HEALTH

KwaZulu-Natal

KwaZulu-Natal Treatment Protocols for Mental Health Disorders

INTRODUCTION

These *KZN Treatment Protocols for Mental Disorders* have been developed in response to a need for practical guidelines to managing common psychiatric disorders at District and Community level. With this in mind, the editors and contributors have ensured that the protocols are based on the Standard Treatment Guidelines and Essential Drug List (2006) issued by the Department of Health. Thus all medications named in the protocols are available at District and Community level health facilities in KwaZulu-Natal. Furthermore, these protocols are aimed at non-psychiatrist clinicians (e.g. Medical Officers and Psychiatric Nurses) who are involved in the day to day management of mental health care users. Finally, we have elected to produce protocols that are based on common clinical presentations (e.g. psychosis, aggression, insomnia) rather than on specific psychiatric disorders (e.g. schizophrenia).

The Treatment Protocols are a result of collaboration between the KZN Provincial Directorate for Mental Health, the Psychiatry Department at the University of KwaZulu-Natal and Eli Lilly Pharmaceuticals. The protocols were written and edited by members of staff in the UKZN Department of Psychiatry. We are grateful to these individuals for their efforts. We also thank Eli Lilly for their sponsorship of both this booklet and a number of workshops held throughout the Province to present these protocols. Finally we thank the KZN Provincial Department of Health for their support for this project.

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CONTENTS

GUIDELINES FOR THE ADMISSION OF INVOLUNTARY AND ASSISTED PERSONS UNDER THE MENTAL HEALTH CARE ACT, 2002 (ACT NO. 17 0F 2002)

STEP 1 Friends /family to complete Application for admission on form 04.

STEP 2 Person to be assessed by 2 mental health care practitioners (MHCP) and examination and findings to be recorded on form 05.

STEP 3 MHCP must submit forms 04 and 05 to Head of Health Establishment (HHE).

STEP 4 HHE to decide on whether or not to provide further care and to give notice of consent to such care on form 07.

STEP 5 Person can now be admitted /treated for 72 hrs without his/her consent.

STEP 6 Person to be assessed every 24 hours for 72 hours.

STEP 7 2 MHCP re- assess person after 72 hours have elapsed and examination and findings recorded on form 06.

STEP 8 MHCP submit form 06 to HHE.

STEP 9 HHE decides whether person needs to be further treated as an outpatient (09), inpatient (08), or to be discharged (03) and gives notice to Review Board of same on forms depicted in parenthesis above.

STEP 10 If further treatment is required as an inpatient person must be transferred to a Psychiatric Hospital. HHE to complete form 11.

ALGORITHM FOR THE ADMISSION OF INVOLUNTARY/ ASSISTED PERSONS UNDER MHCA

STEP 1 **APPLICATION FORM 04**

STEP 2 **ASSESSMENT FORMS 05**

STEP 3 **SUBMIT 04 AND 05 TO HHE**

STEP 4 **HHE CONSENT FORM 07**

STEP 5 **72 HOUR ADMISSION**

STEP 6 **ASSESSMENT EVERY 24 HOURS**

STEP 7 **POST 72 HR ASSESSMENT FORMS 06**

STEP 8 **SUBMIT FORM 06 TO HHE**

STEP 9 **HHE TO DECIDE: DISCHARGE O3**
OUTPATIENT 09
INPATIENT O8

STEP 10 **TRANSFER TO PSYCHIATRIC HOSPITAL 11**

MANAGEMENT OF AGGRESSIVE, VIOLENT PATIENTS

DEFINITIONS

Aggression is any form of behaviour directed towards the goal of harming or injuring another living being who is motivated to avoid such treatment.
Violence is harmful behaviour inflicted upon another person or property involving the use of force. Violence is defined as the act that leads to physical harm or destruction. Aggression may or may not result in violence but all violence is aggression.

Phases of dealing with aggression or violence:

Phase 1: De-escalation
Phase 2: Physical restraint
Phase 3: Sedation
Phase 4: Mechanical restraint
Phase 5: Post sedation / Seclusion / Transfer

Phase 1: De-escalation

De-escalation is a process to defuse a potentially violent or aggressive situation without having to resort to physical restraint.
During physical restraint there is a risk of injury to both the patient and the staff, therefore there is a need for verbal intervention, which could help to reduce the threat of violence and return the patient to a calm state of mind.

- Show concern or empathy
- Speak quietly but clearly and calmly; don't argue
- Assist patient to stay in control
- Set limits firmly but do not threaten
- Allow extra personal space
- Deal with the issue at hand
- Ensure safe environment and remove all potential weapons (alert SAPS if patient has dangerous weapons on hand)
- Ensure safe exit point for staff
- Encourage patient to talk and make use of appropriate listening skills
- Offer medication to patient; initially oral therapy
- Allow patient to find a solution to the problem

Phase 2: Physical Restraint

- Team leader to co-ordinate
- Evacuation of staff and patients not involved
- Obtain assistance of at least 4 other staff members
- Inform the patient that the intention is to restrain and sedate
- Each person should hold a limb and the team leader should hold the patient's head while talking to the patient

Phase 3: Sedation (See flow chart)

- Initially offer patient oral therapy
- If patient refuses and de-escalation techniques have failed, use intramuscular or intravascular therapy
- Lorazepam (Ativan) 2mg – 4mg IMI/IVI stat – give slowly over 3 minutes after diluting
- Do not risk needlestick injury if IV is difficult
- If patient not sedated after 20 minutes, administer Haloperidol 5mg IMI stat which may be repeated using 5mg every hour to a maximum of 20mg
- Obtain collateral information from family members or those accompanying the patient

Phase 4: Mechanical Restraint

- Not to be used as a punitive measure, but for the safety of the patient and others, until sedation takes effect
- Not to be used for longer than 30 minutes at a time according to the Mental Health Care Act regulations
- Form MHCA 48 to be completed and presented to the Hospital Manager daily and to the Mental Health Review Board quarterly
- Restrain in a semi-prone position ensuring that the limbs are not contorted, to prevent aspiration and compression injury

Phase 5: Post Sedation/Seclusion/Transfer

- Assign a staff member to be with patient until he/she becomes ambulant or until transfer effected
- Patient to be preferably nursed in a seclusion room
- Once sedated or calm, to attempt history taking, physical mental state examination and special investigations (esp. blood glucose) to evaluate cause of behavioural disturbance
- Blood pressure, pulse rate and respiration to be monitored every 5 – 10 minutes in first hour and then every 15 minutes until ambulant
- If BP drops below 100/60, elevate lower limbs of patient
- If BP does not respond, IV fluids need to be commenced
- Document all nursing care and medication accurately
- If secluded, form MHCA 48 needs to be filed and presented to the Hospital Manager daily and the Mental Health Review Board quarterly
- Transfer of patient to a psychiatric hospital should occur after 72 hours assessment at District Hospital or as an emergency before 72 hours after necessary arrangements being made

GUIDELINES FOR THE RAPID TRANQUILLISATION OF AGGRESSIVE, VIOLENT PATIENTS

INITIAL CONSIDERATIONS

1. **DE-ESCALATION** – Talking down, time out, distraction, privacy and quiet.
2. **MEDICATIONS** – Note any Psychotropic medication received in last few hours.
3. **ADVANCE DIRECTIVES** – Patient preferred treatment choices.

↓

OFFER ORAL THERAPY

CHLORPROMAZINE (LARGACTIL) (Max 300mg /24hrs) 25 – 75mg initially (Sedation in 30 minutes, peaks in 1 –3 hours, lasts 3 – 4 hours)
Take special note of contraindications for use e.g. epilepsy, elderly, alcohol abuse, liver disease, CVS disease, coma or CNS depression, etc.
OR
HALOPERIDOL (SERENACE) 5 –10mg (Max 30mg/24hrs) – not for the neuroleptic naïve
Review temperature, pulse, blood pressure and respiratory rate every 5 – 10 minutes for one hour and then hourly until patient is ambulatory.

↓

INTRAMUSCULAR THERAPY

LORAZEPAM (ATIVAN) 2 – 4 mg IMI (Max 6mg/24hrs) Sedation in 30 – 45 minutes; peaks in 1 – 3 hours, lasts 4 – 6 hours
+ / -
HALOPERIDOL (SERENACE) 5mg IMI (Max 18mg / 24hrs) Sedation in 10 minutes; peaks in 20 minutes

OR

OLANZAPINE (ZYPREXA) 5 – 10mg IMI (Max 20mg/24 hrs) 2 hour interval between injections; peaks 15 – 45 minutes

OR

CLOTHIAPINE (ETOMINE) (max 360mg/24 hrs) Initial dose 40 – 80mg and repeated 2 – 3 times per day

[DO NOT MIX INJECTIONS IN ONE SYRINGE]

Review half hourly and repeat as necessary up to maximum dose. Monitor respiratory rate and give Flumazenil if rate falls below 10 per minute

↓ **IF NO IMPROVEMENT, REVIEW AND CONSULT SENIOR COLLEAGUE** ↓

Consider
DIAZEPAM (VALIUM) 10mg 1V
Ensure Flumazenil available
Monitor vital signs, especially respiration throughout
Oxygen and airway must be available

Consider
CLOPIXOL ACUPHASE IM 50 – 150mg (Sedation in 1 – 2 hrs, peaks in 36 hours, lasts 72 hours)
ONLY IF
Patient is detained under Mental Health Act
AND is not antipsychotic naïve.

NB: For elderly patients, halve doses and titrate according to response

MANAGEMENT OF THE SUICIDAL PATIENT

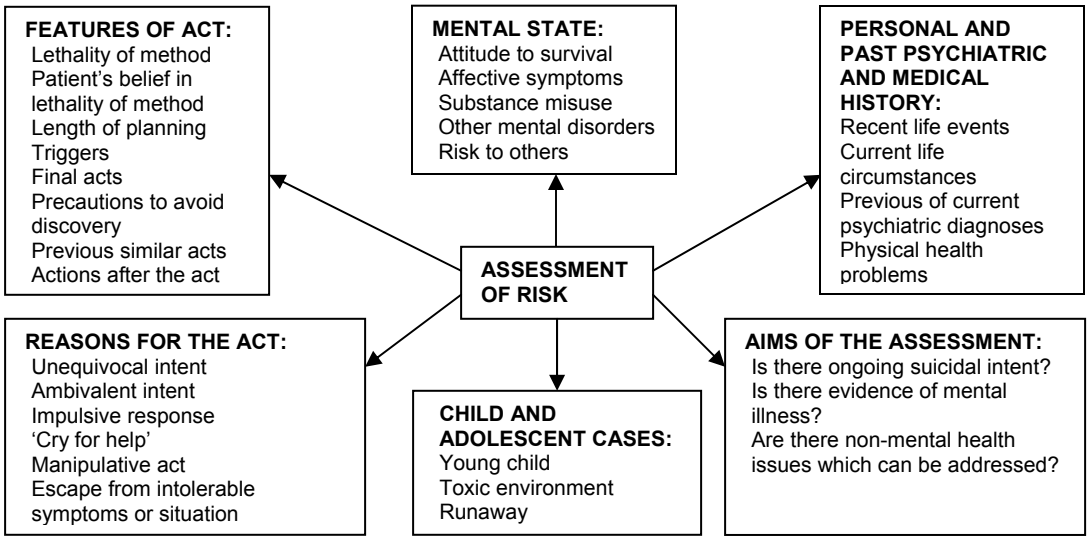
EPIDEMIOLOGY

- Increase during the 20th Century
- Rates: 25/100000 (N. Europe) – 10/100000 (S. Europe)
- Two peaks: 15-24 years and over 45years
- 3rd cause of death in adolescents (12%) - steadily increasing!
- Completed suicide: male: female 3:1
- Attempted suicide: male: female 1:4

RISK FACTORS FOR SUICIDE

- Male
- Elderly
- Single, divorced, widowed
- Living alone, poor social support
- Unemployed
- low socioeconomic status
- Previous suicide attempt or self-harm
- Any mental disorder
- Alcohol/ drug abuse/dependence
- Recent in-patient Psych Rxn
- Concurrent physical disorder
- Recent bereavement

ASSESSMENT



MANAGEMENT

1. Assess suicide risk
2. Consider the need to hospitalize
3. Treat mental disorder
4. Refer to relevant professionals
5. Liaise with relevant parties
6. Form a contract with the patient
7. Provide emergency contacts
8. Regular follow-up

MODIFIED SAD PERSONS SCALE OF HOCKBEYER AND ROTHSTEIN

PARAMETER	*FINDING*	*POINTS*	*PATIENT'S SCORE*
Sex/Gender of Patient	Male	1	
	Female	0	
Age	< 19	1	
	19 – 45	0	
	> 45	1	
Depression or Hopelessness	Present	2	
	Absent	0	
Previous suicide attempts or psychiatric care	Present	1	
	Absent	0	
Excessive Alcohol or drug use	Excessive	1	
	Not excessive or more	0	
Rational thinking loss	Loss due to organic brain syndrome or psychosis	2	
	Intact	0	
Separated, divorced or widowed	Separated, divorced or widowed	1	
	Married or always single	0	
Organised or serious attempt	Organised, well thought out or serious	2	
	Neither	0	
No social support	None (no close family, friends, job or active religious affiliation	1	
	Present	0	
Stated future intent	Determined to repeat attempt or ambivalent about the prospect	2	
	No intent	0	

Interpretation:
Minimum score: 0 Maximum score: 14
The higher the score, the greater the risk of suicide.

Score	**Management**
0 – 5	May be safe to discharge, depending on circumstances, rarely requires hospitalization
6 – 8	Emergency psychiatric consultation
9 - 14	Probably requires hospitalization

THIS SCALE IS A GUIDE ONLY!
CLINICAL JUDGEMENT MUST BE EXERCISED!

AN APPROACH TO PSYCHOSIS AND THE USE OF ANTIPSYCHOTICS

The **five D**'s serve as a good guide:

- **D** iagnosis
- **D** rug
- **D** ose
- **D** uration
- **D** epot antipsychotics

DIAGNOSIS

Antipsychotics are to treat Psychosis.
Therefore use in any condition where psychotic symptoms are present.
Psychotic symptoms include:
a) Hallucinations
b) Delusions
c) Disorganized behaviour
d) Negative Symptoms – alogia, amotivation, etc

DRUG

Only 2 antipsychotics are available on the EDL for use by medical officers at Primary Health Care as well as Hospital level.
Both are Typical Antipsychotics. They are:

CHLORPROMAZINE (LARGACTIL)
and
HALOPERIDOL (SERENACE)

Chlorpromazine in comparison to Haloperidol has:

- Greater potential for sedation
- Has less extra pyramidal side effects (EPSE's)
- Greater propensity to cause postural hypotension
- Greater propensity for anticholinergic side effects
- Greater propensity for seizure induction
- Greater propensity to cause tachycardia
- Greater propensity for hepatotoxicity
- A tendency to cause skin photosensitivity

Chlorpromazine should therefore be used in patients without Medical comorbidity who require sedation

Haloperidol should be used in patients with Medical comorbidity whether or not they require sedation (as it is preferable for the patient to be disruptive and alive rather than asleep and dead.)

DOSE – ADULT

		AVERAGE DOSE RANGE	MAXIMUM DAILY DOSE
CHLORPROMAZINE		200mg - 600mg	900mg
HALOPERIDOL		0.5mg---10mg	30mg

DURATION

		MINIMUM NUMBER OF WEEKS TO WAIT	MAXIMUM NUMBER OF WEEKS TO WAIT
LITTLE OR NO RSPONSE		3 WEEKS	6 WEEKS
PARTIAL RESPONSE		4 WEEKS	10 WEEKS

DEPOT ANTIPSYCHOTICS

Use if adherence to oral medication is a problem or if patients request it for convenience.

If sedation required: Fluphenazine Decanoate 12.5mg – 50mg IMI monthly OR Zuclopenthoixol Decanoate 200mg – 400mg IMI monthly

If sedation not required: Flupenthixol Decanoate 20mg – 40mg IMI monthly

INDICATIONS FOR REFERRAL

a. Diagnostic clarification
b. Poor response to drugs on code
c. Intolerable side effects to drugs on code
d. Prominent negative symptoms
e. Psychotic disorder with mood symptoms

AN APPROACH TO MOOD DISORDERS AND THEIR TREATMENT

MAJOR DEPRESSIVE DISORDER

Major Depressive Disorder (MDD) is a common condition characterised by one or more Major Depressive Episodes (MDE). Depressive disorders have a prevalence of 5-10% in primary care settings. They rank fourth as causes of disability worldwide, and it has been projected that they may rank second by the year 2020. The prevalence of *depressive symptoms* may be as high as 30% in the general population with women being twice as likely to be affected as men. There is high morbidity and mortality associated with depressive disorders. Suicide is the second leading cause of death in persons aged 20-35yrs and depressive disorder is a major factor in around 50% of these deaths. Successful diagnosis and treatment of MDD has been shown to improve both medical and surgical outcomes (e.g. post myocardial infarction). MDD is associated with high rates of comorbid alcohol and substance misuse, and has a considerable social impact on relationships, families, and productivity.

DIAGNOSIS

Core symptoms:

- *Depressed mood* – present most of the day, almost every day.
- *Anhedonia* – diminished interest and pleasure in most activities.
- *Social withdrawal.*
- *Weight change* – usually loss with loss of appetite (may be increased).
- *Disturbed sleep* – usually insomnia, especially early morning waking.
- *Psychomotor retardation or agitation* – observable by others.
- *Fatigue or loss of energy*
- *Loss of motivation.*
- *Poor concentration, attention and memory.*
- *Decreased libido.*
- *Feelings of hopelessness, worthlessness or guilt.*
- *Recurrent thoughts of death or suicide.*

1. Symptoms must be present for at least 2 weeks and represent a change from normal.
2. Symptoms are not secondary to substances, a medical disorder or bereavement.
3. Symptoms cause significant distress and/or impairment in general, social or occupational functioning.

Note:

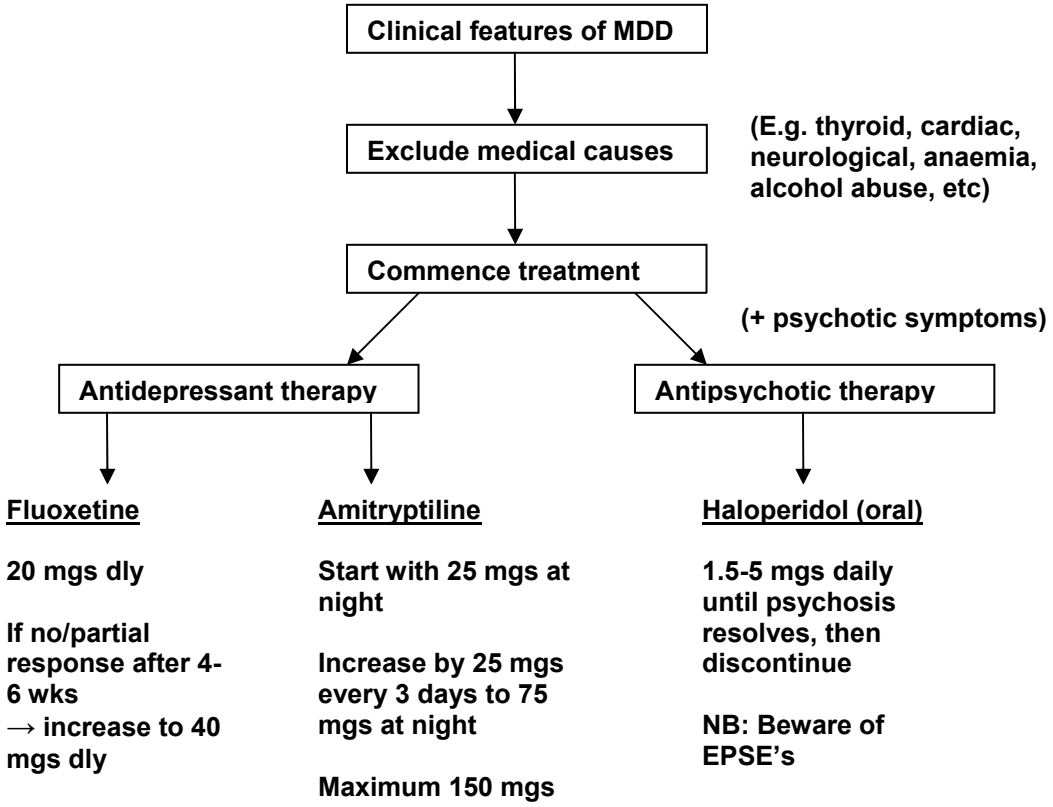
- ❖ Severe MDD may present with *psychotic symptoms* which include delusions (of guilt, disease, punishment, disaster, paranoia) and/or hallucinations (auditory of insulting, accusing voices, visual of demons, death, etc or olfactory of terrible smells).
- ❖ Adolescents and children with MDD should be referred to a psychiatrist for treatment.

TREATMENT

Pharmacological treatment:

1. All antidepressants take 4-6 weeks to achieve maximum effect.
2. There is no evidence for combination antidepressant therapy.
3. Tricyclics (TCA's) and SSRI's are of equal efficacy.
4. Choice of antidepressant depends on side-effect profile; comorbid states and risk of suicide (e.g. avoid TCA's in cardiovascular disease.)
5. Following remission, continue medication for at least another 6 months.
6. At 6 months, review the need for ongoing therapy. When discontinuing medication, taper off slowly over 2 weeks. If symptoms recur, restart medication at the same dose.
7. Patients with 3 or more episodes require maintenance medication.

TREATMENT ALGORITHM FOR MDD



Psychosocial treatment:

1. Crisis management may be indicated.
2. Psychotherapy, e.g. cognitive-behavioural; supportive; family therapy.
3. Usually outpatient treatment is appropriate.

REFERRAL CRITERIA

- Treatment-resistant MDD
- Serious suicide risk
- Children, adolescents or serious co-morbid illness

BIPOLAR DISORDER

Bipolar Disorder (BPD) is a lifelong, episodic illness. It has a variable presentation, is difficult to diagnose and is associated with a relatively high risk of suicide (10%). BPD is characterised by alternating episodes of profound depression, mania, hypomania and mixed states. The diagnosis requires a previous or current episode of mania, hypomania or a mixed episode. Importantly, the treatment of a major depressive episode in BPD differs from that in MDD.

DIAGNOSIS

Manic episodes:

- *Elevated, expansive or irritable mood* – out of keeping with usual state
- *Increased energy* – over-activity, racing thoughts, pressured speech, reduced need for sleep
- *Increased self-esteem* – over-optimistic, grandiosity, over-familiarity, disinhibition, facetiousness, etc
- *Reduced attention/ increased distractibility*
- *High-risk behaviours* – spending, inappropriate sexual behaviour
- *Other* – excitability, irritability, aggressiveness, suspiciousness

1. Elevated mood must be present for at least 1 week (or less if hospitalisation required.)
2. Symptoms are not secondary to substances or a medical disorder.
3. Symptoms cause significant distress and/or impairment in general, social or occupational functioning.

Note:

- ❖ Severe BPD may present with *psychotic symptoms* which include delusions (of grandeur, religiosity or paranoia) and/or hallucinations (auditory of spiritual voices, visual, etc). There is often complete loss of insight.
- ❖ Adolescents and children with BPD should be referred to a psychiatrist for treatment.

Hypomanic episodes:

- *Mildly elevated, expansive or irritable mood*
- *Increased energy* – over-activity, talkativeness, increased sociability, reduced need for sleep, increased libido
- *Increased self-esteem* – over-optimistic, over-familiarity, disinhibition
- *Marked feelings of wellbeing*

1. 3 or more symptoms for at least 4 days
2. Does not impair function or require hospitalisation
3. No psychotic features

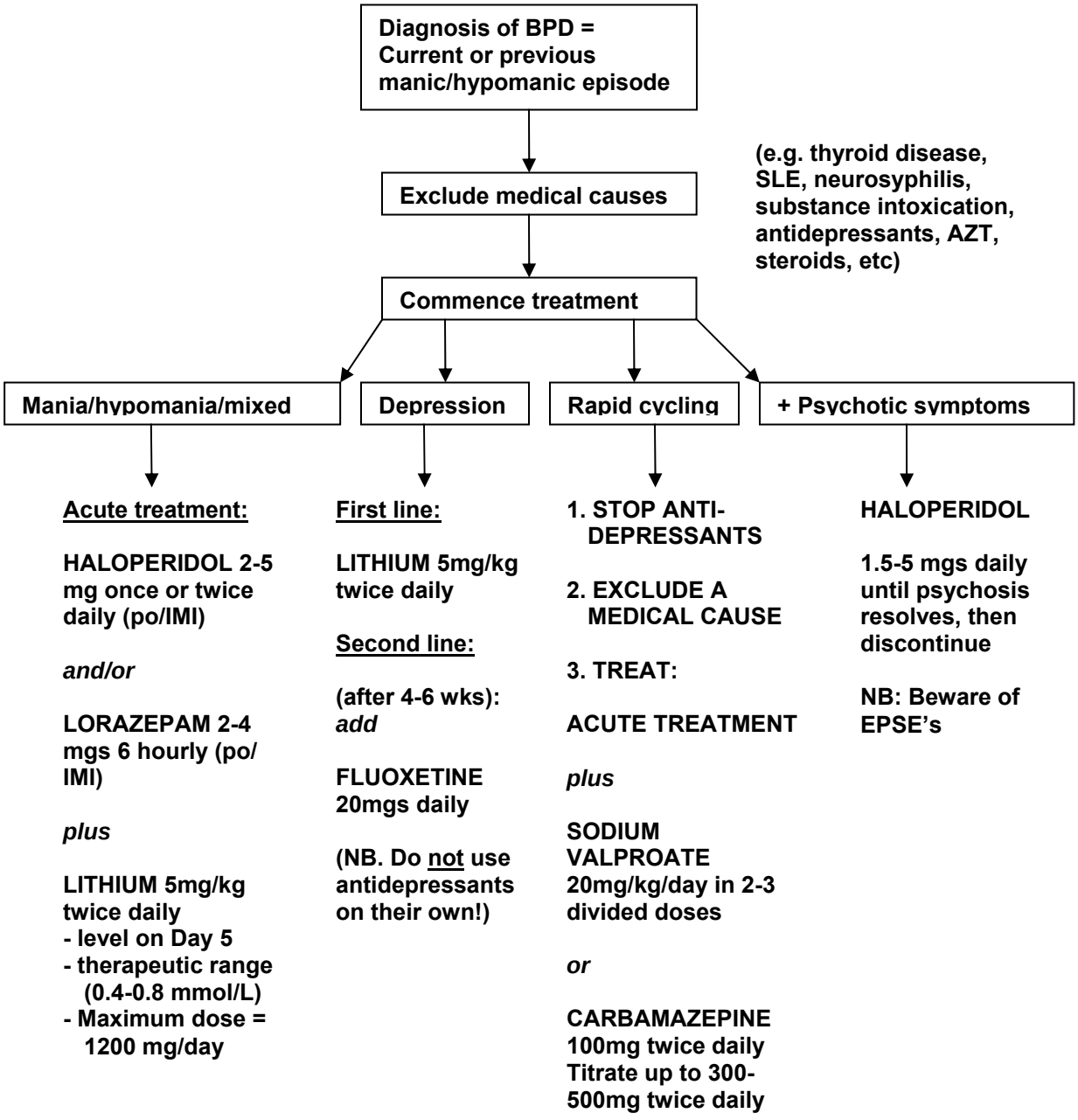
Mixed episodes:

- *Both depressive and manic/ hypomanic symptoms in a single episode*
- *Symptoms present for at least 1 week*

Rapid cycling BPD:

- *4 or more episodes in a year* – with full remission intervening
- *Exclude organic causes* – e.g. hypothyroidism, alcohol abuse, etc

TREATMENT ALGORITHM FOR BPD



MAINTENANCE: Continue Lithium or Sodium Valproate; Wean off antipsychotics and benzodiazepines if possible; Monitor Lithium levels 3 monthly and thyroid and renal function yearly.

REFERRAL CRITERIA

- Treatment-resistant BPD
- Mixed or rapid-cycling states
- BPD patient becomes pregnant

AN APPROACH TO ANXIETY DISORDERS AND THEIR TREATMENT

INTRODUCTION

Anxiety is a normal emotion experienced by everyone.
Distinguish between normal and pathological anxiety.
Normal anxiety allows individuals to function optimally.
Pathological anxiety results in both social and occupational dysfunction.
Anxiety symptoms may be psychological, physical or both.
Symptoms may be part of an anxiety disorder or may be the effects of a general medical condition or substance.

APPROACH TO DIAGNOSING AND TREATING ANXIETY DISORDER

Within the spectrum of anxiety disorders, each disorder has a characteristic set of symptoms. Three symptom groups have been identified viz. panic, phobic and general anxiety.

Step 1:

- Exclude - underlying medical condition
  - substance abuse
- Detailed history and physical examination is essential.
- Common medical conditions include:
  - asthma
  - cardiac disease such as unstable angina
  - hyperthyroidism
- Common substances include:
  - caffeine-containing beverages
  - over-the-counter medications or illicit drugs

Step two: Enquire if:

- the presenting symptoms include panic attacks.
- the presenting symptoms are suggestive of a phobia.
- the presenting symptoms are related to obsessions or compulsions.
- the anxiety symptoms are related to having experienced highly traumatic events.
- the symptoms of anxiety and worry are pervasive and excessive.
- the symptoms are causing social and occupational dysfunction.

Step three: Management includes:

- *biological:*
  - Tricyclic antidepressants
  - Serotonin selective reuptake inhibitors (SSRIs)
  - Benzodiazepines
- *psychosocial:*
  - Psychoeducation for both patient and family
  - Psychotherapy – behaviour modification and cognitive therapy
  - Occupational rehabilitation

1. ASSESSMENT OF PATIENT

This includes:

- detailed history of panic, phobic, general anxiety symptoms
- mental state examination
- physical examination

NB. Once diagnosed, patients require referral for specialist evaluation.

Panic Symptoms	**Phobic Symptoms**	**General Anxiety**	**Other**
- Acute onset of intense fear - palpitations and chest pain - sweating - tremulous - shortness of breath - choking sensation - dizziness - fear of dying	- Fear in relation to a specific object or situation - Avoidance of the offending situation - Anxious participation in such a situation	- Excessive anxiety and worry - Poor concentration - Irritability - Restlessness - Constant anxiety - Difficult to control worry	- Recurrent intrusive thoughts (obsessions) - Ritualistic behavior - Recurrent mental acts (compulsions) - Anxiety symptoms following a traumatic event. Persistent re-experiencing of event, avoidance of stimuli related to event and hyperarousal.

2. INVESTIGATIONS

Initial laboratory tests may be limited to the following:

- Full blood count
- Chemistry profile
- Thyroid function test
- Drug screen
- ECG
- Syphilis serology

3. MANAGEMENT

3.1 PATIENT EDUCATION - Lifestyle modification
- Avoiding excessive caffeine
- Coping with daily stresses
- Sleep hygiene

3.2 PRESCRIBING ANXIOLYTICS

Benzodiazepines - for acute situational anxiety.
- Use should be limited to 4 weeks.
- Clonazepam 0.5mg bd/tds

Antidepressant agents are the drugs of choice in the treatment of anxiety disorders.

- Tricyclic antidepressants – imipramine 25mg to 150mg for panic disorder
- - clomipramine 25mg to 150mg for OCD
- SSRIs - fluoxetine 10mg to 20mg

MANAGING SUBSTANCE AND ALCOHOL PROBLEMS

DEFINITIONS

A. **Alcohol abuse** spans the continuum from brief episodes of excessive drinking to chronic patterns that produce significant problems but never progress to psychological or physical dependence (Table 1).

B. **Alcohol dependence (alcoholism)** is defined as the excessive and recurrent use of alcohol despite medical, psychological, social, and/or economic problems. As classified in DSM-IV (Table 1), it usually includes tolerance and withdrawal symptoms, but these signs of physical dependence are not required for the diagnosis.

Table 1. DSM-IV Diagnostic Criteria

ALCOHOL ABUSE: One or more of the following present at any time during the same 12 month period.

1. Alcohol use results in failure to fulfill **major obligations**.
2. Recurrent use in **physically dangerous situations** (such as drunk driving).
3. Recurrent alcohol-related **legal problems**.
4. Continued use despite recurrent **social or interpersonal problems**.
5. Has never met criteria for Alcohol Dependence.

ALCOHOL DEPENDENCE: Three or more of the following present at any time during the same 12-month period.

1. **Tolerance**.
2. **Withdrawal**.
3. Use in **larger amounts**, or for **longer periods** than intended.
4. Unsuccessful **efforts to cut down** or control use.
5. A great deal of **time spent** obtaining alcohol, using or recovering from alcohol use.
6. **Important activities given up**.
7. **Continued use despite knowledge** of problems.

Source: Adapted from *DSM-IV* Criteria for Substance Abuse and Substance Dependence, American Psychiatric Association, 1994.

COMPREHENSIVE DIAGNOSTIC ASSESSMENT COVERING

1. Alcohol use – patterns, quantity, assess for abuse or dependence.
2. Comorbid general medical conditions.
3. Comorbid psychological/psychiatric conditions.
4. Social and occupational functioning and support systems.
5. Use of other substances.
6. Investigations where indicated.

MANAGEMENT

Intoxication:

- *Mild* – self limiting, safe environment, supportive interventions
- *Severe* – e.g. history of withdrawal symptoms → admit to hospital
  Monitor clinical state; supportive interventions
  Gastric lavage if recently ingested substances

LONG TERM GOALS – ABSTAINANCE, RELAPSE PREVENTION & REHABILITATION

Withdrawal:

DETOXIFICATION:

- *Mild*
  - Sweating, anxious, tremor; lasts hours to 1 – 2 days
  - Rx as Out-patient; ensure support, caregiver
  - Diazepam regime; start 5 – 10 mg. tds po and taper over 10 days
  - Thiamine 100 mg. daily po; MVT tablet daily; Vit B Co 2 daily tablets

- *Severe*
  - Complicated with past history of seizures, 'DT's, fever, physically ill
  - Treat as in-patient
  - Ensure adequate hydration – IV 5% Dextrose water
  - Diazepam 5-10 mg. every 2 – 4 hours until stable in first 24 hours;
  - Then stabilization dose in 4 divided doses the following day;
  - Then taper over 3-5 days
  - Thiamine 100 mg. daily, IV initially then po
  - MVT one tablet daily; Vit. B Co 2 tablets daily
  - Reduce external stimuli
  - Monitor clinical status, and intervene as indicated
  - If history of withdrawal seizures, Diazepam is effective *OR*
    Carbamazepine 600-800 mg/day for 48 hours then taper by 200 mg/day
  - Withdrawal seizures → Phenytoin IV 10 mg/kg
  - Psychosis → Haloperidol 0.5-5mg tds, po or IMI
  - Aggressive/Restless → Lorazepam 2-4mg IMI 8hourly

REHABILITATION:

Various treatment settings:
SANCA – OUT PATIENT
REHABILITATION PROGRAMMES – IN PATIENT
SELF HELP - AA

THE MANAGEMENT OF DELIRIUM

DEFINITION

Delirium is the acute or subacute onset, over a period of hours or days, of impaired cognitive functioning as a result of diffuse brain dysfunction. The central feature is a fluctuating level of consciousness.

CLINICAL FEATURES

NB. a change in the level of consciousness

- Changes in behaviour i.e. increased or decreased activity
- Thought processes are fragmented and incoherent. Sleep disturbance
- Hallucinations tend to be visual or tactile, and delusions are transitory and fragmented
- Mood may be anxious, irritable or fearful. Perplexity is characteristic. Labile mood
- Memory is markedly affected, registration and new learning are impaired
- Disorientation is more marked for time than place or person
- Neurological signs e.g. unsteady gait, tremor, asterixis, myoclonus, paratonia

CAUSES

- CNS disorders e.g. trauma, seizures, vascular disease, degenerative disease
- Metabolic disorder e.g. hypoxia, hypoglycaemia, thiamine deficiency, anaemia, renal or hepatic failure, electrolyte imbalance
- Cardiopulmonary disorder e.g. CCF, MI, arrhythmia, shock, respiratory failure
- Systemic illness e.g. substance intoxication or withdrawal, infection, neoplasm, postoperative state, temperature dysregulation

MANAGEMENT OF DELIRIUM

Basic principle – treat underlying cause

General Principle – alleviate distress, control anxiety, reassure patient. Prevent self-harm, monitor vital signs, maintain adequate fluid balance, nurse in a well-lit room and prevent further complications. Regularly monitor symptoms and behaviours as they can fluctuate rapidly.

Specific management – appropriate investigations to identify underlying cause e.g. blood screen including full blood count, urinalysis, chest x-ray, arterial blood gases
Additional tests if indicated include blood cultures, LP, CT, EEG, drug screen
Screening tools: Cognitive testing e.g. Folstein MMSE, Delirium Rating Scale (DRS)

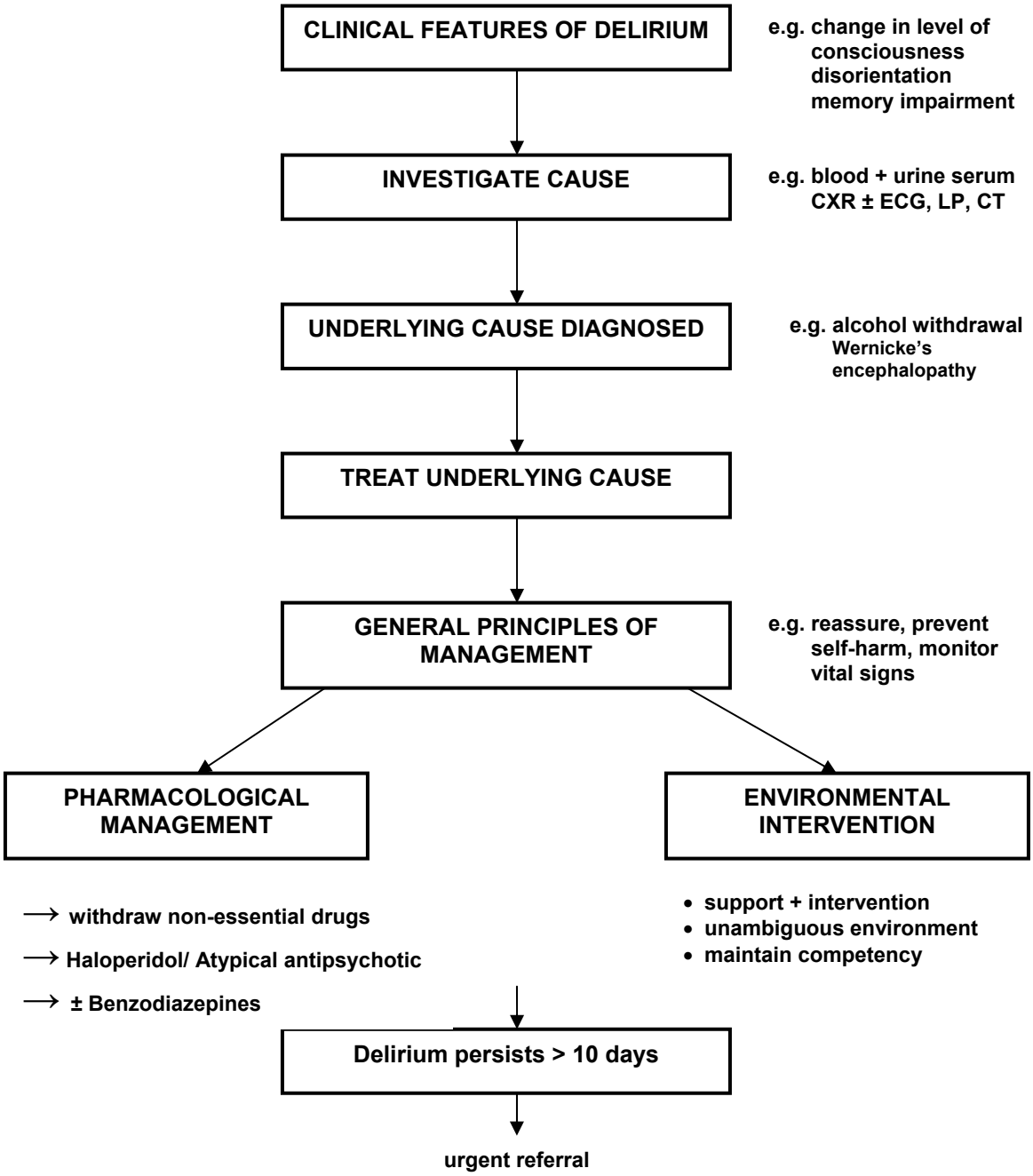
Pharmacological management – withdraw all non-essential drugs
Haloperidol is frequently used because it has few anticholinergic side effects, few active metabolites, and a relatively small likelihood of causing sedation and hypotension.

- Haloperidol 1-5mg two to three times a day orally, increasing to haloperidol 10mg three times a day, for the more agitated or behaviourally disturbed patient (alternatively, IMI route): Risperidone, Olanzapine and Quetiapine are increasingly being used, due to their more tolerable side effect profile.
- Benzodiazepines as monotherapy are generally reserved for patients with delirium caused by seizures or withdrawal from alcohol/ sedative hypnotics
- Diazepam is an option but it has a long half life and therefore accumulates within the body. Further complications include a disinhibiting effect, further disturbing behaviour, and, in the longer term, dependency in vulnerable persons. Useful starting doses are Diazepam 2-5mg two to three times a day, titrating up to Diazepam 10mg three times a day.
- In the more agitated patient Lorazepam 2-4mg IMI is useful. It can be repeated at eight-hourly intervals for no longer than 72 hours.
- Regular monitoring is mandatory. Once patient stabilizes, gradually taper and discontinue medication.
- By treating the underlying cause, the features of delirium should resolve in a matter of days. The symptomatic treatment described previously should then be withdrawn. A delirium persisting for more than ten days requires urgent referral.

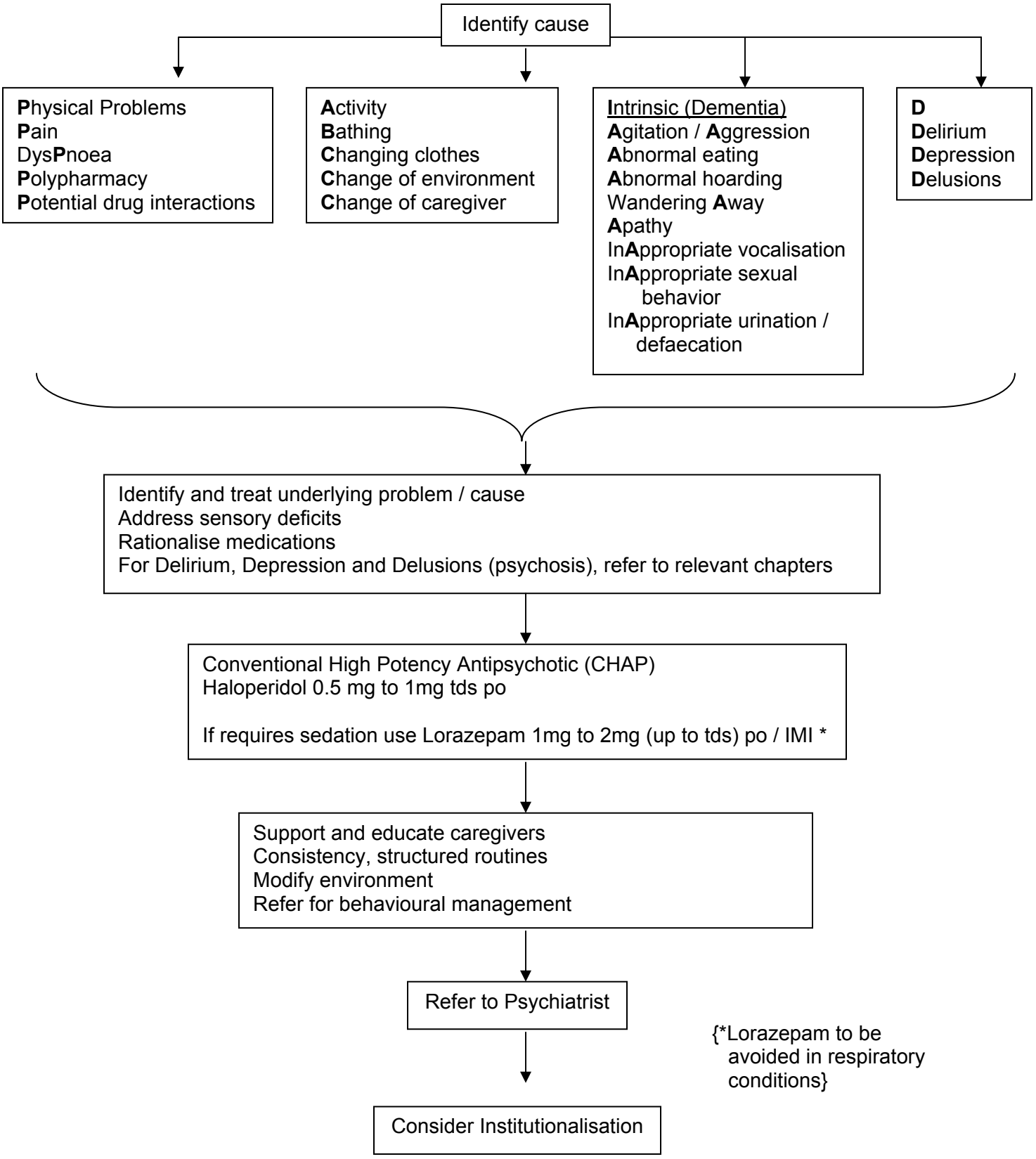
Environmental Interventions:

1. Provide support and orientation: communicate clearly, repeated verbal reminders, clear signposts with a clock, calendar and day's schedule. Ensure staff consistency and family support.
2. Provide an unambiguous environment: allow adequate space, avoid extremes of sensory experience, avoid medical jargon, ensure adequate lighting.
3. Maintain competency: identify and correct sensory impairments, encourage self-care and participation in treatment, allow maximum periods of uninterrupted sleep and maintain activity levels.

DELIRIUM ALGORITHM



BEHAVIOURAL PROBLEMS IN THE ELDERLY



{*Lorazepam to be avoided in respiratory conditions}

DISRUPTIVE BEHAVIOUR PROBLEMS IN CHILDREN AND ADOLESCENTS

Long Standing

Symptoms

- Hyperactivity
- Impulsivity
- Inattention
- Developmentally appropriate
- in more than 1 setting before age 7

→ ADHD

Disruptive behaviour + Breaking rules, e.g. lies, steals, truancy, aggression

- No violation of rights of others → Oppositional defiant disorder
- Violates rights of others e.g. physically/ sexually, running away → Conduct disorder

Delayed milestones + Disruptive behaviour + Impulsivity

→ Mental retardation with behavioural problems

Management

- Counselling for parent and child
- Medication – stimulant e.g. methylphenidate, dose 10-60mg per day in divided doses; monitor side effects
- Alternatively, if has tic disorder, imipramine or clonidine
- Appropriate school placement

- Psychological
- Social

- Psychotherapy
- Risperidone
- Appropriate school placement

Recent onset

- Substance abuse
- Psychiatric e.g. depression
  → Management through counselling and SSRI
- Abuse
- Chaotic home circumstances

Note:
1) Often have co-morbidity
2) Use 1 drug at a time
3) Always combine psychosocial interventions for effective management
4) Refer for further psychological/ psychiatric assessment if poor response

BEDWETTING

Long Standing

Primary = never been dry

Exclude:

- General Medical Condition
  - Neurological e.g. seizures
  - Spinal disorders
  - Urological disorders, including bladder dysfunction
- Drugs
- Psychosocial
  - E.g. abuse, inadequate toilet training

↓

Diagnosis of Enuresis:

- Repeated voiding of urine
- Minimum developmental age of 5 years
- Twice a week for at least 3 months

↓

Management:

- Reassure
- Education to parent
- Behaviour modification – bladder training, fluid restriction
- Medication – Imipramine 10 – 50mg nocte, start low and titrate dose
- Monitor pulse and BP
- Monitor cardiac S/E

Recent onset

Secondary = Been dry and now wetting self

Exclude:

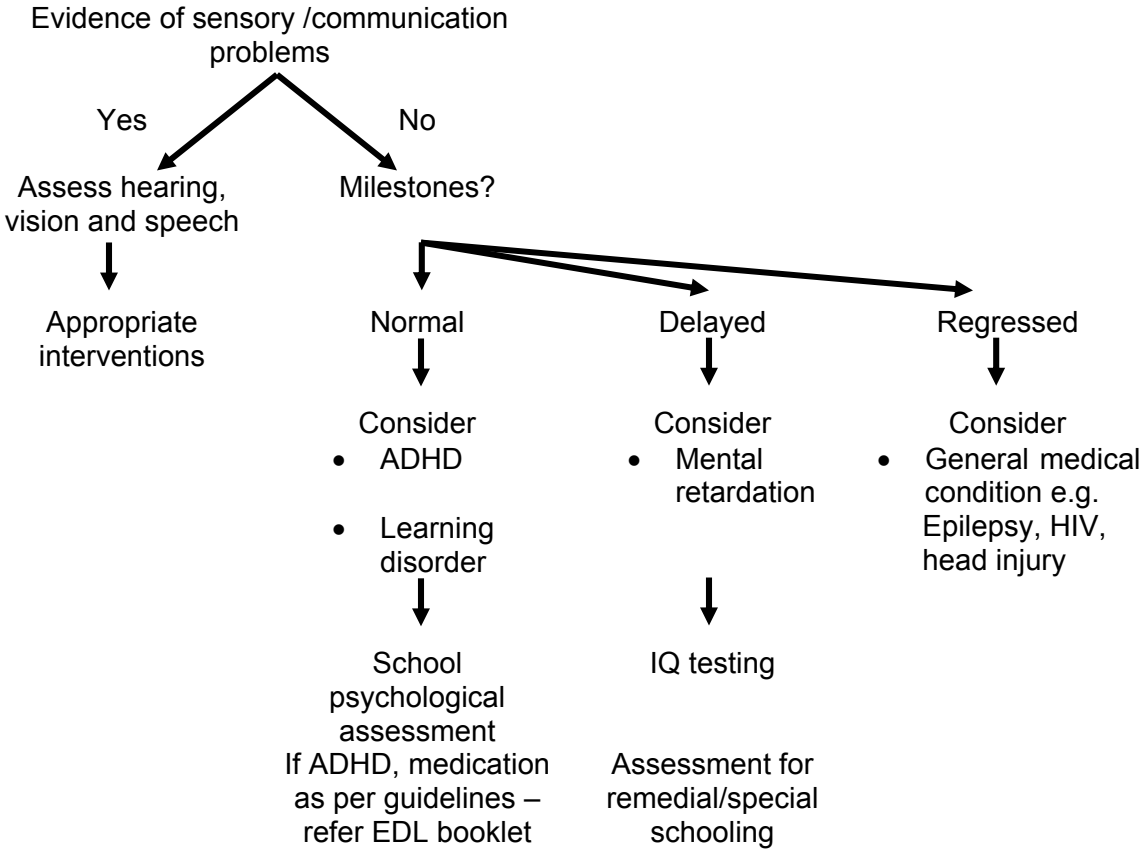
- Biological – medical, e.g.
  - Urinary tract infection - investigate accordingly
  - Seizure - investigate accordingly
- Psychosocial
  - Family disorganised, neglect, sexual abuse

↓ NO

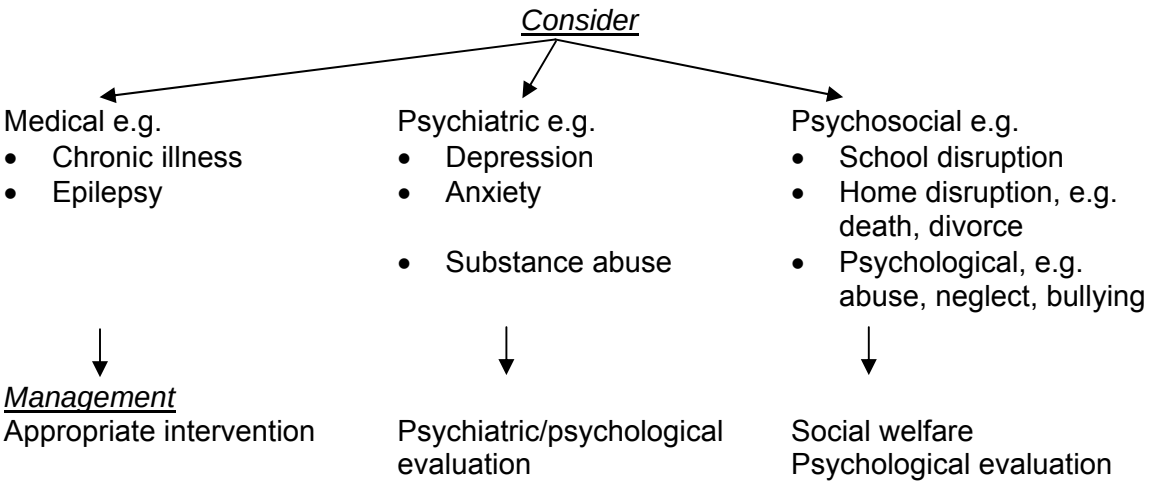
Treat as for enuresis (see above)

POOR SCHOOL PERFORMANCE

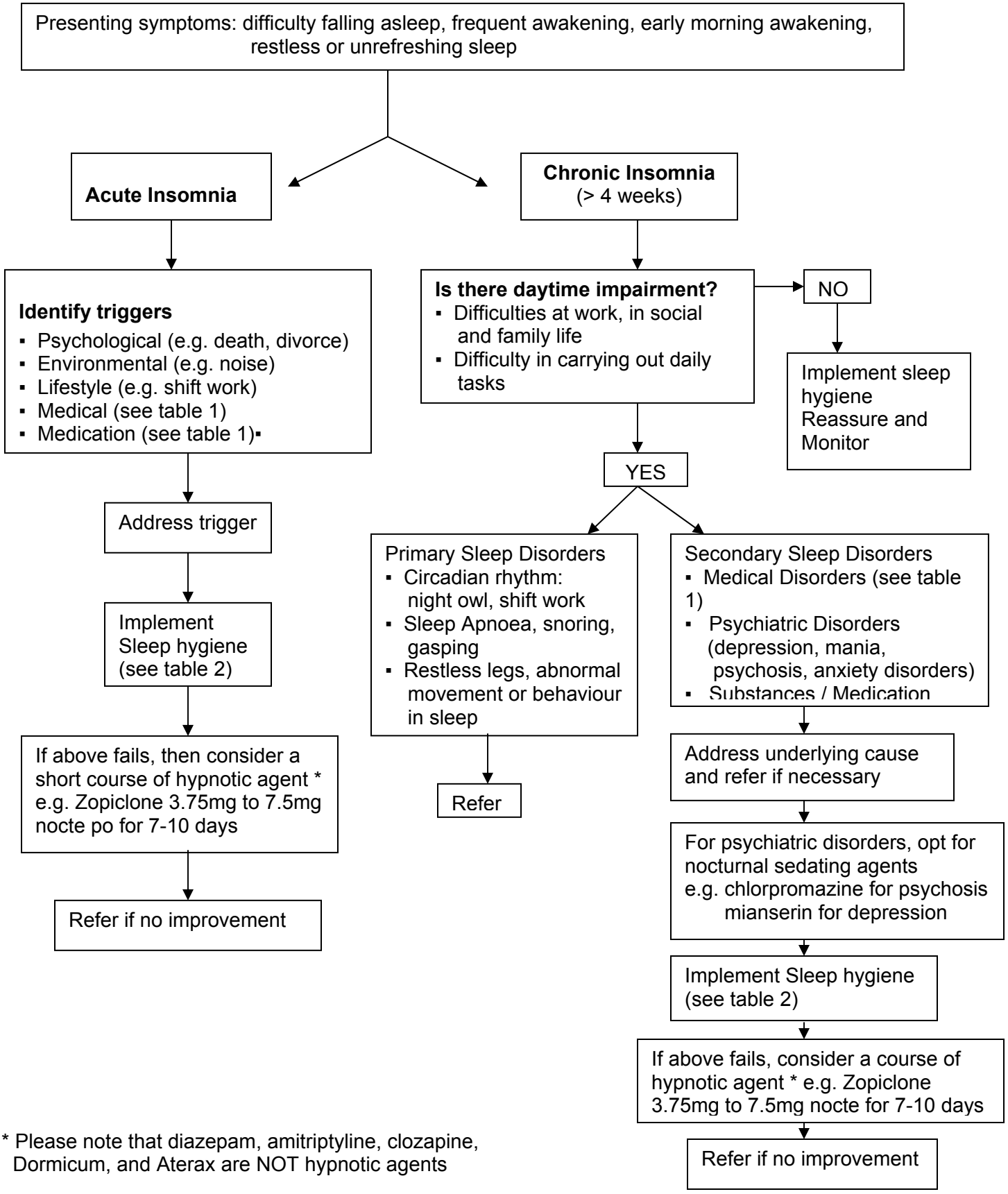
Long Standing



Recent onset



THE MANAGEMENT OF INSOMNIA



* Please note that diazepam, amitriptyline, clozapine, Dormicum, and Aterax are NOT hypnotic agents

Table 1: Causes of Insomnia

Cardiovascular disease	Cardiac failure Arrhythmias
Gastrointestinal disease	Gastro-oesophageal reflux Peptic ulcer disease
Respiratory diseases	Dyspnoea from any cause Asthma Chronic obstructive airway disease
Endocrine disorders	Menopause Hyperthyroidism Hypothyroidism
Neurological diseases	Parkinson's Alzheimer's
Other medical conditions	Obesity Pain from any source or cause
Substances	Alcohol Caffeine Nicotine Amphetamines e.g. tik Hallucinogens e.g. ecstasy Cocaine
Medications	Corticosteroids Decongestants Stimulants e.g. Ritalin Beta blockers Theophylline Amphotericin B Ciprofloxacin

Table 2: Sleep Hygiene

- Avoid oversleeping and daytime naps
- Develop a regular routine of rising and retiring the same time each day
- Do not work at falling asleep, rather read a book until you become drowsy
- Practice relaxation techniques e.g. deep breathing exercises
- Reduce noise and light in the bedroom, or try low background music
- Only use the bed for sleeping, do not watch TV in bed
- Do not go to bed hungry, but do not overeat either
- Do not drink beverages that contain caffeine, e.g. coffee, Red Bull in the evening
- Do not consume alcohol at night
- Do not smoke in the evening
- Exercise every day, but not too strenuously before bedtime
- Try to lead an active life e.g. go for a brisk walk daily
- Avoid chronic use of sleeping pills

FORENSIC PSYCHIATRY ISSUES

INTRODUCTION

The area of mental illness and crime is a specialized topic and many medico-legal factors need to be considered.

For the purposes of these guidelines we are just looking at the basic procedures that need to be done.

The forensic observation unit is based at Fort Napier Hospital (Pietermaritzburg) and services the entire KZN region.

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THE CRIMINAL PROCEDURE ACT (CPA)

(a) The CPA guides the process on how to deal with mentally ill criminal offenders. Section 79, 78 and 77 explain the process.
(b) It is the responsibility of the SAPS and Court Prosecutors / Magistrates to deal with these cases. Medical personnel will only be requested to give an opinion and do not have to arrange the entire process.
(c) Once an individual has committed a crime and has been charged, they are awaiting trial cases and not Mental Health Care Users in terms of the MHCA. They fall under Correctional Services and SAPS.

PROCEDURES

a) If a person is brought to a clinic or hospital and you are aware that they have committed a crime, you are required to inform the SAPS even if the family does not want to lay charges against the individual e.g. domestic violence cases.
b) If the issue of mental illness or mental retardation (intellectual disability) is raised, this is a matter for the court to decide if the person should be sent for a 30 day observation period at FNH.
c) The court may ask for the Mental Health Care Practitioner to offer an opinion, but you do not have to make any comment regarding their fitness to stand trial.
d) If the individual is acutely medically or psychiatrically ill, then this should be the priority to treat first then deal with the legal issues.

e) The individual may be treated at a local hospital (with SAPS guarding her/him) or in a detention centre or correctional facility that has medical and or psychiatric services available.
f) It is important to ensure that the individual does not have a head injury, infection, epilepsy or any cause of delirium (see management of psychiatric patients with medical conditions).
g) Once the individual is stable he can be sent to court to stand trial. The court may wish to send the individual to FNH, but a booking has to be made first for a bed. There is currently a waiting list.
h) The awaiting trial individual should be kept in a detention centre unless the court has granted bail.
i) Once the case has started it becomes a legal process and medical or psychiatric intervention will be on a required basis only.

MENTALLY ILL PRISONERS

(a) Convicted individuals who become mentally ill may be seen on an out-patient basis brought by correctional service staff.
(b) They are prisoners and should be treated within the prison.
(c) Most prisons have doctors who see to the medical or psychiatric needs of the prisoners.
(d) Advice can be given as to how to treat the prisoner in the prison by the prison doctor or nursing staff.

STATE PATIENTS ON LEAVE FROM FNH

(a) Once a person has been declared a State Patient by the court, he/she is treated at Fort Napier Hospital.
(b) The State Patients are sent out on leave to their families intermittently.
(c) They will require medication and depot injections, which would be clearly indicated on the documentation sent from FNH.
(d) A six monthly report may also need to be filled in by the district hospital doctor. This report will be supplied to the hospital and needs to be completed and sent to FNH.