Management of Overseas Psychiatric Emergencies

Kenneth B. Dekleva, MD
Department of State
Regional Medical Officer/Psychiatrist, Moscow
Overview

- Models of care: ER Psychiatry vs. Crisis Intervention
- Treatment and medico-legal issues
- Aeromedical evacuation
- Case examples
- Questions?

Foreign Service Life

Terrorism
Frequent moves
Change of school
Lack of spousal employment
Excessive travel
Environmental
Loss of control

Fishbowl phenomenon
Work Stress
Inadequate resources
Family issues
Lack of support system
Crime
War-zone deployments
A Typical Embassy

State Dept.  CDC
DAO  NASA
AID  DoD
FBI  Peace Corps
DEA  DOE
DHS  DOJ
FAS  Treasury
FCS  Other agencies
FAA
Mental Health Program

Culture shock
Stress management
School consultation
Management consultation
Travel medicine
Occupational health
Medical diplomacy
Disaster response
General psychiatry
Security/forensic issues
Emergency Response
Family advocacy
Crime
War Zone issues

March 9, 2012
2012 Bangkok CNE

Examples of Psychiatric Emergencies

- Suicide threat/attempt
- Psychotic agitation
- Violence; family advocacy
- Severe anxiety
- Victimization
- Alcohol/drug states
- Delirium

March 9, 2012
2012 Bangkok CNE
Emergency Psychiatric Assessment

- R/O serious medical conditions
- Risk: danger to self/others, or risk of dangerous deterioration if untreated
- Crisis intervention
- Consultation
- Diagnosis; treatment; aeromedical evacuation; hospitalization
- Documentation; medico-legal issues

Crisis Intervention

- Crisis: response to severe stress; disruption of one’s psyche and its equilibrium
- Crisis intervention: mobilize adaptive resources; emphasis on coping and recovery; change and growth
- Utilization of HU, family, peer, and community supportive interventions
- Psychotherapeutic model: supportive; ‘here & now’; direct, active
- Duration is typically brief (weeks)
Medical Conditions as Psychiatric Emergencies

- Medications: toxicity; drug interactions
- Drug/ETOH intoxication & withdrawal states
- Endocrine; Metabolic
- Infectious (encephalitis; meningitis; HIV)
- Cardiac; Pulmonary
- Neurologic (CVA; TBI; dementia; seizures; tumors; DCS; AGE)
Triage/Assessment

- Vital Signs
- ABCs
- Pulse Oximetry
- Labs; 12-lead EKG; CXR
- Medications; IV hydration; calories
- Neuroimaging
- Medical/psychiatric consultation

Alcohol/Drug Intoxication & Withdrawal States

- ETOH; opiates; BZDs
- Risk assessment
- Calm environment; team approach; HU location
- Local hospitalization?
- Medical evacuation?
- Consult with RMOP, ADAP
Treatment of drug/ETOH emergencies

- Labs: often not available --- reliance upon clinical assessment
- BZDs; vitamins; thiamine; fluids; nutrition
- Crisis intervention, family support
- Safety issues
- Special concerns: co-morbid medical conditions; seizures; DTs

Management of Suicidality/Violence

- Psychiatric consultation
- Take all threats/attempts seriously
- Treat underlying medical/psychiatric illnesses
- Consider medical evacuation or inpt. care; treat-in-place?
- 1:1 observation where indicated
- Risk assessment; elopement risk
Treatment of psychotic agitation

- RX endpoint: “calm wakefulness”; sedation; diminished arousal state
- *Rapid Tranquilization* (PO or IM, q30 min *prn*):
  - Lorazepam 2mg & Haloperidol 5mg;
  - Lorazepam 2mg; Haloperidol 5-10mg
- **Newer agents**: Olanzapine; Risperidone; Ziprasidone; Aripiprazole
- EPS: Benztropine 2mg; Diphenhydramine 25mg
- NMS: 0.5-1.4% risk; mortality = 40%

Medico-legal Issues

- Documentation; consultation with MHS
- Aeromedical evacuation?
- Confidentiality; HIPAA; Tarasoff
- Medical clearance: return to post?
Aeromedical Evacuation

- Consultation (medical; psychiatric)
- Cabin conditions: crowding; relative hypoxia; airport transfers; elopement risk; dehydration
- Seclusion; restraint; safety; liability
- Medical escort? Air ambulance?
- Medical clearance to fly
- On-board medical kits
- Which medications available?

Air Rage; Passenger Misconduct

- Incidence: 10000/year in 2000 in US; 3-15% are psychiatric; approx. 33 medical incidents/day
- Causes: psych disorders; ETOH/drugs; personality disorders; stress/crowding; hypoxia
- Liability; Good Samaritan laws vary
- 1963 Tokyo Convention
- Restraint; seclusion; diversion
- 10% of diversions are caused by neurologic sx
Cases

1. Young female, G1P1, with new-onset post-partum psychosis
2. Adolescent male with 1st-break psychosis
3. Young female with psychotic agitation
4. Middle-age female with history of suicidality, recurrent depression, borderline PD, and alcohol dependence
5. Adolescent male with ETOH OD/intoxication
6. Young female with phobia, recurrent MDD, post-partum, marital strain, and significant stress

Pearls

- The patient is the person in crisis
- Pay attention to boundaries
- Pay attention to your stress levels
- Self-care is very important; remain calm
- Pay attention to countertransference
- Most crises resolve if managed properly
- Offer reassurance, calm, and hope
Questions?

References

References: Air Rage

- JI Sirven et al., *Is there a neurologist on this flight?*, Neurology 2002 June 25; 58 (12):1739-44

