ABC of mental health
Mental health emergencies

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An emergency is a situation that requires immediate attention to avert a serious outcome. Mental health emergencies range from situations where a patient is at risk because of intense personal distress, suicidal intentions, or self neglect to those where a patient places others at risk. Some patients may behave in an aggressive manner, make threats, or act violently. Such behaviour may produce physical or psychological injury in other people or damage property.

In difficult circumstances almost any patient may behave violently and pose a risk to their own safety or that of others

Causes of mental health emergencies

What makes a situation an emergency depends on the individual patient and the circumstances. Surprisingly, patients with mental disorders are more often the victims than the perpetrators of violence. They are often feared by the public, and this may render them vulnerable to assault. A patient's own health is often at risk from his or her behaviour, as in attempted suicide or severe depression. Other people may be more at risk of neglect or accidental involvement than of intentional violence.

Not all emergencies involve psychotic disorders. Neurotic disorders such as acute anxiety or panic disorder can cause chaotic or dangerous behaviour. Misuse of alcohol or illicit drugs may increase a patient's vulnerability, risk taking behaviour, and propensity to violence. The recent increase in suicide rate among young men seems to be due to social and psychological factors rather than recognised mental disorder.

Some mental health emergencies

Immediate risk to a patient's health and wellbeing
- Nihilistic delusions or depressive stupor (stops eating and drinking)
- Manic excitement (stops eating, becomes exhausted and dehydrated)
- Self neglect (depression, dementia)
- Vulnerability to assault or exploitation (substance misuse and many mental disorders)
- Sexual exploitation

Immediate risk to a patient's safety
- Suicidal intentions (plans and preparations, especially if concealed from others)
- Deliberate self harm (as result of personality disorder, delusional beliefs, or poor coping skills)
- Chaotic behaviour (during intense anxiety, panic, psychosis)

Immediate risk to others
- To family (due to depressive or paranoid delusions)
- To children, who may be neglected due to parent's erratic behaviour (in schizophrenia or mania)
- To newborn baby (in postnatal depression or puerperal psychosis)
- To general public (due to paranoid or persecutory delusions or passivity symptoms such as delusions of being controlled by a specific person)

Safety and risk

Preventing violent incidents has two main components—preparation and prediction.

Preparation

This requires constant awareness of potential risks and hazards to personal safety and of the need to maintain a safe environment. The design and layout of the clinic or surgery should be as pleasant and relaxing as possible—patients do react according to their environment. Dead ends, blind spots, and potential weapons should be minimised. All staff should receive regular training in personal safety and emergency procedures.

Dealing with emergencies in the community can be particularly difficult. Just as for medical emergencies, the ability of the lone general practitioner to manage a situation may be limited: the priority is to raise the alarm and obtain assistance without delay.

Prediction

This requires awareness of the risks posed by a specific patient or situation.

Long term prediction—Although its reliability is poor, the best long term predictor of a person's propensity for violence is a history of violent behaviour. Knowledge of a patient's patterns

Some important risk factors for violent behaviour

Psychological
- Anxiety or fears for personal safety (attack as means of defence)
- Anger or arguments
- Feelings of being overwhelmed or unable to cope
- Learned behaviour
- History of physical or sexual abuse

Organic
- Intoxication with alcohol or illicit drugs
- Side effects of medication (sedation, disorientation, akathisia, disinhibition)
- Inadequate control of symptoms
- Delirium

Psychotic
- Delusional beliefs of persecution
- "Command" hallucinations to harm others
- Depressive or nihilistic delusions and intense suicidal ideas

Social
- Group pressure
- Social tolerance of violence
- Previous exposure to violence (in home, environment, or media)

The most consistent risk factor is a personal history of violent behaviour

of behaviour, and of what triggers violence, is of greatest importance. This requires careful recording of incidents and clear communication between staff and other agencies.

Short term prediction of violent behaviour depends on recognising the early signs. Threats of violence should always be taken seriously. Worsening of symptoms, especially delusions or hallucinations that focus on a particular person, can be predictive. Other warning signs will vary from patient to patient and may not be reliable. These include changes or extremes of behaviour (shouting or whispering), outward signs of inner tension (clenched fists, pacing, slamming doors), and repetition of previous behaviour patterns associated with violence.

The violent incident

The first consideration in dealing with emergencies, whether violent or not, is the safety of all concerned. Actions taken in good faith to avert imminent disaster are sanctioned by common law and do not require recourse to the Mental Health Act. Formal detention and admission to hospital for continued treatment may be considered later.

Access—Try to obtain unobstructed access to the patient. Clear away movable furniture and potential weapons and ask onlookers to leave quietly.

Time—Do not rush, allow time for the patient to calm down. Most patients can be "talked down" in time. Engaging patients in conversation and allowing them to vent their grievances can be all that is required.

Manner—Talk calmly. Reassure patients that you will help them to control themselves, as aroused patients can be frightened of their own destructive potential. Try to find the cause of the present situation, but avoid heated confrontation. Explain your intentions to the patient and all others present. Be clear, direct, non-threatening, and honest as this will help confused and aroused patients to calm themselves.

Posture—Stand sideways on to the patient: this is less threatening and presents a smaller target. Keep your hands visible so that it is obvious you are not concealing a weapon.

Staff—Trying to cope alone can lead to disaster. Adequate numbers of staff, preferably trained in dealing with such situations, should be available to restrain the patient and contain the incident. In the community, this means summoning help before attempting to deal with a situation.

Medical support—Rapid access to medical services and resuscitation equipment (by ambulance if necessary) should be arranged.

Rapid tranquillisation

Rapid tranquillisation is the short term use of tranquillising drugs to control potentially destructive behaviour. It should be used only under medical supervision and when other, non-pharmacological, methods have failed. In most patients the precipitating symptoms of arousal (tension and anxiety, excitement and hyperactivity) respond to adequate drug treatment in a few hours.

Before administering drugs, ensure that the patient is securely restrained. Injecting a struggling patient risks inadvertent intra-arterial injection (causing necrosis), damage to sciatic nerve (if the buttock is the chosen site), or other injury. In specialist units drugs such as amylobarbitone sodium 500 mg intramuscularly or 200 mg orally may sometimes be used.

After intramuscular or intravenous administration of drugs, patients should continue to be restrained until they show signs of sedation: further doses might be required. Patients who

Emergency admission to hospital

Section 4 of the Mental Health Act in England and Wales
- Permits emergency admission to hospital on the recommendation of one doctor, preferably with previous knowledge of the patient, and a social worker or the nearest relative
- There must be "urgent necessity" (the expected delay if other routes are taken must be stated)

Section 5(2) of the Mental Health Act in England and Wales
- Allows an inpatient to be prevented from leaving hospital on the recommendation of one doctor, provided the patient is under the care of a psychiatrist
- If the doctor in charge of treatment is not a psychiatrist, he or she must act in person (a deputy cannot be appointed) and should obtain a psychiatric opinion as soon as possible

Notes
- It is good practice that these sections be converted to section 2 (which requires the recommendations of two doctors, one of whom must be a psychiatrist)
- If the act is invoked the correct forms must be used and attention paid to detail. It is useful to familiarise yourself with the forms beforehand

Staff practising how to restrain a violent patient without injury

Precautions with rapid tranquillisation
- Intravenous administration only under medical supervision: use "butterfly" cannula in large vein
- Administer intravenous drugs slowly
- Ensure resuscitation equipment is available
- If antipsychotic drugs are used, have antimuscarinic drug (such as procyclidine) available in case of acute dystonia
- If benzodiazepines are used, have flumazenil available in case of respiratory depression (give 200 μg intravenously over 15 seconds if respiratory rate falls below 10 breaths/min)
- Use lower dose in
  Older patients
  Patients not previously exposed to drug
  Patients intoxicated with drugs or alcohol
  Patients with organic disorder (delirium)
- Avoid intramuscular chlorpromazine (risk of hypotension and crystallisation in tissues)
- Avoid long acting antipsychotic drugs (including zuclopenthixol acetate) in patients not previously exposed to them
- Avoid antipsychotics in patients with heart disease (use benzodiazepines alone)

accept oral tranquillisation should be allowed to calm down in a quiet room. When sedated, patients should be placed in the recovery position and their heart rate, respiration, and blood pressure should be monitored.

After the incident—aftercare

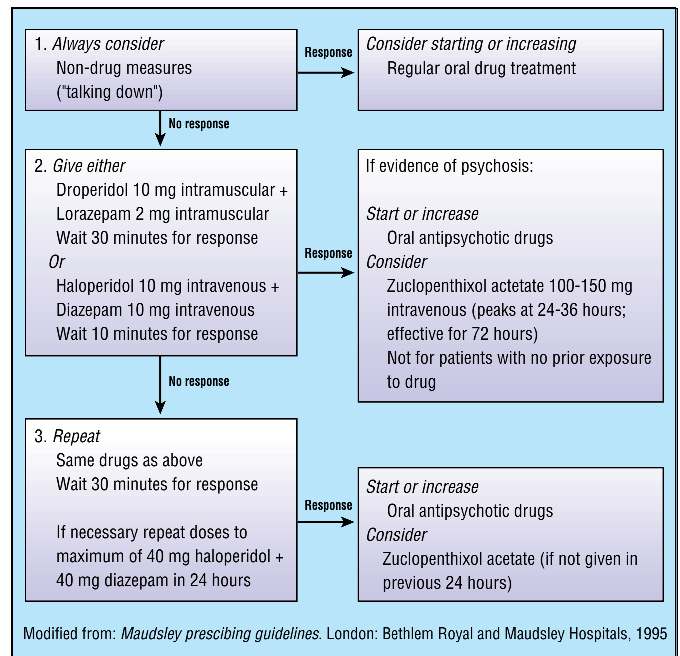
Everyone involved in a violent or distressing incident, including the patient and any onlookers, may suffer psychological distress. For example, the victim of an assault may go through several phases, being initially numbed or "shocked," later showing anger or emotional distress, and finally succumbing to mental and physical exhaustion. Others may show some of these reactions. Ample time should be allowed for all involved to talk about the incident. Some will be unable to resume work for hours or days. Late sequelae include anticipatory anxiety, flashbacks, and nightmares. Some people may require treatment for depressed mood.

Treating injuries—Any physical injuries sustained during the incident by the patient, staff, or others should be examined and treated.

Recording the incident—The details of the incident should be carefully recorded and reported to the appropriate authority. All services should have specific procedures for this. Staff involved in the incident may require help in recording their involvement.

Involving the police—The police should always be informed if a criminal offence has been committed or weapons have been used. It is usually in the interests of the public and patients to deal with offending behaviour through the courts.

Debriefing—All staff involved should assemble a day or two later to discuss the incident, support each other, and glean any lessons that may be learned.



Flow chart for rapid tranquillisation of acutely disturbed patient

Staff may be reluctant to report minor injuries or damage to the police, but their rights to compensation may be compromised if they do not

Suicidal patients

Usually, suicidal patients will talk about their intentions: they should be interviewed sensitively but fully about the frequency and intensity of suicidal ideas and about preparations and immediate plans. Their intentions should be viewed in the context of their current circumstances (precipitating events, losses, social support); history (previous self harm or suicide attempts, known mental or personality disorder); and mental state (depressed, angry, deluded, pessimistic). Those who show clear suicidal intent may need admission to hospital: they should be supervised until their suicidal ideation diminishes in intensity and be given the opportunity to talk of their anguish.

Patients intent on suicide may present a danger to others as well as themselves. They may need to be restrained physically or tranquillised, and all the considerations of safety and follow up mentioned above apply. Profoundly depressed patients, even if showing severe motor and cognitive slowing (retardation), may react with unexpected physical arousal at attempts to intervene.

Major incidents

After a major incident, such as a train crash or a Dunblane-type tragedy, it is now customary to provide counselling for all those involved. This may not be necessary for everyone, but deciding who requires such form of support is difficult in the face of an overwhelming tragedy. Psychological and specialist psychiatric help should be available to those deemed by the emergency services to need it. This will include members of the emergency services themselves. Post-traumatic stress disorder may not be evident for weeks or even months after a serious incident.

Further reading

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