is confirmed on obtaining collateral information and a drug screen. The BPSP approach should once again be followed. Sedation and settling with benzodiazepines and/or antipsychotics is usually a first priority and thereafter one should consider referring patients and their families to a specialised treatment unit and/or to Narcotics Anonymous. Substance abuse is on the increase, and substance abuse problems deserve a totally separate article.

Borderline personality disorder

Borderline personality disorder (BPD) is more commonly seen in acute clinical situations than most other personality disorders, and can be a very common crisis in general practice. It presents with instability of affect, relationships and impulses. Patients with BPD are frequently in a crisis following some personal or interpersonal difficulty

and they respond in a threatening, tearful, intoxicated and angry manner. The management would be via the BPSP approach as well as referral to a mental health facility. Patients with this disorder can easily exhaust a primary care physician with their never-ending demands and emotional instability. When confronted with a crisis, sedate with lorazepam but be cautious, since it sometimes can paradoxically disinhibit the patient and cause further chaos. It is not recommended that a primary care physician take on the long-term management of these patients.

Manic patients should be referred to a psychiatrist, and they need admission to a psychiatric unit, either voluntarily or involuntarily.

The homicidal patient

The homicidal patient usually has a background of socio-economic stressors, depression, psychosis or substance use disorder. A calculating murderer would rarely come to your attention in general practice, but if there is a homicidal patient in a family situation, one should be aware of it. In South Africa, family murders are especially common, and if a high-risk, depressed, isolated male threatens to kill himself and his family (particularly if under the influence of alcohol), one should take it seriously.

The assaultive and aggressive patient

Assaultive and aggressive patients have more or less the same profile as homicidal patients, and one would follow the BPSP approach in

the management of both the homicidal and assaultive/aggressive patient.

In both these cases it is important to get support from security services and/or from the police. If a patient becomes threatening or if you feel threatened or scared, you should listen to your intuition because you are probably reacting to appropriate non-verbal clues. To subdue the patient, try to get at least four security people. Allocate one person to each of the patient's limbs, hold these limbs tightly and then give lorazepam and haloperidol intramuscularly. Hold the limbs until the patient is quite sedated. Often the mere presence of police or security personnel will help the patient to be compliant and to calm down. At this point, it is important to decide whether the patient needs to go into the care of the police (not all violent people have a psychiatric disorder), or a hospital. If the patient is going a hospital, make sure it has secure facilities and advise the admitting doctor of the patient's potential violence, so that adequate sedation can be maintained.

NOT SO DRAMATIC PSYCHIATRIC EMERGENCIES

Depression

Depression is commonly missed, and less than 50% of depressed people are treated. Even fewer see a psychiatrist. Among the categories of people suffering from depression who are commonly missed would be the elderly or middle-aged, stressed male who is abusing substances. Depression during pregnancy is a very serious condition that is often undiagnosed and not addressed because of the myth that antidepressants are dangerous for the mother or the fetus. Recent research concludes that high anxiety levels and a depressed mood in

the pregnant mother can, through catecholamine elevation, cause distinct biological changes in the neonatal brain, making the child more vulnerable for depression in the future. Ten per cent of women suffering from postnatal depression commit suicide (see article by Van der Westhuizen, p.162 this issue).

Adolescents are inclined to somatise their distress, abuse substances, have behavioural problems at school and commonly experience a decline in academic performance, when they are depressed.

How to diagnose

One should be looking for the physiological symptoms of depression as well as the impaired function in the adolescent in the areas of sport, scholastic achievement and social function. In adolescence, suicide is the second to third highest cause of death and the long-term prognosis of an untreated or undertreated adolescent is poor. Adolescents probably need to be managed by mental health professionals.

Most mild to moderate depressions can be adequately treated by the family physician, who has known the person over the long-term.

When to refer

Most mild to moderate depressions can be adequately treated by the family physician, who has known the person over the long term, and who can provide a biopsychosocial approach. Patients can be treated by supportive counselling and medication by the GP, or psychotherapy

by a psychologist and medication by the GP. However, if there is anything atypical in the presentation, if there is suicide risk, if the patient does not respond to treatment or is particularly difficult (e.g. an adolescent), a psychiatric referral is necessary.

Alcohol dependence

Alcohol dependence can be managed via the BPSP approach. The initial diagnosis and timely referral by the family physician can alter the lives of many people. Statistics show that on average eight people are affected by the substance problems of one alcohol-dependent person.

Panic attacks

Patients experiencing a panic attack present with brief episodes of dyspnoea, palpitations, chest pain, dizziness, sweating, headaches and stomach aches, and feelings that they are going to faint, die or have a heart attack. They often present as an emergency to the emergency room or general practitioner's rooms because of their fears and associated physical symptoms. Comorbid disorders such as depression, substance misuse and social phobia are often present.

The immediate treatment would be to provide rapidly acting benzodiazepines to reduce the anxiety. They would only be used in the longer term management of panic disorder, for a brief interval, while introducing the main therapy, which is an antidepressant.

Patients are usually started on an SSRI, or any other antidepressant (the majority of them are effective anti-panic agents), together with an anxiety management package which includes cognitive behavioural therapy (CBT). Good results can be obtained with the proper long-term intervention sustained over a period of 6 months. By treating panic

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attacks with long-term benzodiazepines only, one could end up with multiple psychopathology and a very difficult, if not impossible, patient to handle.

Delirium

Delirium is usually defined as a disturbance of consciousness with reduced ability to focus, sustain or shift attention. There are changes in cognition-memory, disorientation, and language disturbance.

Perceptual and thought processes can be disturbed. This disorder usually develops over a short period of time and tends to fluctuate over the course of the day.

The commonest causes of delirium in South Africa are alcohol withdrawal, drug or medication use or withdrawal, secondary to epilepsy, secondary to infection (UTI and lung), hypoxia and head injuries (particularly in the elderly and alcoholic). There is a certain morbidity and mortality associated with this disorder. It is a medical emergency and the patient should be admitted to a hospital and fully investigated for physical causes.

Caregiver burn-out

People caring for patients suffering from dementia or a terminal illness often present with symptoms of lassitude, apathy, irritability and anxiety. This can be presented acutely in a situation where the individual

indicates they can no longer cope. Burn-out is described as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that occurs in individuals who do 'people work'. Many psychiatrists believe that burn-out may be a depressive equivalent. Give practical support and antidepressants. Validate the trauma and stress the caregiver has been enduring, and give permission for time-out.

CONCLUSION

Psychiatric emergencies are very common and present in different ways. They can be both stressful and dangerous for the doctor, the patient and the family. Four South African psychiatrists have been murdered by their patients in recent years. When dealing with an emergency keep the diagnosis and management simple. Stick to the principles of the BPSP approach. Use medications that you are familiar with, and that are effective. Be cautious with intravenous etomine because of the risk of seizures, arrhythmia and hypotension. Similarly, be aware of paradoxical disinhibition of certain patients on benzodiazepines. Avoid using intramuscular diazepam. Lorazepam is tried and trusted, and usually works well. If the benzodiazepines are not sufficient consider haloperidol. Risperidone solution

is an option for the paranoid delirious patient.

References available from author.

IN A NUTSHELL

Work in a team, and do not try to do it all on your own. Collaborate with the patient, family members, colleagues, nurses, security officers and the police.

Many psychiatric emergencies need either a medical or a psychiatric referral.

Psychiatric disorders cause four of the ten most disabling medical disorders in the world.

Psychiatric emergencies can present dramatically or not so dramatically.

A BPSP approach with an emphasis on teamwork is important.

'Dramatic' psychiatric emergencies include suicidality, psychotic episodes, major depressive disorder, alcohol and substance abuse disorders, bipolar mood disorder, homicidal or aggressive patients.

'Not so dramatic' emergencies include depressive disorders, alcohol dependence, panic attacks, delirium and caregiver burnout.

Each of the abovementioned emergencies require correct and comprehensive assessment, adequate diagnosis and appropriate management.

It may be necessary to commit the patient, involuntarily.

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