Emergency in the Psychiatric Care and its Legal Regulation

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Psychiatric Emergency I.

- Any disturbance in toughts, feelings or actions for wich immediate therapeutic intervention is necessary
- The emergency psychiatrist must be up-to-date on medico-legal issues and managed care
- the number of emergency patients is rising (dementia, alcohol, and other drugs)

Psychiatric Emergency II.

- Violent behaviour :
  - suicide (self-injury)
  - causing bodily harm, assoult, homicide

- Life-threatening psychiatric disorders:

  stupor (catatonic sch., depression)

  impaired consciousness (delirium tremens)

  EPS – e.g laryngospasm (side-effect)

  NMS – neuroleptic malignant syndrome

Violence

- The most common diagnoses are:

mood disorders (mania, depression),

schizophrenia (agitation, anxiety, hallucination, thought dis.)

addict-problems (alcohol) ---- delirium

Intoxication (f.e. „bad trip”)

personality disorders (antisocial, borderline)

Organic psychiatric syndromes (dementia)

OCD

Prediction of violent/assaultive behaviour

Consider:

- Violent ideation, wish, intention
- Demographics – sex (male), age (15-24)
  socioeconomic status (low), social support (few)
- Patient's history: h.of violent acts with arrest or criminal activity, h.of childhood abuse, substance abuse (alcohol), dyscontrol (gambling), self-injury,…etc
- Overt stressors (marital conflicts, real or symbolic loss)

Acute Treatment

- Short interview – supplemental history from accompany of the patient
- (Acute transfer to forensic institute - maximum/high security hospitals)
- Pharmacotherapy (Haloperidol, Risperidone) repeated in 20-30 min. until the patient becomes calm
- Acute ECT (rare)

Suicidal Behaviour I.

psychological

„final common pathway”

sociocultural

biological factors

Suicidal Behaviour II. – epidemiological data

- **Suicide rate**: suicidal cases/100.000 people

≥ 25 Scandinavia, Germany, **<u>Hungary</u>**

< 10 Spain, Italy, Ireland, Egypt, Netherland

Suicide behaviour III.

- 1989-ongoing: WHO monitoring study in 13 European Countries, 16 centers:

Was detected the decline of number of the suicidal persons (male:14%, female: 17%)

- Typical attempter: young, white, single unemployed woman
- Typical succesfull suicidal person: man over the 65 age, white

Suicidal Behaviour IV.

- Accountable factors:

Race (white)

Religion (protective: catholic religion)

Marital status (risk: single, previously or never married person)

Occupational status (risk: without work/job)

Climate: in Autum rise the suicidal cases

Physical/Mental Health

Suicidal Behaviour V. Mental Health

- Background: magnitude mental disorders

10% of sch. die because of suicide

Depression (50%)

Alcohol (drug) abuser, - dependent patients

Anxiety disorders

Personality disorder

Suicidal Behaviour VI. Treatment

- Treatment of the psychiatric disorder (AD ---SSRIs, AP)
- Treatment of the crisis: focused psychotherapy – crisis units

Legal Regulation of Admission on the Psychiatric Unit and Patient's Restraint (EU - recommendation)

Having regard:

- Convention for the Protection of Human Rights and Fundamental Freedoms of 4 Nov 1950
- Convention on Human Rights and Biomedicine of 7 April 1997
- other international conventions on the regulation

Criteria for Involuntary Treatment

1. The person has a mental disorder
2. The person’s condition represents significant risk of serious harm to his/her health or to other persons
3. No less intrusive means of providing appropriate care are available
4. The opinion of the person concerned has been taken into consideration (inform the patient)

Procedures for taking decisions on involuntary placement and/or involuntary treatment

- should be taken by a court or another competent body -------- previously
- -------- in emergency situation
- (Voluntary admission)