

Emergency Psychiatry

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Overview

- Safety and violence in the ER setting
- Physical restraints
- Pharmacologic support
- Suicide
- Psychosis, affective disorders, substance abuse/dependence and personality disorders

Keep an eye on your immediate surroundings

- Look for potential weapons such as IV poles or things that can be thrown
- Look for objects that the patient could use for self harm
- Give yourself and the patient equal access to the door

- The comfort zone for most people is hand shaking distance.
- The comfort zone for paranoid or agitated patients may be 2-3 X the usual distance.
- Remember the patients history when you are in their personal space. When you do a physical exam and you invade their space they may react defensively.

Assessing the risk of violence

- Immediate past, recent past and more distant history of violence is the best predictor of future violence.
- Circumstances of violence and characteristics of people involved are important.
- Substance dependence or abuse carries a 30X increase risk than the general population!!

- Antisocial personality disorder with comorbid substance abuse or dependence carries greater than 100X the risk compared to the general population.
- Mental illness carries a 9X greater risk than the general population particularly paranoid schizophrenia and confused states related to medical problems.

Behavioral Predictors of violence

- Angry words
- Loud language
- Abuse language
- Physical agitation such as making fists, pacing and akasthisia

How to de-escalate a patient

- Use a calm voice
- Sit down with the patient
- Maintain adequate physical distance of at least 6 feet
- Attempt to establish rapport
- Listen to the patients concerns

When verbal de-escalation is not enough:

- When there is risk of imminent harm and verbal de-escalation has been ineffective either pharmacologic supports or physical restraints may be needed.

Physical restraints

- Have restraints, stretcher and restraint keys ready
- Use a show of force with 5 or more trained staff who may need to physically lay hands on the patient. Sometimes gathering that many clinicians will persuade the patient to comply.
- Try to talk the patient into lying on the stretcher

- If the patient will not comply the team will put the patient in restraints.
- Remember people can bite and spit so one of the team will control the head during the restraining procedure
- A minimum of two points (one arm and one leg)

Once the patient is in restraints:

- Search the patient for potentially harmful objects such as lighters, knives
- Perform a brief survey for any physical injuries to the patient including head injury and observe movement in all 4 limbs
- Check the head and eyes including eye movements and pupillary response

Pharmacologic Support: Benzodiazepines

- Lorazepam is one of the most useful meds in the emergency setting. In the first 24 hours agitation is as effectively addressed with lorazepam as antipsychotics even if psychosis is present.
- Lorazepam is best absorbed IM. Diazepam and chlordiazepoxide have erratic absorption. PO or IV administration of diazepam is effective and actually has a more rapid absorption than PO lorazepam.

- Lorazepam is available in PO, IM and liquid forms. In Canada a sublingual form is also available.
- The primary reason not to use a benzodiazepine is its sedative hypnotic effect which can be additive with other such agents (ex. Alcohol) resulting in excessive sedation and respiratory depression.

- There is always a risk of an allergic reaction although this is rare for benzodiazepines
- Patients can have a paradoxical reaction and actually become more agitated. This is seen in about 5% of the population.

Pharmacologic support: Antipsychotics

- Antipsychotics can be quite effective in reducing agitation.
- There are options in the following forms:
 - PO
 - IM
 - Quick dissolving tabs

IM Antipsychotics

- Ziprasidone (Geodon) 20mg IM q 4 hours or 10mg q 2 hours not to exceed (NTE) 40mg/24 hours
- Olanzapine (Zyprexa) 5-10mg IM NTE 20mg/24 hours (caution with the elderly)
- Haloperidol (Haldol) 1-5mg IM q 1 hour NTE 20-30mg/24 hours
- Droperidol (Inapsine) 2.5-5mg IM/IV- note black box regarding arrhythmias

Antipsychotics continued

- Generally long acting depo forms of antipsychotics are not started in the emergency room since arrangements for outpatient follow up are needed to continue them

PO antipsychotics

- Risperidone (Risperdal) 1-2 mg po NTE 6mg/24 hours. Also comes in a rapid melting tab called Risperdal M-tab.
- Olanzapine 10-20mg po NTE 20mg/24 hours. Also comes in a rapid melting tab called Zydys.
- Haloperidol 1-5mg po q 1-2 hours NTE 30mg/24 hours

Extrapyramidal symptoms

- Haldol is the most likely to cause extrapyramidal symptoms (eps) followed by risperidone with the other atypicals having less eps risk.
- EPS is most likely to occur in young males and older women.
- EPS is usually noted as muscle tightness in limbs, tongue thickness and neck tightness. More rarely laryngeal and pharyngeal spasm and a sense of choking.

EPS treatment

- Be ready to give O2 if breathing problems develop.
- PO, IM or IV diphenhydramine (Benadryl) 50mg q 4-5 hrs. IV form acts very quickly so great to use if pt has IV access already. If not may need to use IM. IM takes about 30 minutes to improve sx and po takes around 60 minutes.
- Benzotropine (Cogentin) 1-2mg PO or IM q 8-12 hours.

Suicide

- Suicidal ideation is common. As many as 1/3 of college students have had SI.
- Approximately 1/3 of people who kill themselves tell their doctors. More tell family members about their thoughts therefore getting collateral information from family members is important.
- People who talk about suicide do kill themselves

Suicide statistics

- The rate of suicide in the general population is 12/100,000
- Suicide is the 2nd or 3rd most frequent cause of death in adolescents and young adults
- Men attempt less often but use more lethal means than women (shooting, hanging, jumping)

Risk factors for suicide

- Mental illness including mood disorders, psychotic disorders, borderline personality disorder, anxiety disorders, substance issues
- Older men (>65) particularly those who have lost a partner
- Caucasian
- Chronic illness and/or intractable pain
- Hopelessness

Suicide in the mentally ill

- The first year after psychiatric hospitalization for major depression carries the highest risk
- People with a history of psychiatric hospitalization for major depression or bipolar disorder have a lifetime suicide risk of 10-20%
- Schizophrenics who have had a psychiatric hospitalization have about a 10% lifetime risk of suicide
- Substance abuse and dependence also increases the risk

When assessing for suicide consider:

- current suicidal ideation
- intent to die
- plans and details of the plans including efforts to secure means to carry out the plan if applicable
- recent attempts
- past attempts
- hopelessness and other risk factors listed on previous slide

- Having the patient contract to not kill themselves has little support in research or practice in preventing suicide however if a person cannot agree that they will be safe there is an indication of more risk.
- The strength of the contract may depend on a long term meaningful relationship and strong connection with the provider rather than short term rapport.

- Suicides are often seen by the patient as problem solving behavior. Understanding which problems are perceived to be solved can allow for alternative options to be introduced. Similarly understanding the rewards in the suicide attempt can help in changing the contingencies.

Suicide prevention

- Have a structured plan at discharge
- Try to have the patient stay with others after a suicide attempt or after intense suicidal ideation
- Develop a contingency plan if SI returns including names, phone numbers and places to go

Suicide prevention cont.

- Develop plans for management of symptoms such as anxiety and akathisia.
- Develop plans for management of cravings to use drugs/ETOH.
- When appropriate choose meds that decrease the risk of suicide. These include Lithium for bipolar patients and Clozaril for psychotic patients. Antidepressants have not been shown to decrease suicide risk in terms of long term risk.

Suicide prevention cont.

- Providing a positive experience for the patients while on the unit. A study on inpatient medicine floor found in patients post SA who perceived being treated kindly has reduced frequency of subsequent suicide attempts.

Psychosis in the emergency setting

- When evaluating a patient with psychotic symptoms think about environmental stressors, medical causes and drugs.
- Patients may experience an exacerbation of symptoms with environmental stress such as intense emotional encounters. This can occur even if the patient is taking their meds.

Non psychiatric causes of psychosis*

- Medications particularly steroids
- Head injuries
- Metabolic abnormalities
- Infection, particularly those involving the CNS
- Amphetamines
- Cocaine
- PCP
- LSD
- *this is not an exhaustive list

Affective disorders in the Emergency setting

- Always assess for suicidal ideation and psychotic symptoms.
- Typically do not start antidepressant or mood stabilizer in the ER because require close monitoring and take several weeks to become effective.
- If the patient deemed not at imminent risk for suicide and able to provide self care then establish outpatient follow up.

Substance abuse/dependence in the Emergency setting

- Alcohol abuse/dependence is the most common.
- Presenting alcohol levels are important. If a patients blood alcohol level is 200+, they are alert and clearly conversing abuse/dependence is likely.
- Withdrawal from alcohol is potentially life threatening so keep a watchful eye for the signs of ETOH withdrawal and treat early with benzodiazepines

- Approach the patient about engaging in Alcoholics Anonymous. There are always groups available, it is free and for many patients is helpful.
- Patients often have been given the same information many times before but a significant percent eventually do follow through so don't give up!!!!

- Always perform a Utox because it can help give you tools to battle denial of use.
- In the ER prescribing medications with abuse potential such as benzodiazepines and opiates is avoided.

Personality disorders in the Emergency Setting

- People with Antisocial Personality Disorder tolerate a straight forward business like problem solving approach. Remember to screen for substance use which is a common comorbid condition and risk to others.
- People with Dependent Personality Disorder can have frequent visits trying to seek support. Work on avoiding reinforcing aspects of the ER.

- People with Borderline Personality Disorder (BPD) account for up to 10-20% of psych admissions. Often depression, self harm and behavioral lack of control are the reason.
- Always assess for suicidality in a person with BPD. They make many suicide attempts without success however many eventually succeed.

Take home points

- Safety is always the first concern in the emergency setting
- To maintain safety both physical restraints and pharmacologic support may be needed
- Assess carefully for suicide
- Screen for addiction, affective, psychotic and personality disorders