Disordered Thoughts

Mental Health in the ED

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ACEM Winter Symposium – Rotorua NZ

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Introduction

think

- Why give this talk?
  - Mental health – 7% of ED patients
  - Major contribution to ED workload
  - Trauma (for patients and clinicians)
- Collaboration and empathy
- Some basic revision
- ‘Medical clearance’
- Alternative models
- ACEM Mental Health Summit
- Education and training
- More collaboration and empathy
- Questions and homework

A comparative exercise

- *Chest pain*

vs

- *Mental Health*

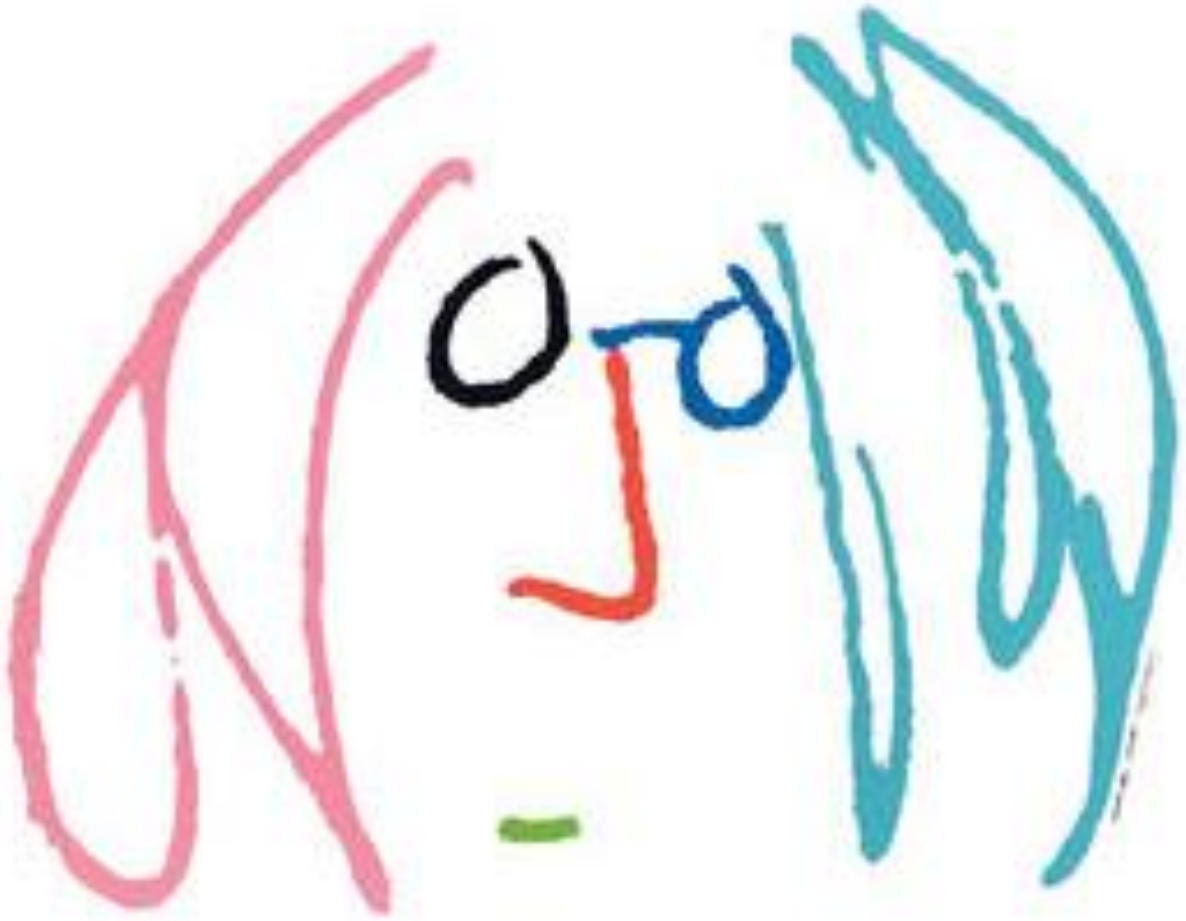
Collaboration

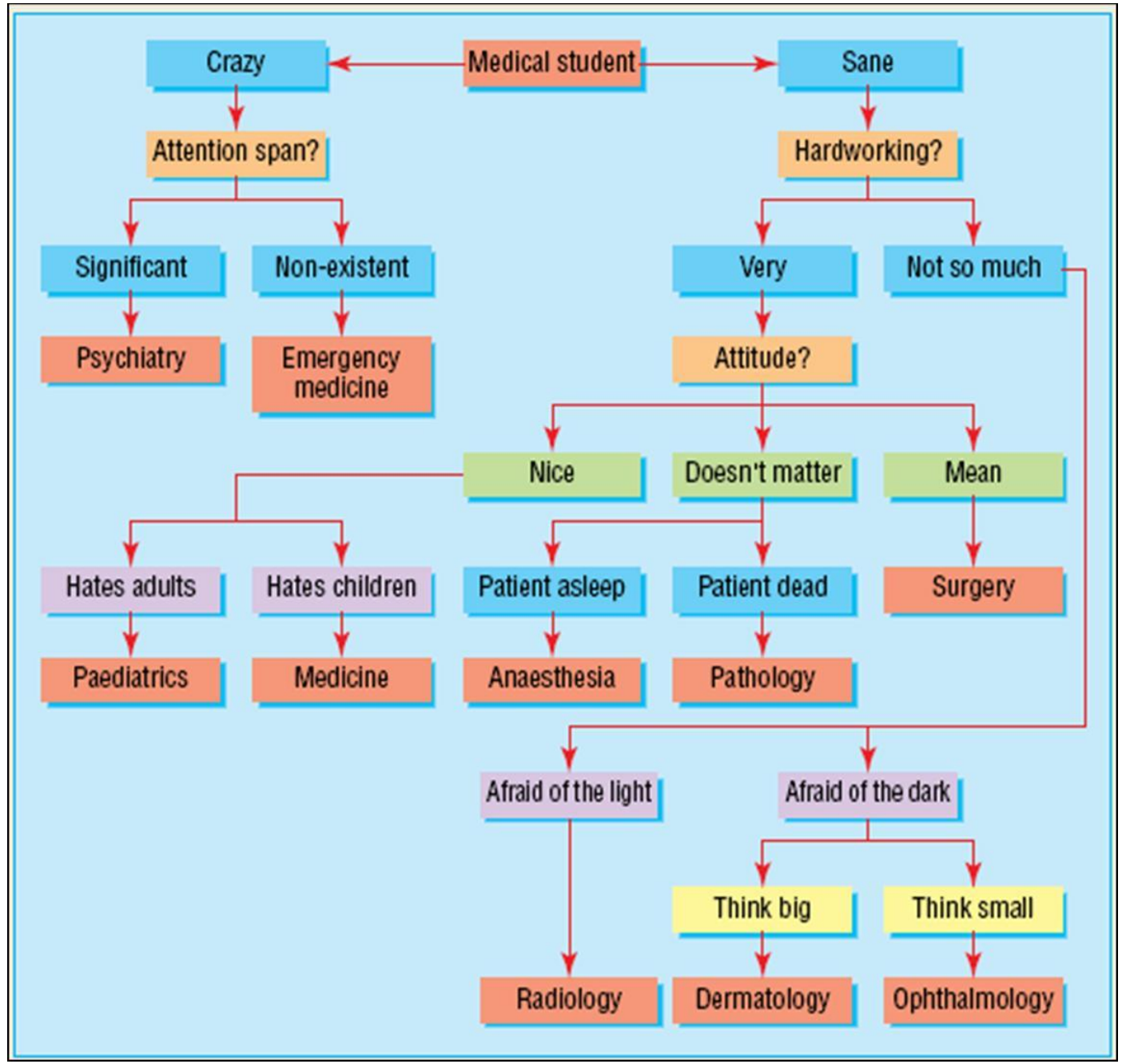
- With our patients (consumers)
- With their carers
- With our mental health colleagues
- With our ED colleagues

We share responsibility

When something doesn't seem quite right to you, try looking at it again through the ***'lens of empathy'***

Just imagine…




Medical student
Crazy
Sane
Attention span?
Hardworking?
Significant
Non-existent
Very
Not so much
Psychiatry
Emergency medicine
Attitude?
Nice
Doesn't matter
Mean
Hates adults
Hates children
Patient asleep
Patient dead
Surgery
Paediatrics
Medicine
Anaesthesia
Pathology
Afraid of the light
Afraid of the dark
Think big
Think small
Radiology
Dermatology
Ophthalmology

Approach to mental health problems

‘SACCIT’ – from NSW Health Mental Health for ED Reference Guide

- S – SAFETY
  - Manage risk of harm to self or others for duration of ED admission
- A – ASSESSMENT
  - History, mental state examination, risk assessment, vital signs, physical examination
- C – CONFIRMATION OF PROVISIONAL DIAGNOSIS
  - Corroborative history – use the telephone
  - Investigations to confirm or exclude organic factors
- C – CONSULTATION
  - ED senior, Mental Health team, Drug & Alcohol team

Approach to mental health problems

- I – IMMEDIATE TREATMENT
  - Biological – eg sedation, pharmacological symptom control, treat underlying causes
  - Psychological – eg therapeutic engagement, counselling, de-escalation
  - Social – eg mobilise social supports, emergency accommodation
- T – TRANSFER OF CARE
  - Inpatient or community settings
  - Documentation and communication

Mental State Examination

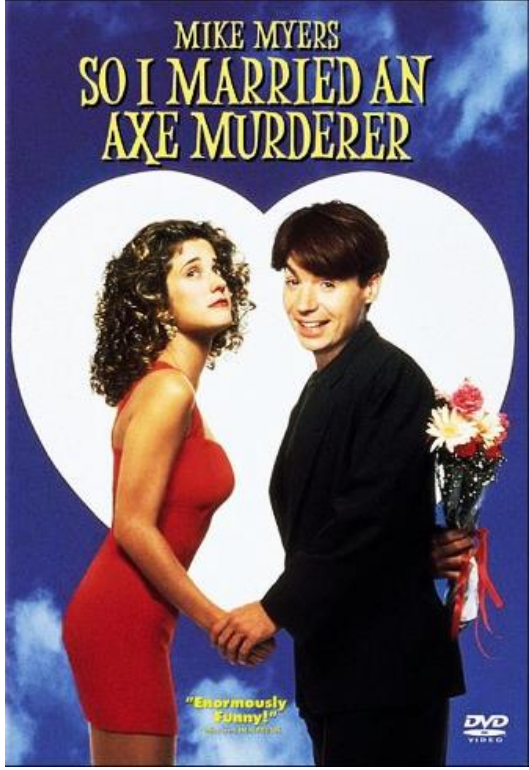
Comprises 10 aspects:

- **Appearance**
  - Eg posture, body appearance and condition, grooming
- **Behaviour**
  - Features eg mannerisms, tics
  - Descriptor eg impassive, restless, agitated, aggressive
- **Co-operation**
  - Eg friendly, cooperative, uncooperative, suspicious, hostile, evasive, seductive, perplexed

Mental State Examination

- **Affect and Mood**
  - Affect – observation of emotional range and appropriateness
    - Range – eg flat, blunted, restricted, normal, labile
    - Appropriateness – in context of patient's speech or ideation
  - Mood – how the patient perceives their own mood
    - Use patient's own words
    - Eg depressed, anxious, irritable, angry, euphoric, euthymic
- **Speech**
  - Rate – slow, normal, rapid or pressured
  - Volume – soft, normal, loud or shouting
  - Quantity – spontaneous, normal, talkative, garrulous, nil
  - Quality – accent, rhythm, impediments

Mental State Examination



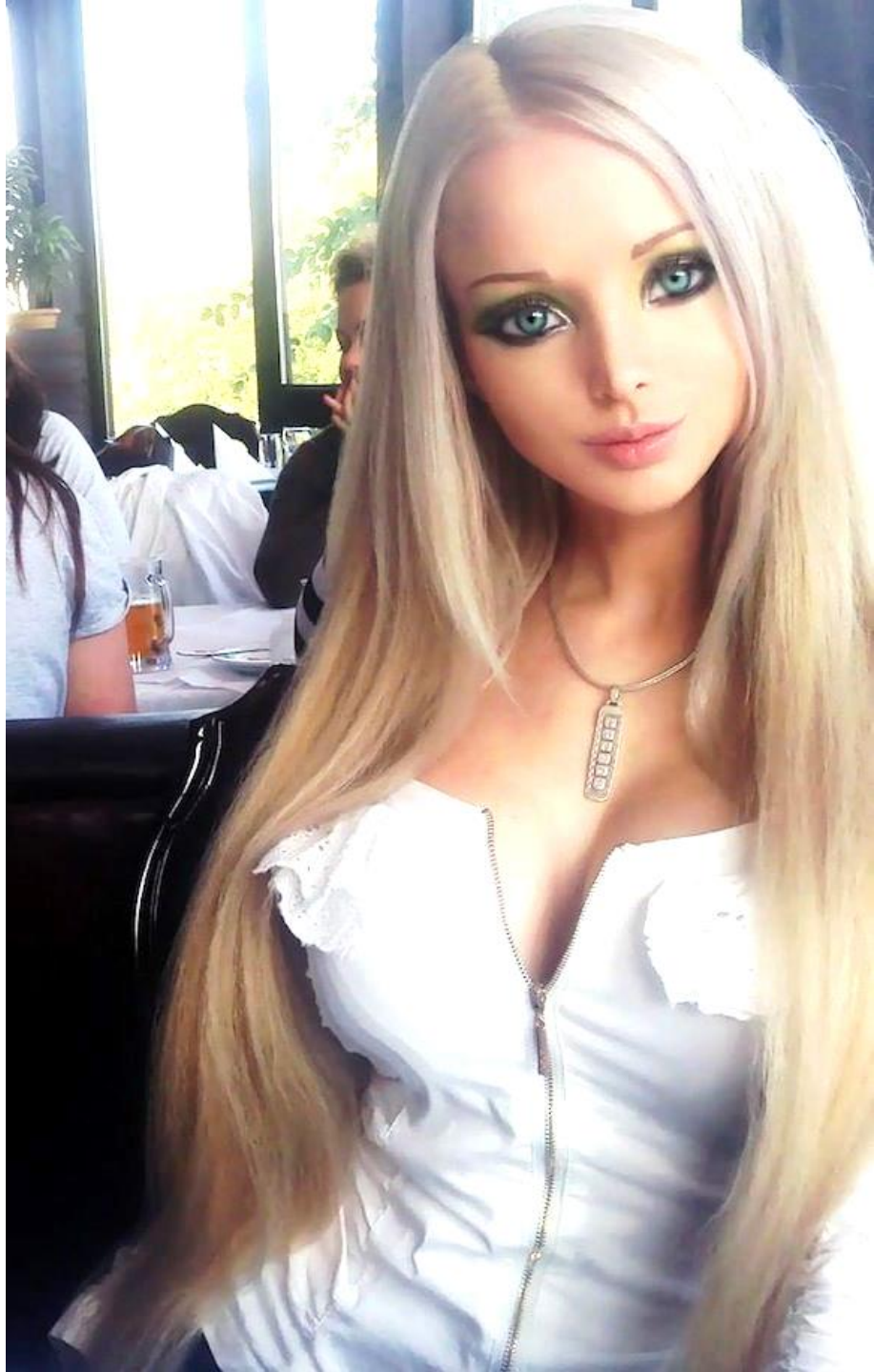
- **Thought Form and Content**
  - Thought Form
    - Quantity – eg thought blocking, poverty of content, racing thoughts
    - Logical connection/sense – eg circumstantial, tangential, normal
    - Other – eg clang associations, punning, neologisms, perseveration
  - Thought Content
    - Eg preoccupations, overvalued ideas, delusions, ideas of reference, obsessions, compulsions
    - Suicidal or homicidal ideation
- **Perception**
  - Unusual sensory phenomena
    - Such as – hallucinations (especially auditory), illusions, heightened perception, de-realisation/de-personalisation

Mental State Examination

- **Cognition** (MMSE)
  - Level of consciousness – alert, hypervigilant, drowsy, stupor, coma
  - Memory – immediate, short-term, long-term
  - Orientation – time, place, person
  - Attention and Concentration – ability to follow conversation, participate in immediate matters
- **Insight**
  - Awareness of illness, effects and implications – good, partial or poor
- **Judgement**
  - Ability to assess situation and act appropriately – intact or impaired

Mental State Examination

- ***How much of this do I really do?***
- *Enough to –*
  - Identify a diagnostic category
  - Inform the risk assessment
  - Fill in the schedule paperwork
  - Engage the mental health team
  - *Feel like I have done a good job*
- **MSE Summary for ED**
  - **GFCMA – 'Got Four Clients Monday Afternoon'**
  - General Appearance, Form of thought, Content of thought, Mood and affect, Attitude



Risk Assessment

- ***Essential*** part of initial assessment
  - Influences disposition and treatment plannin
- Consider:
  - Risk of harm to staff/carers
  - Risk of untreated physical illness
  - Risk of absconding
  - *Risk of self-harm*
  - *Risk of suicide*

- Incorporate information from family, friends, carers, other health care providers, community support services
- ***But – REMEMBER – whose risk are you trying to manage?***

‘Medical Clearance’

- Tension between pragmatic ED approach to ‘medical clearance’ vs Mental Health team expectation of comprehensive medical assessment
- *‘No significant acute physical issues currently identified’*
- Emergency Care Institute NSW (2012)
  - Physical assessment for mental health patients checklist
  - (see next page for current form)
  - Updated electronic version currently in development
- Mental health vs medical ward
  - Should be medically stable enough for discharge
  - Arrange inpatient medical team consults for sub-acute issues requiring assessment or management during admission

Physical Assessment for Mental Health Patients Form

Emergency Care Institute NEW SOUTH WALES

Patient's details (or sticker)

Name_____
Age_____
DOB_____
Address_____

Brief description of presenting problem

_____

_____

_____

Physiological observations

Heart rate	BP	Temp.	Resp. Rate	O2Sats	BSL

Meets low risk criteria (all required)

- ☑ Age 15-65 years
- ☑ No acute physical health problems (including trauma, ingestion or drug side-effects)
- ☑ No altered level of consciousness (confusion vs psychosis)
- ☑ No evidence of physical cause for the acute presentation
- ☑ Not the first or significantly different psychiatric presentation

Patient may be referred to mental health service

Doesn't meet low risk criteria (write in notes)

- Urgent resuscitation/sedation alert senior ED, NUM, security if required
- Further medical review based on observations discuss with senior ED
- Investigations done based on clinical findings
- Subacute medical issue identified, flag for psychiatric services

Transfer to Mental Health Services? ☐ **Yes** ☐ **No**

Referred to_____ **for**_____ ☐ **n/a**

Is the Mental Health Services aware of the patient? ☐ **Yes** ☐ **No**

_____ _____ _____

ED doctor's name printed **Signed** **Date and time**

Safety Information 002/18

Blood Alcohol Level (BAL) Testing in Emergency Departments

14 August 2018

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Directors of Emergency Departments
- Directors of Mental Health
- Clinical Directors, Mental Health

Expert Reference Group

Content reviewed by:

- Chief Psychiatrist
- Clinical Director, Emergency Care, Agency for Clinical Innovation
- Director, Patient Safety, Clinical Excellence Commission
- MH RCA Review Sub - Committee

Clinical Excellence Commission

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Intranet Website
http://www.health.nsw.gov.au/sabs/Pages/default.aspx

Review date

August 2019

Assessment of mental health patients in the Emergency Department: Blood alcohol level is not to be used to determine eligibility for service provision

There is concern that there is delay in undertaking physical and mental health assessments of patients presenting to Emergency Departments (ED) due to waiting for the result of blood alcohol drug testing, or because of positive blood alcohol or drug screen levels.

A recent Root Cause Analysis (RCA) report described an incident where a patient did not receive physical or mental health assessment in the Emergency Department (ED) on repeated presentations due to returning a high level, blood alcohol level. The patient attended the ED with suicidal ideation and requested support for alcohol detoxification. He was informed that he would not be assessed until his blood alcohol level was lower. On each occasion, the patient was unwilling to wait and left the ED prior to being assessed. Within seven days the patient suicided.

Issues to consider

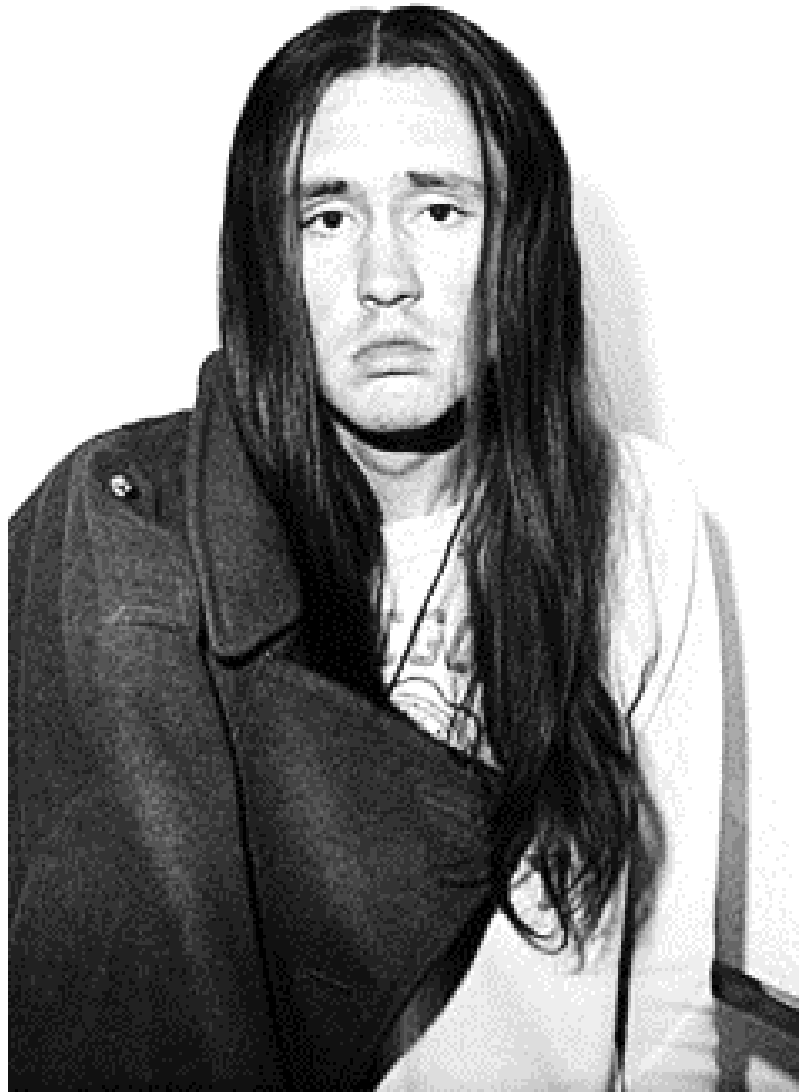
- Patients at risk of self-harm who present to EDs require immediate assessment. Alcohol and Drug screening are not a prerequisite for medical or mental health assessment.
- Awaiting the results of a patient's drug screen and / or reduction in blood alcohol level prior to assessment causes unacceptable treatment delays.
- Assessment of drowsy patients can still provide valuable information for mental health and physical health management planning.
- Blood Alcohol Level testing in the ED is irrelevant to a patient's suitability for assessment, and, could (in some cases) result in a dangerous cognitive bias that may contribute to poor patient outcomes.
- These tests may be useful in formulating a general management plan for certain patients after their physical and mental health assessments have been completed.

Suggested actions by Local Health Districts/Networks

1. Forward this information notice to appropriate staff and departments for action
2. Review local processes to ensure timely physical and mental health assessment of patients in the Emergency Department occurs.
3. Ensure a system is in place (and documented) to reduce unnecessary delays in undertaking physical and / or mental health assessments of patients due to alcohol and drug screening in the Emergency Department.

Alternatives to the Emergency Department

- Community
  - Outreach and support – telephone/email/internet
  - Outpatient clinics/groups
  - General Practice/Psychiatrist rooms ($)
  - Residential care/supported living
- Hospital
  - Direct admission to Mental Health units
  - Shared care models
    - Psychiatric Emergency Care Centres – models vary
    - Behavioural Assessment Units
    - Medical/mental health shared care wards
  - Urgent need for new models
    - Dual/Triple/Quadruple diagnosis – body vs mind???
    - Toxicology and addiction
    - Child and adolescent issues



Mental Health in the ED Summit Oct 2018

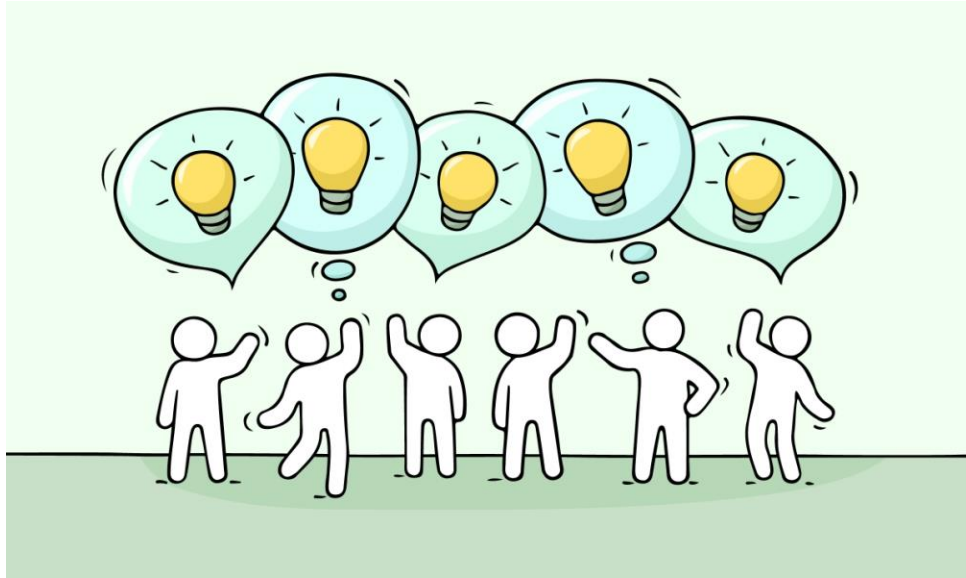
- ACEM/RANZCP, consumers, paramedics, politicians, journalists
- Focus on the lived experience – patients, carers and clinicians
- Increase in non-acute psychiatric presentations to ED (80% workload)
- Psychiatrists in ED – The Alfred Hospital, Melbourne
- Lots of work on new models of care
  - Shared care – MH/D&A/Medicine/Toxicology – eg BAU (RMH) and PANDA (St V Sydney)
  - Drop-in centres – eg Safe Haven Cafe (St V Melbourne)
  - Peer support workers – in ED and Mental Health Units
  - Sensory modulation strategies – eg sensory kits (RAH)
  - Social determinants work – Homelessness Support Program (RPH)
- https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Mental-Health-in-the-Emergency-Department-Summit

Education and training

- Current approach – martial arts and sedation
  - Should be – engagement, de-escalation, assessment and treatment
- Include Mental Health topics in formal and informal teaching
- Combined ED/MH/Peer-worker education sessions
- Simulation and case-based discussion
- College curriculum and examinations
- Conferences and research
- Role-modelling and mentoring

Mental Health is ED core business

Get comfortable with it



More collaboration and empathy

- Adjust your mindset
- Talk to your patients
- Do the ED bits well
  - Do proper assessments
  - Make good referrals
  - Use clinical language
  - Be mindful of resourcing and context
- Build relationships
  - Be open-minded
  - Be kind
  - Be honest
  - Use the lens of empathy
- Try, try harder, and keep trying

Emergency Mental Health

The next subspecialty???

(Trainees – get thee to a Psych term…)

Any questions?

Thanks for listening

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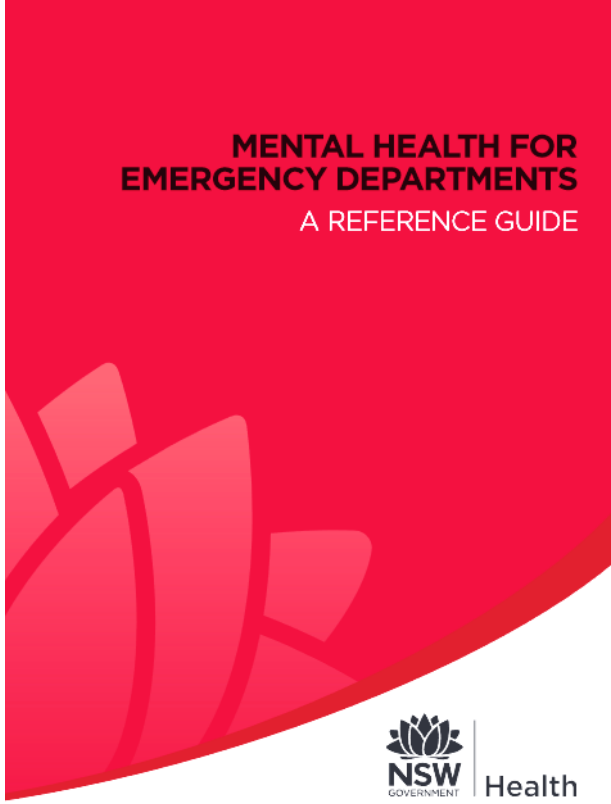

Homework:

Mental Health for Emergency Departments

A Reference Guide

NSW Ministry of Health – Amended March 2015

https://www.health.nsw.gov.au/mentalhealth/publications/Publications/mental-health-ed-guide.pdf

Emergency Care Institute NSW - Mental Health resource page

https://www.aci.health.nsw.gov.au/networks/eci/clinical/clinical-resources/clinical-tools/mental-health

Civility Saves Lives

https://www.civilitysaveslives.com/

Emergency Care Institute
NEW SOUTH WALES

CIVILITY SAVES LIVES