Managing Common Mental Health Problems

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Psychiatry – A world in one subject!

• The Brain – one organ or multiple systems?

• “Disorders” – remembering these are essentially syndromes

• Mind or matter? – Usually both!

• Working with multidimensional processes.

• Complexity! So always a work in progress.
When?

• Do you have any problems sleeping at night?
• Have you been feeling as if you have lost interest in your usual activities?
• Have you been feeling sad or unhappy recently?
• Have you been feeling scared or frightened of anything?
• Have you been worried about drinking too much alcohol/using drugs recently?
• How much money and time have you been spending on alcohol/drugs recently?
• Family history?

Rapport

• Essential! This is highly personal stuff.

• Know thyself!

• This is going to take time...

• Confidentiality and its limits.

• Organisation and confidence (sometimes in NOT KNOWING).

• Safety
Involving Others

• How many of us really know ourselves? Or how we come across to others?

• Context is critical!

• Loss of insight a common feature of MI.

• Collateral is therefore critical.

• Get permission up front.

• Establish limits of confidentiality.
The Assessment *is* Treatment

- Insight and motivation are critical elements of successful treatment.
- Stigma – from others and self – do not underestimate!
- Most psychiatric treatments require relatively long-term use *and* take time to start working beware the “quickfix”
- Substantial variation WRT tolerability and effectiveness.
- Time spent building a collaborative relationship is well-invested.
- Developing Theory Of Mind is of itself beneficial.
Risk Assessment

• Must always be considered
• To self or to others
• Direct or indirect
• Duty to ask, duty to act, duty to warn.

• Details of the risk factor
• The seriousness of the risk
• How specific the risk is to any individual
• How immediate is the risk
• What interventions are required to reduce the risk and what steps have been taken
• MHCA: “self, others, financial interests or reputation”
Diagnosis

• A continual process of hypothesis formation, testing of evidence and re-formulation

• Diagnostic Hierarchy: Begin by excluding “organic aetiology”, substance use and in vulnerable groups: abuse.

• It is generally not helpful to try to come up with a definitive diagnosis too quickly but to think rather in terms of broad syndrome groups.
Syndromes

• Disorders associated with an underlying general medical condition including epilepsy/seizures
• Drug and Alcohol Use Disorders
• Self-Harm and Suicide
• Psychotic Disorders
• Bipolar Disorder
• Depression and generalised anxiety disorders
• Other significant or medically unexplained complaints, including specific anxiety disorders
• Dementia and other Mental Health Problems in the Elderly
• Mental Health Problems in Children/ Behavioural Disorders
• Intellectual Disability/Developmental Disorders

Disorders associated with an underlying general medical condition including epilepsy/seizures

• Always consider first!
• Commonly acute but can be chronic
• Associated physical signs or history
• Disorientation, impaired or fluctuating LOC
• Multiple hallucinations
• Insight poor

• Treat underlying cause
• Sedation NB! Restore sleep patterns
• Benzodiazepines, low dose haloperidol (0.5mg)
Drug and Alcohol Use Disorders

• Always consider
• Can result in almost any psychiatric presentation
• Also can be self-medication (NB anxiety especially Social Phobia!)
• Assess readiness
• MI

• Risk of harm to self and others
Self-Harm and Suicide

• If you think of this your patient has already!
• Raise the subject

• Key to differentiate from Self-harm, carried out with an intention other than to die. Common feature in Personality Disorder.
Psychotic Disorders

- Insight almost invariably poor
- Complaint is from others
- Collateral critical – ignore at peril: beware paranoid schizophrenia!!

- Proceed with caution
- Do not manage alone!
- Begin gently, with low does atypical agents wherever possible.
Bipolar Disorder

- Key features are manic behaviour or a history of mania/hypomania in someone who suffers from depression
- Often respond poorly to antidepressants or switch
- Individuals with symptoms of mania can be extremely self-confident and even seductive, intimidating or aggressive so safety considerations are essential
- Lack of sleep is a useful feature in mania, but not generally a complaint as it manifests as increased energy and a decreased need for sleep
- Risk of harm to self or others, either directly or as a result of reckless behaviour
- Risk to financial interests and reputation
- Mood stabilizers: Lithium still best evidence, atypical antipsychotics becoming well-established.
Depression and Generalised Anxiety Disorders

• Usually self-present, less so in men
• Be aware of differing cultural idioms for depression

• NB Sleep disturbance
• Suicide risk!

• Antidepressants: Start with SSRI’s but beware increased risk in early response phase
• Anxiety and agitation
• Short-term use of benzodiazepines helpful BUT...
Specific Anxiety Disorders

Panic Attacks:
- Often presents as a medical complaint: MI, asthma, seizures, fainting
- Cycle of panic: symptoms of anxiety misinterpreted as the cause leading to further anxiety

PTSD
- Restore a sense of safety, normalize responses.

OCD
- A specific recurrent thought, identified as irrational and responded to with a compulsive behaviour often deeply integrated into lifestyle
  - CBT and SSRI’s a mainstay
  - Benzodiazepines useful but SHORT-TERM
• Dementia and other Mental Health Problems in the Elderly
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• Exclude the organic
• Get collateral
• Establish safety!