Treatment of the Psychiatric Patient in the Emergency Department

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What We Will Discuss Today
Part II: Treatment of Acute Behavioral Disorders in the E.D.

✦ Your Safety
✦ Work Up - What Studies?
✦ Medications
✦ Life Threatening Conditions
✦ Putting it All Together
Some Important Issues

Your Safety
Physical Protection

✦ Santa Clara Valley E.D.
  Intern removes restraints placed by “pigs”
  Intern assaulted

✦ Stanford E.D.
  Intern evaluates patient in Room 8
  Intern shot in chest

✦ USC/LAC
  3 doctors killed in the ED
If you feel uncomfortable

There’s probably a good reason!
Don’t get too close to a potentially violent patient.
Never turn your back on a potentially dangerous patient!
Always stay between the patient & the door

Have a plan of escape

Never get trapped!
Physical Protection

- If you feel uncomfortable
  - There’s probably a good reason!
- Don’t get too close to the patient
- Have an escape plan
  - You between patient & door
  - Never turn your back!
- Do not remove restraints until you assess violence potential
- Beware of PCP & amphetamines
Physical Protection

- Adopt a calm, reassuring manner
- Have sufficient help available
- If needed
  - Show of potential force is often sufficient
  - Humane - but maximum - restraint if necessary
    - 1 person for each extremity
- Beware of potential for vomiting
Physical Protection

IM Pharmacologic restraint

- Psychotic
  - Haloperidol (Haldol™) 5mg
- Agitated
  - Lorazepam (Ativan™) 2 mg
- Both
  - Both
- Consider benztropine (Cogentin™) 2 mg or diphenhydramine (Benadryl™) 25-50 mg with haloperidol
Some Important Issues

What Studies are Indicated?
Case No. 8

- 32 year old known schizophrenic
- Found naked in airport security line
- No need for further screening...
- Perhaps cavity search??
- Hasn’t taken his psych meds in weeks
- You are asked to “medically clear” him
Case No. 8

- Alert
- Oriented x 4
- Counts backward from 20-1
- Remembers 3 objects
- Knows name of his psychiatrist and his meds, with the dosages
- Spells "world" backward & alphabetizes

LOAMI
Case No. 8

- Physical exam normal
  - VS
  - Skin
  - Eyes
  - Head
  - Neuro
  - Chest
  - Heart
  - Abdomen
Case No. 8

- Is he confused?  
  - Yes
- Is he psychotic?  
  - Yes
- Does he have OBS? (delirium or dementia)?  
  - No!
- His cognitive function is normal
Case No. 8

- **Question**
  - Do you need to order any labs?
  - If so, what?
  - Does he need a CT
  - Or MRI, PET, CTA, LP...
Evaluation

Question -
What testing is necessary in order to determine medical stability in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and psychiatric symptoms?
Evaluation

ACEP - Level B recommendation

In adult ED patients with primary psychiatric complaints, diagnostic evaluation should be directed by the history and physical examination.

Routine laboratory testing of all patients is of very low yield and need not be performed as part of the ED assessment.

Evaluation

Question -
Do the results of a urine drug screen for drugs of abuse affect management in alert, cooperative patients with normal vital signs, a noncontributory history and physical examination, and a psychiatric complaint?
Evaluation

ACEP Level C recommendations.

Routine urine toxicologic screens for drugs of abuse in alert, awake, cooperative patients do not affect ED management and need not be performed as part of the ED assessment.

Urine toxicologic screens for drugs of abuse obtained in the ED for the use of the receiving psychiatric facility or service should not delay patient evaluation or transfer.
Question -

Does an elevated alcohol level preclude the initiation of a psychiatric evaluation in alert, cooperative patients with normal vital signs and a noncontributory history and physical examination?
Evaluation

**ACEP Level C recommendations.**

The patient’s cognitive abilities, rather than a specific blood alcohol level, should be the basis on which clinicians begin the psychiatric assessment.

Consider using a period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves.
Some Important Issues

Medications
1st generation (typical) antipsychotics

- Chlorpromazine (Thorazine™)
- Thioridazine (Mellaril™)
- Trifluoperazine (Stelazine™)
- Perphenazine (Trilifon™)
- Fluphenazine (Prolixin™)
- Mesoridazine (Serentil™)
- Haloperidol (Haldol™)

*Dopamine-2 receptor blockers*
Treatment

2nd generation (atypical) antipsychotics
- Clozapine (Clozaril™, FazaClo™)
- Risperidone (Risperdal™)
- Quetiapine (Seroquel™)
- Olanzapine (Zyprexa™)
- Ziprasidone (Geodon™)
- Aripiprazole (Ablify™)

_Dopamine-2 receptor blockers with added anticholinergic & antiserotonergic activity_
Treatment Recommendations

- Psychotic
  - Haloperidol (Haldol™)
    - 5 mg PO, IM or IV
- Agitated
  - Lorazepam (Ativan™)
    - 1-2 mg PO, IM or IV
- Both
Treatment Recommendations

- When giving haloperidol (Haldol™), consider
  - benztropine (Cogentin™)
    - 2 mg IM or IV
  - Alternative:
    - dephenhydramine (Benadryl™)
      - 25 - 50 mg IM or IV
Treatment Recommendations

2nd generation anti-psychotic agents

- Some available in parenteral form
- Olanzapine (Zyprexa™)
  - 10 mg IM (or less)
  - Also available as oral dissolving tablet
- Ziprasidone (Geodon™)
  - 10-20 mg IM
Current Stanford Psychiatry
Recommendations for acutely psychotic patients needing treatment in the E.D.

- Not agitated
  - Risperidone (Risperdal™)
- Agitated
  - Quetiapine (Seroquel™)
- Violent
  - Olanzapine (Zyprexa™)
Some Important Issues

Life Threatening Psychiatric Conditions
Life Threatening Psychiatric Conditions

Suicidal Ideation
Homicidal Ideation
Grave Mental Disability

Involuntary Psychiatric Holds
Suicidal Ideation

- May be psychotic or quite rational
- May be obviously depressed, hostile, paranoid, or seemingly normal
- ASK SPECIFICALLY
  - You won’t “give them the idea”
Suicidal Ideation

- Females more often try
- Males more often succeed
- Adolescents more often try
- Elderly more often succeed
Suicidal Ideation

- High Risk
  - Detailed plan
  - Recent attempt
  - Elderly, spouse deceased
  - Living alone, lonely
  - Money problems, unemployed
  - Major depressive disorder,
    - Especially when apparently recovering
Suicidal Ideation

- Feeling of hopelessness
- No response to offer of help, referral, intervention, etc.
- Schizophrenia or Mood Disorder
- Alcohol or drug abuse
  - May resolve as alcohol/drug is metabolized
- Reason to be depressed
BANG !!
Homicidal Ideation

- High Risk
- Specific plan
- Specific victim
- Past history of violence
  - The best predictor!
- Persecutory delusions
- Paranoid ideation
Homicidal Ideation

- High Risk
- Postpartum depression
- Provocative/taunting victim
  "You don’t have the guts to shoot..."
Grave Mental Disability

- Inability to care for oneself
- Activities of daily living
  - Food, clothing, shelter
- May be psychotic or not
- Usually acutely psychotic
- Gross impairment of thought process or content, or cognition
Grave Mental Disability

- Inquire in detail about immediate plans
- How will the patient get home?
- Where will the patient sleep tonight?
- Arrangements for meals
- Plans for tomorrow
- History & Information from family may be crucial
So -

What Can We Take Away From Our Discussion Today?
Putting it All Together

Psychiatric patients in the E.D. are OUR patients also

History

Is this behavioral problem acute?

Physical Exam

Vital signs
Skin
Pupils
Head
Neck
Neuro
Putting it All Together

- Use the MSE to distinguish purely "psychiatric" patients from those with abnormal behavior due to medical/surgical causes ("organic")

- The cognitive function portion of the MSE is your key
Putting it All Together

- Mental Status Exam
  - With attention to COGNITION
    - Level of Consciousness
    - Orientation
    - Attention
    - Memory
    - Information
Putting it All Together

A few important points from our cases

- **Elderly folks**
  - Dementia is a slow process
  - An acute change is delirium
  - Think especially medications, infection, metabolic, or occult head trauma
Putting it All Together
A few important points from our cases

- First time acute confusion in folks over 45 is organic
  - Find the cause!

- Affective disorders and schizophrenia begin earlier
Putting it All Together

A few important points from our cases

- **Auditory hallucinations** (hearing voices)
  - Usually not organic (though may be)
- **Non-auditory hallucinations** are organic!
  - **Visual**
  - **Olfactory**
  - **Tactile**
  - **Gustatory**
Putting it All Together

A few important points from our cases

- Patients with a known psychiatric history who have normal cognitive function do not need screening studies unless there is a specific reason.
- They may be medically “cleared” BUT
- Document your evidence
“Medical Clearance” for Psychiatric Patients

“CYA” charting

At this time there is no apparent evidence of a non-psychiatric medical emergency that would preclude (admission, transfer) to ____ for further psychiatric as well as medical evaluation.
At this time there is no apparent evidence of a non-psychiatric medical emergency that would preclude (admission, transfer) to _____ for further psychiatric as well as medical evaluation.
Case No. 7

- 37 year old man with erratic behavior
- He attempted to push his chauffer out of a moving car. When asked why, he responded: “I don’t know.”
- Two months after that, he smeared a gift box of chocolate all over his body.
- Both times, this bizarre behavior was accompanied by the smell of burning rubber
Case No. 7

Three years before he had complained of a frequent sensation of smelling burning rubber.

Evaluated by his physician, who could find nothing wrong.

He was advised to take a vacation and not work so hard.

He had a long history of food intolerance, was an “artist” (a musician), and the etiology was felt to be somatization.
Case No. 7

- Three months later he presented with headaches and increasing somnolence
- His MSE is not known - probably not done

Exam
- Loss of upward gaze
- Papilledema
- Retinal hemorrhages
Case No. 7

- **Diagnosis?**
  - Temporal lobe tumor
- **Outcome?**
  - Death at age 39
- **His name?**
Case No. 7

- **Diagnosis?**
  - Temporal lobe tumor
- **Outcome?**
  - Death at age 39
- **His name?**
  - George Gershwin

Case No. 7 - What can we learn from this case?

- New onset of bizarre behavior at age 37
  - Could have been non-organic etiology
- **Olfactory hallucinations**
  - Definitely organic
- **Auditory hallucinations** common in non-organic psychosis
- Any other type is organic!
  - Olfactory, tactile, visual, gustatory
Some Final Thoughts
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