Emergency in Psychiatry

Dr Maha .S.Younis
Assistant professor in psychiatry
College of Medicine-Baghdad University
What does it mean

It’s the clinical application of psychiatric knowledge in emergency settings.

It’s rendered by professionals in the field of psychiatry, nursing, medicine, psychology, and social work.

The demand for emergency psychiatric services worldwide had been rapidly increased since the 1960s, especially in urban areas.

Workers in this field are under the danger of the mental states of their patients.
Emergency in psychiatry

- Attempted suicides
- Drugs and substance abuse
- Depression
- Psychosis
- Violence or other change in behavior
- Voluntary, or through referral from other health professionals, or court cases
Factors effecting emergency psychiatric services

- After 60 de institutionalization in Europe and US
- Multiplication of temporary treatment options like increase the numbers of psychiatric medications
- Personnel working in emergency psychiatric services are drifted from the low social class who failed to compete for a better health sector so may be they share some of their characters with the patients
Measures in EPServices

Decision has to be taken rapidly either to referral and voluntary admission to a psychiatric ward may be as the same rate of involuntary admission because of the insurance policy involuntary commitment (sectioning) police, health professionals classify an individual as dangerous and behave according to the governmental law and regulations in that region

Discharge the presumed dangerous patient to the society
Types of emergency psychiatry

- Attempted suicide
- Violent behavior
- Substance abuse (intoxication and withdrawal)
- Personality disorders
- Psychosis
- Abuse
- Disaster (natural, man made)
- Hazardous drug reaction and interactions
- Extreme cases of anxiety
Violence as emergency

Assessment and management of violent patient

Most acts of violence by mentally ill patients do not lead to serious harm or homicide, can be prevented by understanding and proper management.

Risk factors:
- Male gender
- Young age
- History of physical abuse during childhood

Present environment: Cultural acceptance for aggression as away to express anger and frustration, physical crowdedness, poverty, unemployment, ethnicity is not

History of violence
Specific Mental Disorders More likely to be Associated with violent behavior

1. Schizophrenia
2. Manic Phase, bipolar disorders
3. Substance and alcohol abuse
4. Personality disorder
5. Intermittent explosive disorder
6. Mental disorders due to general medical condition
7. Dementia, delirium
8. Psychotic disorder, mood disorder
Work-Up of Violent Behavior

Violence is a symptom and therefore should be evaluated like any other presenting symptoms. Through history of violent behavior.

Present and past behavior.

Detailed questions about violent threat: onset, duration, frequency, intent, access to weapons.

Mental status and cognitive examination.

Agitation, signs of psychosis, mania, intoxication, memory disturbance.
Work up of violent behavior

Physical and neurological examination
Laboratory tests
Blood tests, thyroid function test, B12, calcium, mg, po4, serum and urine toxicology CT, MR, EEG
Documentation
Seclusion and restrains
Proper prescription of drugs-chemical restrains

Benzodiazepine; lorazepam 0.5-2 mg oral or i.m every 1-4 hours
Barbiturates; less used because of laryngospasm and respiratory depression
Work-up

Neuroleptics

- Haloperidole: 0.5-5 mg PO or IM
- Droperidole: 5 mg IM or slow iv push every 15 minute until sedated, not to exceed 50 mg/24 hours
- Chlorpromazine: 10-25 mg every 1-4 hours

Watch for side effects, extra pyramidal treated by benzotropine: 1-2 mg every 4 hours
predictability

Impending violence is not preceded by warning signs. However, clinicians should be familiar with certain common indicators:

- In the emergency room, refusal to treatment.
- In the hospital; first day or hours where the patients is not aware of the limitation of acceptance to violent behavior.
- Sudden change in behavior.
- Evidence of intoxication, wearing sunglasses indoors.
- Agitation,


Pacing, loud or pressured speech and sign of anger

Verbal threat of violence

Presence of neurological disorder like epilepsy – post ictal state, systemic disorder, hypoglycemia, electrolyte disturbance, head trauma, MS, parkinson’s disease, endocrine diseases

Your response: verbal response; try to maintain calm controlled manner, don’t get angry, this will lead to escalation of the patients aggression
Response to violence

Admit that you feel frightened, this will de-escalate the patients rage and give you time to ask questions and identifying the emotions

Be close to the door

Call for help

Leave the room arrange for safety measures

Seclusion and restrains. A specific form of management, form of team with the leader talking to the patient while the other applying the restrains, choice of ordinary or chemical restrains depends on the situation