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PSYCHIATRIC EMERGENCIES

Managing a Psychiatric Emergency

What Every Psychiatrist Needs to Know to Be Prepared

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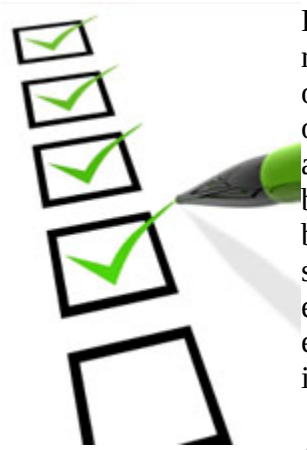

Psychiatric emergencies encompass situations in which an individual cannot refrain from acting in a manner that is dangerous to himself or herself or to others. The patient may be aware of the danger his behavior poses (as with an overdose with the intent to die) or he may lack insight into the effects of his actions (as in the case of a manic patient who engages in reckless sexual behavior). Even if the patient perceives that his actions are dangerous, he may be bent on engaging in these behaviors despite the risks. (A patient with schizophrenia who follows command hallucinations to commit theft is an example). Because of their lack of insight and judgment, patients in psychiatric emergencies are often brought to the attention of medical professionals by people in the community, including friends, family, police officers, or even bystanders.

Astute psychiatrists may also recognize psychiatric emergencies during routine outpatient care. Patients may report their inability to remain safe, either spontaneously or as elicited by the psychiatrist. When an emergency is recognized, the clinician must:

- Perform a complete assessment of the concerning behavior
- Reduce risk by transferring the patient to an emergency department (ED) or to a psychiatric hospital as needed
- Provide or arrange for follow-up for continuity of care

Agitation is a common element in many psychiatric emergencies and poses unintentional danger both to self and to others. Intentional self-endangerment is often accompanied by suicidal ideation. This article will focus on these presentations.

Pre-crisis planning

The process of safe assessment and successful resolution of many psychiatric emergencies begins well before the patient arrives. The physical environment is an important consideration. Patient evaluation

rooms can be constructed to allow escape from an agitated patient and to safely contain the dangerous individual. In addition, the waiting room can be arranged so that all areas are visible from the reception desk. This enables early intervention for patients who become agitated. Finally, the reception desk itself can be constructed to allow for easy communication while still being high and broad enough to prevent an agitated patient from jumping over the desk.[1]

Appropriate staff training is invaluable. Those who sit at the front desk should be trained to recognize the warning signs of agitation because they are best positioned to observe those in the waiting area. They should also know how to alert the appropriate clinician and other staff about a developing emergency. Given that patients may become agitated during an interview, it is equally important for clinicians to have a mechanism for communicating distress to staff (eg, use of a hotline or panic button).[1,2]

Staff members should be assigned clear roles in the case of an emergency. For example, some could direct other patients away from an agitated patient while others contact security or police. Running a drill of the situation, as other disciplines do in “mock codes,” helps cement these roles and can reveal any deficiencies before a true emergency develops. Such training may reduce the frequency of assaults in the workplace.

CHECKPOINTS

The safe assessment and successful resolution of a psychiatric emergency begins well before the patient’s arrival and includes preparation of the physical environment and a well-trained staff.

In determining whether a patient is dangerous, focus on factors that tend to elevate the patient’s risk of intentional or unintentional harm to self and others.

If an empathetic response by the clinician is not enough to diffuse a dangerous patient, patient referral to the emergency departmentis essential.

Initial evaluation

The clinician has 2 essential responsibilities in a psychiatric emergency: to maintain the physical safety of everyone involved and to assess the patient’s mental status for appropriate triage of subsequent care.

The appropriate action to maintain the safety of staff and other patients varies with the situation. A severely depressed or quietly delirious patient can be directed to a private room for further evaluation and management. On the other hand, a psychotic or otherwise agitated patient is unpredictable and potentially dangerous to others if cornered.

Initial assessment should focus on factors that elevate the patient’s risk of intentional or unintentional danger. In addition to assertions of suicidal or homicidal ideation, notable risk factors for imminent danger include evidence of intoxication, expressions of hopelessness, irritable affect, thought disorganization, disheveled appearance, and psychomotor agitation.

Immediate management and disposition

Agitated patient. When an agitated patient has been identified (**Table 1**), determine the area in which and the manner by which that person will be engaged. The site of evaluation should be free of potential

weapons, such as lamps, cords, or chairs that can be easily lifted. Clear exits for both the clinician and patient are needed. The clinician may need to flee if the agitation escalates, but the patient may also relax if he does not feel involuntarily confined.

Table 1 Signs of agitation

Verbal	Behavioral
Becoming louder	Inability to sit still
Demanding or menacing content	Fierce eye contact
Foul language	Making fists
Oppositional or foreboding tone of voice	Muscle tightness
Put-downs	Tensing jaws

Finally, the presence of other staff members in a "show of force" often dissuades the agitated patient from actually becoming combative. The examiner should not hesitate to have this assistance on hand or on call when interviewing an agitated patient.[2] Of course, if a patient becomes agitated very rapidly, there is little time to plan and perform an evaluation. This heightens the importance of designing the environment with safety in mind and having a pre-practiced plan for managing emergencies.

Engagement of the agitated individual begins with verbal interventions. Pointing out the patient's restlessness or loud voice encourages him to recognize and modulate his behavior and opens a dialogue about what troubles him. This should be done as respectfully as possible while refraining from being provocative. The clinician can offer choices to address the patient's needs while setting supportive limits regarding unreasonable requests. This can result in better communication, stronger rapport, and progress toward resolution of the acute crisis.[3] Formal training in verbal de-escalation, such as that offered by the Crisis Prevention Institute,[4] can further enhance the clinician's ability to address agitation.

Pharmacological interventions for agitation have a smaller role in the clinic than in the ED or inpatient settings, simply because they are less likely to be available. However, the patient may have brought his own medications. Oral benzodiazepines and antipsychotic medications effectively reduce agitation.[5]

If the agitated individual does not respond to these interventions, further evaluation and management in the ED may be warranted. However, the clinician may be safer if he or she allows an agitated individual to flee the clinic; the clinician can then provide information to police or security to retrieve the patient. If the patient is calm enough, he may be able to wait until transport to an ED is available. Because agitated patients may pose a risk to emergency medical services personnel, consider having police transport the patient.[6]

Suicidal patients. Patients who are suicidal but not agitated typically present less of an immediate challenge, although they represent just as much of a psychiatric emergency as an agitated patient. The patient should be kept in a quiet area but closely observed. It is important to maintain strong rapport with the patient so that he is comfortable discussing any distressing thoughts.

Table 2 Major risk factors and protective factors for suicide[1,14]

Risk factors
Active suicidal ideation
Developed plan for suicide
Prior suicide attempt
Access to weapons or other lethal means
Thought distortion (secondary to psychiatric illness or substance use)
Family history of suicide
Protective factors
Redirectable from thoughts of suicide
Feeling socially connected
Not feeling like a burden
Moral opposition to suicide
Hope for improvement

When a patient reveals suicidal ideation, questioning should be aimed at determining the acute risk. Important factors include frequency of suicidal thoughts and ability to redirect these thoughts. Furthermore, the presence of a considered plan, rehearsal of the plan, and lethality of the intended means are important considerations. Inquire about number and severity of previous suicide attempts if this information is not already known. A family history of suicide is another risk factor. Protective factors such as social support and moral opposition to suicide are also important to establish (**Table 2**). To the extent possible, key elements of the recent and remote history should be confirmed with collateral sources.

Outpatient management of some patients with suicidal ideation is possible. For instance, a patient with support at home and without prior suicide attempts who describes only vague, passive suicidal ideation

may be a candidate for discharge with close clinical follow-up. Patients with acute-on-chronic suicidal ideation who participate in dialectical behavioral therapy (DBT) may best be served by a DBT approach to their current crisis. DBT encourages the use of learned skills in self-management and may prevent hospitalization.[7] However, even for DBT patients, referral to a psychiatric ED is advised if the clinician has any concerns about the patient's safety. In general, patients at higher risk for suicide should be transferred to a local ED for further evaluation and possible hospitalization.

The manner in which a patient is transported to the ED depends on his mental status. Family members may be able to transport a patient who poses a danger only to himself. However, severely suicidal patients may convince family members to take them home instead. Moreover, the medical stability of patients who have made a suicide attempt before presenting to the clinic cannot be guaranteed until a medical evaluation is performed. Many patients warrant transportation by emergency medical services.

Continuity of care and follow-up

As a courtesy and to ensure continuity of care, any psychiatrist who refers a patient to an ED should contact the ED with details about the patient's status and with recommendations for treatment. Likewise, the treatment provider in the ED who is aware of a patient's outpatient care should send a report about the ED's treatment plan to the referring clinician. Patient privacy should be respected when completing these reports, and written consent for communication with providers outside a given medical system should be obtained when possible. However, if the circumstances of the emergency do not permit this, the need to ensure continuity of care in an emergency trumps privacy considerations.[8]

The outpatient psychiatrist continues to be responsible for the patient's care if the patient is not referred to an ED. Such a patient should be provided with medications or other interventions needed to prevent relapse of the psychiatric emergency and scheduled for follow-up at an appropriate interval. Most important, the patient should be given a means to obtain emergency psychiatric care in the event of a relapse of the emergency after hours.

Finally, when the crisis has passed, the clinic's staff may elect to review the way that the crisis was managed, in the interest of quality improvement and to provide support for staff members involved in the crisis.

Crisis calls

Telephone management of a patient in crisis can be challenging. As with face-to-face emergencies, the interaction should focus on assessment of risk of intentional or unintention-al danger. Patients do reach out by telephone when they are considering suicide.[9] Responses that feature empathy, respect, and collaborative problem solving decrease the risk of suicide following the call.[10] Agitated patients will reveal themselves through the content and manner of their communication. The verbal engagement strategies discussed earlier may prove effective in addressing the agitation.

In higher-acuity circumstances (eg, a high-risk patient with active suidical ideation) or if the telephone intervention does not yield improvement of mental status, it is appropriate to involve family members to obtain collateral information or local authorities to bring the patient to the nearest ED for further evaluation and treatment. All patients should be asked where they are and who they are with. Patients may resist these inquiries; therefore, the clinician may have to infer these points using clues in the conversation. Many medical centers have protocols for involving the police in these circumstances and may also have the technical ability to locate the person making the call.

Summary

Psychiatric emergencies, defined as acute elevations in an individual's risk of danger to self or to others, may arise in any treatment context. When a crisis reveals itself, the treating provider is responsible for assessing the concerning behavior. Preincident preparation is the key to accomplishing this task in a safe manner. An empathetic response may be sufficient to defuse the crisis. If this is not enough, a patient referral to the ED for further evaluation and management is essential. Finally, the treating provider should initiate and receive communication from the ED to ensure continuity of care. If these steps are taken, the crisis can be a brief diversion on the patient's path to mental wellness.

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