MANAGING PSYCHIATRIC EMERGENCIES

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- Behavioral emergencies are common and the goals of intervention are rapid evaluation, containment and referral to appropriate follow up.
- Clinicians will likely be called upon to assess and manage agitation, acute psychosis and suicidality; alone or in combination.
Identifying an accurate diagnosis is essential. Physicians need to be aware of the differences among the major psychiatric disorders, as well as look for medical causes in patients with psychiatric presentations.
Due to the complexity of a patients’ presentation, the emergency clinician must be a clinical and medical specialist, anthropologist, detective and a diplomat.
In dealing with psychiatric patients, empathy is the most useful psychotherapy tool for understanding patients’ feelings of grief, fear, agitation and powerlessness.

Patient's anger is often a defense against intolerable emotions.

Physicians are making decisions when a patients’ impaired mental faculties prevent him/her from making sound autonomous decisions.
ACUTE PSYCHOSIS

- The definition of the term psychosis is “disorganized speech, grossly disorganized or catatonic behavior, delusions or prominent hallucinations”.

Emergency physicians regularly attend to patients presenting with acute psychosis and 20% of the patients are found to have a purely medical etiology.

Every disturbance of the central nervous system increases the probability that psychiatric symptoms will arise.
While the physician should be aware of the differences among the major psychiatric disorders, it is equally important for physicians to rule out medical causes in patients with psychiatric presentations.

Additionally, the source diversity of acute psychosis mandates different approaches in management.
Two patients in their twenties reported to the emergency department with acute psychosis and severe agitation.

They had anxiety, restlessness, paranoia and visual hallucinations.

In addition to dry mucous membranes, thirst, flushed face, blurred vision, hyperthermia, urinary retention, tachycardia and decreased intestinal motility.
CASE

- One patient needed mechanical restraints for extreme agitation and the possibility of hurting himself.
- Patients got IM antipsychotics (Haldol 5mg) and IM benzodiazepine (Ativan 2 mg) as needed for psychosis, agitation and anxiety in addition to IV fluids.
WHAT DO YOU DO NEXT?
One of the patients' mothers called the ER and stated that they were drinking Moonflower tea and developed the manifestations of anticholinergic syndrome.

Both patients obtained it from fields near where they live.

User of such substance can eat it or drink tea brewed using the seeds.
Treatment was mainly supportive care with intravenous fluids, gastrointestinal decontamination and benzodiazepines as needed for agitation.

Phyostigmine can be used as an antidote in severe cases.
Differential diagnosis of non-psychiatric causes for new onset acute psychosis is broad and it may include a history of trauma, organ failure, neurological disorders, endocrine disturbances, metabolic imbalances, infection or a history of ingestion of toxins and/or illicit drugs.
After excluding medical causes of acute psychosis, the next step is to consider possible psychiatric disorders.

It is important to gather the patients’ past psychiatric history, substance abuse history and family psychiatric history.

Differential diagnosis of psychiatric disorders with psychotic symptoms as a prominent aspect of a patients’ presentation includes psychotic disorders, mood disorders and substance induced psychotic disorders.
MANAGEMENT

- Initial management should focus on attempts to calm the patient through empathic, yet firm verbal means, and establishing a collaborative relationship between the patient and the treatment team.
- When approaching an agitated psychotic patient, one should remember the potential for violence and the approach should include speaking softly to the patient in non-judgmental way. It is better not to gaze directly in the patients’ eyes, to appear calm, unthreatened, in control, and to be concerned about one’s own safety.
A violent patient should not be interviewed alone. At least one other person should be present. In situations that are more volatile, the other person should be a security guard or a police officer.

Other precautions include leaving the interviewing room door open and situating the interviewer between the patient and the door.

The emergency room physician must make it clear in a firm, non-angry manner to the patient that he/she may say or feel anything, but are not free to act in violent or threatening manner whatsoever.
The next step would be rapid tranquillization using emergency medications that have the benefits of reducing the agitated and psychotic state. These types of medications have been found to lessen the time in seclusion and restraint and facilitate greater ease of the evaluative procedures.

The choice of medications and the route of administration is guided by the degree of agitation, concomitant medical conditions, drug use and patient preference.
Benzodiazepines and typical or atypical antipsychotics are the main classes widely used. Occasionally, more than one medication can be used and alternating between different classes can be useful.

Atypical antipsychotics are available in new formulations for treating behavioral emergencies (e.g. intramuscular [I.M.] olanzapine and ziprasidone; rapidly dissolving tablets of olanzapine and risperidone). It is recommended that calming, rather than sedation is the more appropriate endpoint of behavioral emergency interventions.
The last resort is to use physical restraints. For example, in centers providing Medicare and Medicaid services, the rules indicate the use of restraints when all other less restrictive measures have failed and unanticipated severely aggressive or destructive behavior places the patient or others in imminent danger.
Agitation is a state of severe inner tension that generally produces motor hyperactivity and behavioral disorganization.

Aggression is any behavior that is intended to be destructive to persons, animals or objects.

Impulsivity is the tendency to act without the ability to match the act to its context to consider the consequences for the self or others. Impulsivity includes greater motor activation, less attention and less planning.
DIAGNOSIS

- Impulsivity and aggression are not limited to any specific psychiatric disorder, or even to the presence of a ‘disorder’.
- Mechanisms that lead to agitation also predispose to impulsivity, aggression and psychosis.
- These mechanisms include manic episode or mixed state of bipolar affective disorder, intermittent explosive disorder, agitated depression, anger attacks in patients with depression, posttraumatic stress disorder, obsessive-compulsive spectrum of disorders, anxiety disorders, dementia, delirium, psychotic disorders, personality disorders, especially cluster B (antisocial, borderline and narcissistic), substance intoxication, including alcohol, stimulants and cannabis, or withdrawal from sedatives or alcohol.
Medical disorders, such as metabolic imbalances, infections, trauma, neurological and endocrinial dysfunction could be causes of impulsivity, aggression and agitation.
Aggression is common in elderly patients with dementia and often leads to placement of these patients in long-term care facilities; it is best understood as a product of the interaction of neurobiological, cognitive and environmental factors.
**MANAGEMENT**

- Offer the patient help, food and bolster the patient’s esteem by commenting on his or her strengths and self-control efforts.
- Do not touch or startle the patient, such as approaching too quickly or closely without warning. Finally, if the patient is transferred, inform the admitting physician about any specific threats and concerns.
Suicide is a serious, growing and complex public health problem, and its rate continues to rise. Each year 30,000 Americans take their lives. It is estimated that each year more than half a million Americans make suicide attempts that are serious enough to warrant medical attention.

Suicide is by far the most common cause of premature death among patients with major mood and psychotic disorders. A major affective or psychotic disorder increases the risk of suicide from 8 to 22 fold. A history of at least one suicide attempt increases the patients’ suicide risk 38 fold, so the likelihood of dying by suicide becomes greater than one in four (28%).
Attempted suicide is approximately 10 to 20 times more common than completed suicide in the general population.

Factors associated with increased risk for suicidal behavior include a history of psychiatric disorders, previous suicide attempts and recent losses.
The most useful psychotherapeutic technique in the treatment of a patient who is suicidal is establishing a therapeutic alliance. It is then important to determine patients’ personal and demographic risk factors with diligent questions regarding the patients’ social history, current stressors or recent losses.

Evaluation should include the assessment of suicidal ideas, wishes and motives, and then the suicidal intent to act on such thoughts.
- It is imperative to question the patient about specific suicidal plans and then following up to see if the details of the plan actually exist.
- It is of extreme importance to look for available means for the patient, such as pills, guns, sharps, and even a vehicle if it is part of the suicide plan.
- Assess the patient’s future plans, which should include questions to find out if the patient has been giving up personal belongings, has written a will or recently put other affairs in order.
Evaluation of a suicide attempt is important in order to understand the patient’s intention and motivations. Asking about the method used, did the patient think it would work, was it a discrete attempt, was the patient expecting to be rescued, did the patient call anyone after the attempt, what was the reasoning behind the attempt and was it an act of impulsivity or was it well planned out?
In some cases, suicide can be combination of depression, hopelessness and impulsivity. After a complete evaluation, treatment and referral depend on the patients’ risk for suicide. It is essential to incorporate family and friends in the evaluation and eventually in the treatment plan. It is crucial to mobilize the patients’ social supports, as it is vital in determining disposition.
Disposition of a patient with no risk to attempt suicide should be with a quick follow up appointment that the patient can make and family or responsible friends know about.

Admission to the hospital is recommended to patients with suicidal risk or following suicidal attempt. Admission can be voluntary or involuntary according to the appropriate legal processes when necessary.

Finally, carefully document the entire evaluation, decision-making process and dispositional steps.
THANK YOU
Datura inoxia, one of several plants known commonly as "moonflowers"

Photo/R Goets, Cincinnati Drug and Poison Information Center