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Benzodiazepines in emergency psychiatric treatment

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The Norwegian Directorate of Health's decision that benzodiazepines cannot be used in emergency psychiatric treatment without the patient's consent reduces the quality of treatment for patients.

In a letter to county governors, the Norwegian Directorate of Health explains that decisions pursuant to Section 4–4 of the Mental Health Care Act do not encompass benzodiazepines (1). First, the Directorate refers to the risk of developing a tolerance and an addiction, secondly that coercive drug treatment can only be initiated and carried out when there is a high probability of it leading to recovery or significant improvement in the patient, or if it prevents significant deterioration. Thus, more than a general preponderance of evidence of a positive effect on a severe mental disorder (psychosis) is required. The Directorate of Health takes the view that benzodiazepines do not generally meet this strict requirement. It states that benzodiazepines do not treat the psychosis symptoms directly, but are used to treat symptoms such as anxiety, restlessness, sleep disorders and agitation (1).

The reality of everyday life on psychiatric wards is that most of the patients are admitted with complex psychiatric conditions. The patients are often suffering acute life crises complicated by substance use, withdrawal symptoms and polypharmacy, and they often have multiple psychiatric and somatic problems (2). Half of the emergency admissions to psychiatric wards are under the influence of several substances at the same time (3).

Benzodiazepines for various conditions

In international guidelines, benzodiazepines are recommended for a number of acute psychiatric conditions, including psychosis with or without comorbid substance use disorder (4). This is because benzodiazepines are an effective and safe choice. According to Norwegian guidelines, antipsychotic drugs are the primary treatment for psychosis. However, for a number of conditions, including in patients with symptoms of psychosis, the use of antipsychotics will increase the risk to the patients. Some patients will be put into acute mortal danger, for example, if they develop symptoms of catatonia (5). Several types of drugs such as amphetamines, hallucinogens and opiates increase the risk of serious adverse effects when using antipsychotics (6). Acute or chronic psychosis is a core symptom in a

number of organic psychiatric conditions. In general, caution should be exercised in giving antipsychotics to patients with, for example, traumatic brain injuries (7). If organic psychotic conditions are triggered by paroxysmal cerebral hyperactivity, antipsychotics will lower the convulsion threshold and have the potential to increase epileptiform activity and thereby prolong and further exacerbate acute psychosis.

Some patient groups in psychiatric wards have a high/increased incidence of suicide during admission and immediately after discharge (8). These patients suffer from agitation, panic, desperation and sometimes psychosis (9). Over the last 20 years, we have learned that the primary suicide prevention treatment for this group should be to ensure adequate treatment for anxiety and sleep disorders (10). Benzodiazepines are an obvious first-line choice.

Lack of understanding

It is not clear what the Norwegian Directorate of Health means by 'treating psychosis symptoms directly' (1). For example, in depressive psychosis, the accompanying anxiety, agitation and insomnia are not only triggers of suicide, they are also part of the affective syndrome. Organic psychosis can be triggered by, for example, altered cerebral electrophysiological activity, as in epilepsy (11). Direct psychosis treatment entails stopping such activity with benzodiazepines and mood-stabilising antiepileptic drugs.

The risk of abusing benzodiazepines is small for both short and long-term treatment (12). The vast majority of patients do not abuse; they do not increase the dose even during long-term treatment of anxiety disorders. The patients want benzodiazepines because they help with a variety of symptoms, including 'psychosis'.

The conclusion is that the Norwegian Directorate of Health's decision robs many patients of safe, gentle and effective treatment. It deprives them of a treatment that they themselves want. The decision is based on an incomplete assessment of the complexity of the daily life on psychiatric wards.

REFERENCES:

1. Brev til landets kontrollkommisjoner fra Helsedirektoratet. 12.2.2019. https://helsedirektoratet.no/Documents/Lovfortolkninger/Psykisk%20helsevernloven/Svar%20p%C3%A5%20sp%C3%B8rsm%C3%A5l%20om%20behandling%20uten%20eget %20samtykke%2C%20benzodiazepiner%20og%20tabletter%20f%C3%B8r%20injeksjon.pdf (27.3.2019).

2. Zealberg JJ, Brady KT. Substance abuse and emergency psychiatry. Psychiatr Clin North Am 1999; 22: 803–17. [PubMed][CrossRef]

3. Mordal J, Holm B, Mørland J et al. Recent substance intake among patients admitted to acute psychiatric wards: physician's assessment and on-site urine testing compared with comprehensive laboratory analyses. J Clin Psychopharmacol 2010; 30: 455–9. [PubMed][CrossRef]

4. Allen MH, Currier GW, Hughes DH et al. Treatment of behavioral emergencies: a summary of the expert consensus guidelines. J Psychiatr Pract 2003; 9: 16–38. [PubMed][CrossRef]

5. Daniels J. Catatonia: clinical aspects and neurobiological correlates. J Neuropsychiatry Clin Neurosci 2009; 21: 371–80. [PubMed][CrossRef]

6. Toce MS, Chai PR, Burns MM et al. Pharmacologic treatment of opioid use disorder: a review of pharmacotherapy, adjuncts, and toxicity. J Med Toxicol 2018; 14: 306–22. [PubMed][CrossRef]

7. Plantier D, Luauté J. Drugs for behavior disorders after traumatic brain injury: Systematic review and expert consensus leading to French recommendations for good practice. Ann Phys Rehabil Med 2016; 59: 42–57. [PubMed][CrossRef]

8. Walby FA, Myhre MØ, Kildahl AT. Contact with mental health services prior to suicide: A systematic review and meta-analysis. Psychiatr Serv 2018; 69: 751–9. [PubMed][CrossRef]

9. Fredriksen KJ, Schoeyen HK, Johannessen JO et al. Psychotic depression and suicidal behavior. Psychiatry 2017; 80: 17–29. [PubMed][CrossRef]

10. Goodwin FK. Preventing inpatient suicide. J Clin Psychiatry 2003; 64: 12–3. [PubMed][CrossRef]

11. Brewerton TD. The phenomenology of psychosis associated with complex partial seizure disorder. Ann Clin Psychiatry 1997; 9: 31–51. [PubMed][CrossRef]

12. Starcevic V. The reappraisal of benzodiazepines in the treatment of anxiety and related disorders. Expert Rev Neurother 2014; 14: 1275–86. [PubMed][CrossRef]

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