ASSOCIATION FOR THE CHRONICALLY MENTALLY ILL (ACMI)

FEBRUARY 24TH, 2021

The webinar will start @ 6:00 PM

ACMI EDUCATIONAL WEBINAR:

EMERGENCY PSYCHIATRIC ASSESSMENT

- Information presented is not medical advice
- Please mute all lines except presenters
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EMERGENCY PSYCHIATRIC ASSESSMENT

Presented by Dr. Carol Olson M.D. DFAPA, Chair, Psychiatry Department, Valleywise Health System

MEDICAL SCREENING

- Need to evaluate for medical conditions masquerading as psychiatric problems
- Increased suspicion if:

Abnormal vital signs (temp, heart rate, respiratory rate, blood pressure)

Over age 50 with no prior psychiatric history

Patient with physical health conditions known to have psychiatric symptoms (e.g., AIDS, Huntington's disease, lupus, etc.)

Atypical symptoms/time course

Prominent disorientation, changing levels of alertness, visual or tactile hallucinations

FURTHER TESTING

- Should be clinically indicated. "Medical Clearance" doesn't have much meaning, especially for ED doctors. Blood alcohol level and urine drug screen most helpful; other testing based on history and symptoms.
- There are not lab tests or imaging studies to "prove" the existence of most psychiatric conditions; these tests are used to rule out other causes of the symptoms, but making a specific psychiatric diagnosis generally relies on getting a good history and observing the patient. This means establishing rapport with the patient in order to encourage them to share their history and inner experience is *crucially important.*

PHYSICAL EXAM

- May be quite limited in a psychiatric emergency room, and typically is problem-focused there, while a newly admitted hospitalized patient gets a full physical exam.
- Important to assess gender identification and trauma history before examining the patient. Use gender-appropriate chaperone.

CHART REVIEW

- Very important to review any available records before seeing the patient, unless it is an acute emergency, because:
- Helps with immediate risk assessment
- Helps guide diagnostic enquiry
- Helps establish rapport
- If family or other collateral sources of information are available, TALK TO THEM. Obtaining information does not violate confidentiality, and it is okay to do so, over the patient's objections, if there is a good-faith concern about dangerousness to self or others.

CHIEF COMPLAINT

- What brings you here today?
- Also need to evaluate:

How did patient present for evaluation (e.g., independently or brought in by others)

What concerning statements/behaviors have been reported?

What is the patient's appearance?

What is the patient's legal status (voluntary vs. involuntary for evaluation? In police custody?)

What is the patient's capacity to make decisions about psychiatric or medical treatment?

Is the patient cooperative?

How reliable is the information provided by the patient? By family members?

HISTORY OF PRESENT ILLNESS

- Timing, intensity and duration of symptoms
- Effect of symptoms on patient's function at work, with family, and caring for self
- Presence of "vegetative symptoms" – i.e., effects on sleep, appetite and energy level
- Presence of mood or anxiety symptoms, including irritability, panic attacks, anhedonia (loss of pleasure in everything).
- Psychomotor agitation or retardation
- Pathologic guilt
- Patient's subjective judgement regarding cognitive deficits (problems with memory, attention, concentration)

HPI, CONTINUED:

- Presence of psychosis (hallucinations, delusions, or disorganized thought process)
- Obsessions (intrusive thoughts) and compulsions
- Eating disorder symptoms (compulsive dieting, binging, purging)
- Substance use
- Problematic sexual behaviors
- Suicidal or homicidal thoughts/intent/plans/access to means

PAST PSYCHIATRIC HISTORY

- 1st psychiatric contact – when, why, with whom, outcome
- Prior psychiatric hospitalizations or ED visits
- Past trials of medications or other treatments (ECT, TMS, psychotherapy)
- Current psychiatric provider and duration of care
- Prior history of intentional self-harm and harm to others
- Description of prior depressive, manic or psychotic episodes
- Description of personality traits prior to the current illness – best to get this from others as well as the patient (e.g., Stable or unstable temperament? Impulsivity? Concern for the welfare of others? Ability to handle stress?)

SUBSTANCE ABUSE HISTORY

- Amounts, rates and last use
- Correlation with psychiatric symptoms (e.g., does patient have psychiatric symptoms when not using substances; does the substance abuse post-date the onset of psychiatric symptoms)
- Prior complicated withdrawal (e.g., seizures, DTs). Most likely with abuse of alcohol or benzodiazepines
- Prior treatment and its results

PAST MEDICAL/SURGICAL HISTORY

- Current active medical diagnoses
- Prior medical diagnoses. Prior brain injury?
- Prior surgeries
- Current care providers
- Current medications (both prescribed, over the counter and herbal).
- Allergies and intolerances

FAMILY HISTORY

- History of psychiatric illness, suicide or substance use disorder in blood relations
- History of medical illness in blood relations, especially those which might cause psychiatric symptoms (e.g., Parkinson's disease, Huntington's disease, Alzheimer's disease…)

SOCIAL AND DEVELOPMENTAL HISTORY

- Complications while in utero or at time of birth
- Achievement of developmental milestones such as walking and talking (on time or delayed)
- Childhood behavior problems
- Educational attainment
- Work history
- Military service
- Relationship history
- Current relationships

SOCIAL HISTORY, CONTINUED:

- Living arrangements
- Public benefits
- Sexual history (sexual orientation, gender identity, pattern of relationships)
- Legal history (prior arrests and convictions; currently on probation or parole?)
- History of abuse, neglect or trauma
- Religious/spiritual history

REVIEW OF SYSTEMS

- Review of each body organ system for presence of physical symptoms, by patient report

MENTAL STATUS EXAM

- Appearance (neat, disheveled, unshaven, dirty, clad in multiple layers of clothing, dramatic makeup, shaved head, etc.)
- Level of alertness
- Level of cooperation
- Abnormal movements or other physical abnormalities (eg, unsteady gait, lack of eye contact, tremor, etc.)

MSE, CONTINUED:

- Assessment of Speech/Language –e.g., rate, rhythm, quantity, volume, fluency
- Assessment of Thought – e.g., level of organization; abnormal content (suicidal or homicidal thoughts/ intentions/plans; auditory, visual, tactile or olfactory hallucinations; illusions; delusions (fixed false beliefs not held by the patient's sociocultural group); hyper-religiosity; grandiosity; paranoia
- Assessment of mood (patient's description of his/her emotional state)
- Assessment of "affect" – observer's description of patient's emotional state, and how it varies over time
- Cognitive assessment (memory, orientation, attention, concentration)

DIAGNOSES

- Emergency evaluation often ends in a “differential diagnosis” – ie, several possible diagnoses, with further refinement possible as more information is obtained, and patient is observed longer

RISK ASSESSMENT

- Can use some evidence-based tools (e.g., Columbia Suicide Severity Rating Scale) to help assess risk for suicide, but suicide is a rare act and ultimately it is a clinical judgement. Increased risk with male sex, older age, concurrent substance abuse, high level of anxiety, prior suicide attempts, high impulsivity, h/o suicide of close family members, hopelessness, chronic pain, and acute psychosocial stressors
- Best predictor of future violence is past history of violence
- CANNOT do proper risk assessment in intoxicated patient

TREATMENT PLAN

- Must decide on level of care required (hospital; detox program; residential treatment; partial hospital program; intensive outpatient treatment; outpatient treatment). This may depend on level of social support available.
- Voluntary vs. involuntary? To pursue involuntary treatment, the person must be a danger to self or others, or very disabled in daily activities, or suffering severe physical or emotional harm from their symptoms – this must be caused by a mental disorder – and the person must be unable or unwilling to have treatment voluntarily.
- Outpatient care plan might include referral for SMI services; ACT services; case management services; integrated care clinic
- Mobilization of community supports
- Limiting access to firearms/stockpiled medications/ vehicle
- Consider providing naloxone nasal spray kit for use by those living with a person with an opioid use disorder
- Education regarding availability of crisis services 24/7 for high- risk patients
- Education to family regarding criteria for involuntary mental health treatment

TAKEAWAYS:

- Consider all available sources of information when making an assessment and plan – e.g. patient, family, records, test results.
- The first goal of the patient interview is to establish rapport
- Take a careful history and do appropriate testing to rule out physical health problems presenting with psychiatric symptoms.
- When evaluating risk for potential dangerousness to others, the most important factor is past history of violence
- Do not make decisions about future risk to self or others on a patient who is still intoxicated.
- Do not assume that the psychotic or mood symptoms are due to substances without doing a careful review of the history and observation of the patient once he/she is no longer intoxicated.

THANK YOU FOR ATTENDING

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