

EMS EVALUATION OF PSYCHIATRIC EMERGENCIES

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CASE SCENARIO

You are called to the home of a mother and her 18 year old daughter after the mother calls 911 because she states "I'm afraid my daughter is going to hurt herself." You arrive at the home, both the mother and daughter are in the living room, the mother seems very upset, the daughter is tearful at times, at times is very aggressive almost to the point of being combative. You immediately recognize that this is emotionally a very charged situation, you attempt to keep everybody calm and are able to get a very brief history from the mother and daughter. The mother starts by explaining how over the last several days her daughter has been extremely volatile, at times tearful, at times very aggressive and threatening the mother, at times seemingly depressed and withdrawn. The mother states that the daughter had a boyfriend and that the relationship has recently fallen apart. The mother also states that she is fearful that her daughter may be involved with "drugs" and that she thinks her daughter's ex-boyfriend was involved with "drugs." The mother also states that six months ago the mother's husband and daughter's father died in a car accident. As you speak with the daughter you immediately recognize that she is not very coherent. You are unable to follow her thoughts, she is constantly changing subjects. She states that her mother is "smothering" her, that she "hates" her mother. She also states that she has been involved in a mystical cult that is awaiting the second coming of "Isis" and that she thinks at times she is able to speak with "Isis." You think you can smell alcohol on the daughter's breath. The daughter states that she does not desire any help but the mother insists that her daughter needs medical attention and wants you to take her to the emergency room via ambulance right away.

PSYCHIATRIC EMERGENCIES: AN OVERVIEW

As the above case scenario illustrates, psychiatric emergencies challenge our interpersonal skills, our diagnostic abilities, medical and legal knowledge. When we are confronted with such an emotionally charged situation, it is very helpful to first identify that a psychiatric crisis is most likely present. The first question then is:

(1) does this patient represent a danger to themselves or others? The second question is: (2) is this patient medically competent, i.e., does this patient have the capability at this moment of making a rational decision about themselves or is there some functional or organic process present. The third question that must be addressed is: (3) given the answers to questions 1 and 2, what, if any, are the medical-legal issues of this present situation?

(1) Does this patient represent a danger to themselves or to others?

The question whether a patient represents a danger to themselves or others is perhaps the most important question the examiner must answer when evaluating a psychiatric patient. This information is obtained from the circumstance of the current situation, from the history and from

the initial physical exam or survey. When one is in a situation where the patient is in the act of attempting, has attempted or is threatening suicide, this portion of the evaluation is obviously not very difficult. Examples of such situations might be when you are called to go to a scene which is located in a 10 story building downtown and the patient is standing on the ledge of a window threatening to jump. Another example might be if you are called to a scene at a river where the patient has jumped into the water from a bridge in an apparent suicide attempt and requires immediate CPR. An example of the third situation might be where you are called into the home where a teenager has just cut their wrists with a kitchen knife. An example of a patient being a danger to others might be when you are called to evaluate a domestic dispute where the husband who is taking lithium for manic depressive disorder has struck his wife and the police are uncertain whether they should take this patient to jail or request that you take the patient to the emergency department.

Observe the situation

A more difficult situation arises in the case scenario describing the situation with the mother and her daughter. In answering whether this patient (the daughter) is a danger to herself you should first simply observe the situation. Is there any evidence that the daughter has just attempted suicide? Are there any empty pill bottles noticeable? Are there any knives, ropes, guns or other objects the daughter may have just used to attempt suicide? Is the room or apartment in a high rise where the patient may have attempted or thought about jumping out of a window?

Physical exam or survey

Next comes a cursory physical exam or survey. Is the patient bleeding from any site, especially from the wrists? Are there any rope marks around the patient's neck? Is there any evidence from looking at the patient's head that a failed attempt at using a gun to the head has recently been made? The initial physical exam or survey is also very helpful in obtaining parts of the history. Are there any scars at the wrists, neck or head which suggest the patient may have made a suicide attempt in the past.

Preliminary history

The third phase includes the actual history. After initially entering the room and hearing the mother's concerns and observing the daughter, attention should immediately focus on the daughter. A introduction might be "hello Ms. Jones, I'm Robert Smith with Blue Service EMS; we work with the doctors at Blue Hospital; what happened today that had your mother call us to come and see you? In such a situation, it is important to present yourself to the patient in an open, and professional manner and to indicate that, although you were called by the mother, your main concern as a health care professional is the patient. If possible, allow the patient to present the situation as they perceive it. This will immediately permit you to assess the patient's memory, judgment, affect (or emotional state). After this preliminary introduction and assessment, do not be inhibited in going directly to the core issue. Ask the patient "Ms. Jones, have you thought about hurting yourself lately?" Wait and allow the patient to respond in their own words. If the patient says yes, ask about any specific plans. Has the patient thought of driving her car over a

bridge or into another vehicle or brick wall? Has the patient thought of taking pills and, if so, what type of pills? Is there a gun in the house and, if so, has the patient thought of using it? The patient's answers to such questions will give you an immediate assessment as to the patient's suicide potential. It is important to take all affirmative answers to such questions seriously. Any "yes" answer indicates that the patient has suicidal ideation and this should always be taken seriously. Do not attempt to second guess the patient's intentions. If a patient says they have thought about suicide, believe them until proven otherwise. Only a psychiatric evaluation by the emergency physician and possibly psychiatrist in the emergency department will be able to determine the seriousness of any "yes" answers to these types of questions.

It is also important to ask about past suicide attempts and any past or present psychiatric history. Has the patient ever tried to "hurt themselves" in the past? Is the patient presently being seen by a psychiatrist? Is the patient currently on any psychotropic medications, i.e., antidepressants, lithium, anti-psychotics? Has the patient ever taken any psychotropic medications in the past? Any affirmative answer to such questions increases the likelihood that the patient is a suicide risk.

(2) Is this patient medically competent?

A good rule of thumb is to remember that "medical competence" implies "reasonable behavior." In other words, are the patient's behavior and responses to questions the type of behavior and responses you would expect from most reasonable people. This issue is very important because you may be asked by the physicians who have radio-control and by police officers at the scene to assist in making a determination whether a patient is medically competent. This becomes especially important in situations where the patient refuses medical treatment.

Mental status examination

A brief mental status examination is essential in assisting to determine whether a patient has an abnormal mental status. It is sometimes useful to think in terms of organic or functional causes of altered mental status. The mental status examination will usually include memory, affect (or emotional state), judgment and ability to think abstractly.

Organic causes of changes in mental status

Organic causes of mental status changes fall into two broad categories: Toxic-metabolic and structural. Toxic causes include a drug or chemical ingestions. More common examples include illicit drugs. In our case scenario, the suggestion by the mother that the patient was involved in illicit drug use indicates that the daughter's aggressive behavior and any suicidal ideation may be due to illicit drug use or alcohol.

In our case scenario, the patient had alcohol on her breath which may be responsible or contribute to the daughter's behavioral changes. As about any present or past illicit drug use, including marijuana, LSD, narcotics, etc. Is the patient taking any medication which might be affecting the patient's behavior? Other substances such as household detergents, Clorox,

insecticides and pesticides may have been ingested in a suicide attempt and may be responsible for any behavioral changes.

Structural causes of mental status changes usually include cerebrovascular accidents (CVA), brain tumors, trauma, and organic dementia. Was the patient's change in mental status and behavior gradual or did it occur abruptly? Is there any paralysis of the arms or legs? Is the patient experiencing any difficulty with speech? All of these may give clues that a structural organic process may be responsible for the patient's change in mental status.

Functional causes of changes in mental status

Functional generally implies psychiatric. It is sometimes helpful to separate psychiatric disorders into affective (or emotional) disorders, psychoses and personality disorders. Personality disorders are often difficult to initially diagnose in an emergency setting, but these patients will often have symptoms similar to patients with psychosis and depression.

One very common emotional disorder which can be responsible for changes in mental status is depression. Are there any recent stressors in the patient's life which may have precipitated depression (death in the family, loss of relationship, divorce, marriage, etc.). In our case scenario, the death of the patient's father must have undoubtedly had an emotional impact, as well as the loss of the relationship with her boyfriend. Patients who are depressed will usually have such vegetative symptoms as loss of appetite, weight loss, loss of sleep, loss of interest in usual activities, interests and hobbies as well as loss of libido. It is important to ask for any changes in these spheres of the patient's existence.

The psychoses generally include schizophrenia, manic-depressive or bipolar disorder and affective disorders such as depression with psychoses. A hallmark of psychoses are distorted sensory perceptions. For example, in our present situation, the daughter indicated that she could sometimes converse with "Isis." An important question to ask would be: "Ms. Jones, do you sometimes hear Isis' voice speaking to you?" If she were to answer yes then this is a sign of a possible psychosis. Another hallmark of psychoses are "flight of ideas" in which the patient is continuously changing the subject and it becomes impossible to follow the patient's train of thought. Bipolar disorder usually implies the patient has periods lasting from days, weeks, months or even years where they are extremely manic, go on shopping sprees, ideas of grandiosity, sexual promiscuity, etc. and then go through periods of depression. It is usually well controlled with lithium but if the patient is not taking their medication as prescribed or is not taking enough, often they will present with acute changes in their mental status. Schizophrenia is a type of psychosis which usually begins in late adolescence or early adulthood and can be controlled with antipsychotics such as haldol.

(3) Medical-legal issues

Most legal experts, law enforcement professionals and physicians seem to agree that if there is any indication that a patient is suffering from either an organic or functional acute change in mental status and is a danger to themselves or to others, then such a patient should undergo emergency

medical evaluation and attention. Many of these patient's will submit to such an evaluation voluntarily. Some, however, will not voluntarily submit to medical evaluation and will require a request for emergency medical evaluation from either a judge, justice of the peace or police officer.

The health care professional must first decide whether the patient is a danger to themselves or to others. Second, it must be determined whether the patient is medically competent. If it is determined that the patient is not rational because they are suffering from an organic or functional disorder which has altered their mental status, then the patient is probably not medically competent. If such a patient is a danger to themselves or others, then the patient should undergo emergency medical evaluation in an emergency department. If the patient refuses to go voluntarily, the health care professional has the option of requesting that a police officer submit a request for emergency medical evaluation. In many situations the police will also be at the scene so that this becomes an issue which can quickly be addressed and resolved. In situations, however, where the health care professional is at a scene without police present, the base physician and possibly police should immediately be radio called for further guidance.

Once the decision has been made to transport the patient to the emergency department via ambulance with a police request for emergency medical evaluation, chemical or physical restraints may become necessary in the combative patient. Physical restraints include soft restraints, leather restraints as well as handcuffs and foot chains that are sometimes placed by police officers. Chemical restraints include parenteral Haldol and Versed. When it becomes necessary to use chemical or physical restraints, it is best to discuss this directly with the base physician who has radio control. Protocols for restraints will vary from community to community.

OUTCOME

You were able to convince the patient to go with you in the ambulance voluntarily to the EMD. Subsequent EMD and several days of voluntary inpatient psychiatric care revealed that the patient was suffering from major depression with psychoses, marijuana use and alcohol addiction. The patient was begun on anti-depressant medication and began an outpatient treatment program for substance addiction. The patient also began outpatient psychotherapy to resolve some family issues, including the recent death of her father. The following fall the former patient began attending college.

References:

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