Psychiatric emergencies

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UNTIL recent times, the suspicion and fear of mental illness shown by the community has resulted in a tendency to reject and isolate psychiatric patients. It is probably as a consequence of this that many mental hospitals have been sited away from centres of population and this has contributed to the unreasonable division which has developed between psychological medicine and general medicine, a segregation only now slowly being overcome. But still psychiatry has insufficiently been accepted into the general hospital and, therefore, Casualty Departments, where the need can be most acute, usually have considerable difficulty in obtaining psychiatric advice when it is required.

Casualty officers understandably may lack confidence in dealing with psychiatric cases, partly because of limited training in this subject and partly because of the lack of specialized support. In addition, psychiatric patients are not easy to deal with, even by those experienced in doing so. The patients are often unco-operative, aggressive or unpredictable, and they tend to arouse conflicting emotions both in relatives and in doctors and nurses. Diagnosis and prognosis are often difficult to formulate and considerable time may be needed to assemble the necessary information. Disposal problems can be complex, and all these difficulties are enhanced in a busy Casualty Department where many other patients require attention, who by contrast are usually both co-operative and responsive to the help given them.

Incidence

Psychiatric illnesses

It is unnecessary to stress the prevalence of psychiatric associations with physical illness in general, and estimations of incidence depend upon the criteria used and the sample studied. In general practice, for example, it has been shown that about 10% of patients attending their doctors were psychiatrically ill, and 1% were seriously disabled (Watts, Cawte & Kuenssberg, 1964). Bellak *et al.* (1964) reported that as many as 50% of patients attending an emergency clinic were suffering from a psychiatric condition, either directly related to

the presenting somatic complaint or independent of it. The incidence of primarily psychiatric cases in Casualty Departments has been variously reported from 1.4% to 6.6% (Errera, Wyshak & Jarecki, 1963; Blackwell & Mallett, 1964; O'Regan, 1965). Whiteley & Denison (1963) have shown that the junior casualty officer in their study saw twice as many new psychiatric patients as the psychiatric out-patient clinic of the hospital in the same period of time. The incidence of psychiatric emergencies is more difficult to assess but Bridges, Koller & Wheeler (1966) found that a psychiatrist was called to the Casualty Department of one hospital to give urgent advice for 0.09% of all new patients seen in the department. However, this was not regarded as a true incidence as it was known that in some psychiatric emergencies where the necessary management was obvious, this was often carried out without specialist help being requested; advice was usually needed more for problems in diagnosis.

The recognition of psychiatric conditions in the Casualty Department is often complicated by the frequency of physical associations. Blackwell & Mallett (1964) found that 43% of psychiatric patients diagnosed at a Casualty Department had presented with physical complaints while the remainder had psychological symptoms. Frequently psychiatric illness is suspected when no organic cause for physical complaints is found, and these cases amounted to 27% of patients attending a Casualty Department in one study, the incidence rising to 50-60% when the complaints were of lassitude or transient loss of consciousness (Mestitz, 1957). In another investigation of patients in a general hospital referred for a psychiatric opinion only because no organic cause had been found for their symptoms, one-third were found to be suffering from endogenous depression and two patients were schizophrenic (Bridges *et al.*, 1966). Thus, the presence of psychiatric illnesses may be obscured by somatic presentation and such cases are not necessarily diagnostically distinct from those with recognizable psychological symptoms. On the other hand, while many cases in whom no organic cause is

found for complaints have a psychiatric aetiology, sometimes physical disease remains undiscovered and, therefore, a psychiatric diagnosis may only be made on the basis of positive evidence of mental illness.

Diagnosis

An estimation of the prevalence of various diagnoses among cases in a psychiatric emergency clinic has been reported by Brothwood (1965) who found that 22% were suffering from psychoses, 59% had psychoneuroses and 11% personality disorders. These findings are similar to those of Whiteley & Denison (1963) in a general casualty department.

Disposal

In the studies already quoted, from 15% to 45% of psychiatric emergencies required admission, either to psychiatric care or to medical wards after suicide attempts. The largest proportion, usually about half, were referred to psychiatric out-patient departments and the remainder were discharged, referred to their general practitioners or to social services. Whiteley & Denison (1963) have stressed that a common feature among psychiatric patients seen in the Casualty Department is that their presenting symptoms often rapidly resolve after the crisis has been dealt with and a high proportion later discontinue the treatment arranged for them; they either do not keep subsequent appointments or may discharge themselves if admitted. But the need of such patients is a real one and effective emergency treatment can be of prime value to them.

Assessment

By contrast with physical illness, where symptoms and signs are primarily sought for and may be relatively clear-cut, psychiatric conditions are often more difficult to diagnose from the patient's presentation and usually require information from other sources for their clarification. Sometimes management must be decided upon only in relation to the patient's behaviour without other information being readily available. But in most cases independent information is essential for formulating decisions, and although its collection may be time-consuming, the time is well spent and may otherwise be wasted in errors of judgement or in doubt and indecision. Difficulties associated with managing an unco-operative and unaccompanied patient may be resolved by taking the trouble to contact the relatives, the general practitioner or a psychiatric hospital where the patient may be known.

Adequate assessment of the psychiatric emergency requires information about the following:

- (1) The patient's behaviour.
- (2) The patient's complaint. (His own account, allowing him to tell it as freely as possible.)
- (3) Physical examination.
- (4) History from others (e.g. relatives, G.P., psychiatric hospitals, Mental Welfare Officer).
- (5) Observation of the patient over a period of time, if necessary.

Problems and management

Anxiety and panic

An acute anxiety state consists of an intense feeling of fear together with symptoms such as palpitations, dyspnoea, tremor, sweating and restlessness. These patients are often in severe distress, their panic being enhanced by physical accompaniments such as difficulty in breathing and swallowing, so that secondary accentuation of the anxiety may ensue with fears of being overwhelmed by a serious physical illness. In these cases there will usually be evidence of earlier neurotic traits and there may be a history of proneness to anxiety under stress. The urgent treatment consists of firm, calm reassurance of the patient and also those accompanying him. Sodium amylobarbitone 200 mg or more by mouth and the company of a reassuring nurse usually settle the patient effectively. These patients may be given a small supply of barbiturates to ensure a good night's sleep and they may be assessed again later, perhaps by their own doctor. Recurrent attacks can be controlled by chlorthalidoxepoxide (Librium) 10 mg t.d.s. or diazepam (Valium) 5 mg t.d.s., and higher doses may be used if necessary.

Similar symptoms are encountered in cases of hysterical excitement, anxiety being sometimes associated with hysterical symptoms and quite often experienced by those with hysterical personalities when reacting adversely to stress. These patients will tend to be histrionic and manipulative, but the treatment is similar. Adequate sedation should be given and the patient looked after by a mature nurse in a room separated from other people who may be over-involved in the emotional turmoil.

These acute neuroses cause considerable distress but do not usually present undue difficulties in management. However, care is needed in differentiating them from other, more serious conditions. Hypomania may present with much restlessness and overactivity but there will be elation and grandiosity present with little insight into the illness. Some schizophrenics may experience anxiety associated perhaps with their perplexity, suspicions or hallucinations. Patients with early organic confusional states sometimes experience anxiety and restlessness which can mask early

symptoms of confusion and disorientation so that an organic aetiology may be missed. The anxious misery and restlessness of the agitated depressive must always be considered as these cases are likely to constitute a suicidal risk.

Aggressive and bizarre behaviour

The most serious diagnosis in patients showing these symptoms is schizophrenia. These patients often show evidence of abnormal social behaviour and occasionally they may be violent. There will be other symptoms of schizophrenia such as abnormalities of thinking, flattened or incongruous emotions, catatonic symptoms, delusions, hallucinations and loss of insight. In acute cases the diagnosis may be obvious but sometimes the symptoms are difficult to elicit and, in particular, older paranoid schizophrenics who conceal their delusions can be very difficult to recognize. They may show no abnormality unless their delusions can be revealed, and this is facilitated if the nature of the paranoid ideas is known from an informant. Acutely disturbed schizophrenics are likely to require compulsory admission for treatment but there are chronic cases whose behaviour has been strange for a long time who may not necessarily require admission although further psychiatric assessment and social care may have to be arranged.

Patients with mania and hypomania are not common but they may also present with aggressiveness and irritability. There will usually be, in addition, an infectious elation, overactivity, overconfidence and grandiose ideas. Some of these cases may be difficult to differentiate from schizophrenics and mixed states do occur. Epileptics often show aggressive behaviour, either associated with a deteriorating personality or during post-ictal states. Sometimes patients with organic confusional states present with abnormal behaviour and it is important to recognize these cases in order that the underlying physical condition is not missed. Patients with psychopathic personalities are easily provoked and may become uncontrollably aggressive; they are diagnosed by a history of impulsive antisocial behaviour and by the absence of psychotic symptoms. Psychopaths in general are regarded as being responsible in law for their actions and if over the age of 21 years they may not be compulsorily admitted on the basis of this diagnosis.

With severely disturbed patients prompt and effective sedation is needed, one of the main hazards being in its administration. Therefore physical control over the violent patient may be required and this is likely to fail unless really adequate resources are assembled before necessary force is employed, the usual recommendation

being one person per limb and one in addition. There is no doubt that inadequate control of the patient tends to increase fear, anger and struggling. On the other hand, there is the well-known description of the confident psychiatrist calling off the fighting attendants and leading the mollified patient away for a quiet consultation.

The best drug to use is a phenothiazine such as chlorpromazine 50–100 mg given intramuscularly and repeated if there is an inadequate response in about 1 hr. Thereafter it may be given 4–6-hourly. A potent injection in exceptional circumstances is a mixture of morphine sulphate 10–15 mg and hyoscine hydrobromide 0.4–0.6 mg given subcutaneously, and in a few cases, if special care is taken, sodium thiopentone intravenously might be indicated. The use of intramuscular paraldehyde has often been condemned, and rightly so, for reasons that are well known and which include the pain of injection and the possibility of abscess formation. Therefore this drug should not be used routinely but, nevertheless, it is safe and rapidly effective, so that it probably has a use sometimes when dealing with very disturbed patients, although not more than 10 ml should be given in one site.

Confusion and impaired consciousness

Patients may present with symptoms of confusion, disorientation and impaired consciousness or defective memory. In addition, they may of course be restless, violent or anxious as well. In some cases there may be evidence of personality change and deterioration in social behaviour. With this group of symptoms the principal general aetiology is likely to be organic. Any illness producing a systemic disturbance, and in particular any cerebral disease may result in a confusional state. These patients may show the acute symptoms of delirium or a subacute fluctuating state of awareness (clouding of consciousness) in which they are correctly orientated only for limited periods and at other times tend to become confused, frightened and hostile. Dementia is a chronic and usually irreversible condition. In these cases the first essential is to recognize that an organic pathology is responsible for the psychological symptoms so that appropriate physical investigations are carried out and a very wide range of conditions needs to be considered, among which may be electrolyte disturbances, infections, poisoning, states of anoxia, space-occupying lesions, head injuries and cerebro-vascular conditions. Epileptics may also present similar symptoms during post-ictal confusion.

If physical abnormalities can be confidently excluded there are some less common conditions, primarily psychiatric, which may result in altered

consciousness and stupor, but psychiatric illnesses are not associated with clouding of consciousness and dementia, which are typical of organic states. Hysteria may present as an amnesia and sometimes quasi-confusion. Patients with schizophrenia sometimes appear to be confused and both schizophrenia, endogenous depression and hysteria can be associated with stupor. In such cases the differential diagnosis between psychiatric and organic aetiology is often difficult so that observation and detailed investigation are usually needed.

Disturbed behaviour resulting from organic states requires the usual symptomatic treatment. The phenothiazines (chlorpromazine, promazine) are especially useful in these cases as barbiturates may increase the confusion and thus aggravate disturbed behaviour. In general, confusional states need medical observation and treatment, and patients should be adequately sedated so that admission to a medical ward is possible, a side-ward often being needed at first. While some of these cases may be so disturbed that admission to a psychiatric hospital would seem appropriate, these hospitals may not be able to carry out the physical investigations and treatments needed and therefore medical admission must be considered initially.

Alcohol and drugs

The effects of excessive intake of alcohol and some drugs, either acutely or chronically, is to produce a toxic confusional state so that much of the foregoing will apply, but there are also other considerations in these cases.

If the patient smells of alcohol he tends to be regarded with some hostility as merely having over-indulged, and in most cases this may be the extent of the problem. But other concealed aspects frequently co-exist in drunken people. For example, many suicidal patients take tablets together with alcohol, some patients with severe mental illnesses drink in an attempt to relieve their distress, and head injuries occurring while the patient is drunk are a well-known possibility. Hence, these patients require careful assessment and examination including investigation of the aspirated gastric contents if suicidal attempts are suspected. It is also wise to keep patients under observation for a time if there is any doubt. The raging drunk is a frequent problem and it should be realized that this behaviour results from depression of higher cortical control. Therefore, inadequate sedation and also sedation with barbiturates tends to decrease control further and enhances confusion. The best drugs for use in these cases are the phenothiazines given intramuscularly, and they are particularly effective in patients with delirium tremens. The earlier treat-

ment of giving more alcohol to such patients has been superseded by high doses of phenothiazines and vitamins. Finally, Alcoholics Anonymous, whose address appears in most telephone directories, can be helpful in assisting with some alcoholic patients.

Addiction to drugs is increasing, and the rather disorganized individuals involved are especially likely to attend Casualty Departments for help. The drugs most commonly abused by young people in probable order of frequency are amphetamines and amphetamine-barbiturate mixtures such as Drinamyl, cannabis (marihuana), heroin and cocaine, and lysergic acid diethylamide (LSD) (*Brit. med. J.*, 1967). The patient's usual complaint will be that he is suffering from withdrawal symptoms and requires more of his drug. These patients frequently have psychopathic personalities so that they are very liable to be manipulative and to exaggerate their symptoms to obtain more drugs. But it is unnecessary to give the medication asked for as withdrawal symptoms can usually be adequately controlled by phenothiazines, which provide effective emergency treatment. Subsequent psychiatric help can then be offered but this is likely to be rejected by the patient. However, severe withdrawal reactions, especially when associated with physical symptoms and signs, suggest that admission is necessary. In some cases there may be difficulties in diagnosis. For example, amphetamine addiction may produce not only excitement but paranoid states and acute conditions resembling schizophrenia, and LSD may result in florid psychotic states. Some addicts present problems as to whether an excessive dose of drugs was taken in order to increase their effect or with suicidal intent and sometimes the distinction is only theoretical. If there is serious doubt the patient needs psychiatric admission. Unless a suicidal risk is present, or there is an associated psychosis or the patient is seriously affected by drugs, it is not legally appropriate to arrange compulsory admission in order to ensure treatment for addiction.

Depression and suicide attempts

Depression is the most common psychiatric symptom and suicide is closely associated with depression (Bridges & Koller, 1966). Therefore, the emergency management of depression and of suicidal attempts is essentially the prediction of an attempt, or the possibility of further attempts, occurring. The diagnosis of depression is complicated by controversies about classification, but the precise nature of the depression is likely to be less important in emergency situations than the severity of the illness. Patients with severe depression reactive to misfortune may be as likely to

take their lives as those with typical endogenous depressions which are, however, especially dangerous in this respect even in apparently milder forms. In addition, a considerable suicidal risk is present in some schizophrenics whose tendency to unpredictability has to be taken into account. It is the view of the Ministry of Health (H.M. [61] 94) that all patients who have made suicidal attempts should be seen by a psychiatrist, and while this may be idealistic in many hospitals, great care should be exercised in discharging these cases without adequate assessment and arrangements for supervision.

The belief that people who threaten to attempt suicide do not do so is untrue, for it has been shown that the majority of patients who have attempted suicide previously communicated their intention (DeLong & Robbins, 1961). Equally it is not valid to make a clear distinction between the 'gesture' and the 'real attempt'. For as Stengel (1963) has shown, seriousness of intent is a continuum and all attempts carry some risk so that each must be considered in its individual circumstances. Furthermore, those who have made an attempt have an increased likelihood of repeating it, sometimes with greater determination (Ettlinger, 1964).

The assessment of depression involves consideration of the symptoms, the patient's social circumstances and history. Regarding the symptoms, in general the greater the unhappiness and distress, the more likely the patient is to require admission. This is especially so if suicidal thoughts are present, and *questions must be asked to elicit this*. Symptoms typical of endogenous depression must be taken very seriously and these particularly include a diurnal variation of mood with exacerbation in the morning, guilt and self-blame, pessimism about the future, early morning waking and insomnia, and retardation or agitation. This illness can be very deceptive. For example, there is the 'smiling depression' with the patient maintaining a front despite his misery, and some cases present principally with anxiety which may obscure the basic depressive symptoms and the desperation. In addition, the diurnal mood variation may result in the patient being reasonably optimistic when seen in the afternoon, only to plunge into a suicidal depression next morning after being allowed to return home. Suicidal attempts may notoriously be made as a patient is beginning to recover, in the early stages when retardation lessens but the unhappiness remains.

The history will also yield important information. A previous attack of the illness, especially one requiring admission or electro-convulsive therapy, a positive family history, especially in-

cluding a suicidal attempt, and a previous suicidal attempt by the patient will suggest that admission is imperative and even arranging it for the next day at the request of the patient may prove too late. Patients at special risk are those who are alcoholic, who have disabling physical illnesses and those who are socially isolated, especially single, divorced or widowed patients (Stengel, 1964). The highest rate of suicide attempts occurs among patients in their third decade, especially females, while that for completed suicide occurs among patients over 60 years, especially males.

When a suicidal attempt has occurred, both the method employed, events leading up to it, and the situation in which it happened must be carefully elicited in order to assess the case. Clearly, the seriousness of intent of an angry woman rushing into the next room to take aspirin tablets after an argument with her husband is less than that of the patient who travels to a remote spot in order to jump from a height. In addition, the events following an attempt may also be important and it is worth investigating whether there has been a resolution of difficulties as a result of the episode. Another aspect of suicide attempts is the likelihood of concealment. The patient and relatives are often anxious to avoid the implications of the event, and explanations of taking tablets by mistake or just to sleep or to ease pain, must be treated with suspicion. Sneddon (1965) has also described various physical conditions which may mask attempts: examples are young people with haematemesis and no history of peptic ulcer, sudden dizziness or drowsiness, accessible straight lacerations attributed to being attacked, and epileptics not recovering from their fits.

Admission

Psychiatric hospitals

It has been shown that a large proportion of psychiatric emergencies require admission. Some will need urgent medical or surgical treatment after suicide attempts when further psychiatric assessment will be carried out subsequently. Some patients require observation for only a few hours or overnight, as the situation may become clearer when acute symptoms subside, or after a visit by relatives. The remaining patients need psychiatric care and while a psychiatric ward may be available in some general hospitals, the majority of patients will have to be transferred to psychiatric hospitals although there may be difficulties with this, usually associated with their inaccessibility. Communication may not be easy, transport may be a problem and patients are often understandably reluctant to go to what is usually a rather distant hospital. In addition, most psychiatric

hospitals have a rigidly defined catchment area and will only accept patients living within it, a situation which is particularly complicated in London. Advice about catchment areas and about difficulties in getting a patient admitted can be obtained from Mental Welfare Officers (M.W.O.) who are available at any time at the offices of local authorities.

Mental Welfare Officer

The office of Duly Authorized Officer (D.A.O.) disappeared with the Mental Health Act of 1959 and was replaced by the new Mental Welfare Service which was a new service and not merely a new name, as the functions are different. The D.A.O. was primarily responsible for the legal aspects of compulsory admission, but the M.W.O., although he may also be involved with applications for compulsory admission, is primarily concerned with psychiatric care in the community in its widest aspects. Therefore, his special knowledge of local psychiatric services, of psychiatric patients, hospitals and hostels, and his practical experience of psychiatric problems in general, may be utilized by the casualty officer in cases of difficulty.

Compulsory admission

This is an unpleasant necessity in psychiatry and such an interference with personal liberty should never be undertaken lightly; it certainly must not be used merely because patients are a nuisance or are aggressive. However, it should not be avoided where a patient's life and health may be at stake.

The Mental Health Act of 1959 made considerable changes in the law regarding compulsory admission, the main one being abrogation of judicial authority with the abolition of the D.A.O. and its replacement in England and Wales solely by medical recommendations. In Scotland the approval of a Sheriff is also needed.

Compulsory admission now requires only: †

1. An application, preferably by the nearest relative, but if he is unobtainable the M.W.O. can act in his place.
2. A medical recommendation by one or two doctors.
 - (a) *Section 29.* In cases of *urgent necessity* any doctor alone may recommend admission for observation for 3 days.
 - (b) *Section 25.* Normally two doctors are needed to recommend admission which is then for up to 28 days. One of these doctors must be approved for this purpose by the local authority.

† These sections paraphrase parts of the Act and do not give the official wording.

The medical recommendations are made on the grounds: †

- (a) That the patient is suffering from mental disorder of a nature or degree which warrants detention in a hospital for at least a limited period, *and*
- (b) That he should be so detained in the interests of his health or safety or with a view to the protection of others, *and*
- (c) That informal admission is not appropriate.

The final requirement is important: if patients agree to go into a psychiatric hospital they may be transferred without any formalities, subject to the concurrence of the hospital. If the patient consents to admission he must not be placed on an order except in those unusual cases where admission is imperative but the patient's insight and co-operation cannot be relied upon.

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