Psychiatric Emergencies

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Due to the heterogeneity of the subjects, there are no consistent guidelines even for evaluation

In cases of risk of harm to self or others coupled with pathological mental status, documentation of your reasoning becomes all important.

Epidemiology

- Equals 5 to 7 % of all emergencies
- More males
- Seasonal variations

Seasonal Variations

- Spring: Organic, Affective, Schizophrenic
- Summer: Schizo & Adjustment
- Winter: Drug Induced

- No peak for personality disorder

Keys

- Awareness of potential scenarios
- Familiarity with appropriate interventions
- Understand patient rights and legal issues

Psych Emergencies Requirements

- Calm, objective assessment
- Swift, decisive action

Psychiatric Emergencies

- Suicide Risk
- Violence and Aggression
- Impaired Decision Making
- Others:
- Psychiatric medication side effects

Psychiatric Emergencies

- TCAs
- Neuroleptic malignant syndrome
- Serotonergic syndrome
- Anticholinergic psychosis

Psychiatric Emergencies

- **Suicide Risk**
  - Statistics
- **Violence and Aggression**
- **Impaired Decision Making**
- **joke**

Assessment of Suicide Risk- Some Statistics

- 31,000 deaths each year – US
- 9th leading cause of death – US
- 3rd leading cause of death 15 – 25 year olds – US

Psychiatric Emergencies

- **Suicide Risk**
  - Statistics
  - **Assessment**
- **Violence and Aggression**
- **Impaired Decision Making**

Assessment of Suicide Risk- Assessment

- **Clinical suspicion**
  - Stated ideation
  - Risk Factors

Risk Factors for Suicide

- Major depression
- Alcoholism
- History of suicide threats/attempts
- Male gender
- Increasing age
- Substance abuse
- Widowed or never married
- Unemployed and unskilled
- Chronic illness or pain
- Terminal illness
- Guns in the home
- Family history of suicide

The BEST PREDICTOR of completed suicide is…..

A history of attempted suicide

Evaluation of Patients with Suicidal Ideation

- History of ideation
- History of attempts
- Screen for alcohol abuse
- Mini Mental Status Exam (MMSE)
- Interview the family

Assessment of Suicide Risk Assessment Suggestions ("C" Recommendation)

- Delirium, psychosis, depression present
- Elicit patient's assessment of suicidality
- Elicit patient's ideas about what would help
- Confirm story with a third party
- Ask steadily escalating questions addressing suicidality

Assessment Questions ("C" Recommendation)

- Have you ever thought about hurting yourself?
- Have you thought about a way (plan)?
- Do you have a way? (means)
- Can you resist the feeling?

Be Alert for Indirect Statements:

- “I’ve had enough”
- “I’m a burden”
- “It’s not worth it”

Specific Questions to Ask about Suicidal Ideation:

- When did you begin to have suicidal thoughts?
- Did anything precipitate them?
- Howe often do you have them?
- What makes you feel better?
- What makes you feel worse?
- Do you have a plan to end your life?
- How much control of these ideas do you have?
- What stops you from killing yourself?

Questions About Plans

- Do you have a gun or access to one?
- Do you have access to harmful medications?
- Have you practiced your suicide?
- Have you changed your will or life insurance or given away your posessions?

Asking patients about suicide does not give them the idea!

To Hospitalize or Not…?

- Access to means
- Poor social support
- Poor judgment
- Cannot make a contract for safety

Outpatient?

- No intent nor plan
- No means, has social support and good judgment
- Can contract for safety

In Doubt on Hospitalization?

Consult psychiatry

Legal Issues

- If in imminent danger, confidentiality can be breached
- Involuntary hospitalization in most states
- Unsure? Call a crisis center.

Non-Harm Contracts

- Specific and brief time (24- 48 hours)
- Patient to contact provider if situation changes
- Accompanied by frequent follow-up contact
- Renewed at end
- No credence if patient is intoxicated, psychotic, too depressed, or made a serious attempt in the past.
- Involve the family

Assessment of Suicide Risk-Interventions,Short-Term Risk

- Intermediate follow-up
- Remove as many risk factors as possible before discharge

Treatment

- Treat depression
- Treat anxiety
- Treat insomnia

Anxiety – Insomnia Treatment

- Lorazepam 0.5 – 4.0 mg /day
- Oxazepam 15 – 30 mg/day
- Temazepam 15 – 30 mg at bed time
- Zolpdidem 5 – 10 mg at bed time

- joke

Psychiatric Emergencies

- Assessment of Suicide Risk
- Violence and Aggression
  - Overall goals
- Impaired Decision Making

Violence and Aggression Overall goals

- Ensure safety of patient and staff
- Determine whether aggression stems from psychiatric or medical disorder
- Do a medical evaluation
- Do a psychiatric assessment
- Effect appropriate treatment
- Warn third parties if they are under threat

Management of Violence

- **Depends on your ability to:**
  - Predict violence
  - Reduce the threat
  - Manage the setting
  - Manage your reaction

Psychiatric Disorders Most Commonly Violent in the ED

- Psychotic disorders- schizophrenia, mania, paranoid states
- Drug abuse – especially PCP, Cocaine, and other CNS stimulants
- Alcohol abuse

Violence Decision Making Patients and Hospitalization

- **Most likely need hospitalization**
  - Referred by police or health professional
  - Psychosis diagnosis
  - Prior hospitalization
  - No Community programs
  - No P.E.S.
- **Less Likely:**
  - Defined precipitant
  - Good social support

Hierarchy of Assault Predictors

- **Uncertain Risk – May need precautions**
- **Medium Risk – Requires precautions**
- **Imminent Danger – Requires action**

Assault Predictors (Uncertain Risk)

- Threats only
- Poor Insight
- Dementia
- Schizophrenia
- Sensory Defects
- Aphasia
- Head Injury

Assault Predictors (Medium Risk)

- Prior assault
- Arrest record
- Threats
- Alcohol abuse
- Verbal abuse
- Personality Disorder
- Paranoid
- Antisocial
- Borderline
- Agitation

Assault Predictors (Imminent Danger)

- Recent assault
- Repeated assaults
- Psychosis
- Mania
- Delirium
- Intoxication
- Threats
- Threatening body language
- Weapons

Manage the Setting

Weapons Screening

- **Self Reports indicate**
  - Good idea: 84% ED patients, 88% ED staff
  - Didn't think it violated civil rights: 85% ED patients, 89% ED staff
  - 15% patients upset by procedure

Weapons Screening

- **Questions:**
  - Civil rights …..?
  - What do you do with found weapons?
  - What to do with refusals?

Psychiatric Emergencies
Tools for Intervention

- **Non- pharmacologic**
  - Redirection/de-escalation

Redirection/de-escalation

- Sit with a table between you and the patient
- Make sure you both have access to the door
- Avoid frustrating the patient
- Avoid staring at the patient
- Do not turn your back to the patient
- Keep hands open and visible
- Do not be judgemental

Psychiatric Emergencies Tools for Intervention

- **Non- pharmacologic**
  - Redirection/de-escalation
  - Restraint
    - Show of force
    - Seclusion
    - Restraint

Restraint Policy

- Indications (which accounts for ”least restrictive treatment” requirements of JCAHO, etc..)
- Technical issues
- Facility requirements

Restraints

- Never used as a threat
- Do not attempt without sufficient help
- Apply calmly and nonpunitatively

Legal Issues

- All 50 states have laws requiring involuntary detention of dangerous patients
- 1982 Supreme Court “restraints are justified to protect others or self in the judgment of the health professional.”
- Ensure restraints are not negligently used
- More cases of negligent disposition of a harmful patient than false imprisonment

Psychiatric Emergencies Tools for Intervention

- **Non- pharmacologic**
  - Redirection/de-escalation
  - Restraint
    - Show of force
    - Seclusion
    - Restraint
  - **Pharmacologic**

Pharmacologic

- **Benzodiazepines**
- **Antipsychotics**

Benzodiazepines

- **Desired effects: sedation, decreased anxiety**
- **Lorazepam**
  - Kinetics
  - Lipophillic
  - Multiple routs of administration (1 – 2 mg orally or IM injection every 1 -2 hours as needed)

Antipsychotics

- Can be given every 30 minutes until effect
- Haldol and droperidol 5mg IV or IM
- Be aware of side effects

Antipsychotics

- **Desired effects: sedation, EPS**
- **Haloperidol**
  - Kinetics
  - Lipo[phillic
  - Multiple routes of administration (10-20 mg/day orally or IM injection as needed
- **Side effects**

Tarasoff vs. Regents of the University of California 1975

- Requires notification of intended victims of violence (or the appropriate law enforcement agency in the locality of the victim(s).

- Never tested elsewhere?
- joke

Psychiatric Emergencies

- **Assessment of Suicide Risk**
- **Violence and Aggression**
  - Overall goals
  - **Specific considerations**
- **Impaired Decision Making**

Delirum

- Infection
- Withdrawal
- Acute metabolic
- Trauma
- CNS Pathology
- Hypoxia
- Deficiencies
- Endocrinopathies
- Acute Vascular
- Toxin or Drugs
- Heavy Metals

Manage Your Reaction

- Avoid confrontation
- Avoid condescending tone
- Set limits
- Avoid unbearable situations

Disposition

- 1/3 No further interventions (30%)
- 1/3 Outpatient intervention (37%)
- 1/3 Hospitalized (34%)

Response Algorithm in a Psychiatric Emergency