BEHAVIOURAL DISORDERS, EMERGENCY ASSESSMENT

THE ROLE IN ED IS INITIAL ASSESSMENT AND MANAGEMENT OF PSYCHOTIC, SUICIDAL AND VIOLENT PATIENTS

AS THE DEFACTO MENTAL HEALTH CARE SAFETY NET, ED SERVES AS THE DEFAULT OPTION FOR URGENT AND ACUTE CARE OF PSYCHIATRIC PATIENTS WITHIN THE HEALTH CARE SYSTEM

ASSESSMENT:

Table 283-1 Emergency Psychiatric Assessment Steps

Step	Comment
Safety and stabilization	Contain violent and dangerously psychotic persons to provide a safe environment for staff, patients, family, and visitors while simultaneously attending to airway, breathing, and circulation.
Identification of homicidal, suicidal, or other dangerous behavior	Determine if the patient needs to be forcibly detained for emergency evaluation.
Medical evaluation	Determine the presence of any serious organic medical conditions that might cause or contribute to abnormal behavior or thought processes (e.g., hypoglycemia, meningitis, drug withdrawal, or other causes of delirium).
Psychiatric diagnosis and severity assessment	If the behavior change is not due to an underlying medical condition, it is primarily psychiatric or functional, requiring a psychiatric diagnosis and assessment of the severity of the primary psychiatric problems.
Psychiatric consultation	Determine the need for immediate psychiatric consultation.

SAFETY FIRST ➔ SECLUSION, RESTRAINT AND MANAGEMENT OF VIOLENCE:

- Mental health emergencies include situation in which patients are highly distressed, suicidal and/or homicidal
- About 10% psychiatric patients in ED exhibit violent behaviour
- We need to be familary with risk factors and warning signs of violent behaviour, verbal de-escalation techniques, quick access to rapidly tranquilising or neuroleptic medications and know protocols to get help quickly (CODE BLACK)
- The physician should stay distant, avoid excessive eye contact, maintain a somewhat submissive posture and tone of voice and stand in a location that neither threatens the patient nor blocks the exit from the room
- Allow patients to verbally ventilate their feelings
- RESTRAINTS:
    - In many cases, there is no substitute for safe application of physical limb restraints ➔ provide clear, ongoing explanation of all procedures to the patient and their family

    - Position securely to restrain the patient, but minimally to reduce risk of injury
    - Elevate head to avoid risk of aspiration
    - TIME-LIMIT SHOULD BE WRITTEN
- EXAMINATION ROOMS AND SECLUSION:
    - Use of security staff, metal detectors, rooms that permit rapid and easy exit, panic buttons
    - Removal of any objects that can be used in violent attacks or suicide attempts ➔ neckties, large earrings, belts, shoes, stethoscopes
    - Patient should be searched before entry

SUICIDAL PATIENTS:

- Patients who present with suicidal ideation, suicide plans or suicide attempts require specific measures for protection
- Staff members or a reliable family member should accompany the patient if it is necessary for the patient to leave the waiting area or examination room
- MEDICAL EVALUATION OF PSYCHIATRIC AND SUICIDAL PATIENTS:
    - Should be the same as that of patients presenting with medical conditions
    - HISTORY:
        - Talk to patient, caregivers/family-members about recent changes in behaviour
        - Sudden onset of major changes in behaviour, mood or thought in a PREVIOUSLY NORMAL PATIENT, or deterioration in a patient with a chronic behavioural disorder, should STIMULATE EVALUATION FOR AN UNDERLYING MEDICAL OR NEUROLOGICAL DISORDER
            - Especially so if patient >40
            - This sudden change is an important indicator of a new and correctable disease process
        - INITIATION OF SUBSTANCE ABUSE (or changes in pattern of abuse or drug used)
        - Adherence to medication regiment
    - MEDICAL COMORBIDITIES:
        - Must be identified
        - Ask specifically about:
            - Fever
            - Head trauma
            - Immunocompetence (malignancies, HIV or risk factors for HIV, dm, pulmonary disease, toxic ingestions or drug overdose)
    - MEDICATION/DRUG HISTORY:
        - Behavioural changes can be due to OTC or prescription drugs (sedative-hypnotics, stimulants, psychotropic agents, anticonvulsants, anticholinergic agents, ACE-I, β-blockers, steroids, opioids, antiparkinson medications)

        - Street drugs (LSD, amphetamines, cocaine, THC) can produce a toxic psychosis
    - ALCOHOL OR SUBSTANCE ABUSE:
        - Patients with chronic mental illness have a higher incidence of alcohol and substance abuse than the general population
        - Syndromes associated with alcohol/substance abuse that can change behaviour:
            - Intoxication
            - Withdrawal
            - Delirium
            - Hallucinosis
            - Paranoid behaviour
            - Dementia
    - NEUROLOGIC EXAMINATION:
        - Explore neurological symptoms associated with behavioural change:
            - Fainting
            - Dizziness
            - Disorientation
            - Impairment of speech
            - Confusion
            - Loss of consciousness
            - Headaches
            - Difficulty performing routine tasks
            - Focal weakness

Table 283-2 Medical Evaluation of the Psychiatric Patient
Document behavioral changes through history.
Identify medical symptoms.
Determine medical comorbidities.
Obtain medication and drug history.
Perform physical examination.
Perform neurologic examination.

MENTAL STATUS EXAMINATION:

- The mental status exam is analogous to the medical evaluation and is conducted to distinguish psychiatric from medical disorders (see table below for factors consistent with organic psychosis)

Table 283-3 Features Associated with an Organic Cause of Psychosis
Abnormal vital sign values
Disorientation with clouded consciousness
Abnormal mental status examination findings
Recent memory loss
Age >40 y without a previous history of psychiatric disorder
Focal neurologic signs
Visual hallucinations
Psychomotor retardation

- A great deal of information is gained through observing the patient's appearance, behaviour, language, and affect during the initial interview
- Important aspects of the mental state exam include:
    - Physical appearance
    - Level of consciousness
    - Spontaneous speech
    - Spontaneous behaviour
    - Ability to provide historical information
    - Attention
    - Speech patterns
    - Language comprehension
    - Affective state
    - Affective state
    - Presence of psychotic phenomena (hallucinations/delusions)
        - Patients with visual hallucinations should be assumed to have organic pathology until proven otherwise
    - Level of cognitive functioning
    - Degree of insight and capacity for introspection

Table 283-4 Mental Status in the ED: An Outline	
Behavior	What is the patient doing?
Affect	What feelings is the patient displaying?
Orientation	Does the patient know what is happening, where, and when?
Language	Is the patient understanding and being understood?
Memory	Can the patient recall historical details, recent and remote?
Thought content	Is the patient reporting beliefs that make little sense?
Perceptual abnormalities	Is the patient experiencing unusual sensory phenomena?
Judgment	Is the patient able to make rational decisions?

PHYSICAL EXAMINATION:

- Aim of physical exam is to identify medical disorders that may cause or have an impact on behaviour and to identify the presence of medical problems that may need special care or are inappropriate for management in a psychiatric setting
- FEVER ➔ very important, because both local and systemic infection can cause altered mental status, as can meningitis, encephalitis and brain abscess
    - NEUROLEPTIC MALIGNANT SYNDROME causes very high fevers (sometime >40.6C) and is an important life threat ➔ identification is crucial as treatment with DANTROLENE is life-saving

LABORATORY EVALUATION:

- This depends on clinical suspicion as well as findings from the history and the physical exam
- Urine toxicology screen and blood alcohol are commonly requested ➔ these are most helpful when the cause of abnormal thought or behaviour is unknown
    - Routine metabolic testing and testing for anaemia as well as endocrine disorders may be prudent in older adults (>65 years)
- Elderly patients are particularly susceptible to:
    - Electrolyte imbalances
    - Hyperglycaemia
    - Hypoglycaemia
    - Cardiovascular disease
    - Renal diseaes
    - Pulmonary disease
    - Thyroid abnormalities
    - Drug interactions
        - ALL OF WHICH CAN PRODUCE AN ACUTE ORGANIC PSYCHOSIS
- DETERMINATION OF SERUM DRUG LEVELS ➔ lithium, valproate, phenytoin, carbamazepine, paracetamol, digoxin, cyclosporine

DIAGNOSTIC IMAGING:

- CT and related brain imaging should be considered if a clear change in behaviour or an organic intracranial cause is suspected
    - Behavioural change accompanied by FEVER, NEW HEADACHE, FOCAL NEUROLOGICAL FINDINGS, TRAUMATIC BRAIN INJURY
- High index of suspicion in immunocompromised and those with altered mental state with fever/meningism

<u>SPECIAL POPULATIONS</u>

SUICIDAL PATIENTS:

- These patients can present to ED with suicidal ideation, suicide plans, threats or attempts
- A significant fraction of those who present to ED for non-mental health reasons have occult or clinical depression that is often missed by ED physicians

- People who present to ED with occult or explicit suicidal ideation and those who make suicide attempts must be regarded as being at serious risk of suicidal behaviour
    - Their risk of suicide is 0.5-2% at one year after their attempt and >5% at 9 years
- THOSE WHO DIE BY SUICIDE COMPARED TO ATTEMPTERS ARE MORE LIKELY TO BE:
    - Male
    - Older
    - Living alone
    - Physically ill
- Young females (15-19) are most likely to present to ED with nonfatal suicide attempts
- SUICIDAL THINKING → more frequent among women than among men and is associated with clinical depression, social isolation, undesirable life events, history of childhood and family adversity (sexual and physical abuse), parental psychopathology
    - Those who present to ED with suicidal ideation have the same risk of recidivism and suicide as those who present after suicide attempts and should receive the same intensity of assessment as those who attempt suicide
- At least 90% of those who suicide in Developed nations have at least one mental disorder at the time of their attempt
    - Depression, bipolar disorder, substance abuse, anxiety disorders, antisocial disorders, schizophrenia and eating disorders
    - Suicide risk increases exponentially with increased comorbidity
- Most common method is DRUG OVERDOSE (85% of attempts)
    - It is necessary to explore the patient's understanding of the toxicity of the agent used, as well as their intent as some are unaware of a certain drug's toxicity
    - VIOLENT ATTEMPTS ➔ shooting, jumping, hanging ➔ all protend high risk for a future attempt
- Physical illnesses associated with increased risk of suicide include:
    - Renal failure (especially those on dialysis)
    - Spinal cord injuries
    - Progressive neurologic disorders
    - AIDS
    - SLE

SUICIDE AND INTIMATE PARTNER VIOLENCE:

- Those exposed to intimate partner violence frequently have comorbid mental health conditions and are at serious risk for both self harm and being a victim of homicide
- Violence that is escalating, partner threats of suicide, threats to children and pets, the presence of a firearm as well as a history of attempted strangulation/choking all increase the risk of lethality for victims

SELF-INJURIOUS BEHAVIOUR:

- Young adult and adolescent patients often present with self-harm behaviours that are not dangerously suicidal but nonetheless require both medical and mental health care
    - Explanations are that patients are aiming to feel a certain way or are trying to "relieve tension" by cutting/scratching/burning themselves
- This usually does not represent suicidality, but rather a poor learned coping mechanism
    - A small proportion do have clinncial symptoms ➔ high anxiety and suicidality

ASSESSMENT OF SUICIDAL RISK:

- Requires attention to diagnosis and treatment, as well as to immediate and long-term safety
- ESTABLISH RAPPORT AND THERAPEUTIC ALLIANCE
- Key points outlined below:

Table 283-6 Key Points in Assessment and Management of Suicidal Patients
Establish rapport.
Assess suicidal intent.
Determine access to means of suicide.
Assess current mental state.
If no evidence of a mental disorder, offer a safety plan, including help-seeking and problem-solving strategies.
If interpersonal or family issues, allow catharsis and offer problem-solving strategies; consider psychosocial referral.
If a mental disorder is present, arrange appropriate referral or management.
Ensure that a safety plan is in place before discharge.
Arrange follow-up before discharge.

- Arrange private area for assessment
- Show respect/courtesy
- Elicit any symptoms of psychological and physical illness
    - Assess especially for evidence of depression, schizophrenia or substance abuse
- Useful aid is shown below ➔ **SAD PERSONS**

Table 283-7 SAD PERSONS*	
S	Sex
A	Age
D	Depression
P	Previous attempt
E	Ethanol use
R	Rational thinking loss
S	Social supports lacking
O	Organized plan
N	No spouse
S	Sickness

*Each factor is assigned 1 point, and patients who score ≥5 points should be considered at high risk of suicide.

- SUICIDAL INTENT CAN BE DETERMINED ON THE BASIS OF:
  - Degree of planning
  - Lethality of the method considered
  - Existence of any suicide notes
- Good question ➔ "what has stopped you from killing yourself so far?"
- Patients who are single, divorced, separated, widowed or recently unemployed are at higher risk than those who are married and employed
- SECONDARY GAIN:
  - A term that indicates that although the primary motive for a suicide attempt appears to be death, the attempt may meet another need, such as a desire to gain attention or receive emotional help
- IMMEDIATELY AFTER THE ATTEMPT:
  - The patient who sits quietly, engages poorly with the clinician, voices regret at surviving, expresses feelings of hopelessness, helplessness or exhaustion and refuses to provide additional information should be considered high risk
- Prior attempts are a significant warning if the intensity and apparent lethality of the attempt escalate with each attempt

*SIG E CAPS + MOOD is a mnemonic for the eight symptoms of depression plus depressed mood: S = sleep disturbance; I = loss of interest in usual pleasurable activities; G = guilt; E = loss of energy; C = inability to concentrate; A = loss of appetite; P = psychomotor slowing; S = suicidal thoughts, MOOD = depressed mood (i.e., "Have you felt blue, down, or depressed most of the day for most days in the last 2 weeks?"). Fulfillment of five or more of the eight items from the list of eight symptoms indicates the presence of major depression. Symptoms must be present nearly every day for 2 weeks and must include depressed mood or loss of interest or pleasure in activities. Symptoms must represent a change from previous functioning resulting in social, occupational, or other life impairment, and they cannot be the direct result of substance use, a medical condition, or bereavement.

Table 283-9 Evaluation of Suicide Risk in Adults and Adolescents

Demographic, Health, and Social Profile	High Risk	Lower Risk
Gender	Male	Female
Marital status	Separated, divorced, or widowed	Married
Family history	Chaotic, conflictual	Stable
	Family history of suicide	No family history of suicide
Job	Recently unemployed	Employed
Relationships	Recent conflict or loss of a relationship	Stable relationships
School	In disciplinary trouble	No disciplinary problems
Religion	Weak or no suicide taboo	Strong taboo against suicide
Health		
Physical	Acute or chronic, progressive illness	Good health
	Excessive drug or alcohol use	Little or no drug or alcohol use
Mental	Depression (SIG E CAPS + MOOD)*	No depression
	History of schizophrenia or bipolar disorder	No psychosis
	Panic disorder	Minimal anxiety
	Antisocial or disruptive behavior	Directable, oriented
	Feelings of helplessness or hopelessness	Has hope, optimism
	Few, weak reasons for living	Good, strong reasons for living
	Unstable, inappropriate affect	Appropriate affect
Suicidal ideation	Frequent, intense, prolonged, pervasive	Infrequent, low intensity, transient
Suicide attempts	Repeated attempts	No prior attempts
	Realistic plan, including access to means	No plan, lacks access to means
	Previous attempt(s) planned	Previous attempt(s) impulsive
	Rescue unlikely	High likelihood of rescue
	Lethal method	Method of low lethality
	Guilt	Embarrassment about suicide ideation
	Unambiguous or continuing wish to die	No previous or continuing wish to die; large appeal component
Relationship with health professional	Lacks insight	Insight
	Poor rapport	Good rapport
Social support	Unsupportive family, friends	Concerned family, friends
	Socially isolated	Socially integrated

DISPOSITION AND FOLLOW UP:

- High risk patients with strong, pervasive suicidal intent require immediate psychiatric hospitalisation
- Moderate risk patients in a serious suicidal crisis but who, because of a positive response to initial intervention and favourable social support may be considered in imminent danger may be discharged with close care and follow up
- Low risk patients frequently present with suicidal ideation, threats, plans or minor attempts that occur in the context of a clearly definable external crisis
    - Family and social support is usually readily available