REFRESHER COURSE FOR GENERAL PRACTITIONERS

THE ACUTE MENTAL CASE

BY

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Acute mental cases can be divided into those in which the diagnosis is obvious and those in which it is not. If an individual becomes violent and noisy it is clear to all that something should be done; but when patients are quiet and do not show dramatic changes in behaviour the need for action may not be realized until it is too late. A substantial number of potentially recoverable melancholics are permitted to commit suicide because the severity of their condition is not realized.

The incidence of acute mental breakdown is high. In round figures, of the 20,000 Health Service patients admitted to mental hospitals in England and Wales in 1950, 1,000 (5%) were admitted on Urgency Orders. In addition, a high proportion of the patients not so admitted—for example, many voluntary patients—suffered from acute conditions. In 1948, 4,604 individuals (2,900 males and 1,704 females) committed suicide; there were probably ten or even twenty times that number of unsuccessful attempts. Most murders are committed by the insane; 30–40% of murderers commit suicide before arrest.

History Taking

An independent account is quite essential, as from the nature of their condition acute mental patients are usually uncooperative or even actively antagonistic. Difficulties often arise and much time is wasted because doctors are rushed off to see a patient knowing nothing except that he has become "violent." An adequate opinion about the diagnosis and appropriate treatment can seldom be formed solely from an examination of the patient without prior knowledge of the past history and the development of the symptoms. Again, the assistance and equipment that may be necessary should often be mobilized before the patient is examined, if struggles and scenes are to be avoided. It is, for example, both difficult and dangerous to give an injection to any resistant adult without assistance.

A satisfactory history can seldom be obtained from more than one informant at a time. The worst possible conditions are to have a number of agitated relations and friends all together, interrupting and contradicting each other, with perhaps "noises off" from the patient concerned, or, worse still, with the patient repeatedly trying to get into the room to see what is going on. The most sensible and informed relations and friends should be seen separately. If possible, they should be induced to come round to one's house; or an assignation can be made in a house or flat near that of the patient. If neither of these courses is practicable, the relatives can be seen in one's car. In this connexion it is difficult to write on the steering wheel and annoying to have the informant overlooking one's notes. It is better to sit in the back seat with the informant in the front seat.

The main practical issues are (a) whether the acute mental condition is of such a type and severity and

probable duration that admission to hospital, and in particular to a mental hospital or observation ward, is called for; or (b) whether it is likely to be a transient reaction with a reasonable prospect of settling rapidly at home.

Broadly speaking, with the exception of the psychopathic, the hysterical, and the acute alcoholic, most patients who can reasonably be regarded as acute mental cases need hospital care as soon as possible. With few exceptions, they will need sedation and subsequent observation and supervision, at least for a time. The great thing is to have sufficient sedation and enough assistants.

Diagnostic Categories

The diagnostic categories likely to result in acute mental states may be listed as follows: (1) manic-depressive psychoses and the involuntional melancholias; (2) schizophrenia; (3) organic reactions, especially toxic confusional conditions (including alcohol); and (4) hysterical and psychopathic outbursts.

It is clearly impossible to summarize briefly the possible symptoms in all these conditions. Moreover, mixtures are not infrequent—for example, hysteria and alcohol. Nevertheless, the following points may be of some value.

Manic-depressive Psychoses and Involuntional Melancholias.—Manic-depressive psychoses and involuntional melancholias seldom show a really acute onset, and, though not invariably, occur in relatively stable individuals, so that the breakdowns come as a surprise to the informant, unless there is a history of a previous attack. There is a history of increasing excitement or depression extending over days or weeks. Manics may be socially impossible but are seldom actively dangerous to others—that is, homicidal. The milder or "hypomanic" cases can present the most difficult problem of any, when not certifiable.

The risk in depressions is of course mainly that of suicide; the popular fallacy still persists that those who talk of suicide are unlikely to do it: nothing could be more mistaken.

Those with depressions may be difficult to diagnose because they are transiently better after an unsuccessful attempt at suicide. Good indications of severity are definite ideas of reference (the belief that others are talking about them and looking at them in a disparaging way), self-reproachful ideas of sin, the belief that the police are after them, delusions of disease—for example, venereal disease—and delusions of poverty. In my experience the commonest psychiatric mistake is not to take depressions seriously enough.

Schizophrenia.—The apparently sudden development of a state of excitement or violence is relatively common in schizophrenia. Schizophrenics can be extremely impulsive and dangerous, quite suddenly and without warning. Special care and precautions are therefore necessary. The history will usually disclose

premonitory symptoms of being abstracted and withdrawn, of decrease in activity and "remoteness," coupled with persecutory ideas. Various odd misinterpretations and the finding of "special meanings" are highly characteristic, as also is talk of being hypnotized.

Organic Reactions.—Conditions of severe and dangerous excitement can occur in general paralysis of the insane, nowadays a rare condition. The history should disclose impairment of judgment, memory, and grasp. Toxic confusional ("delirious") states are typically variable, and are characterized by restlessness and above all by confusion. Paranoid or persecutory delusional ideas, typically fluctuating in intensity, are very common. These states tend to be worse at night and there is increased restlessness then; for example, patients may try to dress up and go out. Visual hallucinations are in practice diagnostic of a toxic confusional condition. Owing to the increasing number of old people, one sees more and more delirious reactions in the aged or senile. Occasionally prolonged and dangerous confusional states occur in epileptics. With alcohol one must remember that drinking can be symptomatic of other conditions, in which case there will be a history of symptoms preceding the indulgence. Delirium tremens is now relatively rare, but I have been surprised to see a number of typical cases not recognized; the usual duration is three to five days. The possibility of drug intoxication should be borne in mind in any unexplained confusional state, and the room should be searched for evidence of this.

Hysterical and Psychopathic Outbursts.—Of this group it can be said that a past history of instability is invariable, unless there is also a history of quite exceptional stress. These reactions are therefore *not* a source of surprise to the friends or relations who have seen comparable manifestations before. This group includes the emotionally unstable people who indulge in violent outbursts when confronted with difficulties or when they cannot get their own way. These outbursts are typically histrionic, melodramatic, and uncontrolled; but the patients remain well in touch, the whole condition being highly reactive to environmental factors. Accusations, complaints, and threats may be made; but true paranoid delusional ideas are not expressed.

General Management

Acute mental patients need to be under care, supervision, and control, for their own benefit and that of society, until their acute mental breakdown has subsided. The first step must usually be to achieve adequate sedation, to be continued as necessary. When not in hospital, similar precautions should be taken, so far as is possible.

Acute mental patients will often reject control and refuse sedation. When this occurs, force must be used. As trained nurses are seldom available, untrained helpers must be used instead. The cardinal importance of having enough assistants has already been emphasized. It is far better to have too many than too few; at least three helpers should be available. Moreover, patients will often stop resisting when it is clear that this is useless. If necessary, there should be no hesitation in calling in the help of the police.

Discretion must be exercised in deciding when to use force. If a patient is actively violent he should be

controlled as soon as possible; but it is often reasonable to postpone any exhibition of force until the time comes for compulsory removal to hospital. In any doubtful case this should be preceded by adequate sedation to facilitate the removal to the ambulance or car.

When confronted with a powerful patient who is armed or clearly prepared to put up a fight, it may be helpful to throw a bucket of water over him before seizing him. A low-pressure hose, if available, affords the safest and most humane method of all. Once the patient is held, first remove his boots or shoes; then his kicking is not so dangerous and it is harder for him to run away.

Sedation

The next step is to give *adequate* sedation by hypodermic injection. The syringe should be in readiness near by, but preferably out of sight; nothing is more vexing than to have one's syringe broken and no other available. It can be very difficult to remove the coat of a violently struggling patient. In such cases it may be necessary to give the injection through the clothes into the buttock while the assistants are sitting on the patient, who is on the floor face down. The needle may easily get broken off by violent muscular movement, with the unfortunate result that only the needle is injected. Needles usually snap off at the junction with the nozzle. A long—even 4-in. (10-cm.)—needle is therefore the best because it can be held distal to the nozzle so that if snapped off it is still held, and because if necessary it can be stuck *through* the clothes. The standard injection is morphine, $\frac{1}{2}$ gr. (32 mg.), and hyoscine, 1/100 gr. (0.65 mg.)— $\frac{1}{4}$ gr. (16 mg.) of morphine may not be enough. Other possibilities are phenobarbitone, 3 gr. (0.2 g.), or paraldehyde, usually made up in 30-min. (1.8-ml.) capsules; four of such capsules should be injected intramuscularly.

The advantage of sedation by injection is of course that a powerful action can be induced quickly. If neither of these effects are so necessary and the patient can be induced to swallow, sodium amytal, 9 gr. (0.6 g.), is useful (6 gr.—0.4 g.—is often not enough), to be repeated as necessary, but it is well to let perhaps four hours elapse. For old people chloral hydrate, 45 gr. (3 g.), repeated when necessary, is often useful; bromides are better avoided because of the risk of bromide intoxication.

Other Precautionary Measures

Undress the patient. Remove all stockings, straps, bands, and dressing-gown and pyjama cords, and anything that could possibly be used for hanging or strangulation, or swallowing—for example, handkerchiefs. Keep the patient on the ground floor, so that if he jumps out of the window he will not harm himself much. Keep him warm, perhaps with blankets on a mattress on the floor. Remove all sharp objects (scissors); lock the doors. The patient must always be accompanied to the lavatory or bathroom. Preserve a constant watch, preferably with two people; it is consoling for an untrained watcher to have another with him, and it also helps to keep him awake.

Again discretion must be used before attempting to approximate the room to a padded cell; but if mistakes are to be made it is better to make them in the direction

of unnecessary precautions. Moreover, the adoption of stringent precautions is not necessarily a bad lesson for the 'hysteric who may need them least.

In addition to sedation, it is very important to see that the bowels are open, for which purpose calomel ($\frac{1}{2}$ gr.), followed by magnesium sulphate, 2 dr. (7 ml.), the next morning, may be recommended. The fluid intake should amount to at least six pints (3.4 litres) a day. It is also important to keep the mouth washed and clean.

The Relatives

Removal to a mental hospital or observation ward still bears a considerable stigma and is apt to be strongly resented or resisted by relations. I have found the relatives of schizophrenics particularly difficult; they are often queer people themselves.

The main points to make are: (1) The patient is clearly sick and in urgent need of treatment; this can be properly carried out only in hospital. (2) An ordinary general hospital cannot admit a patient against his expressed wish, nor has it the facilities to deal with this type of case if it could. (3) All one wants to do is to achieve a period of observation; certification may not be necessary and one hopes not. (4) To convey indirectly that the main issue is what is best for the patient and not the feelings of the relations. (5) That even if certification is necessary, this is not a permanent and irrecoverable step. An astonishing number of people still believe this is so. It can also be pointed out that over 60% of the patients in mental hospitals are voluntary patients; that nobody wants to certify a patient unless it is essential; that there are the most elaborate safeguards against wrongful detention; and that, with few exceptions, patients can be removed from mental hospitals, even against medical advice, if the relations are prepared to accept responsibility.

Sometimes it is necessary to be firm and to state that unless the relations are willing to abide by the advice given it is one's medical and legal duty to inform the appropriate authorities of the position.

Admission to Hospital

If the patient or relatives are able and willing to pay the appropriate fees, the procedure for admission is by Urgency Order. The nearest friend or relation must act as petitioner. The appropriate "private" mental hospital is then rung up and the presence of a vacancy ascertained. Many are willing to send an ambulance or car with nurses. But they cannot act unless the Urgency Order is available for them to take with them. Urgency Orders may be obtained from any Law stationer.

An Urgency Order lasts for only seven days; it is not certification, and is intended to provide a breathing space pending further action. It is much the most convenient method for private patients; a magistrate need not be called in.

Do not try to write up the Urgency Order—a lengthy but self-explanatory document—except with the friend or relation who is acting as petitioner. Lead him or her off to a quiet place for the purpose, preferably near a telephone, for it will almost certainly be needed.

If not a private patient—that is, one who cannot afford private fees—the procedure nowadays is easy and consists in ringing up the duly authorized officer (formerly known as the relieving officer) of the district,

and subsequently giving him or leaving for him a written report on why you think action is necessary. The D.A.O. will then make all the necessary arrangements; but they appreciate one's help. In my experience—mainly in London—they are wonderfully obliging and efficient; but quite inevitably there may be delays before they can act.

Prognosis and Treatment

It is unwise to be too dogmatic or specific or optimistic. With the exception of psychopathic or hysterical outbursts and the acute alcoholic, the duration of the illness in acute mental cases is apt to be prolonged. While it is reasonable to stress the great advances that have been made in psychiatric treatment, it is most unwise to indicate what the treatment should be. It is better to emphasize that only more prolonged investigation and observation will permit of a proper assessment of the condition, this constituting one of the main reasons for admission to hospital. To pitch hopes too high in order to get consent for action, or give your opinion on the absolute necessity for a certain type of treatment—for example, insulin shock—which may be unsuitable, is apt to cause justified bitterness and disappointment later.

Finally, to have a near friend or relation removed to a mental hospital is necessarily an extremely upsetting experience. It is therefore often reasonable and humane to give sedation to help the relation to sleep that night, sodium amytal, 3 gr., being a suitable drug for the purpose.

Conclusion

I am sure doctors are prone to act too late rather than too early. This may be in part a reflection of their lack of psychiatric knowledge and also of the reluctance of relations to take steps because of the stigma of insanity. But the "genuine" acute mental case usually needs hospital care. To repeat: the main mistakes are to have an inadequate number of helpers and to give inadequate sedation. Lastly, in self-protection, take and keep really full notes.

The air transport of casualties began during the siege of Paris in 1870, when 160 patients were successfully evacuated by balloon. The first recorded case of a casualty transported by aircraft was in 1915, when Captain Dangelza flew a wounded Serbian airman to safety during the retreat of the Serbian army. The French used air ambulances in Morocco in 1918, and the following year the R.A.F. moved patients in Somaliland. Emergency medical cases in Egypt were evacuated from isolated areas by air, and the Vickers Vimy aircraft allocated for this service bore the Geneva Red Cross. This was later removed, as it restricted the use of the aircraft, but the stretcher fittings remained so that it could be used as an ambulance when necessary. The first air ambulance service in Britain was started in 1925 at Halton, and covered a radius of 100 miles. The service was disbanded two years later, as it was found that the use of troop carriers was more economical. Between 1925 and 1938 a total of 2,112 patients were transported by the R.A.F. An air ambulance organization was established in Britain in June, 1941, consisting of seven specially fitted aircraft marked with the Red Cross and stationed at Hendon, Abbotsinch, and Wick. By V.J. Day approximately 400,000 patients had been carried by the R.A.F., and during the latter stages of the war in Europe 90% of casualties were transported by air. In the Korean war the R.A.F. are transporting British and French casualties home via the Middle East.