Psychiatric Emergencies Offshore

Contents

Introduction

Psychiatry is a specialist area concerning disorders of the mind. The full range of psychiatric illness covers everything from minor disorders related to life events to major psychosis. As an offshore medic you would not be expected to become an expert in these disorders however you must be prepared for every eventuality.

The type of individual you might be presented with may just be unhappy with life in general and so finding it difficult to concentrate as they are preoccupied with their own problems. Alternatively, they may be completely disruptive thus creating confusion and distress within the close offshore community.

Either way they may not be open to any advice or reasoning from yourself or colleagues and friends on board.

For the safety and wellbeing of the said individual and or the crew and vessel, a speedy resolution must be sought.

It is worth noting that this kind of emergency will be time consuming and will have a serious impact on the rest of your day-to-day activities, it will also be one of the most difficult types of medical emergency to resolve in the offshore or remote setting.

This unit is designed to give you general management guidelines on the management of such conditions, but you must read and adhere to local guidelines and protocols. You will also need to be flexible and sensitive in your approach.

1. Review

To conduct a comprehensive psychiatric interview requires:

- Method
- Time
- Patience
- Experience

The objective being to make an assessment of your patient's illness, and on the basis of your assessment and Topsides advice, deal with the situation appropriately and as speedily as possible. By following the systems below, you will be able to gather all aspects of your patient's background. Where it is possible you should endeavour to obtain a full history of the presenting illness together with:

- General Health
- Family history
- Past illness
- Psychiatric illness
- Social history
- Drug taking and alcohol consumption
- Work, colleagues and life on board

Consider:

- Appearance and behaviour
- Speech form
- Mood
- Beliefs and thoughts
- (Suicidal, worries, phobias)
- Delusions
- Hallucinations
- Cognition
- Insight

Organic causes:

- Hypoglycaemia
- Infection
- Cardiac failure
- Alcohol abuse (delirium tremens)
- Substance abuse
- Subdural haematoma

Red flags for suicide:

- Present or previous psychiatric illness
- Personality disorder
- Previous suicide attempts or self-harm.
- Suicidal thoughts / family history of suicide
- Demographic – male - > 40yrs. Single/unmarried/divorced, Unemployed, alcohol excess and a recent life crisis

Note: Do not try and play the part of an amateur psychologist. Do not offer the patient any explanations for their illness as this is unlikely to be of any help to them or yourself.

In order for you to take a history of your patient's current complaint you will have to address some areas which are very different from those in a physical illness.

Specific questions should be asked about:

- How is their mood?
- Are they anxious or depressed?
- If so for how long?
- Do they feel the same level of mood disturbance all the time?
- Alternatively is the level of mood disturbance altered by external events?
- Are there particular times of day when they feel worse or better?
- Do they feel tearful at times?

The next question is regarding sleep patterns and disturbance:

People often find it difficult to get off to sleep when they are worried or anxious, wakening very early in the morning and being unable to get back off to sleep suggests significant depressive illness.

You then need to ask questions such as:

- Do you have problems concentrating?
- An example of the above could be, do you have trouble following TV programmes, does your mind wander?
- Have they been getting out and about recently when at home?
- Have they stopped activities such as Golf or meeting friends for an evening?

If your patient is expressing strange ideas, try to understand what is behind them. If they are expressing delusions (fixed unshakable false convictions) no amount of explanation or argument will change their view. These are often paranoid in nature:

- People are plotting against them
- They might feel they are at great risk of physical injury from people who want to harm them
- They may hallucinate (auditory are often found in schizophrenia, taking the form of voices)
- They might tell you they hear voices from the TV or other electrical equipment
- The voices might be talking to them or about them

Last of all try to assess how the patient is communicating with you.

- Are they speaking very fast with words and information and ideas bursting out at you?
- Or are they subdued and monosyllabic?
- Are they restless?
- Trembling?
- Moving around the room rapidly and apparently pointlessly?
- Are they lying on their bed motionless?
- Are they and refusing to speak and not making eye contact?

2. Case studies

We have used two case studies to illustrate.

Case Study: Phil's Tale

Phil is an engineering foreman. On two occasions within the space of three days he had been unable to board the helicopter that was to take him from the accommodation barge to the satellite platform. The idea caused him to become sweaty and anxious. Phil was a man of 40 years, 20 of which he'd spent working in the offshore industry.

What had brought on this sudden irrational fear? To find out, you'll need to take a history.

History taking

1. Welcome him, sit him down, act in a friendly manner.
2. Give him an opening. Traditional expressions such as:

'What seems to be the trouble?' or *'How can I help you?*' are best.

It is important that you allow the patient to tell his tale in his own words.

Give him time and only interrupt if, either he needs encouragement to continue, or he is rambling in a meaningless way. Use only general comments. It's more important that you keep him talking rather than respond at this stage.

Phil: *"I don't know why, I just couldn't face the idea of getting on that helicopter. I hadn't slept too well during the night and when I got up that morning, I immediately felt a sense of panic. I suppose I was frightened that the helicopter might crash."*

Phil continues… *"Anyway, I got dressed and forced myself to have a bit of breakfast. I thought that if I stuck to the usual routine I would settle down and stop being so stupid. After all I've been flying about in helicopters for the last twenty years. Not that I have ever been very keen on flying but you just get used to it and put your fears to the back of your mind."*

At this point Phil stopped. He looked down at his hands and rubbed them together. When he looked up his eyes were moist.

"I don't know what else to say. I've got work to do, but at the moment, I just don't think I could face it. Can you give me something to calm me down a bit?"

You are on the spot and, if Phil is having problems at work, you will have a better understanding of these problems than a psychiatrist will for example. Furthermore, the cause of Phil's problem needs to be resolved as quickly as possible otherwise he is going to be unable to earn a living. You are seeing Phil in the acute phase. The fact that he can open up to you will, in itself, be very therapeutic for him.

Back to the history taking

So far Phil has given you a brief account of how he sees the problem as it affects him.

How does it affect him as far as he is concerned? What can he do?

The problem affects him to the extent that he says: *"I can't board a helicopter"*.

Phil, by asking for something to help, feels he's reached the end of his explanation of the situation. But, we know better - we need to learn how Phil is viewing things at the moment. There are 3 things that are affecting Phil's wellbeing, what are they?

Those things that will affect him directly are:

- His work
- His home
- His current physical health

Let's ask Phil:

"What about your work Phil? Any problems there?"

Phil: *"No not really. I've been doing this job for years, so I know it backwards. We've been under a bit of pressure these last few months, as you know, but then so has everybody else on the platform."*

"Tell me a bit more"

Phil: *"Well, we're fabricating some new panels for the accommodation extension. I'm the foreman you understand. I've got four men working for me. We've got behind with the schedule because the materials didn't get here on time. I've had to work long hours I admit."*

"How long?"

Phil: *"Well, I've only had a couple of days break between trips for the past two months. The day before yesterday I worked 36 hours without rest. I admit I haven't had much sleep this week."*

And so it transpires that Phil is close to exhaustion. Having got as full a story as seems necessary on the work front, it's time to get Phil to talk about his domestic situation. Before we do that, you might like to consider the problems facing a couple or a family when one partner is away from home for long and regular periods. You may have experienced this yourself and you'll have probably learned that even shift or night duty brings its own problems.

"Everything all right at home Phil?"

Phil: *"Wife hasn't been too good lately. She's got to see a specialist next week. She's really nervous about going. Wish I could go with her, but I'll probably be stuck on this bloody platform."*

Again, Phil stops and tears well up in his eyes.

"How's your general health been lately, Phil?"

Phil: *"Can't complain."*

What would you do now? You must pursue this. Ask the direct questions suggested about mood, sleep pattern etc.

Phil: "Well, as you ask, yes, I suppose I have been rather bad-tempered lately but that's because of the pressure we are all under."

Note: Men often admit to being irritable rather than feeling low in spirits.

Phil: *"I feel absolutely knackered. I can't keep my mind on the job. I want to sleep, but as soon as my head hits the pillow, I'm awake. I've got permanent indigestion. So what do you make of all that? … Sorry, I didn't mean to snap."*

Phil is starting to get irritated. Tears well up in his eyes and pour down his face. There is no need for you to react or feel embarrassed. Just allow the moment to pass and carry on with your enquiry.

You've covered work and domestic matters, and Phil has given you an idea of the way it affects him. What else would you want to check on? Is there any help Phil might be giving

himself? You would need to enquire about alcohol and cigarette consumption as Phil may be using either or both to excess to help him get along.

As he has only been at home a few days here and there, Phil has not had much opportunity to drink alcohol. He is however smoking 40 cigarettes a day.

General Procedure

Here a formal psychiatric interview would continue with enquiries about background, family history, and life history. This is not of immediate relevance here and would probably not be pursued unless the cause of Phil's disorder remains a mystery, particularly as he is starting to get fed up.

However, you have now been given enough information to make a fair assessment as to why Phil is 'breaking down'.

There are various tools we can use for helping assess a patient's presentation.

For anxiety we can suspected anxiety we can use GAD-7, this is a seven-item instrument that is used to assess generalised anxiety disorder (GAD). Each item asks the individual to rate the severity of his or her symptoms over the past two weeks.

Although there are many patients with other disorders, such as social phobia, post-traumatic stress disorder, who need clinical attention, the GAD-7 provides only probable diagnosis that should be confirmed by further evaluation

Patient health questionnaire (PHQ-9) is a self-administered diagnostic instrument for common mental disorders. The nine-item questionnaire the severity of depression.

Case Study: Ian's Tale

Ian is a young steward who has worked on the installation for a few years. He is a pleasant young man who is a hard worker and is generally well liked. He married shortly after starting on the installation and has a little girl who is 18 months old.

Over the past few trips he has seemed a little quieter than normal but nothing that has caused you any specific concern. Today however, the Camp Boss has a word with you about him. The standard of his work has been slipping and there is going to have to be a disciplinary hearing, but he wants you to speak to him first. He has been such a good worker that he feels there may be something behind his current poor work and he doesn't want to make things worse.

You want to ask around to see if anyone else has noticed any change in Ian so that you can begin to get a feel for the situation but you need to do it subtly so that you don't breach confidentiality.

This leads to you joining the catering staff at one of their breaks, something you do from time to time anyway so you feel confident no-one will read anything into your behaviour. Luckily for you, Ian is the main subject of conversation. His roommate is complaining that Ian keeps getting up very early in the morning, disturbing his sleep. He feels he has been carrying Ian these last few trips and this is the last straw. He tried to speak to Ian about it but ended up get his head bitten off. Everyone else joins in with complaints about his poor work and his grumpiness.

Armed with this, you arrange to see Ian in the Sick Bay that evening. He wasn't keen to come but you managed to persuade him. Now you are worried about how you are going to manage the situation. How should you start? What if you just end up irritating him further?

When he does arrive he says virtually nothing and avoids eye contact. Close up you realise he looks dreadful; he has lost weight and he is grubby and poorly shaved. In these circumstances, it is best to be honest with the patient and let him know that people have noticed that he is not himself and in what way.

Reluctantly at first, Ian finally admits to not feeling right for some months. He feels he can't be bothered with work or with people and even when he is at home he takes little interest in his house or family.

Loss of interest alerts you to the fact that he may be depressed so you ask questions specifically to try to clarify this.

On direct questioning he admits to loss of appetite and weight loss of a stone. He tells you he gets to sleep without problems at night because he is exhausted but wakes at 3 am every morning and cannot get back to sleep. He gets up and sits in the TV lounge dreading the day ahead and can't even be bothered showering or shaving.

He doesn't feel depressed he says but has been very irritable with everyone, even his wife and child. He feels his marriage is in trouble and his wife won't put up with him for much longer. He feels miserable about the future because he cannot see things getting better and really his family would be better without him.

Further questioning tells you that he has never been like this before but that his father committed suicide when he was still at school.

Asking someone whether he feels suicidal is one of the most difficult questions to pose. Not to ask it however may mean that you miss the signs of the severity of the illness with the attendant risk involved.

The best way is to be direct:

"Things sound as if they are really bad for you just now and it must be difficult going on. Do you ever think it would be easier just to end it all?"

Often the patient will say that it has crossed their mind, but they have dismissed it because they couldn't think of the grief it would cause to their family – this is worth interpreting as a "yes" and taking it further.

Ask if they have ever thought about it in any detail –for example, choosing a method. If they admit to this then the patient has a very high suicide risk and must be managed accordingly. The offshore environment offers many possibilities for someone intent on committing suicide and there have been several cases over the years.

It is a myth that those who talk about suicide do not do it – many do. Those who have a family history of suicide are at increased risk.

Several aspects of this case alert you to the fact that this is a case of severe depression, even before you ask about suicidal intent:

- Self-neglect
- Early morning wakening
- Loss of hope in the future
- Feeling that others would be better if he were no longer there

Often depressed patients feel a little better having admitted that there is something wrong with them. They find it a huge effort to try to keep a front up so there is a sense of relief in being able to let this drop.

At this stage, you need to speak to the Topside doctor to discuss getting Ian medevac'd and treated. Nothing can be done for him offshore and he is a serious suicide risk. He may be

concerned about his job and his future at this stage, fearing they will be at risk if it is known he has had a psychiatric illness.

He needs to be reassured that the illness is treatable and that a full recovery is possible with a return normal life.

In a case of this severity it is a kindness to offer some sedation, perhaps with a benzodiazepine whilst transportation is being organised. He should remain under your direct supervision until he leaves the installation and would be best with a First Aid escort in the helicopter. The Topside doctor will arrange for him to be assessed at a suitable psychiatric hospital.

In using Ian's case as an example, we have addressed depressive illness at the extreme end of the range. Many cases are more minor but essentially anyone with any evidence of depression should be medevac'd.

Many cases which you will see will be related to events in someone's life e.g. marital problems or family difficulties. In Ian's case the likely cause is genetic given his family history. With the correct treatment, the prognosis is good.

3. Psychiatric Emergencies and Management

Psychosis

Key Features

- Disordered thinking and behaviour
- Delusions – unshakable beliefs, paranoia, being watched, feel they are “on a mission”.
- Hallucinations – visual or auditory, sometimes a characteristic of delirium.
- Behavioural abnormalities – varies from aggressive and threatening to withdrawn and argumentative.

Treatment

- Contact topside.
- Remain calm when approaching patient and empathetic.
- 5 – 10ml IV/IM Diazepam in addition to IV/IM antipsychotic e.g. Haloperidol (2.5 – 5mg IV/IM)

Considerations

Restraint – Under the OIM`s – not under the Mental Health Act 1983

- Have a clear plan and sufficient numbers of staff available.
- OSM priority is to maintain airway and administer medication.
- When using manual restraint, avoid taking them to the floor, but if this becomes necessary: use the supine (face up) position if possible, or if the prone (face down) position is necessary, use it for as shortest time as possible.
- Do not use restraint that in anyway that interferes with their airway, breathing or circulation e.g., applying pressure to the ribcage, neck or abdomen or obstructing mouth or nose.

Depression

Key Features

- Misery
- Lethargy and lack of motivation
- Low self esteem
- Agitation and guilt
- Early morning wakening
- Weight loss
- Self-neglect
- Suicidal thoughts
- Crew approaches medic with concerns for colleague

Treatment

- Good communication, sympathetic approach, and an ear to listen.
- Complete questionnaire PHQ9 and GAD7 (see appendix)
- Call Topside discuss the need for follow up and support.
- Any indication of self-harm or suicidal thoughts Medivac

Anxiety

Key Features

- Physical
  - Tachycardia /palpitations
  - Dry mouth /sweating
  - Breathlessness / flushing
  - Tremors
  - Urine frequency
  - Nausea / diarrhoea
  - Hyperventilation
- Psychological
  - Fear / apprehension
  - Loss of patience / irritability
  - Insomnia

Treatment

- Reassurance is the best treatment.
- Hyperventilation can be controlled by making the patient breathe in and out of a paper bag until the symptoms resolve
- Call Topside for advice with regard to the longer plan

Insomnia

Key Features

A common complaint offshore due to shift pattern, noise, anxiety, and jet lag. The medic must follow a thorough examination to identify and rule out any underlying problems such as depression.

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Questions for your tutor