

MENTAL HEALTH FOR EMERGENCY DEPARTMENTS

A REFERENCE GUIDE



Health

This Reference Guide is intended to assist emergency department staff and other clinicians in their care of people experiencing emergency mental health problems.

It is intended to support the wealth of experience and evolved practice that exists in emergency departments and not to supplant nor replace local protocols and practice. It is meant to encourage, not replace, consultation with senior colleagues who remain the best source of information and advice. Further, it is not a substitute for sound clinical judgement.

This Reference Guide builds upon the earlier versions of the reference guide (2001; 2002; 2009). It has been prepared through an extensive review process involving clinicians from the emergency medicine, mental health and drug and alcohol fields, as well as consumers and carers.

This Reference Guide represents the views of clinicians with extensive experience in the field, as well as the views of consumers and carers. It is based on the best clinical advice currently available, however it will require updating in the light of evolving evidence and changes to clinical best practice. This is particularly the case with the more technical aspects such as medication regimes.

If you believe information contained in this publication is incorrect or open to misinterpretation, or if you have any general comments, please contact the Mental Health and Drug and Alcohol Office at the NSW Ministry of Health, 73 Miller Street, North Sydney (telephone (02) 9391 9000).

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ACRONYMS	
ACAT:	Aged Care Assessment Team
ASET:	Aged Care Service Emergency Team
ATS:	Australasian Triage Scale
CAM:	Confusion Assessment Method
CAGE:	(Alcohol Assessment Tool) Cut down; Annoyed; Guilty; Eye opener
GDS:	Geriatric Depression Scale
PTSD:	Post Traumatic Stress Disorder
SAC:	Safety; Assessment; Confirmation of Provisional Diagnosis
SACCIT:	Safety; Assessment; Confirmation of Provisional Diagnosis; Consultation; Immediate Treatment; Transfer of care
SMHSOP:	Specialist Mental Health Service for Older People
STARTTS:	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

INTRODUCTION

This document is a reference guide for clinicians working as first responders to mental health presentations, particularly for emergency and acute presentations.

The purpose of the guide is to provide practical guidance in the initial clinical assessment and management of mental health presentations.

Background to the Guide

This document is a revision and update of the 'Mental Health for Emergency Departments – A Reference Guide 2009', and replaces that document. It was developed following an extensive consultation process and is the result of collaboration between mental health, drug and alcohol, emergency department clinicians, consumers and carers. Collaboration between all parties involved in the care of the person is essential for the effective implementation of this Reference Guide and delivery of best practice clinical care.

Setting for the Guide

While many of these presentations occur at the Emergency Department (ED), the material contained in the document has relevance for all first-presentation settings. However, the ED setting and its staff are a key consideration for this document.

The general health and mental health resources available to the setting need to be taken into account when using the guide and the tools contained in this document. It is acknowledged that EDs and other first-response settings have varying levels of available emergency medicine and mental health specialist (on-site and/or consultancy) resources. The guide therefore needs to be adapted to the available resources.

EDs with fewer resources need to have lower thresholds for referral and service escalation. Do not attempt to manage major risks (e.g. aggression) without adequate support and resources.

The issue of available resources is particularly important for small rural EDs, as they may have only on-call medical cover, limited security, and remote consultancy support from mental health staff.

It is important for protocols to be developed to guide local practice, consistent with the available resources and patient-flow practice of the hospital. In developing these protocols, regular liaison between mental health and ED staff (and other relevant services, e.g. D&A), at the clinician and management levels, is important for maintaining good working relationships and to address any problems that may arise.

Irrespective of site, this guide needs to be applied with the needs of the patient as the main focus, and service delivery must be consistent with the principles contained in the Charter for Mental Health Care in NSW, notably:

- respect for human rights
- compassion for, and sensitivity to, the needs of the individual
- provision of service in the least restrictive environment consistent with treatment requirements.

(See Appendix 1 'Charter for Mental Health Care in NSW'.)

OVERVIEW OF THE DOCUMENT ORGANISATION

TRIAGE – THE FIRST STEP

ESSENTIAL CLINICAL PROCESSES IN EMERGENCY SETTINGS

Assessment and management points for Emergency Department clinicians

The document has been developed to provide guidance regarding:

- **Clinical issues that apply to all stages** of the mental health patient's initial care contact (Overarching Aspects – Chapter 2).
- **Clinical issues that apply to particular stages of care:**
 - Triage of potential mental health presentations (Chapter 3)
 - Initial emergency assessment (Chapter 4 – 6)
 - Ongoing care (Chapter 7 and 9)
 - Discharge planning (Chapter 8)
- **Key specific management issues:**
 - Management of patients under mental health legislation and agreements (Chapter 10 and 11)
 - Management of severe behavioural disturbance (Chapter 12).
- **Practical assistance :**
 - Contacts (State-wide numbers; websites, Chapter 13)
 - Assessment, screening tools and resource documents (Appendix 1 – 9).
 - Psychiatric terminology (Appendix 10).

Accurate mental health triage is essential for the safe and effective delivery of mental health care in the ED. All patients presenting to EDs with mental health problems must be triaged appropriately.

The triage assessment will determine:

- Urgency – using the mental health/behavioural indicators of the Australasian Triage Scale
- Initial risk assessment
- Observation/supervision level that the patient requires in the ED.

Although it is acknowledged that the availability of medical and mental health resources will influence the use of this guide, there are six essential clinical processes that need to be provided in all emergency settings for all mental health presentations following triage.

The sequence of providing these clinical processes will vary between sites depending on local practice.

The essential processes of assessment and management in the ED are covered by **'SACCIT'**.

Clinicians should become well versed in **'SACCIT'**:

S – SAFETY: ensuring that the patient's risks of harm to self or others are well managed **for the duration** of their ED admission.

A – ASSESSMENT: comprises: a clear and reliable history, mental state examination, risk assessment, vital signs and physical examination. Note: the accuracy of the history may be affected by mental state impairment.

C – CONFIRMATION OF PROVISIONAL DIAGNOSIS: obtaining the vital information to assist in reaching a provisional or working diagnosis (**Note:** definitive mental health diagnoses are rarely made in the ED).

Confirmation comprises two key elements:

- a) Obtaining corroborative history:
 - Clear history and a reliable corroborative history are essential components of any mental health assessment.
 - It is vital to obtain a history (recent and past) from family, friends, accompanying agencies (e.g. Police; Ambulance), the patient's GP or case manager.
 - There should be clear recognition that the absence of such information reduces the confidence a clinician can place in their assessment.
 - In collecting history the clinician needs to consider the patient's right to privacy against information that could be provided by others to assist with the discharge of the clinician's duty of care.
- b) Performing investigations to confirm or exclude organic factors

Relationship between mental health and physical disorders

C – CONSULTATION:

- ED consultant for initial advice.
- Accessing the local mental health service as soon as possible. Clinicians should not hesitate to seek Mental Health consultation or referral.
- Seeking advice and assistance is an exercise in sound judgement and an opportunity to learn.
- Chapter 3 contains specific information about when to involve Mental Health Services and/or when to involve other services such as Drug and Alcohol, Aged Care, or Child and Adolescent Mental Health Services.
- Rural services should use video-conferencing, where available, to assist with consultation

I – IMMEDIATE TREATMENT: providing the right short-term intervention, using the biopsychosocial paradigm:

- **Biological:** e.g. treating any underlying cause, pharmacological treatment of presenting psychiatric symptoms, medication for sedation.
- **Psychological:** e.g. therapeutic engagement, supportive counselling, using de-escalation.
- **Social:** e.g. mobilising social supports, family and others to provide care post-discharge, finding emergency accommodation.

T – TRANSFER OF CARE: ensuring the safe and effective transfer of care to inpatient or community settings. This will require appropriate documentation and communication.

- Patients presenting with a mental health complaint or symptoms may have an underlying physical illness that precipitates these symptoms (e.g. aggressive behaviour or visual hallucinations may be secondary to delirium).
- Mental health symptoms in a person with a known mental illness may arise from a physical illness and not the mental illness (e.g. hallucinations in a person with schizophrenia may be secondary to delirium).
- Mental illness may prevent the effective communication of physical symptoms (e.g. a patient with schizophrenia who is very thought-disordered or preoccupied with delusions may not be able to describe their chest or abdominal pain).
- Physical illness may be a stressor that could exacerbate a person's mental illness.

A corroborative history is essential and should be sought in every case. Please use the telephone. The most effective investigation tool available to you is the telephone. Use it to obtain corroborative mental health information from the patient's GP, case manager or other mental health clinician.

Corroborative history is of the highest importance. As well as health professionals, information should be sought from the patient's family/carers/friends wherever possible. This information can aid in diagnosis, assessment of risk, and influence management and discharge planning.

Obtaining corroborative history can also be a first step toward engaging others in a collaborative care plan. How you talk to other parties can influence the outcome.

CHAPTER 2

RECOVERY-ORIENTED PRACTICE

OVERARCHING ASPECTS

The National Framework for Recovery-oriented Mental Health Services defines personal recovery as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.

Recovery-oriented practice and attitudes encapsulate mental health care that maximises self-management of mental health and wellbeing, is person-centred, empowering, collaborative, promotes a safe and respectful environment and assists families to understand the challenges and opportunities arising from their family member's experiences.

The *National Framework for Recovery-oriented Mental Health Services* recognises that all Health Services need to commit to incorporating recovery-oriented principles into practice and service delivery in order to better meet the needs of people with a mental illness.

PHYSICAL HEALTH CARE OF MENTAL HEALTH CONSUMERS

Mental health consumers are entitled to quality, evidence-based care and treatment for all aspects of their health, including their physical health.

People with mental illness often experience high levels of complex medical co-morbidity and poorer health outcomes. As such, Health Services should consider the physical health needs of mental health consumers through the promotion and delivery of physical health examinations and interventions with the aim of improving the physical health of people with mental illness and to prevent disease.

Reference: *Physical Health Care of Mental Health Consumers*, NSW Health GL2009_007

MAJOR RISKS IN MENTAL HEALTH EMERGENCY PRESENTATIONS

Major risks include:

- Patients at risk who abscond
- Aggression
- Self-harm/suicide
- Mental illness not being recognised
- Misdiagnosis or missing a physical cause for the problem
- Severity of risk(s) not being identified
- Attempting to manage risks without the available resources, especially in rural EDs.

Considerations in addressing major risks:

- Patients, staff and the general public are entitled to be protected from harm or injury in all settings.
- Patients presenting with behavioural disturbance may pose a safety risk to themselves and others.
- Behavioural disturbance can arise from underlying physiological (e.g. head injury, malignancy) or mental health (e.g. acute psychotic state) problems, or from intoxication (e.g. alcohol or drugs).
- The risk of harm can be exacerbated by the environment (over-stimulation) or interactions with others (including treating staff).
- Irrespective of the cause, managing safety relies on a comprehensive assessment of the patient's underlying problems, contributing environmental factors and triggering events of the behavioural disturbance.
- **De-escalation and distraction are always the preferred approaches to managing safety risks.**

Strategies to de-escalate the risk

- A calm, courteous approach.
- Keep patients and families informed of waiting times, delays and the reasons for these.
- Listen and talk to the patient, clearly seeking their contribution to their care, explaining actions, and providing reassurance.
- Anticipate the patient's needs (e.g. treat pain or other symptoms (e.g. psychosis), provide information, offer drink and food).
- Reduce the stimulation from the environment if possible.
- Involve **trusted** others (friends, family).

Where de-escalation is not working or severe risk is imminent, other aggression-management strategies (See Chapter 12, Management of Acute Severe Behavioural Disturbance) should be utilised. This can include calling security staff, or specific security/duress response teams (e.g. Code Black teams).

In events where escalation resources within the health services are not sufficient to manage safety for the patient, staff or the public, then Police can be called as part of their role in ensuring public safety as confirmed in Chapter 11 of this reference guide.

CULTURAL CONSIDERATIONS

- It is not uncommon for stress to increase the likelihood that a person from a Culturally and Linguistically Diverse community may revert to their language of origin.
- If the patient speaks a language other than English at home, it may be helpful to use the health care interpreter service.
- Interpreters should be professional health care interpreters and family should not be used except in emergencies. If the Health Care Interpreter Service is unable to provide a service at the time required the Telephone Interpreter Service is available 24 hours a day, 7 days a week on 131 450.
- Family may consciously or unconsciously filter what is being said and confidential issues may be difficult to discuss. (Accurate health interpretation requires training, the ability to maintain confidentiality and accurate documentation.)
- Be aware that a prior relationship between the patient and interpreter can be a problem in small ethnic groups with few interpreters.
- Cultural differences can result in markedly variable mental health presentations. Cultural differences can influence symptomatology, perception of symptoms and help-seeking behaviour.
- Religion and dietary considerations are also relevant to a full assessment. For advice on culturally relevant matters contact the Telephone Interpreter Service and Transcultural Service (refer to Chapter 13 for contact numbers).
- If war trauma is a factor, advice may be sought from the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) (refer to Chapter 13 for contact number).
- For indigenous patients consider involving Aboriginal Mental Health Workers, Aboriginal Health Service or the Aboriginal Medical Service.
- Reference may be made to the NSW Health policy on Aboriginal Mental Health and Wellbeing.

FAMILY VIOLENCE

Family violence relates to all violence which occurs amongst family members or in the 'domestic sphere'. Family violence includes physical abuse; sexual abuse; psychological, emotional and verbal abuse; social abuse; economic abuse; and harassment and stalking and occurs across all cultural and socio-economic groups and gender/sexual orientation.

Men, as well as women and children, can be subjected to family violence and the majority will be women.

Individuals who are subject to violence at the hands of their partner or other family members are often hesitant to disclose this information and generally do not present with obvious trauma. Providing non-judgemental support is essential to assisting people in violent relationships.

Where an injury is a confirmed or suspected result of family violence, give the victim a high priority and advise the medical officer.

Where an immediate threat to safety is present call Security or Police.

In accordance with NSW Health policies, routine screening for family violence must be conducted for all women 16 years and over attending Mental Health and Drug & Alcohol services.

Refer to the following policies for further direction:

- NSW Health Policy and Procedure for identifying and responding to Domestic Violence http://internal.health.nsw.gov.au/pubs/p/pdf/procedures_dom_violence.pdf
- PD2006_084 Domestic Violence – Identifying and Responding to Domestic Violence http://www0.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_084.pdf

DUTY OF CARE

Duty of care requires clinicians to intervene to preserve life and prevent serious injury to the patient's health.

- This duty of care obligation does not overrule the right of the patient to self-determination except in emergency situations where the failure to act would endanger the patient's life or be seriously injurious to their health.
- Situations where a person can be treated against their consent are outlined in Chapter 10, Management of patients under the *Mental Health Act 2007 (NSW)* and *Mental Health (Forensic Provisions) Act 1990 (NSW)*.
- For mental health emergencies the *Mental Health Act 2007 (NSW)* provides the legislative framework for the involuntary detention, treatment and control of people with mental illness. **The *Mental Health Act* is NOT an instrument to be used to authorise emergency medical or surgical treatment in the ED.**

MAINTAINING AND SUSTAINING THE CLINICIAN

Clinicians and their managers should be aware that to maintain and sustain the clinician in the emergency work environment requires

- Keeping knowledge, skills and practice up to date
- Clinical supervision, case conferences, incident reviews
- Working in a supportive team
- Encouraging the use of stress-reduction strategies.

Emergency mental health education opportunities are offered through the Health Education and Training Institute (<http://www.heti.nsw.gov.au/>) and the NSW Institute of Psychiatry (<http://www.nswiop.nsw.edu.au/>).

CHAPTER 3

TRIAGE OF POTENTIAL MENTAL HEALTH PRESENTATIONS

(Also refer to PD2013_047 Triage of Patients in NSW Emergency Departments http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_047.pdf)

Triage represents the first clinical contact with the person to determine urgency of care, and includes:

- Initial risk assessment
- Determination of observation level

Introduce yourself to the patient by name and title, ask what you can do to help, and do your best to understand the person's concerns. Consider both your own observations and the reported behaviour/history. When conducting the risk assessment, wherever possible take into consideration information from family and carers and other service providers directly involved in the presentation. Urgency, risk and level of observation may need to be reviewed if the person's behaviour/symptoms alter. Some patients may have a 'consumer wellness/safety plan' which may assist ED staff in assessing the patient by providing some background information.

People with mental health problems commonly:

- Self-present
- Are referred by health professionals
- Are brought in by concerned friends and relatives
- Are escorted by others such as police or ambulance services.

Triage should be influenced by the following factors

The higher the potential for something to go wrong quickly, the higher the triage rating should be. Consider:

- Risk of aggression
- Risk of suicide/self-harm
- Risk of absconding
- Risk of physical problem.

The observation level should be determined by the assessed risk rather than whether the patient is a voluntary presentation or has been presented under the *Mental Health Act*.

MENTAL HEALTH TRIAGE SCALE

Triage is guided by the **Australasian Triage Scale (ATS)** mental health and behavioural indicators. This scale has been adapted to include general management principles relating to each triage category.

Triage, assessment of risk factors and observation assessment

Lower-risk presentations are less likely to require 1 to 1 nursing ("specialling"), close observation or security presence and could be placed in the waiting room or a general bed in the ED. Higher-risk presentations may require 1 to 1 nursing (specialling), security presence and close observation.

Triage code	Treatment acuity	Description	Typical presentation	General management principles*
1	Immediate	<p>Definite danger to self and/or others</p> <p>Australasian Triage Scale states:</p> <ul style="list-style-type: none"> – Severe behavioural disorder with immediate threat of dangerous violence 	<p>Observed</p> <ul style="list-style-type: none"> – Violent behaviour – Possession of weapon – Self-harm in ED – Displays extreme agitation or restlessness – Bizarre/disoriented behaviour <p>Reported</p> <ul style="list-style-type: none"> – Verbal commands to do harm to self or others that the person is unable to resist (command hallucinations) – Recent violent behaviour 	<p>Supervision</p> <p>Continuous visual observation, or 1:1 special observation (see definition below)</p> <p>Action</p> <ul style="list-style-type: none"> – Alert ED medical staff immediately – Alert mental health liaison/service – Provide safe environment for patient and others – Ensure adequate personnel to provide restraint/detention <p>Consider</p> <ul style="list-style-type: none"> – Calling security +/- police if staff or patient safety compromised. <p>May require several staff to contain patient</p> <ul style="list-style-type: none"> – 1:1 observation – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management.
2	Emergency Within 10 minutes	<p>Probable risk of danger to self or others AND/OR Client is physically restrained in emergency department AND/OR Severe behavioural disturbance</p> <p>Australasian Triage Scale states:</p> <p>Violent or aggressive:</p> <ul style="list-style-type: none"> – Immediate threat to self or others – Requires or has required restraint – Severe agitation or aggression 	<p>Observed</p> <ul style="list-style-type: none"> – Extreme agitation/restlessness – Physically/verbally aggressive – Confused/unable to cooperate – Hallucinations/delusions/paranoia – Requires restraint/containment – High risk of absconding and not waiting for treatment <p>Reported</p> <ul style="list-style-type: none"> – Attempt at self-harm/threat of self-harm – Threat of harm to others – Unable to wait safely 	<p>Supervision</p> <p>Continuous visual observation or 1:1 special observation (see definition below)</p> <p>Action</p> <ul style="list-style-type: none"> – Alert ED medical staff immediately – Alert mental health liaison/service – Provide safe environment for patient and others – Use defusing techniques (oral medication, time in quieter area) – Ensure adequate personnel to provide restraint/detention <p>Consider</p> <ul style="list-style-type: none"> – If defusing techniques ineffective, re-triage to category 1 (see above) – Security/police/equivalent in attendance until patient sedated if necessary – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management

Triage code	Treatment acuity	Description	Typical presentation	General management principles*
3	Urgent Within 30 minutes	<p>Possible danger to self or others</p> <ul style="list-style-type: none"> – Moderate behavioural disturbance – Severe distress <p>Australasian Triage Scale states:</p> <ul style="list-style-type: none"> – Very distressed, risk of self-harm – Acutely psychotic or thought-disordered – Situational crisis, deliberate self-harm – Agitated/withdrawn 	<p>Observed</p> <ul style="list-style-type: none"> – Agitated/restless – Intrusive behaviour – Confused – Ambivalence about treatment – Not likely to wait for treatment <p>Reported</p> <ul style="list-style-type: none"> – Suicidal ideation – Situational crisis <p>Presence of psychotic symptoms</p> <ul style="list-style-type: none"> – Hallucinations – Delusions – Paranoid ideas – Thought disordered – Bizarre/agitated behaviour <p>Presence of mood disturbance</p> <ul style="list-style-type: none"> – Severe symptoms of depression – Withdrawn/uncommunicative – And/or anxiety – Elevated or irritable mood 	<p>Supervision</p> <p>Close observation (see definition below)</p> <ul style="list-style-type: none"> – Do not leave patient in waiting room without support person <p>Action</p> <ul style="list-style-type: none"> – Alert mental health liaison/service – Ensure safe environment for patient and others <p>Consider</p> <ul style="list-style-type: none"> – Re-triage if evidence of increasing behavioural disturbance i.e. – Restlessness – Intrusiveness – Agitation – Aggressiveness – Increasing distress – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
4	Semi-urgent Within 60 minutes	<p>Moderate distress Australasian Triage Scale states:</p> <ul style="list-style-type: none"> – Semi-urgent mental health problem – Under observation and/or no immediate risk to self or others 	<p>Observed</p> <ul style="list-style-type: none"> – No agitation/restlessness – Irritable without aggression – Cooperative – Gives coherent history <p>Reported</p> <ul style="list-style-type: none"> – Pre-existing mental health disorder – Symptoms of anxiety or depression without suicidal ideation – Willing to wait 	<p>Supervision</p> <p>Intermittent observation (see definition below)</p> <p>Action</p> <p>Consult mental health liaison service</p> <p>Consider</p> <ul style="list-style-type: none"> – Re-triage if evidence of increasing behavioural disturbance, i.e. – Restlessness – Intrusiveness – Agitation – Aggressiveness – Increasing distress – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management

Triage code	Treatment acuity	Description	Typical presentation	General management principles*
5	Non-urgent Within 120 minutes	No danger to self or others <ul style="list-style-type: none"> – No acute distress – No behavioural disturbance Australasian Triage Scale states: <ul style="list-style-type: none"> – Known patient with chronic symptoms – Social crisis, clinically well patient 	Observed <ul style="list-style-type: none"> – Cooperative – Communicative and able to engage in developing management plan – Able to discuss concerns – Compliant with instructions Reported <ul style="list-style-type: none"> – Known patient with chronic psychotic symptoms – Pre-existing non-acute mental health disorder – Known patient with chronic unexplained somatic symptoms – Request for medication – Minor adverse effect of medication – Financial, social, accommodation, or relationship problems 	Supervision Routine observation (see definition below) Action <ul style="list-style-type: none"> – Discuss with mental health liaison/service – Refer back to community mental health team if known patient – Refer to Social Worker as appropriate for social problems – Refer to GP – Mobilise usual community support network e.g. Non Government Organisation (NGO)

* **Supervision/Observation Levels** (For use with the mental health triage scale above.)

Note: These definitions may differ in your hospital. The definitions used here are included to explain the levels of observation used in the scale above. **Check local policies and protocols.**

1. **1 to 1 'Special' Observation:** Patient is within close physical proximity of one allocated staff member at all times, under constant visual observation. **The staff member is not responsible for the care of other patients while providing 1 to 1 care.**
2. **Continuous Visual Observation:** Patient is under direct visual observation at all times.
3. **Close observation:** Regular visual observation of patient at a maximum of 10 minute intervals
4. **Intermittent Observation:** Regular visual observation of patient at a maximum of 30 minute intervals.
5. **Routine Observation:** Regular visual sighting of patient at a maximum of one hour intervals.

Acknowledgements:

SESAHS Mental Health Triage Scale.

Australian College of Emergency Medicine (2000) Guidelines for the implementation of the Australasian Triage Scale (ATS) in Emergency Departments. The Emergency Triage Education Kit – Triage Workbook, Australian Government Department of Health & Ageing, Commonwealth of Australia, 2007. Copyright Commonwealth of Australia reproduced by permission.

Features suggesting the need for a more urgent assessment

Features suggesting the need for a less urgent assessment

Factors influencing a more urgent triage category for specific risks

There are some general factors that influence the need for a more urgent triage category.

These are:

- Significant physical injury or illness (e.g. self-poisoning, intoxication, laceration)
- Patient with co-morbid physical and mental health presentation (e.g. suicidal patient who has self-harmed)
- Patient unaccompanied
- No known psychiatric history (i.e. first presentation)
- Dependents (babies or young children)
- If the patient is brought to ED by Police, Ambulance or Mental Health Worker.
- Accompanied
- Cooperative
- Alert
- Sober
- Not distressed
- Known patient who is cooperative and not presenting as acutely unwell
- Able to communicate
- Appears able to wait without getting too angry or distressed
- No significant physical injury.
- Risk of aggression
- Act of violence
- Threatened aggression
- History of violence
- Agitated
- Angry/menacing
- Persecutory ideation
- Delusions or hallucinations with violent content
- Intoxication – drugs or alcohol
- Brought in by Police
- Dependent children who are vulnerable
- Confusion/disorientation
- Anger increasing
- Unwilling to communicate.

Risk of suicide/self-harm

- Significant physical injury (e.g. self-poisoning, laceration)
- Attempt or thoughts
- Past attempt
- Severe depression
- Quiet and withdrawn, difficult to engage
- Unable/unwilling to communicate
- Unaccompanied
- Overt suicidal ideation
- Recent discharge from psychiatric unit
- Agitation
- Intoxication – drugs or alcohol
- Corroborative history indicating recent suicidal ideation
- Impulsive.

**WORKING
COLLABORATIVELY**

**Who needs mental
health service/
consultation/
assessment before
considering discharge?**

Risk of absconding

- History of absconding
- Quiet and withdrawn
- Unaccompanied
- Agitated
- Impulsive
- Intoxication
- Angry
- Persecutory ideation
- Increasing distress
- Confused/disoriented.

Risk of physical problem

- Significant physical injury
- Sweating, tremor, pallor
- Known medical problem
- Recent self-poisoning
- Recent suicide attempt
- Disorientation
- Fluctuating level of consciousness
- Visual (rather than auditory) hallucinations.

Mental Health services should be involved after the initial triage and risk assessment to provide assistance in assessment, behaviour management, care planning and discharge planning.

For some presentations, assessment by specialist mental health services is needed before leaving the ED; while for others it will be sufficient to consult with the mental health team and to refer patients to the community mental health service for follow-up.

A person can receive a mental health assessment if they are medically unwell or undergoing medical treatment as long as such illness or treatment will not prevent them from participating in the assessment. Consider contacting Mental Health clinicians for advice regarding behaviour management and to assist with obtaining corroborative history if the person is too unwell to have a full mental health assessment. In some rural areas of the State, mental health support and consultation is available to staff who work in smaller emergency departments via video-link, from mental health resource hubs.

NSW Health supports local protocols which promote a collaborative, shared-care approach aimed at providing holistic, person-centred care and maximising patient outcomes.

- Patients who request a mental health service
- Patients with complex or difficult mental health problems
- Patients reporting with:
 - Suicide attempt/ideation
 - Self-harm
 - Agitation
 - Mental health-related aggression
 - Severe distress
 - Severe depression
 - Psychosis.

In addition, mental health services may be contacted for assistance in managing the care of patients with:

- Confusion with behavioural disturbance
- A need for advice about sedation.

While awaiting mental health consultation, ensure the patient is safe

- Provide medical treatment for medical problems
- Continuous observation
- Safe area (no access to items that could be used as a weapon)
- Security presence if aggressive
- Calming support person if possible
- Use of *Mental Health Act 2007 (NSW)* if necessary to detain a person if the person is either mentally ill or mentally disordered AND at risk of harm to self or others AND no other care of a less restrictive nature is appropriate and reasonably available to the person.

Location of mental health assessments in the ED

There may be limited locations in the ED to conduct a safe and private assessment of a mental health patient, especially if the patient does not require a bed in the ED.

The key principles in determining the location of mental health assessments are site, practicality and safety of patients and staff.

Each ED should review areas available for mental health assessments in the ED and identify safe and private locations for assessments at different triage categories.

Safe Assessment Rooms

In response to recommendations arising from the Garling Inquiry, the Ministry of Health has been supporting the establishment of Safe Assessment Rooms (SAR) across the State, primarily to emergency departments of hospitals with a Role Delineation Level 3 or above. SARs are multipurpose rooms that provide private spaces to manage a number of sensitive needs, such as for grieving relatives, to manage behaviourally disturbed patients, for patients requiring high-level observation and to undertake assessments of mental health patients.

SARs are not intended to be used as "seclusion rooms". It should be noted that if a person is held alone in any environment from which they believe they cannot exit, then this meets the definition of 'seclusion', with associated clinical, procedural, reporting and review requirements. This includes recording the seclusion event in a Seclusion Register; the development of clinical protocols to provide for regular observations; and the review of the practice to limit its use.

It is acknowledged that balancing multiple demands on SARs and prioritising risk and patient needs requires locally negotiated protocols. Many EDs with SARs are also Declared Mental Health Facilities and therefore have a close operational relationship with local mental health services. A collaborative approach between EDs and Mental Health Services on the governance, safe practice, and use of SARs is beneficial for good patient outcomes and the strengthening of working relationships between the services.

Admission to inpatient Mental Health Services. Possible reasons for psychiatric admission are a mental illness or mental disorder, and one or more of the following presentations

- Danger to self
- Danger to others
- Unable to care for self
- Extreme distress
- Problem/diagnosis uncertain but behaviour causes concern – further assessment/observation necessary
- Need for stabilisation/treatment of condition
- Treatment failure/resistance
- Exacerbation of illness coupled with failure of usual supports.

Admission protocols

There will be local admission protocols that should be followed. In general, it is the responsibility of the Mental Health Service to locate an appropriate bed in a mental health inpatient unit. If a person is to be admitted to a mental health inpatient unit, a copy of ALL ED notes and a copy of results of investigations should be sent with the person to the mental health inpatient unit.

INVOLVING OTHER SERVICES

It may be appropriate to refer the person to other services as well. EDs are seeing an increasing number of people with a dual diagnosis, i.e. mental illness and co- morbid substance use. If there is no dual diagnosis service available, other Drug and Alcohol services may be asked to assess the person and/or to advise or assist with management as needed. Some hospitals may have access to Hospital D&A Consultation Liaison Service staff that may be available to assist in the assessment and provision of advice regarding monitoring, prevention of aggression, and management of any underlying substance-use disorders.

For elderly people, in addition to involvement of mainstream mental health services, it may be appropriate to refer the person to services such as ED ASET (Aged Care Service Emergency Team) nurses, ACAT or SMHSOP (Specialist Mental Health Services for Older People) if available in the area.

Child and adolescent mental health services should be involved where appropriate for younger people.

Assistance may be available from the NSW Department of Ageing, Disability and Home Care for people with a developmental disability. Central Office Phone: (02) 9377 6000 or <http://www.adhc.nsw.gov.au/>

Also refer to NSW Health policy on Provision of Services to People with an Intellectual Disability and Mental Illness ADHC/Health Memorandum of Understanding: PD2011 _001 at http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_001.html

The MOU outlines what is required by Health and ADHC service staff to improve access to services for people in NSW with an intellectual disability and a mental illness.

COMMON MENTAL HEALTH PRESENTATIONS

INITIAL ASSESSMENT OF MENTAL HEALTH PRESENTATIONS

REMEMBER SACCIT

Presenting symptoms may be a combination of:

- Behaviours (e.g. self-harm, aggression, bizarre actions)
- Emotions (e.g. distress, anger, worry, sadness)
- Thoughts (e.g. suicidal ideation, delusions)
- Physical (e.g. agitation, overactivity).

Common mental health presentations can be grouped into eight broad themes, although in reality these are often evident in combination.

- Self-harm and suicidal behaviour or ideation
- Aggressive or threatening violence
- Confused or not making sense
- Bizarre behaviour or speech
- Sad, depressed, withdrawn or distressed
- Hyperactive, loud, grandiose or elevated mood
- Nervous, anxious, panicky or excessively worried about health
- Physical symptoms in the absence of identifiable physical illness.

Common stressors which may precipitate psychosocial distress:

Losses

- Bereavement
- Separation/divorce
- Financial
- Status (humiliation/failure)
- Reduced physical capacity (ill health)

Life changes

- New job
- Moving home
- Entering university
- Marriage
- Retirement
- Developmental stage (e.g. adolescence)

Problems with

- Relationships
- Accommodation
- Work
- Finance
- Legal system

*(Adapted with thanks from Davies J, A Manual of Mental Health Care in General Practice: Commonwealth Department of Health and Ageing, 2000)

Before you interview, be guided by SACCIT. Particularly relevant for assessment are SAC (Safety; Assessment; and Confirmation of provisional diagnosis).

SAFETY

Consider the safety of:

- The patient
- Yourself
- Staff
- Others – (family, dependent children, other patients)

For each presentation, the following questions need answering:

- Can I interview this patient safely on my own, or do I need back up?
- Is the patient going to be safe where they are?
- Can they be left alone safely?
- What degree of observation do they need?
- Where is the most appropriate place to interview the patient given their level of arousal/agitation?

- Be alert to the potential for aggressive, suicidal or absconding behaviours.
- Let colleagues know where you are at all times, in case assistance is rapidly needed.
- Use personal duress-alarms where available.

Maintaining safety in the interview

- Ensure the immediate environment is free from items that could be used as weapons.
- Interview with another member of staff present until the situation is clearly safe.
- Call Security early if worried.
- Allow easy exit for both you and the patient so that neither of you feels trapped.
- Keep potentially self-harming or aggressive patients under close observation.
- Patients who are unaccompanied have an added risk.
- Absconding patients are at greater risk of self-harm.

Alter the interview location to suit the circumstances

Aggressive patients:

- with another staff member
- in view of supporting staff
- with security present
- in a safe area (e.g. no sharp objects or potential missiles)
- with sufficient distance between you and the patient
- with easy access to an exit.

Self-harming/suicidal patients:

- in a safe area
- able to be observed by staff at all times.

ASSESSMENT

Clinicians maintaining their composure will assist in the management of the patient's anxiety and fear. People who are fearful and paranoid can be reassured with a calm presence.

Interview suggestions

It is vitally important that you introduce yourself by name. Explain what your role is in the ED and what you need to do to help the patient. For example, *'I am Jane and I am a nurse. I need to ask you some questions so that we can help you.'* Explain in concrete, simple terms about ED processes. While these processes are familiar to you, they are not necessarily evident to ED patients.

General interview points to consider

- Control or eliminate the number of external distractions, such as pagers, phones ringing and people talking.
- Maintain privacy – avoid asking personal or embarrassing questions at the front desk, or talking loudly on the phone about the patient where others can overhear.
- Limit staff conversations in the vicinity of the patient as they may interpret what is being said as relating to them.
- Pay attention to your vocal manner – speak in a clear, calm voice. Do not show irritation or raise your voice.
- Listen carefully – try not to interrupt initially. If the person seems to be rambling, listen for key words and themes. Themes are often related to how the person is feeling; for example, scared. Respect the patient's concerns.
- Clarify important points – say that you do not understand rather than feign that you do. Say, *'I am trying my best to understand' rather than 'You are not making any sense'*. Paraphrase what you think the patient is saying and ask them if you have understood what they have said.
- Be mindful of your body language – keep your arms open and your facial expression warm and interested. Do not be overly 'nice' but more matter-of-fact in your attitude. Maintain a 'safe' distance and do not enter into the personal or intimate zone of the person (less than one metre).

- Ask (with direct questions) anything else you need to know to complete a good assessment but try to avoid a barrage of questions, which may feel like an interrogation to the patient. Statements such as 'Please tell me about that' or 'Please let me know how I can help' can be as informative as numerous questions.
- Summarise the main points back to the patient in two or three sentences. If the patient is fearful or distressed try to reassure the patient that you are trying to help them (e.g. 'I'm sorry to ask you all these questions, but they will help to sort out what is happening. They are routine questions we need to ask.').
- It is important to keep the patient informed of what is happening. However, at times discretion should be exercised so as not to inflame a situation (e.g. if the patient is aggressive and needs to be scheduled it may be wiser to wait until security or other back-up staff are present before informing the patient).

Clinicians obtain information in different ways. Often they control the interaction by asking all the questions, failing to listen carefully to what is on the person's mind. A good interview will combine:

- **Leading the interaction by asking pertinent questions, e.g. health history; and**
- **Asking questions that follow-up on cues the person may give you.**

Ask simple and direct questions about subjects that are taboo in everyday conversations. It can be a relief for the person to say these things out loud. These examples may be helpful:

'You've told me a bit of what's been happening. Does it seem unbearable sometimes?'

'Have you had thoughts of hurting yourself?'

'Have you ever tried to hurt yourself?'

'Do you ever have thoughts of hurting someone else?'

'Have you ever had to protect yourself from others?'

- Why is the person presenting now?
- Is there a physical problem?
- How did they get here?
- Has anything happened to precipitate this presentation (any recent events or problems)?
- Has anything like this happened before?
- Are they currently in treatment?
- Are they taking any medication?
- Are drugs or alcohol a problem?
- What is their level of social support?

Wherever possible, take into consideration information from family and carers and other service providers directly involved in the presentation. This information can aid in assessment of risk, and influence care and discharge planning.

History: What is the context?

Mental State Examination (MSE)

A key mental health assessment tool is the Mental State Examination (MSE) which comprises 10 major aspects:

Appearance

- E.g. posture, body appearance and condition, grooming.

Behaviour

- Features, e.g. mannerisms, tics
- Descriptor, e.g. impassive, restless, agitated, aggressive.

Co-operation

- E.g. friendly, cooperative, uncooperative, suspicious, hostile, evasive, seductive, perplexed.

Affect and Mood

Affect: Clinician's observation of the range and appropriateness of the patient's emotions.

- Range: e.g. flat, blunted, restricted, normal, labile
- Appropriateness: appropriate/inappropriate in the context of the patient's speech or ideation.

Mood: If possible describe how the patient perceives their own mood, preferably using the patient's own words.

Clinical descriptors include depressed, anxious, euthymic (normal), irritable, angry, and euphoric.

Speech

- Rate: slow, normal, rapid, or pressured
- Volume: soft, normal, loud, or shouting
- Quantity: nil, spontaneous, normal, talkative or garrulous
- Quality: accent, rhythm, impediments.

Thought form and content (judged from listening to the patient's speech)

Thought form

- Quantity: e.g. thought blocking, poverty of content, or racing thoughts
- Logical connection/sense of thought: e.g. normal, circumstantial, tangential, flight of ideas, loosening of association or incoherence
- Other: e.g. clang associations, punning, neologisms, perseveration.

Thought Content

Any pathological features such as:

- Preoccupations
- Overvalued ideas
- Delusions
- Ideas of reference
- Obsessions
- Compulsions.

What is the subject matter of the patient's thoughts or preoccupations? Are there any prominent themes in the patient's narrative? Are there any suicidal or homicidal ideas?

NOTE: If there are thoughts of harm to specific person/s, consult with a senior colleague regarding duty to warn.

Perception

Any unusual sensory phenomena such as:

- Hallucinations (especially auditory)
- Illusions
- Heightened perception
- De-realisation/De-personalisation.

NOTE: In older patients with visual/hearing deficits misinterpretations may occur. These are not necessarily indicative of a mental health problem.

Cognition

Level of consciousness

- Alert
- Hypervigilant
- Drowsy: easily aroused
- Stupor: aroused only by vigorous stimuli
- Coma: unable to be aroused.

Memory

- Immediate, short-term (recent) and long-term (remote).

Orientation

- Time, place and person.

Attention and Concentration

- Ability to follow conversation and focus on immediate matters.

Insight

An individual's awareness of their illness, its effects and implications assessed as good, partial or poor.

Judgement

Ability to accurately assess a situation and act appropriately in response, assessed as intact or impaired.

The Mini-Mental State Examination (MMSE) or the Modified Mini Mental State Examination (3MS) are useful instruments for screening cognitive functioning. A sample of the NSW Health endorsed MMSE is at Appendix 12.

A risk assessment is an essential part of all stages of a patient's management.

A risk assessment should be conducted as part of the formal assessment.

Common risks to consider include:

- Risk of absconding
- Risk of self-harm
- Risk of physical illness being missed
- Risk of suicide
- Risk of harm to others.

Does the person have access to weapons? Try to determine if they are stored safely and who can access them. If you are concerned that the person is at risk of harm to themselves or others and has access to a firearm, you must notify Police and complete the Firearms Notification form – Appendix 9.

Take into consideration information from family and carers and other service providers who are directly involved in the presentation. This information can aid in assessment of risk and influence care and discharge planning.

Risk Assessment

Physical Examination

Note that state-wide guidelines for the Physical Assessment of Patients Presenting with a Primary Mental Health Problem in the Emergency Department" are in development and this section may be subject to amendment

While it has long been recognised that mental and physical health states have complex interactions, there is now a growing body of evidence that indicates the significant impact mental health can have on physical illness and disease as well as the poor physical health of many consumers of mental health services. Such evidence confirms the importance of bringing mental health and physical health together to provide holistic care for people with a mental illness.

Physical investigations are to be related to the specific presenting symptoms. The ED physical examination of people presenting with mental health issues is to reasonably exclude organic disease:

- as a cause for the presentation; or
- as a clinical issue requiring acute management.

An organic cause for the presentation is more likely with:

- new presentations
- the elderly
- abnormal vital signs
- atypical symptoms (e.g. visual hallucinations).

Physical Assessment History

- Should comprise a routine symptom review.
- Specific attention should be paid to medication and substance-use history including over-the-counter, prescribed, and alternative medications.
- Ask specifically about sleeping medication and 'nerve' medication, as patients may not include them with their general medical medication.
- What illicit substances or alcohol has the patient taken?

Physical Examination

Physical examination should be guided by the history and specific presenting symptoms and will vary from a brief examination through to a comprehensive work-up. As a minimum, an examination will include:

- vital signs (temperature, heart rate, blood pressure, respiratory rate, oxygen saturation)
- cardiovascular system
- respiratory system
- gastrointestinal system
- neurological systems.

The NSW Emergency Care Institute has developed a form to guide the physical assessment of low-risk mental health patients in the ED. See *Physical Assessment of Mental Health Patients* form and supporting evidence for physical assessment of mental health patients (Appendix 11). This form is suitable for people:

- Aged 15–65 years
- With no acute physical health problems (including trauma, ingestion or drug side-effects)
- With no altered level of consciousness (confusion vs. psychosis)
- With no evidence of a physical cause for the acute presentation
- For whom this is not the first or significantly different psychiatric presentation.

EDs may have developed their own form for this purpose.

Gross Observations

Sometimes a full physical examination may not be possible (e.g. if the patient is uncooperative, confused, violent, or sedated). Gross observation can still be conducted and will provide important information.

Note the following:

- **Appearance**
 - description (tall, short, thin, obese, gender, age)
 - odour (alcohol, ketosis, chemical poisoning, strong body odour)
 - presentation (well-groomed, dishevelled, unshaven)
 - scars from previous self-harm (be aware that some self-harm may occur in areas of the body that is not obvious, e.g. thighs, abdomen, breasts)
 - substance abuse (track marks)
 - medical information bracelet (epilepsy, diabetes etc.)
 - obvious signs of injury
 - manner (e.g. pacing, restless, calm)
 - colour (e.g. cyanosed, flushed, pale)
- **Gross neurology**
 - moving all limbs
 - facial asymmetry
 - tremor
 - orientation (are aware they are in hospital)
 - level of consciousness (note if stable or fluctuating)
 - pupils (size, reactivity, equality)
 - signs of head injury (recent or old)

A person with complex medical co-morbidity will require further investigation.

Corroborative history

It is essential to confirm the history obtained during the interview with other sources such as the patient's medical file, carers, family, GP, Case Manager, Police, Ambulance, other clinicians or support service providers.

Investigations

Relevant investigations to exclude organic causes or co-morbidities are essential.

It is not the role of the ED clinicians to conduct routine investigations to exclude organic pathology where there are no specific symptoms or signs to warrant this. These are non-urgent tests that can be ordered during the course of admission or community follow-up. **However if the patient is presenting with unusual behaviour, it is important to exclude delirium.**

Investigations in the ED will be guided by history and examination findings.

Examples of presentations include:

- A known patient with an exacerbation of a long-standing psychiatric illness with normal vital signs and physical examination will require no further investigations prior to admission.
- A known patient with a long-standing psychiatric illness presenting with a significant change in their usual symptom picture may require further investigations, especially if their complaints are somatic. However, some patients with chronic mental illness may have difficulty describing their physical complaints due to poor communication skills.
- A patient with a newly diagnosed illness with psychotic symptoms and with suspicious neurological or cognitive signs will require a variety of investigations to exclude organic disease, e.g. acute changes in the mental status of elderly patients are often due to organic illness (e.g. UTI, pneumonia, CVA) and these should be reasonably excluded (e.g. urinalysis, chest X-ray, ECG, cerebral CT).

Relevant initial investigations for first-presentation patients include:

- Full blood count
- Urea and electrolytes
- Blood glucose
- Liver function test
- Thyroid function test
- Others as clinically indicated.

Other investigations that may be considered include:

- Urinalysis/MSU
- Chest X-ray
- ECG
- CT brain
- Lumbar puncture
- Breath or blood alcohol if intoxicated
- Urine drug screen (Dipstick-type UDS are often useful in the ED)
- Vitamin B12 + folate
- Drug serum levels (e.g. lithium, sodium valproate, carbamazepine)
- Calcium
- CK
- ESR/CRP
- Beta-HCG
- Syphilis serology
- HIV

Finally ascertain

- What does the person want now?
- Do I need to consult with Mental Health?
- Do I have enough information to present the person accurately to the mental health team?
- Is the person able to be safely discharged?
- Does the person have a place to go to where they will be safe given their current state?
- Who is the appropriate clinician to follow up this person?
- Will the person comply with follow-up and treatment?

**SPECIAL
CONSIDERATIONS**

Dependent children and pregnant women

- Keep in mind the possibility that female patients may be pregnant, particularly **before prescribing medication**.
- Postnatal depression occurs in up to 13% of women. Urgent mental health assessment is required.
- **Always** consider the welfare of any dependent children – where are they and who is looking after them now? Mothers with post-partum disorders may need assistance in caring for their children.
- **Clinicians may need to be aware that suicidal parents occasionally are so distressed by the thought of abandoning their children that they may consider ending the lives of their children as well as their own.**

If the person has a dependent child consider:

- Where is the child now?
- Is there a reliable adult to care for the child?
- Is the child/young person at risk of physical, emotional or sexual abuse, or neglect?
- Is the child exposed to domestic violence?
- Is FACS currently involved or has it been in the past?
- Is there a risk of harm to an unborn child?

All health professionals are mandatory notifiers. The legal and professional responsibilities of NSW Health workers are set out in *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf). See Chapter 6 for further guidance regarding Child Protection.

If the person has a dependent older person or person with a disability in their care consider:

- Where is the dependent person now?
- Is there a reliable adult to care for the dependent person?
- Is the dependent person at risk of physical/emotional abuse, or neglect?

Summary: What do you do when you are asked to see a patient?

As you reach for the chart, think SAC:

- 1. Safety:** think safety (yours, the patient's, and others')
- 2. Assessment:** history, mental state examination, risk assessment and physical examination
- 3. Confirm** the provisional diagnosis: obtain corroborative history: family, GP, Case Manager, Police, Ambulance, medical record; and perform investigations.

**SELF-HARM/
SUICIDAL
BEHAVIOUR OR
IDEATION**

Consider

What is the context?

**What is the mental/
physical state of the
patient?**

REMEMBER SACCIT

(ALSO SEE APPENDIX 2, SUICIDE RISK ASSESSMENT AND MANAGEMENT IN THE EMERGENCY DEPARTMENT)

- Details of suicidal thinking and planning
- Current mental state (depression, psychosis, impulsivity, hopelessness)
- Risk factors
- What are the main current problems?

High risk is suggested by

- Having a definite plan
- High intent
- Hopelessness
- Recent bereavement/loss
- Old age
- Recent separation
- Depression
- Psychosis
- Past attempts
- Impulsivity
- Intoxication
- Current substance use or dependence
- Recent psychiatric hospitalisation
- Access to means (e.g. to gun, medications, poisons, hose), preparation for attempt.

After an episode of self-harm or attempted suicide

- Is the person physically affected? (E.g. drowsiness, respiratory depression.)
- Do they need medical attention? (E.g. respiratory support, specific treatment, X-ray. Beware of recent ingestion of poison/medication – people may be asymptomatic before suddenly collapsing.)
- What **exactly** did they do? (E.g. how many tablets, length of time in the car, what sort of knife was used, to what was the rope attached?)
- Was there a suicide note or text message?
- *'How did you get to the emergency department?' 'Who called the ambulance?'*
- What precipitated the self-harm? Have the precipitants resolved or are they still present?
- What was the **intention**? (To die, to escape, to hurt themselves, do not know.)
- What are the person's intentions now? *'How do you feel about being alive now?' 'What are your plans?'* Is the person at risk of another suicide attempt?

Empathic, non-judgemental and professional attitudes are critically important for the effective assessment and management of these patients. A critical attitude on the part of the clinician is likely to result in an escalation of the person's symptomatology.

What is the background?

If suicidal thoughts suspected, ask:

- 'Have things been so bad lately that you have thought you would rather not be here?'
- 'Have you had any thoughts of harming yourself?'
- 'Have you ever thought about killing yourself?'
- 'Do you have a plan of what you might do?'

Detail any suicide plan. Consider:

- the means
- preparations
- lethality
- likelihood of intervention or rescue
- planning versus impulsiveness
- determination versus ambivalence.

Does the person have access to the intended means (e.g. medications, rope, or firearm)? **ALWAYS ask about access to a firearm. Any such disclosure requires MANDATORY notification to Police – a firearm notification form is at Appendix 9.**

- Is there evidence of covert suicidal ideation (e.g. making a will, paying debts, hinting – 'You will not have to worry about me any more.')
- Remember some suicidal people may also have thoughts about **harm to others** e.g. children/partner. **Always** ask about this.
- Obtain corroborative history
- How long has the patient felt suicidal?
- Does the patient feel hopeless?
- Are there symptoms of psychosis or depression?
- Is the patient intoxicated, or is there substance abuse?
- Is the patient impulsive?
- Is there a high level of distress?
- What other known risk factors are present?
- Any past suicide attempts?
- Past or current psychiatric history?
- Does the patient have sensible future plans?
- What supports does the patient have?
- Are there any children dependent on the patient?

Conditions particularly associated with suicide/self-harm

- Depression
- Psychosis (especially with command hallucinations)
- Substance-use disorders
- Personality disorder (especially borderline/anti-social)
- Self-harm may sometimes be a coping mechanism.

Self-harm without suicidal intent and attempted suicide

- A history of self-harm is itself a risk factor for suicide
- Regardless of motivation or intention, deliberate self-harm is a dangerous behaviour that is associated with a high risk of death
- Self-harm is a maladaptive behaviour which reflects severe internal distress (that may not always be evident in the external demeanour) and a limited ability to develop effective coping strategies to deal with difficulties.

Specific actions for these presentations: SACCIT

- **Safety:** Keep the patient under observation (see observation definitions at the bottom of the Mental Health Triage Scale in Chapter 3). Do not allow them to abscond or access dangerous objects. This may require a search of the patient and/or their belongings to ensure they do not have anything such as medication, razors/blades/knives with which they could harm themselves or others. **Local policies and protocols will guide this process.**
- **Assessment:** History; Mental State Examination (Chapter 4); Conduct risk assessment: Conducting a suicide risk assessment as per Suicide Risk Assessment and Management in the Emergency Department (see Appendix 2) will assist in confirming the risk level. It clearly explains the role of ED staff in the management of suicidal patients. Physical assessment is necessary even if there has been no attempt at suicide or self-harm.
- **Confirm the provisional diagnosis:** Corroborative history is vitally important to determine the presence of risk factors. Investigations as indicated in Chapter 4.
- **Consult:** **All** patients with self-harm, suicide attempts or marked suicidal ideation require **mental health consultation** before discharge is considered.
- **Immediate Treatment:** Treat any deliberate self-harm, physical injury/self-poisoning.
- **Transfer of Care:** If discharge is possible, firm follow-up arrangements with the person's GP or mental health clinician must be in place before they leave the ED. Do not send patients home alone; ensure there are carers available to supervise in the immediate post-discharge period.

Note: Suicidal behaviour in the elderly

Be aware that all acts of self-harm in people over the age of 65 years should be taken as evidence of suicidal intent until proven otherwise. Always consider admission for mental health assessment, risk assessment and needs assessment, monitoring changes in mental state and levels of risk.

**AGGRESSIVE OR
THREATENING
VIOLENCE
(AGITATED, ANGRY)**

REMEMBER SACCIT

This section will focus on:

- S – safety**
- A – assessment**
- C – confirmation of provisional diagnosis**
- C – consultation**

**Chapter 12 Management of Acute Severe Behavioural Disturbance
needs to be read for information on:**

- I – immediate Treatment**
- T – transfer of care**

Behavioural disturbance can have many causes, and may or may not be related to a mental illness.

Organic disorders, such as delirium, head injury, hypoglycaemia and epilepsy, can cause aggression. (Be particularly vigilant with 'out of character' aggression).

Maintain safety

- Ensure adequate back-up
- Interview with at least two staff, have other staff or security nearby
- Call Security or Police if necessary
- Do not attempt to disarm an armed patient yourself – call Police/Security
- Do not threaten or challenge
- Approach in a calm, confident manner and avoid sudden or violent gestures
- Be respectful
- Avoid prolonged eye contact, do not confront, and do not corner or tower over the person
- Focus on the here and now, and do not delve into long-term grievances or issues
- Seek help if you feel threatened or at risk
- Allow person to settle if indicated.

**Precipitants
of behavioural
disturbance**

Fear

- Psychosis (e.g. delusional belief that they are being persecuted or threatened)
- Anxiety
- People who feel threatened.

Decreased inhibition

- Confusion, e.g. delirium, dementia
- Neurological disorders
- Intoxication/disinhibiting medication
- Poor impulse control (e.g. in some people with a developmental disability or acquired brain injury).

Anger/Frustration

- Humiliation
- Rejection
- Antisocial/borderline/paranoid personality disorder/trait
- Being ignored (e.g. staff talking among themselves)
- Needs not being met
- Concerns or requests dismissed
- Extended waiting times – particularly when the reasons for these are not explained.

Stress

- Grief
- Frustration/helplessness (e.g. the parent of an ill child)
- Pain
- Agitation (e.g. secondary to depression, effects of medication or substances).

NOTE: Early recognition of patients likely to escalate to actual physical aggression is important. Rapid assessment and early intervention – e.g. verbal de-escalation/distraction, offer of oral medication – may prevent escalation to violence.

Risk factors

- History of violence (most important factor)
- Impulsiveness
- Young man
- History of childhood abuse
- Substance abuse/intoxication
- Personality disorder (antisocial, borderline)
- Psychosis (especially command hallucinations, persecutory delusions or systematised delusions focused on a particular person)
- Organic cause/delirium (head injury, metabolic disturbance).

Assessment of behavioural disturbance

As a clinician you need to both gather history and assess mental state, and at the same time attempt to reduce the tension of the situation. This is not the time to take a detailed family history – focus on the immediate situation.

Consider

- Details of aggressive behaviour and thinking
- Current mental state (psychosis, impulsivity, intoxication, delirium)
- Risk factors.

Signs of impending aggression – common behavioural indicators

A variety of behaviours may indicate actual or impending aggression.

- Clipped or angry speech
- Pacing, restlessness
- Angry facial expression
- Refusal to communicate
- Physical withdrawal – particularly into a defensive position
- Threats or gestures
- Physical or mental agitation
- Restlessness
- Loud voice, swearing
- Abusive/derogatory remarks
- Demanding, arguing
- Persecutory ideation
- Delusions or hallucinations with violent content
- Patient themselves reporting violent feelings
- Intoxication or disinhibiting medication

The absence of a calming support person can exacerbate the situation.

What is the context, the presenting history?

- What is the patient saying? Try to ascertain the patient's main concerns
- Try and understand the patient's complaint from the patient's perspective – why are they acting in this way? (e.g. patient is psychotic and thinks the CIA is trying to kill them; or patient is intoxicated and angry with partner for leaving).

What is the mental/ physical state of the patient?

- Is the patient making specific threats to harm self?
- Is there an intended victim? **(If the person is making specific threats to harm someone, consult with a senior colleague about whether you have a duty to warn the person.)**
- Is there a weapon present or accessible, i.e. items that could be used as a weapon, e.g. clothing, walking stick, IV Poles?
- **Does the patient have access to a firearm? Notify Police using the Firearm Notification Form (Appendix 9) which is MANDATORY.**
- Is there a sustained emotional disturbance: anger, stress, fear, frustration?
- Is there a physical problem? (E.g. delirium, head injury, epilepsy.)
- Affect? (E.g. labile, irritable)
- Evidence of psychosis? (E.g. responding to hallucinations or delusions especially with violent content or expressing a sense of persecution)
- Mania? (E.g. rapid speech, grandiose beliefs, elevated or irritable mood, pacing and anxiety.)
- Confusion? (E.g. poor orientation, fluctuating level of consciousness, agitation.)
- Intoxication? (E.g. behaviour influenced by amphetamines, alcohol or other substances.)
- Is the patient reporting violent feelings and thoughts?
- Is the patient making specific threats?
- Is there a specific target? (E.g. *'I'm going to get that bitch of a sister if she comes near me again.'*)

Physical examination

Note that state-wide guidelines for the Physical Assessment of Patients Presenting with a Primary Mental Health Problem in the Emergency Department" are in development and this section may be subject to amendment.

- Often this may not be possible while a patient is aggressive – gross observation from a safe distance may suffice initially.
- Vital signs:
 - Blood Pressure
 - Temperature
 - Pulse
 - Respirations
 - Oxygen saturation
 - Blood sugar level
- Once the patient is settled, perform a thorough physical examination including the CNS.
- If on antipsychotics, check for extrapyramidal side-effects (EPSE) including akathisia.
- Is there evidence of head injury, metabolic insult, substance abuse or other cause of behavioural change?

Confirming the diagnosis

Investigations

Consultation

What to do

Corroborative history

A history of violence is one of the best predictors of future violence.

- Obtain as much history as possible from corroborative sources before approaching the patient, including previous medical records, other staff, police, family and friends.
- How did the patient come to be in the ED?
- Is there a precipitant?
- Has the patient committed a violent act?
- What is the current precipitant or stressor?
- Are there dependent children, or others, at risk?
- Is there a past history of violence?
- Is there evidence of impulsivity in past?
- Is there a common precipitant or stressor in relation to past violence?
- Investigations should be guided by history and physical examination.
- Consider:
 - Full Blood Count
 - Urea, Electrolytes, Creatinine
 - Thyroid function test (TFT)
 - Urinalysis
 - Urine drug screen if available
 - +/- Head CT/MRI
 - +/- Lumbar Puncture

The intention of assessment is to identify any causes of the aggression (particularly a physical or psychiatric illness).

If the patient who is aggressive or threatening violence is assessed as mentally ill or mentally disordered, they will probably require an inpatient admission. Mental health should be involved early to assist with immediate management and transfer to the mental health facility.

Specific actions for these presentations

- Maintain safety
- Verbal de-escalation/distraction
- Medication/sedation
- Physical restraint (manual and/or mechanical)
- Calling for Security or Police assistance

See Chapter 12 Management of Acute Severe Behavioural Disturbance.

REMEMBER SACCIT

It may be very difficult to understand some patients (excluding language/cultural difficulties).

Communication may be affected by an altered level of consciousness, thought disorder, dysphasia, dysarthria, deafness, dementia or other problems. This may be coupled with behavioural disturbance, such as aggression or wandering.

Common causes include:

- Delirium
- Intoxication with alcohol and/or drugs, including deliberate self-poisoning
- Withdrawal from alcohol, benzodiazepines and/or drugs
- Adverse reaction to medication, usually a new medication
- Neurological problem: stroke, head injury, seizure
- Intellectual disability
- Psychosis
- Dementia

NOTE: Patients with an underlying cause for confusion such as dementia can have acute causes that make their confusion worse.

Could this be delirium?

DELIRIUM IS A MEDICAL EMERGENCY

Symptoms of delirium include:

- Impaired concentration/attention
- Disorientation
- Incoherent speech
- Fluctuating level of consciousness
- Rapid onset of symptoms – hours or days
- Other symptoms: memory disturbance, emotional lability, picking at bedclothes, hallucinations, suspiciousness, often worse in the evening ('sundowning').

Note:

- Confused patients rarely have a primary psychiatric disorder
- Delirium is usually reversible once the cause is treated
- Drug and alcohol problems are common causes of delirium
- A clinical feature of delirium tremens ("the DTs") is confusion and disorientation. It is the most severe form of alcohol-withdrawal syndrome and is a medical emergency. It usually develops 2–5 days after stopping or significantly reducing alcohol consumption. The usual course is 3 days, but it can be up to 14 days. Refer to NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines GL2008_011 at http://www0.health.nsw.gov.au/policies/gl/2008/pdf/gl2008_011.pdf

What is the context?

- How did the patient get here?
- Who can complete the history: family, GP, Police, Ambulance?
- What is the chronological sequence of events?
- Has this happened before?
- What is the medical history?
- What is the patient's complete list of medications? Any recent changes?
- Is there a past or current psychiatric history?
- What is the general physical condition of the patient?
- What is the patient's usual level of cognitive function?

What is the mental/ physical state of the patient?

- What is their level of consciousness?
- Is the patient disorientated?
- Is the patient responding to you?
- Does the patient appear to be trying to communicate? Are they able to write?
- Is the patient angry, distressed or crying?
- Is there evidence of thought disorder, hallucinations or delusions?
- Is there any suicidal/self-harming ideation?
- Is there hearing or visual impairment?
- Is there distractibility, impaired concentration or attention (e.g. difficulty answering questions or following instructions).

If the patient cannot give a history

- Who can provide a corroborative history?
- Physical examination, especially neurological (gross observation if comprehensive exam not possible)
- Maintain safety (observation, call Security if aggressive)
- Exclude and/or treat any underlying organic illness.

What to do?

- Introduce yourself and clearly explain your actions.
- Ensure the patient has had a full set of vital signs taken, including pulse oximetry and urinalysis.
- Treat medical problems.
- Ensure the patient is wearing their glasses and hearing aids if possible.
- Optimise hydration and electrolytes.
- Provide a safe, adequately lit, supervised, low-stimulus environment.
- Provide regular reassurance and orientation.
- Explain to the patient, in simple language, what you are doing and why.
- Ensure the patient does not wander away.
- Encourage relatives and other familiar people to stay with the patient.
- Consider the need for a medical admission, or joint/collaborative management with medical/geriatric staff.
- Consult with mental health staff if help needed with managing behaviour, or primary problem suspected to be psychosis.
- Consult with drug and alcohol staff if problem primarily drug and alcohol.

Key Risks

- Physical problem not recognised
- Aggressive behaviour
- Unable to care for self, wandering, unaware of dangers
- Self-harm or attempted suicide.

Delirium is a function of underlying medical illness or intoxication and requires medical investigation (see medical investigations in Chapter 4) and treatment. Investigations that should be carried out include urinalysis/MSU, FBC, UECs, LFTs, chest X-ray. Occasionally, no underlying pathology is evident upon initial investigation and further investigation may be required.

DELIRIUM IS COMMONLY MISSED

The Agency for Clinical Innovation has a wide range of resources to assist with managing the care of the confused older person. See <http://www.aci.health.nsw.gov.au/chops/guidelines>

Further guidance on key issues to consider in the ED is available in the Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A Handbook for NSW Health Clinicians. See <http://www.health.nsw.gov.au/dementia/Publications/assessment-mgmt-people-bpsd.pdf>

The Dementia Behaviour Management Advisory Service provides clinical support for people with BPSD in the community and in residential aged care. See http://dbmas.org.au/Your_state/New_South_Wales.aspx

The ACI's Cognition Screening for Older Adults incorporates the Abbreviated Mental Test scores, Delirium Risk Assessment Tool and Confusion Assessment Method (Appendix 4) and may be used to aid assessment.

**ODD OR BIZARRE
BEHAVIOUR, IDEAS
OR SPEECH**

REMEMBER SACCIT

The patient is acting bizarrely or saying strange things but appears orientated and alert.

The problem is most likely **psychosis**, but delirium, neurological problems and intoxication need to be considered, and organic causes of psychosis ruled out.

Common precipitants are

- Substance use
- Non-compliance with medication
- Psychosocial stressors

What is the context?

- How did the person get here?
- What **exactly** has the person being doing or saying?
- What is their explanation for their behaviour?
- Does it make sense at any level?
- Any mood symptoms?
- Has this happened before?
- Is there a past or current psychiatric history?
- Any recent head injury or medical illness?
- Any use of substances?

**What is the
mental/physical state
of the patient?**

- Is there **thought disorder**? (It is very hard to follow what the person is saying because the points do not hang together.)
- **Delusions** – what is their content?

Questions to elicit delusions:

- *'Do you ever get messages from the TV or radio?'*
- *'Are you able to see significance in events or understand signals that other people can't?'*
- *'Is anything unusual or strange happening?'*
- *'Do you ever feel you have some special purpose or power?'*

Questions to elicit persecutory ideation

- *'Do you feel safe?'*
- *'Do you ever feel in danger?'*
- *'Do you ever feel as if people are out to get you or hurt you in some way?'*
- *'Are people following you or spying on you?'*

Questions to elicit auditory hallucinations

- *'Does it ever seem as if someone is talking to you, but there is no one in the room?'*
- *'Do you ever hear voices but can't see who is speaking?'*

Questions to elicit command hallucinations (NOTE: These may increase the risk of self-harm and/or violence).

- *'Do the voices ever give you instructions, or tell you what to do?'*
- *'Do you feel you have to do what the voices tell you?'*
- *'Do they ever tell you to kill yourself, or hurt yourself at all? Or hurt or kill anyone else?'*
- *'Do you have any thoughts of hurting yourself?'* (suicidal ideation)
- *'Do you ever have thoughts of hurting someone else?'* (homicidal ideation)

What to do?

- Rule out organic illness
- Contact the person's treating mental health clinician/GP
- Consider risk to self or others – manage suicidal ideation or aggression
- Consult with mental health team

Key points

Admission may be considered if:

- Danger to self/danger to others
- Highly disturbed or disorganised behaviour
- Patient distressed
- Illness deterioration
- Need for stabilisation (e.g. repeated episodes)
- Need for further investigation/observation
- Diagnosis uncertain but behaviour of concern.

First episode psychosis

There are many psychiatric and organic illnesses that can cause psychosis. Psychosis in its earliest presentations may not be characterised by overt psychotic symptoms. The main aim is early identification and management of psychosis.

Possible early manifestations of psychosis in a young person:

- Declining work or academic performance
- Decreased motivation
- Withdrawal from family and friends
- Reduced interest in social activities
- Suspiciousness
- Eccentric behaviour
- Transient psychotic symptoms
- Depressed mood
- Irritability
- Poor sleep
- Poor concentration.
- Early recognition and treatment of psychosis is crucial and results in better long-term outcomes.
Thorough physical examination and investigation is necessary to exclude organic causes.
- An empathic, reassuring and competent first assessment is a great building block for ongoing cooperative treatment.
- Urgent referral and facilitated access to specialist mental health services is essential – many mental health services have specialised early psychosis intervention programs.

CATATONIA

- Can be secondary to schizophrenia, affective or organic disorder
- Catatonic stupor (immobile, mute, unresponsive but conscious) or catatonic excitement (uncontrolled and agitated abnormal motor behaviour)
- May refuse food and drink
- Can progress to coma and death.

Intervention

- Patient requires protection from harming self or others
- May need fluid and nutritional support (IV or NG may be needed)
- Exclusion of medical causes, such as encephalitis, intracranial lesions, metabolic abnormality, and drug-induced catatonia
- Urgent referral to mental health team for assessment

REMEMBER SACCIT

A depressed mood is a common symptom which:

- May be a normal response to loss/stress
- May be associated with physical illness
- May be the result of a medical disorder **OR**
- May occur in a variety of mental disorders, such as **major depression**, anxiety, personality disorder or psychosis.

Key symptoms of major depression are:

- Less enjoyment from usual activities
- Negative thoughts about self, the world around them and their future
- Hopelessness
- Irritability
- Difficulty sleeping.

Other symptoms include:

- Change in energy levels
- Concentration difficulties
- Appetite disturbance (usually decreased)
- Weight change (usually weight loss)
- Pervasive lowering of mood
- Suicidal thinking
- Guilty thoughts
- Feelings of worthlessness
- Psychomotor retardation or agitation
- Anxiety
- Older persons with depression may present with somatic symptoms, self-neglect or other change in function and/or cognition.

In older people, adverse effects of antidepressants such as hyponatraemia and agitation may complicate assessment.

Severe depression may be accompanied by **psychotic symptoms** (e.g. delusions that they are dead, their insides have rotted, or that they are bad and worthless, delusions of guilt or somatic delusions), and/or **melancholic features** (distinct quality of low mood, marked anhedonia, waking early, weight loss, guilt, anorexia, mood worse in the morning, feels qualitatively different to sadness).

Early warning signs of depression should alert the health professional to the need for further **assessment of suicide risk**. Early warning signs include:

- depressed mood and/or anhedonia (loss of pleasure in usual activities)
- isolated / withdrawn / reduced verbal communication
- difficulty sleeping
- refusing treatment
- reduced appetite
- complaints of pain / physical discomfort not consistent with physical health
- Why has the person presented?
- Has there been some precipitating event or stressor?
- Is this a change from usual?
- Any substance use?
- Any past history of depression or psychiatric treatment?

Interview questions

- *'How has your mood (or spirits) been lately?'*
- *'How long have you felt this way?'*
- *'Does your mood vary during the day?'*
- *'Do you have any problem sleeping?'*
- *'Are you still able to enjoy the things you used to?'*

What is the context?

What is the mental/physical state of the patient?

- Will the patient talk?
- Is there any suicidal ideation?
- Is there evidence of intoxication?
- Particularly look for psychotic features, such as delusions which are consistent with a depressive mood or hallucinations
- Particularly note depressed appearance/facies, psychomotor agitation or retardation
- Assess the risk of self-harm: be alert for hopelessness, suicidal ideation and agitation.

Key risks

- Depression can mimic the cognitive impairment of dementia
- Depression can result from physical illnesses, such as hypothyroidism or cerebral malignancy
- Missed physical illness. Careful physical examination is needed
- Suicide or self-harm
- Absconding
- May be dangerous to others if psychotic – especially if there are dependent children/babies
- Postnatal depression (See Edinburgh Postnatal Depression Scale at Appendix 5).

What to do?

- Maintain the safety of the patient at all times. This may require close observation and containment pending specialist mental health assessment.
- The patient will need urgent mental health assessment if there is marked depression, any psychotic symptoms or any suicidal ideation.
- Discharge following mental health consultation and organisation of follow-up arrangements may be appropriate if there is no suicidal ideation and the patient is adequately supported.
- Drug and alcohol consultation may also be appropriate for co-morbid disorders.

Key points

- Health professionals commonly under-diagnose major depression.
- Always inquire about suicidal ideation if you suspect depression.
- Close observation is required to maintain patient safety. Patients with depression have absconded from EDs and committed suicide. A high degree of vigilance is required.
- Patients may not complain of feeling depressed at the point of triage or initial assessment. Non-communicativeness, reduced facial expression, agitation or motor-retardation may suggest depression.
- Adolescents with depression may have atypical presentations (e.g. irritability, somatic complaints, mood reactivity, hypersomnia, weight gain, impulsivity).

Suicide is the major risk in patients who are depressed.

**HYPERACTIVE,
LOUD, GRANDIOSE
OR ELEVATED
MOOD**

REMEMBER SACCIT

This presentation may be a result of a number of possible causes, but mania is the archetype of this presentation. Behaviour in mania is overly exuberant, and may involve 'out of character' risk taking (such as gambling large sums of money or indiscriminate sexual activity). There is usually a history of a distinct and acute change in the patient's mood and behaviour. The behaviour usually causes significant relationship or work problems.

IMPORTANT NOTE:

A corroborative history from relatives and carers is extremely important. People with mania may be good at 'holding it all together' for a brief period (e.g. while talking to the doctor).

Always consider the potential for damage to the patient's reputation (or for physical harm) if risk-taking behaviour continues unabated.

Key symptoms of mania:

- Extremely happy mood
- Irritable mood
- Grandiosity
- Decreased need for sleep
- Increased energy
- Increased risk taking
- Increased sexual activity
- Spending money
- Increased goal-directed activities
- Rapid speech
- Racing thoughts.

Other possible causes of elevated mood

- Intoxication (look for signs, e.g. dilated pupils of stimulant use)
- Psychosis (in psychosis, mood elevation is less pronounced, but psychosis can be a symptom of severe mania)
- Organic causes (e.g. associated with corticosteroid use)
- Personality disorder (especially histrionic, borderline, narcissistic – but behaviour tends to be long-standing, emotional lability is often present, and degree of mood elevation may be less pronounced)
- First presentation of mania in an older person is likely to be secondary to neurological or physical illness. Have a high index of suspicion of a medical cause.

What is the context?

- Why has the patient presented?
- Has there been some precipitating event? (Common precipitants include stress, lack of sleep, substance use.)
- Is this a change from the usual?
- Any substance use? (Common in mania.)
- Any biological symptoms of mania? (Increased energy, decreased need for sleep.)
- Assess the potential for harm to others (e.g. irritability, belief they are being obstructed by others, belief that other people are insignificant).
- Harm to self includes damage to physical self, or damage to financial standing, relationships, reputation.
- Any past history of mania or psychiatric treatment? Careful history-taking is important in determining past undiagnosed episodes.

What is the mental/ physical state of the patient?

- Look for bright and garish 'larger than life' appearance
- May be very active, not able to sit still
- Often interaction is good humoured, but may be irritable (e.g. 'stop wasting my time, there's nothing wrong with me')
- Speech is usually very rapid, jumping from topic to topic
- Delusions, particularly grandiose, are common in severe mania (e.g. 'I'm worth millions. I don't have time to sit and talk to you.')
- Insight is often impaired, and judgement poor.
- Mania in an older person may present as irritability
- Check the patient's physical condition. Is the patient at risk of self-neglect, e.g. not eating or drinking with subsequent dehydration and electrolyte disturbance?
- Check levels of medication (lithium, carbamazepine, valproate) if the patient is taking them (**NOTE:** Check timing of last dose in relation to blood levels as the recommended levels are trough levels.)
- Any evidence of intoxication/substance use?

Interview questions may include:

'How has your mood been lately?'

'How long have you felt this way?'

'Does your mood vary during the day?'

'How many hours sleep a night do you need?'

'How are your energy levels?'

'Has your sexual interest changed recently?'

'How are your thoughts – are they moving faster or slower than normal?'

'What are you working on at the moment? How is it going?'

'How is your sense of humour?'

'Have you been spending more money than usual?'

What to do?

- Call the mental health team
- Be aware that absconding may be a problem
- If the patient wants or tries to leave the ED consider duty-of-care issues, including keeping the patient in the safe environment of the ED without placing yourself at risk of physical harm by doing so
- Consider the need to detain under the *Mental Health Act 2007 (NSW)*
- Insight into the illness is often lacking, patients may be irritable and threatening, and patients often will actively resist treatment as they may be feeling so well
- Admission is usually necessary.

Discharge can only occur after consultation with the mental health team, and only under certain conditions, which may include:

- Patient has insight and is willing to take the medication
- Patient has adequate and capable supports
- The diagnosis is clear, and patient has had similar episodes previously (sometimes patients may have 'advance directives' detailing who to contact and what steps to take in the event that they become manic)
- Frequent review of patient and their symptoms will occur – hypomania can rapidly escalate to mania
- Intensive follow-up is organised.

NERVOUS,
ANXIOUS, PANICKY
OR EXCESSIVELY
WORRIED

REMEMBER SACCIT

Brief episodes of anxiety are part of a normal response to stress or threat

Anxiety symptoms may be:

- A primary anxiety disorder
- Secondary to a medical disorder
- Secondary to another psychiatric disorder, such as depression, schizophrenia, acute stress, adjustment or personality disorder
- In an older patient, first-onset anxiety problems are usually accompanied by depression or cognitive changes.

Symptoms of anxiety may be:

- **Mental** (sense of apprehension, worry, fear or threat, agitation, indecision, de-realisation, depersonalisation, obsessions), and/or
- **Somatic** (tremor, palpitations, sweating, nausea, 'tummy ache', chest tightness or pain, shortness of breath, dizziness, paraesthesia, feeling of choking, urinary frequency, hesitancy), and/or
- **Behavioural** (avoidance of anxiety-inducing situations, compulsions).

Always consider possible physical causes (see below), or medical conditions which are commonly associated with anxiety symptoms.

- Cardiovascular: angina, MV prolapse, tachycardia
- Respiratory: asthma, PE, hypoxia, CAL
- Endocrine: hypoglycaemia, hyper/hypothyroid
- Neurological: MS, epilepsy, Meniere's Syndrome
- Malignancy: phaeochromocytoma, carcinoid syndrome, insulinoma
- Medications: antidepressants, bronchodilators, anticholinergics
- Drugs: e.g. stimulant intoxication, sedative withdrawal, alcohol withdrawal
- Exposure to noxious chemicals.

- Do not assume that the patient with chest pain and a history of anxiety disorder is not having an AMI – **always** consider physical illness
- Always consider underlying medical or substance/medication-induced cause of anxiety
- A prior history of psychiatric illness does not exclude the presence of a medical illness
- Liaise with the patient's GP or mental health clinician
- Anxiety symptoms in an acute medical setting such as the ED are common but not necessarily indicative of an anxiety disorder
- There is an association between panic attacks and suicide risk. **Always** ask about suicidal ideation.

Anxiety commonly causes hyperventilation, which may produce unpleasant somatic sensations.

Physical causes of
anxiety symptoms

Key points

Symptoms secondary to hyperventilation

- Dizziness, light-headedness or faintness
- Breathlessness, choking or smothering
- A feeling of unreality
- Blurred vision
- Tachycardia
- Paraesthesia in the hands, arms or feet
- Cold, clammy hands
- Irregular heartbeats.

What is the context?

- Is this 'normal anxiety'? (That is, cases in which symptoms are reasonable in light of the nature of the perceived threat.)
- Is there an identifiable precipitant?
- Has this happened before? If so, is there anything different about this episode (new symptoms require thorough physical assessment)?
- Is there a treating clinician?

What is the mental/physical state of the patient?

- Ask about specific symptoms – patients may be embarrassed by their behaviour or obsessions. Try to normalise symptoms.
- Is there any associated depression?
- Suicide risk?

Interview questions may include:

- *'What do you think might be causing this?' Is the patient able to connect symptoms with psychosocial stressors?*
- *'Are you having any difficulties at work/school/home?'*
- *'Are you worried about anything?'*
- *'Do you ever get panicky?'*
- *'Sometimes people have really unpleasant or scary thoughts that they can't get out of their head – do you ever have anything like that?'*
- *'Do you have any routines or rituals, such as checking, cleaning, counting that causes distress if you are unable to complete them?'*

What to do?

- Thorough **physical assessment** is needed to exclude physical causes and may help reassure the patient
- If hyperventilation is a problem, slow breathing exercises may be helpful (Appendix 6)
- **Reassure** that there is no major physical problem
- **Explain** how anxiety can cause physical symptoms
- **Refer** for treatment to GP or mental health clinician. (Definitive treatments include Cognitive Behavioural Therapy (CBT) and medications such as antidepressants. Benzodiazepines are rarely indicated.)

Anxiety is rarely an emergency: however, if there is any suggestion of depression or suicidal ideation, the mental health team should be consulted.

Anxiety disorders include:

Panic Attacks: discrete episodes of intense fear accompanied by varied somatic (e.g. chest pain, nausea and numbness) and cognitive symptoms (e.g. belief that they are suffering a heart attack, stroke or suffocation).

Agoraphobia: is the specific avoidance of situations in which panic or intense anxiety has been experienced. These can include being in public, in queues, on public transport, shopping centres. In its extreme form, can lead to people being housebound.

Generalised Anxiety Disorder: pervasive and excessive unjustified worry for at least six months, with symptoms such as insomnia, fatigue, edginess, irritability, muscle tension and concentration difficulties.

Social Phobia: exaggerated persistent and unreasonable fear associated with a social or performance situation (e.g. meeting new people, public speaking).

Post Traumatic Stress Disorder (PTSD): following exposure to a life-threatening or shocking situation (e.g. MVA with mutilated bodies) which the patient persistently re-experiences in nightmares and flashbacks. Avoidance, numbing, and increased arousal (insomnia, anger, hypervigilance, easily startled) behaviours may also be present.

Acute Stress Disorder: similar symptoms to PTSD, but occurring within a month of the event and associated with dissociative symptoms.

Obsessive Compulsive Disorder: intrusive unwanted thoughts or images (that the patient knows are absurd or unreasonable) which cause marked anxiety, distress or urges to carry out repetitive behaviours or mental acts (which may reduce the anxiety) and interferes with the person's normal activities.

Slow Breathing Exercise and Sleep Hygiene instruction – refer to Appendices 6 and 7.

REMEMBER SACCIT

Substance-related and addictive disorders:

- Are common
- Are frequently not diagnosed and/or ignored
- Are frequently associated with behavioural disturbance
- Result in severe physical, mental and social problems
- Commonly co-exist with other mental illnesses (such as an anxiety disorder, depression or schizophrenia, i.e. patients with **dual diagnosis**)
- Often involve abuse of several substances (polysubstance abuse/dependence)
- May be a cause of unexplained physical and mental symptoms
- Can be significantly helped by early recognition and brief interventions in the ED, and through appropriate referrals to drug and alcohol services.

Mental and behavioural disorders due to psychoactive substance use:

- **Harmful use** – A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol)
- **Dependence syndrome** – A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical-withdrawal state.
- **Intoxication** – reversible substance-specific cognitive/behavioural changes – can result in overdose
- **Withdrawal syndrome** – development of substance-specific syndrome on cessation of substance, which impairs functioning
- **Substance-induced specific disorders** – e.g. amphetamine-induced psychosis/delirium, alcohol-withdrawal delirium.

Assessment

- Exclude co-morbid physical illness, head injury
- Consider co-morbid psychiatric illness. Clinical Guidelines regarding the management of people with both mental health and D&A issues is described in the NSW Clinical Guidelines for the Care of Persons with Co-morbid Mental Illness and Substance Use Disorders in Acute Care Settings 2009 http://www0.health.nsw.gov.au/pubs/2009/pdf/comorbidity_report.pdf
- Consider poly-drug use.
- For each drug assess:
 - date and time of last use
 - quantity
 - frequency of use
 - duration of use
 - route of administration
- Is there evidence of dependence?
- Are there any harmful consequences of use?
- What does the patient want?
- Is the patient currently intoxicated or in withdrawal?
- Are the effects likely to get worse (e.g. continuing absorption from GIT) or better (e.g. sobering up)?
- If drug use is known or suspected, a urine drug screen can be used for diagnostic clarification where available
- A breathalyser, where available, may be used to estimate blood alcohol content.

A useful screening test for alcohol abuse is the CAGE

Alcohol problem screening questions (**CAGE**):

C – Has anyone ever felt you should **Cut** down on your drinking?

A – Have people **Annoyed** you by criticising your drinking?

G – Have you ever felt **Guilty** about your drinking?

E – Have you ever had a drink first thing in the morning (**Eye-opener**) to steady your nerves or get rid of a hangover?

One positive response is suggestive of an alcohol problem; two or more is highly sensitive.

Other screening tools that cover a range of substances are the ASSIST and the AUDIT screening tools which are available as appendices in the NSW Clinical Guidelines for the Care of Persons with Co-morbid Mental Illness and Substance Disorders.

Intoxication

Intoxicated patients are poor historians, highlighting the need for comprehensive physical examination, corroborative history and an adequate period of observation. Observation until the patient has a clear sensorium is important to confirm the diagnosis. Beware of associated head injury.

Substance-specific features of intoxication

- **Alcohol** – smells of alcohol, ataxia, slurred speech, disinhibition, depression, confusion, hypotension, stupor
- **Benzodiazepines** – slurred speech, sedation, loss of control of voluntary movements, nystagmus, low blood pressure, drooling, disinhibition
- **Cannabis** – conjunctival injection, anxiety, drowsiness, depersonalisation, impaired movements, confusion, persecutory ideation, hallucinations
- **Opioids** – pinpoint pupils, sedation, respiratory depression, hypotension, bradycardia, itching and scratching, calmness, euphoria
- **Amphetamines/Cocaine** – dilated pupils, increased P/BP/RR and temperature, increased motor activity, stereotypical behaviour, agitation, pressured speech, anxiety, aggression, persecutory ideation, delusion/hallucinations, convulsions, arrhythmias
- **Hallucinogens** – hallucinations, heightened perceptions, derealisation, depersonalisation, nausea, dizziness
- **Solvents** – ataxia, dysarthria, dizziness, sialorrhea (excessive saliva), nausea, vomiting, confusion, disorientation, hallucinations, respiratory depression, arrhythmias
- **Anticholinergics** – dry mouth, dilated pupils, flushed face, tachycardia, hypotension, delirium with visual hallucinations, increased temperature, agitation, dysarthria.
- **Synthetic drugs** – depends on the type of synthetic drug. Common classes are:
 - ‘synthetic’ stimulants (including cathionines and piperazines) – act like other stimulants, some have hallucinogenic properties as well
 - ‘synthetic’ hallucinogens – (including tryptamines) – act like hallucinogens
 - ‘synthetic’ cannabinoids – act like other cannabinoids; nausea, vomiting, arrhythmias and seizures have been reported
 - other synthetics – may have a range of physical and mental health effects.

Co-ingestion of different intoxicants may produce a mixture of clinical signs, so the above syndromes are less clearly distinct.

Withdrawal

Withdrawal carries risks of physical harm, psychological trauma and in rare cases may lead to death (e.g. unmanaged severe alcohol-withdrawal delirium).

Withdrawal management reduces the risks associated with withdrawal.

Supportive care including information on the withdrawal syndrome, monitoring, reassurance and a low-stimulus environment are effective in reducing withdrawal severity.

Treatment is largely symptomatic. The exception is the use of benzodiazepines to manage alcohol and benzodiazepine withdrawal (reduces risk of seizures or severe alcohol withdrawal with delirium (delirium tremens)).

All patients who are known to be alcohol-dependent should have alcohol-withdrawal scores assessed and treated with diazepam as per protocol.

Refer to NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines GL2008_011 at http://www0.health.nsw.gov.au/policies/gl/2008/pdf/gl2008_011.pdf

Alcohol withdrawal – occurs 6 to 24 hours following cessation or significant reduction of alcohol consumption. Symptoms include hypertension, tachycardia, tremor, sweating, nausea, seizures (6 to 36 hours) and delirium tremens. Alcohol withdrawal requires diazepam/oxazepam oral or IV, adequate hydration, potassium and magnesium supplements. Oxazepam is used for those that are hepatically compromised or the elderly as it is renally excreted with a shorter elimination time than diazepam. Consultation with the local D&A service is recommended if clarification is required on the use of either diazepam or oxazepam.

Over- or under-medicating withdrawal can blur the overall clinical picture of the individual and delay further assessment and outcomes. It is the responsibility of all clinicians to ensure they are familiar with the clinical practice guidelines for the management of withdrawal states, in order to ensure the best possible consumer and service outcomes.

Thiamine prophylaxis should be considered for all individuals identified with alcohol abuse or dependence. IV thiamine should be considered as first line of approach. If IV access is not available then daily IM should be the second choice. PO thiamine is not considered an adequate replacement for IV or IM thiamine due to low bioavailability of oral doses. Consult with local D&A service regarding dosing policy and procedures.

Opiate withdrawal – commences approximately 12 hours after last opioid use. Syndrome lasts approximately 5 to 7 days in the acute phase and presents as a severe flu-like illness (runny nose, eyes, vomiting, diarrhoea, muscle aches and pains, hot and cold flushes) with anxiety, insomnia and drug cravings. Symptoms usually peak on day three (may be longer for long-acting opioids, e.g. methadone withdrawal).

Medication: short course of buprenorphine is the drug of choice. Other medications that can be used in place include symptomatic medication (anti-diarrhoeals, anti-nauseants, NSAIDs). Short course of benzodiazepines can be used (e.g. diazepam, temazepam) for insomnia and anxiety. Maintenance therapy may be indicated (e.g. methadone maintenance, buprenorphine maintenance – consult with the local Drug and Alcohol service).

What to do?

Identify drug and alcohol problem-type

- Intoxication, withdrawal, dependence or abuse, plus or minus co-morbid physical or co-morbid psychiatric illness
- Consult local Drug and Alcohol service if available and/or uncertain how to manage the patient
- The Drug and Alcohol Specialist Advisory Service is available by phone 24 hours a day. Metropolitan (02) 9361 8006, (Metropolitan) Regional and rural NSW 1800 023 687
- If medical or psychiatric complications or co-morbidity present, consult the appropriate service
- If symptoms are mild, there is no history of complications and the patient is well supported, outpatient referral and follow-up may be appropriate (see flow chart on next page).

Key points

- Do not automatically assume that symptoms are a result of substance use. Always consider other possible organic causes such as subdural haematoma and sepsis.
- Substance-related and addictive disorders should be considered in the differential diagnosis of most medical presentations.
- Clinicians need a high degree of suspicion – always ask about drug use, and seek corroborative history, urine drug-screening. Minimisation of drug history is common.
- Psychosis, depression and anxiety commonly co-occur with substance abuse.
- The patient needs to recover from the effects of intoxication or withdrawal before an accurate assessment can be made, but this should not delay delivery of appropriate treatment.
- It is important to assess the cognitive capacity of such patients. If the person is cognitively impaired, the person's capacity to make decisions, work with follow-up or seek help is significantly altered. If the issue of cognitive impairment in patients with substance use disorders is not addressed in actual practice, it can lead to adverse outcomes.

Nicotine dependence and withdrawal

Many people presenting with mental health issues are dependent on nicotine. It is important to identify this early and it will be helpful to engage the person's carer or family in this regard.

Adequate management of nicotine dependence has been shown to reduce aggressive incidents and the risk of absconding.

In all circumstances the person should be offered counselling and nicotine replacement therapy. Refer to NSW Health Guide for the Management of Nicotine Dependent Inpatients: http://www0.health.nsw.gov.au/policies/GL/2005/GL2005_036.html

Management of acute intoxication and associated behavioural disturbance

Patients who are acutely intoxicated with alcohol or drugs may present challenges for EDs.

- The person's behaviour may pose a risk of harm to themselves and/or others
- Behavioural problems related to aggression must be managed appropriately to maintain the safety of the ED for staff and other patients
- Intoxication can mask serious illness or injury
- Intoxication can be a medical emergency
- Intoxicated persons who express suicidal ideation are a high suicide-risk
- The enduring risk of suicide of an intoxicated person cannot be assessed until they are sober. Consultation with the mental health team should occur in these cases
- There is no definitive breath- or blood-alcohol level that can be used to determine if a person is sober enough for an assessment of enduring risk. Each case must be assessed individually. Mental state examination may be conducted while the patient is intoxicated but the clinician should remain cognisant that the outcome of the examination may change when the patient is no longer intoxicated
- Consultation with mental health and/or drug and alcohol services should be sought if assistance is required with assessment and to manage the care of the person. This can occur even if the person is too intoxicated for the services to conduct a full assessment.

Some indications of overdose

a) sedative overdose

- Decreasing level of consciousness
- Cold and clammy skin
- Pinpoint pupils (opioids)
- Changes to heart rate (e.g. irregular, below 60/bpm)
- Slow and noisy respirations
- Muscle twitching
- Cyanosis
- Pulmonary oedema
- Stupor
- Coma

Airway protection, oxygen and breathing assistance may be required

b) stimulant overdose

- Inability to sit still, pacing
- Increasing agitation, aggressiveness, violent behaviour
- Changing mental state (hallucinations, panic, or depression)
- Increased vital signs (HR above 120 bpm, temperature)
- Convulsions, coma, renal failure, rhabdomyolysis, heart attack, arrhythmias, stroke.

Sedation and monitoring may be required

Management is according to the **Safety, Confirmation of provisional diagnosis and Immediate Treatment** principles. For specific guidelines see the following:

- Suicide Risk Assessment and Management in the Emergency Department (Appendix 2)
- Management of Adults with Acute Severe Behavioural Disturbance (Chapter 12)
- NSW Health 2008 'Nursing and Midwifery Clinical Guidelines: Identifying and responding to drug and alcohol issues' http://www.health.nsw.gov.au/policies/gl/2008/GL2008_001.html

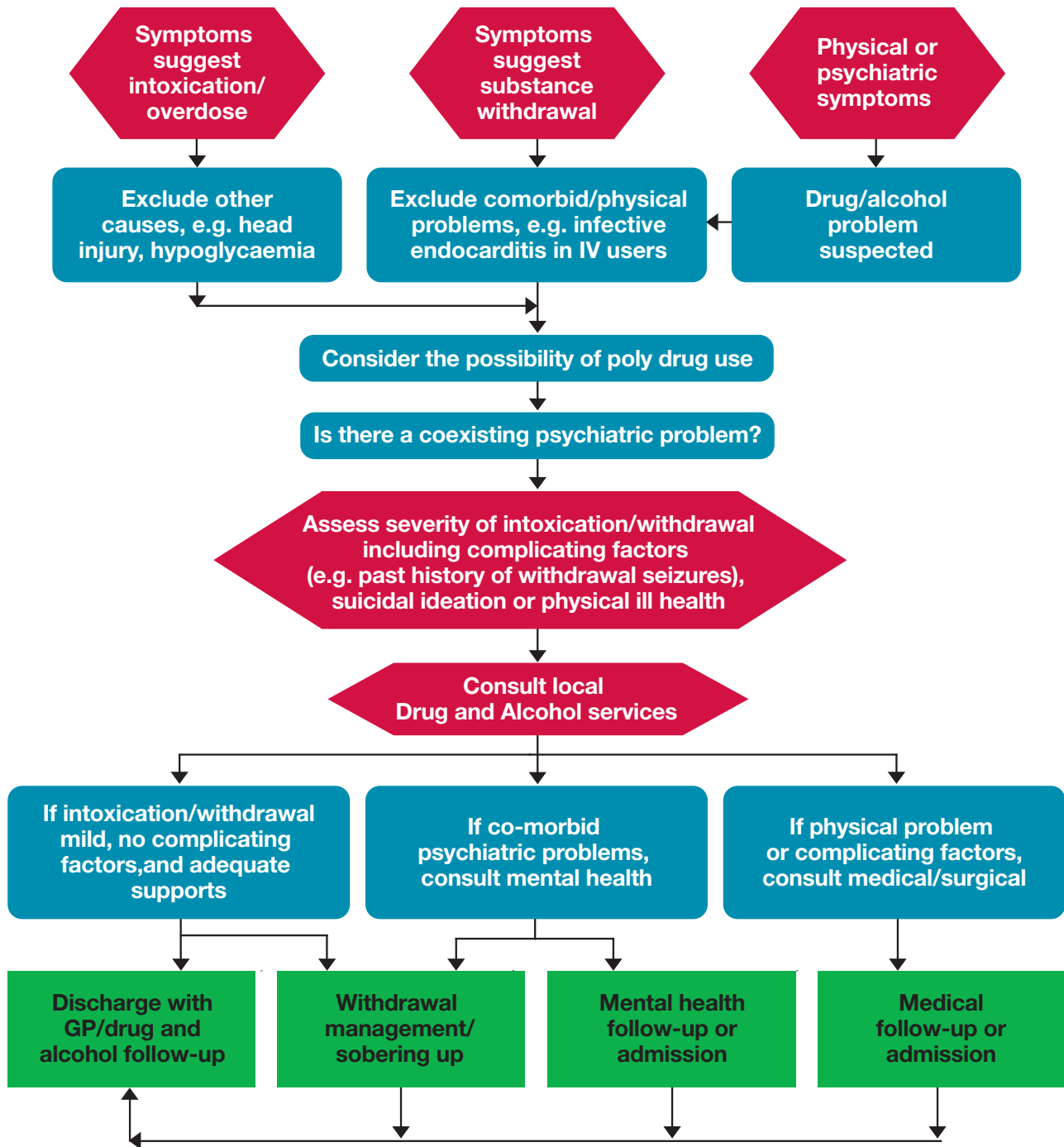
Managing behaviour problems

Guidelines for the Pharmacological Management of Methamphetamine Intoxication

Promoting a Safe Environment	Maintaining a Safe Environment	Restoring a Safe Environment
Early Detection and Intervention	Risk Management and Planning for Safety	Emergency Crisis Intervention
<p>Level 1</p> <p>Definition: Amphetamine identified as likely cause.</p> <p>Behaviours: Anxiety/Agitation Mildly aroused, pacing, still willing to talk reasonably or may be moderately aroused</p>	<p>Level 2</p> <p>Definition: Escalation of aggressive behaviour with reduced capacity to control emotions and behaviour.</p> <p>Behaviours: Verbal Aggression Not dangerous or violent. Moderately aroused, agitated, becoming more vocal, unreasonable and hostile or may be highly aroused</p>	<p>Level 3</p> <p>Definition: Aggressive behaviour poses an imminent threat to safety of all.</p> <p>Behaviours: Violence or danger is imminent or physically aggressive. Highly aroused, distressed and agitated. Patient refuses all medication</p>
<p>ACTION: Aggressive behaviour monitored and controlled</p>	<p>ACTION: Clinical intervention required</p>	<p>ACTION: Crisis intervention required</p>
<ul style="list-style-type: none"> • Pre-empt and intervene early. • Exercise crisis communication skills. • Address concerns and fears. • See Level 1 regimen: 	<ul style="list-style-type: none"> • Co-ordinate intervention. • Monitor the effectiveness of continued engagement. • Continue to address concerns and fears. • See Level 2 regimen: 	<ul style="list-style-type: none"> • Senior Clinician co-ordinates an Emergency Response. • Ensure the safety of others in your care. • Mechanical restraint in extreme violence or combativeness. • See Level 3 regimen:
<p>PER ORAL LEVEL 1 Diazepam 5–10mg Or Combine Diazepam 5–10mg with Olanzapine 5–10mg Review in 30 minutes and repeat if there is minimal clinical response. Further review by senior doctor if necessary.</p> <p>NOTE - DAILY MAXIMUM DOSES Daily maximum dose not to be > 60mg Diazepam Daily maximum dose not to be > 30mg Olanzapine</p>	<p>PER ORAL LEVEL 2 Olanzapine 10–15mg oral wafers with *Lorazepam 1–2 mg (max 8mg/d) or Diazepam 10–20mg Review in 30 minutes and repeat if required for suitable clinical response. NB: Average peak onset for Lorazepam is 2hrs, therefore usual 2hrly dosing interval Typical or Atypical options may be combined with Benzodiazepines and must be in keeping with the daily max dose (see Level 1)</p>	<p>PARENTERAL INTERVENTION LEVEL 3 **Diazepam IVI 10mg, repeated after 5 minute reviews to achieve a clinical response. Max. of 60mg or until sedated. with **IVI Droperidol 2.5–10mg max 20mg/d If IVI route is compromised, in fit adult give Midazolam IMI 10mg (repeat in 10 mins if necessary), max 40 mg/d. NB: ** IVI IM benzodiazepines or droperidol/haloperidol used ONLY when adequate ECG/02 monitoring is available.</p>
<p>ALERTS Benzotropine 2mg IM or IV may be required for acute dystonias: (Max 6mg/24hrs): Consider giving takeaway oral doses of Benzotropine 2mg/d x 2 to any patient who has received droperidol as per Level 2 or 3. Typical and atypical antipsychotics can lower seizure threshold.</p> <p>PRECAUTIONS Lower doses should be considered in elderly, patients with low bodyweight, intoxication, ethnicity, dehydration or no previous exposure to antipsychotic medication. Monitor respiratory function when benzodiazepines are administered parenterally and **monitor postural blood pressure 30 min post-dose. Monitor ECG if using high doses of antipsychotics, particularly typical antipsychotics. Confer with ED/MH CONSULTANT if patient not adequately sedated at maximum daily doses</p> <p>CONSIDERATIONS Be cognisant of cumulative effects of ALL medication. *Level 2 high dose oral Lorazepam preferential to high dose diazepam to minimise drowsiness post symptom resolution.</p>		

Developed by St Vincent's Hospital, Sydney, Departments of Emergency, Alcohol & Other Drug, Psychiatry & Clinical Pharmacology, 2007.
Revised by the PECC/ED Management Committee, October 2013. Adapted from Prof D Castle et al. article *Development of clinical guidelines for the pharmacological management of behavioural disturbance and aggression in people with psychosis.*
Australian Psychiatry Vol 13, No 3, pg 247-252 Sept 2005

Drug and Alcohol Assessment



**In any case of alcohol abuse/withdrawal, consider the use of thiamine.
 Consult a senior ED colleague. For more complex presentations,
 consider referral to the Involuntary Drug and Alcohol Treatment Program.
 See IDAT Fact Sheet Appendix [10]**

REMEMBER SACCIT

Eating disorders are mental and physical illnesses characterised by extreme food- and weight-reduction strategies and usually present with a range of medical complications which can be life-threatening. Eating disorders have the highest mortality rate amongst mental illnesses.

People with eating disorders present a challenge to ED staff. Due to adaptation to starvation they can present with extremely low bodyweight or very frequent purging behaviours and fragile medical status. On examination, however, blood biochemistry can look normal, which belies their fragile medical state.

Common pathways for determining severity of malnutrition in other conditions are not suitable or informative in eating disorders; e.g. despite severe emaciation, serum albumin levels are often normal, along with other biochemistry. The best indicator of a need for admission to address malnutrition and medical stabilisation is Body Mass Index (BMI). Any adult with a BMI of less than 15 is strongly indicated for admission, and for children and adolescents a guideline of less than 75% Expected Body Weight (EBW) indicates the need to assess for admission (see NSW Health Service Plan for People with Eating Disorders 2013–2018). Males become severely medically compromised at BMIs lower than 15 and will require admission.

Upon commencing re-feeding and rehydration, formally normal biochemistry can start to reveal its true abnormal state. Regular biochemistry monitoring is required from the initiation of treatment.

Regular monitoring of vital signs (four times a day) is required to monitor cardiovascular status, which is almost always significantly compromised. Hypotension must also form part of this regular assessment. Other indications of medical compromise are: a discrepancy between lying and standing heart rate; heart rate accelerates on standing or exercising; and blood pressure falls.

People with an eating disorder often feel uncomfortable disclosing information about their behaviours, making the detection of disordered-eating symptomatology difficult at times.

The peak onset of Eating Disorders is at ages 14–16 but eating disorders can affect people of all ages including children and older adults. The ratio in females to males is at least 10:1, but in prepuberty a higher number of males may present to the ED.

- Low bodyweight or failure to achieve expected weight gains
- Fear of weight gain
- Electrolyte disturbance (including hypokalaemia alkalosis, which is indicative of purging via vomiting or laxatives regardless of patient self-report)
- Halitosis, due to dehydration and ketosis
- Body-image disturbances
- Severe body-dissatisfaction and drive for thinness
- Preoccupation with food, weight and shape
- Restricted dietary intake
- Self-induced vomiting
- Misuse of laxatives, diuretics or appetite suppressants
- Excessive exercise
- Amenorrhoea or failure to reach menarche in women, loss of sexual interest in men
- Binge-eating episodes, involving loss of control over eating and eating unusually large amounts of food.

Anorexia Nervosa patients are at 85% or less of their expected body weight for age (body mass index 17.5 in adults).

Bulimia Nervosa patients tend to be normal weight or slightly overweight and are characterised by cycles of uncontrolled bingeing followed by a compensatory behaviour such as purging, extreme dieting or exercise.

**Key symptoms of
eating disorders
may include**

Other symptoms include

- Acute medical presentations include:
 - Dehydration
 - Electrolyte imbalance
 - Hypothermia
 - Syncope
 - Cardiac arrhythmias (Bradycardia)
 - Suicide attempts
 - Overwhelming infection, renal failure
 - Bone marrow suppression, GIT dysfunction
 - Acute massive gastric dilatation from bingeing.
- Co-morbid psychiatric illnesses are seen in up to 80% of patients with an eating disorder including:
 - Major Depressive Disorder
 - Anxiety Disorders
 - Obsessive Compulsive Disorder
 - Substance abuse/dependence
 - Self-harm and suicidal ideation.

What is the context?

- Why has the patient come?
- Has there been some precipitating event?
- Has their physical or mental status changed?
- Is the patient presenting of their own accord, or on family or health professional advice?
- Is there a treating clinician involved in caring for the patient?

Suggested questions

The SCOFF Questionnaire:

1. Do you ever make yourself sick because you feel uncomfortably full?
2. Do you worry you have lost control over how much you eat?
3. Have you recently lost more than 6kg in a three-month period?
4. Do you believe yourself to be fat when others say you are too thin?
5. Would you say that food dominates your life?

(From: Morgan JF, Reid, F, Lacey JH. (1999), The SCOFF Questionnaire: assessment of a new screening tool for eating disorders) British Medical Journal, 319, 1467-1468)

One or two positive answers should raise your index of suspicion and indicate that consultation with mental health is needed.

Some patients will deny these symptoms so it is important to also keep weight and physical markers under review if an eating disorder is suspected.

To help ascertain an accurate clinical picture, interview parents in the case of children and adolescents. Also consider interviewing family members of adults, with prior consent from the patient.

What is the physical state of the patient?

A thorough physical examination is mandatory. Consider also an ECG, urinalysis to assess hydration and look for ketones, and a complete blood picture including electrolytes and renal function, liver function, full blood count, thyroid function (T3, T4, TSH), calcium, magnesium, phosphate, amylase, ESR, Luteinising Hormone, Follicle Stimulating Hormone and Oestradiol.

If patients exhibit any one of the following, physician consultation and admission to hospital is indicated:

- Temperature $<35.5^{\circ}\text{C}$
- Blood pressure $<90/60\text{mmHg}$ in adults or $<80/40\text{mmHg}$ in adolescents
- Postural drop $\geq 20\text{mmHg}$
- Tachycardia
- Bradycardia (heart rate <40 in adults and <50 in adolescents)
- BMI $<14\text{kg/m}^2$ or $<15\text{kg/m}^2$ with coexisting medical conditions (e.g. diabetes or pregnancy)
- Rapid weight loss ($\geq 1\text{kg}$ per week over five or more weeks)
- Dehydration
- Urinary Ketones
- Significant electrolyte disturbance such as low serum phosphate or low serum potassium
- Cardiac arrhythmia including prolonged QT interval on ECG.

(For more detailed management information, go to the Centre for Eating and Dieting Disorders website: <http://cedd.org.au/health-professionals/resources-clinical-guidance/guidelines> and view 'Inpatient Management of Adults' and 'MH-Kids Eating Disorders Toolkit'.)

What is the mental state of the patient?

Screen for suicidal thinking. Eating disorders are associated with one of the highest suicide rates.

Treatment under the *Mental Health Act* and compulsory admission are often required where a fragile medical state or severe emaciation is associated with denial or a delusional belief that nothing serious is wrong. Duty of care may also be exercised if the patient refuses appropriate treatment. (See Chapter 6 regarding consent issues for children and adolescents.)

What to do?

- Screen for significant eating-disorder symptomatology
- Assess motivational status including acceptance of condition, willingness to comply with physical and mental health investigations
- Is there evidence of depression, anxiety, obsessional thinking and/or behaviour, substance abuse, or other psychiatric condition?
- Has the patient any suicidal thoughts or impulses? Are there active self-harm behaviours?
- The moment rehydration or re-feeding is commenced the patient is at risk of 're-feeding syndrome' (a rare, potentially fatal complication of re-feeding of severely malnourished patients. Re-feeding should be managed under close medical supervision.). Refer to Centre for Eating and Dieting Disorders resources detailed above.
- Patients should be assessed for medical complications of starvation or purging behaviours and referred for appropriate medical review.
- If patient is displaying significant eating-disorder symptoms or medical complications of their illness, contact the appropriate medical, mental health or paediatric staff to facilitate admission for weight restoration and management, treatment of co-morbid mental illness or referral to appropriate community-based eating disorders services where available, a mental health professional, General Practitioner and Dietician.

For consultation, contact the NSW Health Centre for Eating & Dieting Disorders on (02) 8587 0204 (Mon–Thurs, 9.00am–5.00pm) or <http://cedd.org.au/>

Key points

People may present to EDs with medical complications of their starvation, self-harm or suicidal ideation, co-morbid depression or anxiety that requires attention in addition to their eating-disorder symptoms.

**PHYSICAL
SYMPTOMS IN THE
ABSENCE OF
IDENTIFIABLE
PHYSICAL ILLNESS**

REMEMBER SACCIT

Patients may present with a broad range of physical complaints, for which no underlying cause can be found (e.g. headaches, fatigue, aches, neurological symptoms, GIT symptoms, sexual dysfunction). The symptoms are often vague or hard to pin down. These patients may be convinced that they have a serious underlying illness.

Possible causes include:

- Unrecognised psychiatric illness (e.g. weight loss secondary to depression)
 - Uncommon underlying unrecognised physical illness (e.g. Multiple Sclerosis, Systemic Lupus Erythematosus)
 - Underlying medical conditions exacerbated by psychological factors (e.g. inflammatory bowel disease, chronic fatigue)
 - Somatoform disorders (including somatisation disorder, hypochondriasis and conversion disorder)
 - Factitious disorders
 - Malingering.
- What is the context?**
- Why has the patient come at this time? Are there new symptoms?
 - Is the patient preoccupied with their symptoms?
 - Has the patient had a thorough medical work up? Take a thorough medical history, including review of medical records, investigations and specialist consultations.
 - Are there any medical illnesses?
 - Contact current primary clinician and seek corroborative history.
- What is the mental/physical state of the patient?**
- Is there evidence of depression, psychosis or anxiety?
 - Has the patient any suicidal thoughts/acts?

What to do?

For patients presenting for the first time:

- Conduct a thorough physical examination (required)
- Acknowledge the person's distress
- Rule out (within reason) physical illness
- Provide consistent reassurance
- Contact the person's GP
- Promote a relationship with their own GP and dissuade them from seeking multiple unrelated opinions.

A mental health review in ED is indicated if:

- Underlying major depression, panic disorder or other mental illness is suspected
- The person threatens suicide
- The person is acutely distressed and unable to settle.

For people who present on multiple occasions

- A brief review of the relevant system is appropriate, e.g. if the person is complaining of chest pain, review cardiovascular system, etc.
- Examine any new symptoms
- Reassure that there is no life-threatening illness
- Acknowledge that they have ongoing symptoms that may not be 'cured' and that this is a difficult predicament
- An integrated management strategy involving all the medical and mental health stakeholders is required to develop a coordinated and practical management plan
- Mental health consultation is suggested if an escalating pattern of presentations or other evidence suggests a breakdown in the patient's wider system of medical care.

Key Points

- Physical symptoms initially need to be treated at face value and assessed calmly and appropriately
- Respect the reality and distress of the symptom for the person, whether or not there is a physical disease explanation
- Consider the possibility of major depression, anxiety or panic disorders and major life stressors
- Rather than say 'there is nothing wrong' or 'it is all in your head', talk about excluding 'serious' or 'major' physical causes
- Always contact their GP/case manager. Effective management requires the GP to be the primary provider/coordinator of care.

Key risks

- Missing a physical illness – especially if new symptoms
- Reinforcing person's behaviour
- Iatrogenic complications.

Communication with the person's GP or case manager is essential in every case.

REPEATED MENTAL HEALTH PRESENTATIONS

REMEMBER SACCIT

All presentations to the ED need to be accorded the same standards of care, irrespective of the frequency of the presentations.

Repeated presentations of patients with mental health problems may be associated with one or more of the following:

- Social adversity – e.g. homelessness, financial difficulties, legal problems
- Relationship problems
- Loneliness
- Lack of community supports
- Non-compliance
- Treatment-resistant illness
- Drug and alcohol abuse
- Failure to be linked with Mental Health or Drug and Alcohol Services.

What is the mental/physical state of the patient?

- What is the patient requesting?
- Is there any suicidal ideation? (Is this new?)
- Is the patient orientated?
- Is the patient intoxicated?

Common diagnoses include:

- Chronic psychosis
- Personality disorder
- Repeated deliberate self-harm
- Substance abuse/dependence.

What is the context?

- What problems confront the patient and how have they resulted in this presentation?
- What explanation does the patient have?
- What patient-need appears to be met by presenting to the ED?

What to do?

- **Always** contact other health professionals involved in caring for the patient
- The Social Worker may be able to assist with accommodation / financial difficulties
- A structured and agreed management plan, supported by all involved health professionals, is essential. The plan should emphasise:
 - Consistent treatment by the same primary clinician, with regular scheduled visits and communication among all care providers
 - Anticipation of crises: what should the patient do if they feel distressed?

CO-OPERATION AND COMMUNICATION BETWEEN ED, MENTAL HEALTH SERVICES AND DRUG AND ALCOHOL SERVICES ARE THE KEYS TO IMPROVED MANAGEMENT. COLLABORATION WITH OTHER SERVICE PROVIDERS MAY ALSO ASSIST.

REMEMBER SACCIT

Patients with drug-seeking behaviour do not necessarily have a mental health problem.

Occasionally people appear to feign pain or other symptoms with the intention of gaining medication. However, some people with chronic pain may not be prescribed appropriate and/or adequate analgesia. It is important to differentiate between the two.

**What is the mental/
physical state of the
patient?**

Clues to identify this type of presentation include:

- Insisting on a specific medication and refusing alternatives
- Vague or evasive history
- Atypical pain, non-anatomical distribution
- Evidence of opioid withdrawal (e.g. dilated pupils, lacrimation, nausea, sweating)
- History of "doctor shopping"
- History of substance abuse
- Non-compliance with suggested treatment
- Intoxication
- Lack of accompanying signs (e.g. no haematuria in renal colic).

The above clues are meant to assist in clarifying the underlying problem. They are not clear evidence of drug-seeking behaviour.

What to do?

- Always take a thorough history and perform an appropriate physical examination to exclude urgent medical conditions
- Clarify the nature of the pain – location, intensity, duration, temporal pattern
- Check the old notes, and if possible contact the patient's primary carer, clinician, GP or other EDs visited by the patient
- Consult with drug and alcohol services if substance abuse is suspected
- The denial of adequate analgesia to a narcotic-dependent person where there is a clear need for pain relief is inappropriate
- Clinicians commonly under-treat pain because they underestimate severity, or fear causing side effects, creating dependency or breaking regulatory guidelines
- The relative risk of providing a person with unnecessary analgesia needs to be balanced against the risk of inadequately treating severe pain
- People with a narcotic dependence will have a greater tolerance to opiate analgesics. Urgent consultation with a pain-management team should be sought to ensure adequate dosage if analgesia is required
- Be wary of discharging the patient with more analgesia than is necessary to maintain them until they see their GP.

REMEMBER SACCIT

Chronic pain is a difficult and often distressing condition to manage. Consistent treatment by a multidisciplinary team is usually needed to provide optimal management.

Key points

Chronic pain is a risk factor for suicide. People with chronic pain also have a high incidence of anxiety disorders and depression.

- Clarify the history of the person's complaint
- Who is managing their pain other than themselves?
- Is there a treatment plan?
- Is there a precipitant for the current episode?
- Is anxiety, depression or suicidal ideation, substance abuse present?

If a person with chronic pain frequently presents to the ED, liaise with their treating team and develop a management plan for ED presentations.

SPECIAL POPULATIONS

REMEMBER SACCIT

Many of the mental health problems and symptoms seen in adults can occur in children and adolescents. However, there are a number of important differences to keep in mind.

- Co-morbidity of physical and mental health problems is very common, especially with neurological disorders
- Delirium is common and its onset can be rapid
- Depression and anxiety are common, and may present with somatic symptoms
- May report less overt psychiatric symptomatology. However, behavioural change and decline in functioning are common symptoms associated with a range of psychiatric disorders
- Substance-use disorders are increasingly common
- Anger in adolescence is often a cover for guilt, shame, hurt, fear or vulnerability.
- **Assessment should be conducted in consultation with specialist paediatric and/or child and adolescent mental health staff whenever possible.**
- **Wherever possible parents/carers/guardians, need to be involved in the assessment and development of a care plan**
- Children and adolescents should be seen alone for part of the assessment, as they may be reluctant to divulge sensitive information in front of their caregivers or parents. Confidentiality should always be explained to a young person and the grounds on which other agencies may need to be informed, e.g. risk of harm to self or others
- Behavioural change is a common presentation. Always assess precipitants including physical conditions and stressors, such as family illness, parental discord, bereavement, separations or abuse. Children who have been abused may display a variety of emotional and behavioural symptoms including depression, anxiety, self-harm, and behaviours such as overactivity, inattention and aggression
- Psychotic-like symptoms in children may also reflect traumatic experiences. Assessment of children and adolescents often takes more time (for both ED and mental health staff) than other assessments and this needs to be respected
- For adolescents, peer relationships are often of a greater significance than family relationships and disruptions to these may have a marked impact on an adolescent's emotional wellbeing
- When assessing a child or young person, consider the social, educational, family and peer context for the patient
- Abuse is not usually the presenting problem. Instead, children often present with complaints that are sequelae of abuse and neglect. While most of these are psychological (anxiety, depression) or behavioural (e.g. aggression, self-harm, overactivity), some are physical (somatic).
- A comprehensive assessment needs to integrate information from multiple informants (e.g. family, GP, teachers). This is usually not feasible in an ED, so a definitive diagnosis is often deferred. Best attempts should be made to obtain a corroborative history.

A physical assessment is essential in every case. Assessment of organic factors should always be considered in the context of the history.

Children

- Particular attention should be paid to how the child responds to the presence or absence of the parent. If the parent's presence exacerbates the child's distress the examination should be conducted without the parent present
- Depression may be indicated by somatic complaints, sad appearance, non-communicativeness, separation anxiety or irritability
- Emotional sequelae are common in children with chronic illness
- Psychosis is rare in children. If delusions or hallucinations are present, consider an organic disorder
- A risk assessment is required when the safety of the patient or others may be threatened by violence or risk-taking behaviour.

Adolescents

When caring for adolescents, a non-judgemental attitude towards their behaviour (e.g. self-harm or acting out) is critical in ensuring engagement and acceptance of follow-up care.

- Deliberate self-harm is not uncommon and it may be secretive, with patients harming less visible areas such as stomach or upper thighs
- Always consider the possibility of deliberate self-harm in any unusual 'accident'
- Separation/individuation is a normal developmental task, but may be associated with family conflict
- 'Adolescent turmoil' is **not** a normal developmental stage
- Depression may be associated with irritability rather than depressed mood
- Social withdrawal, declining school performance and combativeness are other symptoms
- Adolescents may present with early psychosis or prodromal symptoms (especially decline in functioning, irritability, odd behaviour)
- Homelessness, or rejection by family can be a crisis, but admission to hospital is rarely a solution (see **Child Protection**)
- A risk assessment is required when the safety of the patient or others may be threatened by violence or risk-taking behaviour
- Chronic suicidality is a feature of a small cohort of adolescents who frequently present to EDs.

What to do?

See **Chapter 5 Common Symptoms and Presentations** for presentations with specific symptoms.

- Reassuring and helping family/caregivers to contain their own anxiety can assist in the management of children. If it is felt that the presence of family/caregivers is increasing the young person's level of anxiety or agitation then separating them within the department may be beneficial
- An adolescent's emerging independence should be acknowledged with respect to making informed decisions about their care and treatment, mindful of legal requirements for parent/guardian consent
- Consider the possibility of child abuse, and report all child abuse to the Department of Family and Community Services (FACS) (Ph. 13 36 27)
- Have a low threshold for seeking mental health consultation
- Seek mental health consultation prior to prescribing psychotropic medications.

Consent for children and adolescents

Parental or other guardian consent for treatment is required for children under 14 years except for emergency circumstances that apply to treatment without consent for adults. After this age, children may seek treatment and give consent on their own behalf, provided they fully comprehend what is proposed. The decision to give consent can be made jointly with parents. Usually, unless the child objects, a parent or legal guardian is asked for consent where a child is 14 or 15 years old. In most cases a person aged 16 and over is capable of providing informed consent.

Key points

- Physical history, examination and investigation are essential
- Ensure corroborative history is obtained from other key people/agencies involved in the young person's care
- Look for anxiety and depression
- Children are particularly vulnerable to disruption in the family
- Adolescence may be accompanied by increasing family conflict, experimentation with substance use, and the onset of major mental illness such as bipolar disorder or schizophrenia
- Where a parent's behaviour is hostile or disruptive, it may be helpful for staff to acknowledge that a parent is worried about their child, but that their behaviour is interfering with assessment and treatment of their child
- Consider mental health problems, abuse or domestic violence in frequent presenters to the ED
- Be alert for possibility of abuse and/or neglect
- Somatic complaints are frequently reported by children and adolescents experiencing emotional distress
- Consult with child and adolescent mental health staff wherever possible
- Child abuse is not uncommon. It may be physical, sexual or emotional, or neglect. All health workers have a responsibility to protect the health, safety, welfare and wellbeing of children and young people with whom they have contact.

Child protection and reporting suspected child abuse

The legal and professional responsibilities of NSW Health workers are set out in *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_007.pdf).

- All staff should be familiar with local protocols. If it is unclear whether a report is required, consult with a senior clinician, management, or the Local Health District Child Wellbeing Unit and Child Protection Staff
- For support and assistance in determining the level or risk of harm, contact the NSW Health Child Wellbeing Unit (**Phone 1300 480 420 [8.30am – 5.30pm Monday to Friday]**) or use the Keep Them Safe NSW Online Mandatory Reporter Guide: <http://www.keepthemsafe.nsw.gov.au/>
- To report a child or young person suspected to be at **Risk of Significant Harm**, contact the Community Services Child Protection Helpline (**Phone 13 36 27 [24 hours/7 days]**).

What is the mental/ physical state of the patient?**Elder Abuse**

Many of the presentations noted in previous sections can occur in older patients. However, modifications of assessment procedures may need to be made and there are a number of important differences to keep in mind.

Tools such as the Mini-Mental State Examination (MMSE) or the Modified Mini-Mental Scale (3MS) are helpful in identifying cognitive impairment.

A sample of the NSW Health endorsed MMSE is at Appendix 12.

- It can be difficult to distinguish between **dementia** and **delirium** – a recent, abrupt increase in confusion suggests delirium
- **Aggression/challenging behaviours** – assume the patient has delirium, although depression and psychosis may also cause behavioural change
- In an **older patient**, first-onset anxiety problems or agitation are usually accompanied by depression, physical illness or cognitive changes
- The **agitated** patient may have major depression
- **Withdrawn behaviour** – may represent a hypoactive form of delirium, or indicate depression or cognitive impairment
- **Suicidal ideation** – elderly males have very high rates of suicide. Almost all elderly people who attempt suicide have an underlying major depression and should be referred to acute mental health services
- **Physical illness** and **functional impairment** are commonly associated with depression
- **Medication** (prescribed or over the counter) can cause a variety of psychiatric symptoms
- **Misinterpretations** of the environment can occur in older patients with visual / hearing deficits and this is NOT pathological
- **Mobility** and **gait** are important gross observations in older patients.

Elder abuse is any pattern of behaviour which causes physical, psychological or financial harm to an older person. Elder abuse may occur in the community, in residential care or in the hospital setting. It is an under-recognised problem.

Elder abuse is most likely to present with bruises, frequent falls, fearfulness, dehydration, or malnutrition.

Assessment should include the coping capacity of the carer. Review by a Social Worker may be indicated.

See: NSW ADHC Interagency Protocol for Responding to Abuse of Older People 2007 at http://www.adhc.nsw.gov.au/__data/assets/file/0011/228386/InteragencyProtocol1.pdf

Hearing impairment

- Minimise any distracting noise
- Take the patient to a quiet room
- Check that hearing aids are functioning
- Speak in the direction of the 'good' ear
- Speak clearly, but do not shout
- Ask simple, single questions
- Face the patient
- Repeat the questions using the same words.

Speech impairment

- The patient with dysphasia may be mistaken as being confused, psychotic, intoxicated, or as having dementia
- Helping the patient to finish a sentence may disturb the assessment
- Remember that comprehension or expression may be relatively impaired so use alternative modalities of communication if necessary (e.g. writing questions, using pictures or gestures).

Visual impairment

- Optimise lighting
- Stand in front when talking to the patient
- Ensure the patient is wearing their glasses and that the lenses are clean.

The confused older patient

- Introduce yourself and explain your actions
- Orient the patient to time and place
- Repeat the previous two steps at intervals
- Ensure lighting is good and stimulation low
- Ensure physical safety of the patient
- Ask relatives to be present
- Ask staff managing the patient to reassure them regularly.

What to do?

- The person should not be discharged without a clear diagnosis or plan. Ensure the person is returning to a safe environment. The discharge plan should be one that both the person and carer can comprehend and utilise. If in doubt, consult senior ED staff, Aged Care (ASET or ACAT), or SMHSOP staff
- Local aged-care services should be involved and the person linked with appropriate support services
- If there appears to be a mental health problem, or assistance is required in dealing with difficult behaviour, consult the mental health team.

Key points

- Where possible obtain a corroborative history from family or carer
- Where possible, liaise with patient's GP and fax discharge information to the person's GP
- Consult with mental health team regarding sedation or antipsychotic medication
- **Medication should be used cautiously in smaller than standard adult doses. Start low and go slow**
- Co-morbid physical illness is common
- Always consider the possibility of medication causing a delirium
- Delirium, dementia and depression are differential diagnoses and often coexist.

Disturbed behaviour and confusion in the elderly

Remember, an older confused patient is not brought to the ED unless:

- their carers think there has been a significant change in their behaviour or functioning, or
- their carers cannot cope without a change in the person, or
- the supports available to care for the person are inadequate for the person's needs.

This presentation:

- Is associated with high rates of active medical conditions and delirium, even if there is an existing diagnosis of dementia
- Requires careful medical assessment
- May require specialised consultation and assessment for co-morbid psychiatric illness if delirium appears excluded, or behavioural disturbance is escalating. EDs should have clear protocols regarding the roles of Aged Care and Mental Health Services in this situation as these vary across the State
- Is often associated with very different behaviours and level of disturbance in the ED to those where they live. The behaviours can increase or decrease in the ED
- May be exacerbated by overstimulating environments. Assessment in a quieter but observed part of the ED is recommended where possible. If a decision is made to admit, early transfer to an appropriate ward environment may assist management
- Always requires discussion with the people looking after the patient to clarify:
 - what has changed
 - when it has changed
 - details of any events raising safety concerns
 - their ability to resume care of the patient
- These discussions should be held **prior** to any plans being finalised to discharge the patient to ensure the proposed carers are willing/able to accept care with the proposed plan
- Discussions with carers must also be held for patients who live in **residential aged care facilities**. The level of trained staff available within these facilities varies significantly. A discharge plan **must** take this into account
- Any discharge plan should be clear, and specify the follow-up that is to occur outside of the ED, in hospital or by identified services outside of hospital.

The ACI's Cognition Screening for Older Adults incorporates the Abbreviated Mental Test scores; Delirium Risk Assessment Tool and Confusion Assessment Method may be used to aid assessments (Appendix 4).

The NSW Health handbook *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD) - a Handbook for NSW Health clinicians* <http://www.health.nsw.gov.au/mhdao/programs/mh/Pages/assessment-mgmt-people-bpsd.aspx> provides a comprehensive guide for clinicians to manage older persons with mild to moderate confusion and agitation.

Intellectual disability and mental illness

Refer to NSW Health policy PD2011_001 *Provision of Services to People with an Intellectual Disability and a Mental Illness: ADHC/Health Memorandum of Understanding* http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_001.pdf

The MOU is a joint agreement outlining collaborative service provision by NSW Health and Ageing, Disability & Home Care, and Department of Human Services NSW. It is aimed at improving access to mental health and disability services for people with an intellectual disability and a mental illness in NSW, and at ensuring that no person from this population group experiences discrimination in accessing services.

Aboriginal and Torres Strait Islander people

Aboriginal people may experience poorer physical and emotional wellbeing compared to the wider community. Issues of grief, loss, dislocation and despair in communities are based on historical treatment and current poor health outcomes. Consider contacting Aboriginal health workers or an Aboriginal Medical Service where available, for advice and/or assistance when a mental health consumer from an Aboriginal background presents to the ED.

People from a Culturally and Linguistically Diverse background

Mental health presentations often include a range of complexities and sensitivities that can be exacerbated by the prevalence of additional cultural, language and mental health literacy barriers. People from culturally and linguistically diverse backgrounds may have limited understanding, comprehension and command of the English language.

In these situations the NSW Health Care Interpreter Service should be used. For standard procedures in working with health care interpreters refer to NSW Health policy directive: PD2006_053. Should the NSW Health Care Interpreter Service not be able to assist in the immediate provision of a language resource, the Translating & Interpreting Service (13 14 50 – 24 hours) may be called upon for assistance.

The Transcultural Mental Health Centre's Information and Clinical Consultation and Assessment Service provides:

- Information and consultation about mental health and cultural issues.
- Information about Government and non-government health and welfare services for people of CALD backgrounds
- Clinical intervention using bilingual clinicians.

The service can be contacted on (02) 9912 3851 or 1800 648 911, Monday to Friday between 8:30am and 5:00pm, or visit <http://www.dhi.health.nsw.gov.au/Transcultural-Mental-Health-Centre/Transcultural-Mental-Health-Centre-Home/default.aspx>

ONGOING CARE AND MANAGEMENT OF THE PATIENT IN THE ED

REMEMBER SACCIT

While the patient remains in the ED, it is important that appropriate care is given to all the patient's needs. This may include:

- Ensuring safety, supervision/observation of patient, minimising absconding risk
- Monitoring vital signs
- Management of physical problems, fluids, medication
- Attention to non-medical needs, e.g. food, rest (being allowed to lie down on a bed)
- Privacy (as long as safety is not compromised)
- Managing nicotine dependence. See below and refer to *Guide for the Management of Nicotine Dependent Inpatients*: http://www0.health.nsw.gov.au/policies/GL/2005/GL2005_036.html

Safety

When the patient is brought into the ED, consider the safety needs of the patient.

- Will the patient be safe in this area?
- Are there unsecured exit/entry points nearby?
- What equipment could the patient use to hurt themselves or others? EDs are full of potential hazards such as scalpel blades, scissors, needles, medications, IV and oxygen tubing. ED staff should conduct safety walks to ensure that dangerous items and equipment are secured where possible.

The primary strategy of reducing absconding relates to **careful supervision** and **observation** of the patient. If the patient does not need constant or special observation, they will still need to be sighted regularly. If the patient is unaccompanied, it would be advisable not to allow them to draw the curtains around their bed area if this prevents them being directly observed.

The key strategies to prevent absconding and to ensure the safety of the patient are timely assessment, appropriate location, appropriate observation, appropriate medication, elimination of delay to definitive care and admission if required.

See definition of observation levels in Chapter 3 under the Mental Health Triage Scale.

Supervision/ observation of the patient

a) 1 to 1 Observation – One staff member is allocated to be with the patient at all times

- This category of observation is reserved for patients where there is imminent risk of **suicide or self-harm** where less frequent observation is considered inadequate
- The patient must be cared for on a 1 to 1 basis close to the nurses' station. **Constant visual contact should be maintained at all times.** The staff member is to be **within close physical proximity at all times, including when bathing and toileting**
- **The staff member providing 1 to 1 observation is not responsible for the care of other patients as well**
- **The staff member must hand over care of the patient to another staff member before leaving the patient for any reason**
- Patients exhibiting severe, violent or aggressive behaviours towards others may also be cared for on a 1 to 1 basis. In this situation, the staff member needs to be instructed to provide constant visual contact at a safer distance but close enough to intervene if necessary
- If the staff member allocated to provide the 1 to 1 observation is not a nurse, then an ED nurse must be allocated to provide for the nursing care of the patient.

b) Close, routine or intermittent observations

Role of the staff member allocated to close, intermittent or routine observations

- The staff member allocated to provide any of these observations is responsible for visually sighting the patient and ensuring that they are safe at the specified frequency of that observation level
- The staff member must hand over the observation of the patient on Close, Routine or Intermittent observations to another staff member before going on meal breaks or leaving the ED.

A description of the role of the staff member providing 1 to 1 observation is included in Appendix 8.

Monitoring of vital signs

All patients presenting to the ED with a mental health problem must have an initial set of vital signs taken and recorded. If there are abnormal signs then these must be investigated. The need for ongoing monitoring of vital signs will depend on the results of the patient's physical assessment and their initial vital signs.

Corroborative history and investigations as required.

If Mental Health or other services have been asked to assess the patient in the ED, ensure the documentation in the patient's file is completed as well as any history obtained from other sources. This will assist the service and reduce the necessity for corroborative history being sought a second time.

Biopsychosocial

Management of specific physical needs

If the person has any current physical problems, these need to be appropriately treated and managed while the person is in the ED. This can include ensuring routine medications are charted and given, as well as PRN medications to ease any distress, and IV fluids, if needed.

Caring for and supporting the person while in the ED:

- Offering comforts such as food, a drink and a warm blanket can assist in settling the person
- If possible, contact a trusted relative, carer, or friend to be with the person to comfort, support and assist with explanations
- Ensure the person and their relatives are kept informed as to what is happening, especially if there are delays in discharge or transfer
- Consideration to be given to the person's caring responsibilities, e.g. children or pets, in the event there are delays in their transfer. Ask where the children are and who is providing care. FACS may need to be notified.

Managing nicotine dependence

- Cigarette smoking is a serious health matter that raises particularly difficult issues for EDs
- Across the spectrum of serious mental illnesses, the prevalence of smoking is 2–3 times that of the general population
- NSW Health is committed to a smoke-free health service
- Nevertheless, nicotine dependence has serious implications for a person's ability to cope with stressful situations. It has the potential to escalate situations to the brink of violent confrontation and beyond.

Points to consider when dealing with patients who are nicotine dependent:

- Smoking cigarettes decreases the plasma levels of many medications and can offset the sedative effects of others (such as benzodiazepines and antipsychotics)
- Nicotine withdrawal can cause anxiety, insomnia, difficulty concentrating, irritability and headaches.

Assessment

Confirmation of provisional diagnosis Consultation

Immediate Treatment

Management approaches should be:

- Early identification of patients who are nicotine dependent, preferably at triage.
- Simple explanation of the facility's smoke-free policy
- Offering nicotine-replacement therapy in a non-judgemental manner, explaining it as a way of managing their desire to smoke while in the ED
- Diversion.

Facilities should have policies relating to the management of nicotine-dependent patients. Some patients who are heavy smokers may require more than one method of nicotine-replacement therapy.

Adequate management of nicotine dependence has been shown to reduce aggressive incidents and the risk of absconding.

It can sometimes be helpful if staff approach the person with the focus on treating the withdrawal from nicotine rather than the longer-term goal of cessation. Many people view smoking as one of very few activities they feel they can enjoy and will be less receptive to interventions that seem to threaten this. The ultimate goal of health professionals should be that people will cease smoking but this approach should only be considered once the current emergency has abated.

For more information refer to the *Guide for the management of nicotine dependent inpatients*, NSW Health GL2005_036.

Transfer of Care

Ensure arrangements for transfer of care are finalised. If there seems to be any delays, follow-up phone calls may be needed to ascertain the reason for the delay. Arrange for the patient's ED notes and any other relevant documentation to be copied so they can be sent to the clinician/service providing follow-up care. It is important that any medications administered to the patient in the ED, including medications administered to treat their mental health problem or to manage any behavioural disturbance, are documented in the record being sent to an inpatient mental health facility.

TRANSFER OF CARE: DISCHARGE TO THE COMMUNITY

REMEMBER SACCIT

Also refer to:

PD2011_015 *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_015.pdf

PD2014_025 *Departure of Emergency Department Patients* http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_025.pdf

Aim

The main aim of discharge planning is to ensure a safe and successful transition for the patient from the ED setting to the community.

Given the crisis nature of mental health presentations to EDs, effective follow-up is essential for the majority of patients discharged from the initial emergency care setting.

The primary follow-up clinician will generally be the patient's GP and/or mental health clinician/service.

Families and carers provide valuable support and may be able to provide a level of care which enables a person to return home earlier. However, to ensure the safety of the person and their carers and/or family, it is important that a carer's ability to provide care, relative to the current situation, is adequately addressed.

Who can be discharged from the ED to the community?

Generally patients with:

- Low risk (harm to self or others)
- Anxiety spectrum disorders (with no suicidal ideation)
- Non-melancholic depression
- Chronic mental illness not requiring acute inpatient-care, provided there is adequate support and that follow-up arrangements have been made.

Who cannot be discharged from the ED to the community?

Generally patients who are:

- Suicidal without adequate supports, or without a safety plan or carer input
- Dangerous to others (in the context of mental illness/disorder); with impaired judgement
- Intoxicated or delirious and at risk of harm to themselves or others, including not being able to walk unaided or to care for themselves
- Medically unstable (including delirium)
- Unable to manage self-care without adequate support.

A person should not be discharged from the ED to the community without a comprehensive mental health assessment including a risk assessment and a clear management plan.

Pre-discharge considerations

The decision to discharge needs to be informed by consideration of:

- Person's functional status to care for self, e.g. meals, medication, not at risk of accidental harm
- Person's risk of harm to self or others – the first days after discharge can be a high-risk time
- The availability and reliability of the person's required range of supports, including adequate accommodation and assistance to care for children and significant others
- Has the person been provided with appropriate strategies to manage any risks?
- The likelihood of future events occurring that will improve or worsen matters (e.g. the arrival of supports versus further rejection)

- The person's insight and judgement, and their ability to plan and adhere to an agreed course of action including taking medication and contacting services if the situation worsens
- Consultation with the Mental Health Service, including completing a risk assessment
- What follow-up has been arranged?
- Does the carer understand the person's current condition, including the level of support the person requires and any associated risks?
- Does the carer require additional support to assist them in their caring role?

It is also important to be aware of any caring responsibilities the person may have and to assess whether they are still able to perform these duties upon discharge from hospital.

The Carer Information and Support Line ((02) 9332 0700 or 1800 655 198) is available to provide support and advice to carers as well as information on carer programs and support groups.

Key discharge activities

Arrangements need to be put in place to ensure:

- The person is aware of the follow-up management plan, and given specific information and prompts (e.g. appointment cards)
- The person and carer is aware of what to do specifically if the situation deteriorates following discharge, including:
 - a simple escalation plan for contacting family/friends, emergency/crisis services, GP, including relevant crisis contact numbers
 - early warning signs and action plan for them
- The follow-up clinician is notified promptly and supplied with the key clinical information regarding the patient's presentation, treatment, and discharge arrangements.

A discharge fax or phone call should always be made to the person's GP and the mental health clinician/service responsible for follow-up. Where possible communication with the follow-up clinician/service should be made before the person is discharged. A phone call is usually sufficient while the person is still in the ED but, at a minimum, a summary of the ED assessment, treatment and discharge plan should be faxed to the GP and any involved mental health clinician/service.

The person must be given a Transfer of Care Summary that includes medication information, community and GP-referral information and follow-up appointments. This should be provided in plain language and explained to the person. People, at discharge, should be given the contact card for the 1800 011 511 NSW Mental Health Line.

Special Issue:
Notification to Police

Police are to be notified of the discharge of a person if the person:

- Presented under Section 22 (s22) (*Mental Health Act 2007*) and Police have asked to be notified
- Presented under Section 33 (s33) of the *Mental Health (Forensic Provisions) Act 1990*, and the person is to be brought back before the Court
- Discharges themselves or absconds and the clinician is concerned that the person is at risk of harm to themselves or others
- Discharges themselves or absconds and the clinician is concerned that the person has access to a firearm and is at risk of harm to themselves or others. (Complete the Firearms Notification Form – see Appendix 9.)
- If Police specifically request to be notified
- A clinician may decide to notify Police in circumstances where a patient expresses the intention to harm others, regardless of whether the patient is deemed to be mentally ill following assessment and the clinician believes the patient poses an imminent risk to others. Consult with a senior clinician regarding your duty of care to warn the other person
- Comprehensively document all your actions.

ACUTE
DYSTONIAS

Urgent medical intervention is required for these conditions. Consult senior ED staff.

Commonly occur secondary to antipsychotic or anti-emetic medication. May develop after a single dose or after longer exposures and often affect the face, neck, trunk or hands. Less common with atypical antipsychotics.

Types of dystonia include:

- Protruding tongue with difficulty swallowing
- Oculogyric crisis (eyes rolled upwards or laterally)
- Torticollis (head forced to one side)
- Retrocollis (head forced backward)
- Opisthotonos (hyperextension of back)
- Laryngospasm (can cause death. Patient may complain of suffocation or be unable to speak. Listen for stridor.)
- Dysphagia (difficulty swallowing).

Intervention

This is a serious medical condition. Consult a senior ED colleague. Dystonia can be extremely distressing to the patient, but usually responds quickly to anticholinergic medication (e.g. benztropine 1–2 mg IV or IM).

As the dystonia may recur, oral anticholinergics (e.g. benztropine 1–2 mg b.d., p.o.) may then be commenced. Reassure the patient that the dystonia can be controlled by anticholinergic medication. Consider reducing or avoiding exposure to the causative agent, at least in the short-term. Document reaction in patient’s medical file so the medication can be avoided in future.

AKATHISIA

Severe sense of internal restlessness, most commonly in the legs, usually associated with psychotropic medication. Akathisia may be very distressing and is characterised by fidgeting, pacing, or inability to stay still. Patients often report that this is accompanied by distress and mental agitation that could be interpreted as a sign of worsening of psychotic symptoms. This can lead to the patient being prescribed extra antipsychotic medication, which would probably worsen the symptoms.

Akathisia is more often associated with first-generation antipsychotics, but can be found in patients taking second-generation antipsychotics.

Careful observation and direct questioning about akathisia are often required to identify the problem (e.g. *‘Do you have a feeling of restlessness in any part of your body or do you feel you have to keep moving?’*).

Intervention

Benzodiazepines may provide symptomatic relief in the short-term. All such cases should be referred to mental health services for advice about immediate treatment and medication management.

SEROTONIN SYNDROME/ TOXICITY

Symptoms include restlessness, agitation, abdominal cramps, diarrhoea, myoclonus, ankle clonus, hyperreflexia, confusion, diaphoresis, flushing, tremor, progressing to hyperthermia, hypertonicity, renal failure, coma and death.

Thought to be caused by excess stimulation of the serotonergic system by a variety of medications and recreational drugs, including antidepressants, such as SSRIs, SNRIs, TCAs, MAOIs, Tramadol, and Amphetamines (use of St John's Wort has also been implicated in some cases). Often observed in the context of switching between antidepressants, increasing dose, or combination of therapies including stimulant recreational drugs and over-the-counter medications.

Intervention

This is a serious medical condition. Consult a senior ED colleague. The Poisons Information Centre phone 13 11 26 is available for consultation.

LITHIUM TOXICITY

Symptoms include diarrhoea, vomiting, tremor, dysarthria, ataxia, twitching, seizures, hypotension, confusion, ECG changes, arrhythmias, permanent brain damage, renal failure. The therapeutic serum range is generally considered to be 0.4–1.0 mmol/L but note, toxicity can occur at therapeutic levels in the elderly.

Can be precipitated by dehydration (e.g. excessive sweating on a hot day, vomiting or diarrhoea), or interactions with other medications (especially diuretics, ACE inhibitors and NSAIDs).

Intervention

This is a serious medical condition. Consult a senior ED colleague. The Poisons Information Centre phone 13 11 26 is available for consultation.

NEUROLEPTIC MALIGNANT SYNDROME (NMS)

Symptoms include hyperthermia, muscle rigidity, autonomic dysfunction and altered consciousness, associated with antipsychotic medication or reduction/cessation of dopamine agonist medication. Signs are variable and may include tachycardia, tachypnoea, diaphoresis, labile BP, sialorrhoea, nausea, or dysphagia. Sometimes the patient will not feel unwell. Not all symptoms may be present, and a high degree of suspicion should be maintained for NMS.

Thought to be associated with dopamine blockade or reduction in dopamine agonist. Onset hours to days. Higher incidence in: young men, high-dose antipsychotics, recent commencement or increased dose of antipsychotics.

Typically, white cell count, creatinine phosphokinase (CPK) and LFTs are raised (although not in every case, and clinical manifestations can be variable). If diagnosis is unclear, admission for observation and serial monitoring may be required.

Intervention

This is a serious medical condition. Consult a senior ED colleague. The Poisons Information Centre phone 13 11 26 is available for consultation.

AGITATION SECONDARY TO ANTIDEPRESSANTS AGRANULOCYTOSIS

SSRIs in particular can cause agitation especially after commencing treatment. This may complicate assessment.

Is particularly associated with clozapine (around 0.8% of the patients treated) and carbamazepine but can also occur as an adverse effect of first-generation antipsychotics. The condition is potentially fatal.

Intervention

Agranulocytosis should be considered in any patient taking antipsychotics or carbamazepine and presenting with fever and malaise or other signs of infection.

Medical consultation should be sought for patients with low or falling white blood cell (WBC) counts.

CARDIOMYOPATHY/ MYOCARDITIS

Cases of myocarditis, some of which have been fatal, and cardiomyopathy have been reported in patients on clozapine. Both pharmaceutical companies who supply clozapine provide 24-hour advice on the following numbers:

Clozaril Protocol Monitoring Service 1800 501 768

Clopine Connect 1800 656 403 or <http://www.clopine.com.au/>

HYPONATRAEMIA

A number of psychotropic medications can cause hyponatraemia. There is a particularly increased risk for some medications, e.g. SSRIs and venlafaxine; and for older patients or those taking other medications affecting sodium (e.g. diuretics). Whilst mild hyponatraemia is generally asymptomatic, the risk of significant effects increases with severity. These can include delirium, gait disturbance. Impaired consciousness and seizures can occur in severe cases.

Intervention

The need for intervention is dependent upon the severity of the symptoms and extent of hyponatraemia. Untreated hyponatraemia, over-aggressive treatment, and inadequately supervised changes of psychiatric treatment can all have severe consequences. Consult with a senior ED colleague and the mental health team.

SEVERE FUNCTIONAL DECLINE ASSOCIATED WITH PSYCHOTROPIC MEDICATION

The older patient is especially vulnerable to a severe functional decline as a result of psychotropic medication. Common problems that can severely impair function and safety are sedation, falls or gait instability, and cognitive impairment. Less common, but significant, problems include incontinence, urinary retention and severe extrapyramidal side effects.

Intervention

Medication side effects are a major cause of avoidable severe injury.

If functional decline in an older patient has occurred in the context of psychotropic medication, consult a senior ED clinician.

HYPERTENSIVE CRISIS SECONDARY TO MONOAMINE OXIDASE INHIBITORS (MAOIS)

Hypertension and associated symptoms may include severe headache, neck stiffness, diaphoresis, flushing and nausea. This can lead to intracerebral haemorrhage. Usually precipitated by the intake of tyramine (beer, wine, cheese, vegemite) or sympathomimetics.

Intervention

This is a serious medical condition. Consult a senior ED colleague. The Poisons Information Centre phone 13 11 26 is available for consultation.

MANAGEMENT OF PATIENTS UNDER THE *MENTAL HEALTH ACT 2007 (NSW)* AND *MENTAL HEALTH (FORENSIC PROVISIONS) ACT 1990 (NSW)*

(Note: *The Mental Health Act* is currently under review and this Chapter may be subject to amendment.)

A person may be treated without consent or against their wishes under three conditions:

- In an **emergency** where treatment is needed as a matter of urgency to save the person's life or to prevent serious damage to the person's health, and it is not possible to obtain consent, then emergency treatment may be rendered.
- For **non-urgent** treatment on a person incapable of giving consent: substitute consent is required.
- For a **mentally ill** or **mentally disordered** person who requires treatment of their mental condition: the provisions of the *Mental Health Act 2007* (NSW) must be adhered to. In the emergency setting, the application of the Act is with respect to the treatment of a mental illness or disorder only, and **cannot** be used to impose medical or surgical treatments.

Mental Health Act 2007 (NSW) (the Act) and forms can be accessed on: <http://www.health.nsw.gov.au/mhdao/Pages/legislation.aspx>

Mentally Ill Persons

Section 14(1) of the Act defines a **mentally ill** person as one who suffers from a mental illness that has resulted in reasonable grounds for believing that care, treatment or control is necessary to protect the person or others from **serious harm**. The definition of harm is much broader than physical harm, and includes neglect of self and others, harm to reputation and relationships, or financial harm.

Section 4 of the Act defines **mental illness** as a condition that seriously impairs mental functioning and is indicated by one or more of the following:

- delusions,
- hallucinations,
- serious disorder of thought form,
- a severe disturbance of mood,
- sustained or repeated irrational behaviour indicating the presence of any one or more of the preceding symptoms.

The most common, but not the only, illnesses for which patients are scheduled as **mentally ill** are psychosis, schizophrenia, schizoaffective disorder, depression and mania. Patients with dementia may be scheduled, but only if they fulfil the criteria under the *Mental Health Act*.

Mentally Disordered Persons

Section 15 of the Act defines a **mentally disordered person** as one whose behaviour for the time is so irrational that there are reasonable grounds for believing that temporary care, treatment, or control is necessary to protect the individual or others from **serious physical harm**.

This is assumed to be a **temporary** condition. Mental disorder is not specifically defined and can be quite broadly interpreted.

The most common conditions for which patients are scheduled as **mentally disordered** are deliberate self-harm, acute distress, or aggressive behaviour. The diagnoses commonly underlying these include adjustment disorder, personality disorder or substance abuse/intoxication.

Intoxication

Assessment and treatment in the ED under the *Mental Health Act 2007 (NSW)*

Intoxication alone is not sufficient to detain a person under the Act. The Act states that a person cannot be considered mentally ill or mentally disordered merely because 'the person takes or has taken alcohol or any other drugs'. However, if intoxication causes **irrational behaviour**:

- which results in a risk of **serious physical harm**, and
- temporary **treatment, care or control** is necessary,

the person may be **mentally disordered** within the meaning of the Act.

Some EDs are declared under the Act as a Mental Health Facility. These EDs are places to which people who have been detained under the Act can be taken and detained for initial assessment, immediate care and, where necessary, transfer to a mental health inpatient facility.

Assessment and initial treatment can be initiated involuntarily under the Act, for people presenting to the ED by means of:

1. A mental health certificate completed by a medical practitioner or accredited person (under section 19 of the Act – s19), referred to as a 'Schedule 1 'Medical Certificate as to Examination or Observation of Person'.
2. After being brought to the facility by an ambulance officer (under Section 20 (s20)),
3. After being apprehended by a police officer (under Section 22 (s22)),
4. After an order by a Magistrate for an examination and an examination or observation by a medical practitioner or accredited person (under Section 23 (s23)),
5. On order of a Magistrate or bail officer (under Section 24 (s24)) in accordance with Section 33 (s33) of the *Mental Health (Forensic Provisions) Act 1990*.

A person who is receiving care and treatment involuntarily under the Act must be given a **Statement of Rights** (Schedule 3 of the *Mental Health Act*), which sets out their rights and explains what may happen to them after they are brought to a mental health facility. The Statement of Rights is available at <http://www.health.nsw.gov.au/mhdao/Documents/Legislation/h10-41467-statement-of-rights.pdf>

A person who presents voluntarily to any ED and who is assessed by a medical officer or accredited person as requiring involuntary care under the *Mental Health Act*, can be initially detained in the ED by completion of a Schedule 1 under Section 19 of the Act (and then transferred to a Declared Mental Health Facility if they are not already in a DMHF).

Section 27 of the Act sets out the steps to be taken for the ongoing detention of the person in a Declared Mental Health Facility.

Refer to *Guidelines for the Nomination of Authorised Medical Officers under the Mental Health Act, GL2013_017*, which provides information about the role and responsibilities of an Authorised Medical Officer and Medical Superintendent appointed under the Act – http://www0.health.nsw.gov.au/policies/gl/2013/pdf/GL2013_017.pdf.

All patients presenting to the ED by any of the above means will receive:

- Medical and mental health triage (as per Chapter 3)
- Treatment of acute medical issues.
- Initial ED assessment, with a mental health focus (as per Chapter 4)
- Initial management in the ED supported by access to mental health staff for further advice, assessment, and management if available (in person, via phone, or telelink)
- A Statement of Rights
- Management of behavioural disturbance in a safe environment, consistent with the principle of least-restrictive environment allowing effective care and treatment (including sedation or restraint consistent with Chapter 12)
- Contact with the Guardianship Tribunal should the patient be behaviourally disturbed **and** incapable of giving informed consent **but** who does not satisfy the criteria of the *Mental Health Act 2007 (NSW)* for involuntary treatment
- Consideration by the medical officer of the need for involuntary admission and transfer to an inpatient mental health facility
- Discharge planning and arrangements made for transportation, admission, or post-discharge follow-up care.

There is no age criterion for involuntary admission under the Act. Consult with mental health services if involuntary admission is required.

Being detained under the Act does not automatically mean that the patient can be sedated. Treatment must have due regard to the possible effects of the sedation, and must be consistent with proper care, to ensure that the patient is not prevented from communicating adequately with other persons who may be engaged to represent the patient at a mental health inquiry. (Section 29 (s29)).

The clinical situation must warrant the use of involuntary sedation.

If a Magistrate is of the opinion that a person appearing before them is mentally ill (within the meaning of the *Mental Health Act*), the Magistrate may direct that the person be taken to a mental health facility (including an ED that is a Declared Mental Health Facility) for a psychiatric assessment under Section 33 (s33) of the ***Mental Health (Forensic Provisions) Act 1990 (NSW)***.

The Magistrate is not able to authorise involuntary treatment – only assessment. An Authorised Medical Officer at the hospital is obliged to perform a psychiatric assessment.

If the person meets the criteria for involuntary treatment, they may be detained in the ED under the Act, and arrangements made to transfer the person to a mental health inpatient facility.

If the person has a mental illness or mental disorder but **does not** meet the criteria for involuntary treatment, admission as a voluntary patient or referral to community mental health services or the person's general practitioner for follow-up care may be appropriate.

If the person is assessed as not mentally ill or mentally disordered under the Act, and there is no order for them to be brought back before a court, the ED should consult with the mental health staff regarding further management.

Section 32 (s32) of the *Mental Health (Forensic Provisions) Act 1990* is very similar to s33, except that it deals with people who the Magistrate believes to have a developmental disability or a mental illness or mental condition for which treatment is available in a hospital.

If the situation is unclear, the Justice Health and Forensic Mental Health Network may be able to offer advice (**Ph 13 77 88 24/7**). J&FMHN is responsible for providing health services to people in adult correctional centres, to those in courts and police cells, juvenile detainees, and those within the NSW forensic mental health system and in the community.

Police Assistance

Part 2 of Schedule 1 provides for the involvement of Police to assist in the detainment of the patient for the purposes of transport to or from a health facility and is limited to instances where there is a **serious public safety concern**.

If the patient has been brought to the ED by Police under Section 22 (s22) of the *Mental Health Act* and Police have requested to be notified before the person is discharged, the person can be detained awaiting Police attendance for a period not exceeding one hour (Section 32(4)).

Notification to Police

If the patient has been presented under a s33 and has been ordered to be brought back before a court, the medical officer must detain the patient pending the person's apprehension by a Police Officer (s32(5)).

MANAGEMENT OF PATIENTS WITHIN THE MEMORANDUM OF UNDERSTANDING (MOU) FOR MENTAL HEALTH 2007

(Note: The MOU is currently under review and this Chapter may be subject to amendment.)

The MOU (Mental Health) 2007 between NSW Health (Mental Health Services; Emergency Departments, NSW Ambulance Service) and the NSW Police Force sets out the roles of each agency in providing a coordinated response to managing the care and transport of a person experiencing a mental health problem.

All signatory agencies are committed to operate in accordance with the MOU and have a responsibility to ensure clear communication and sharing of relevant information.

The Memorandum of Understanding 2007 can be accessed at: http://www0.health.nsw.gov.au/pubs/2007/pdf/mou_mentalhealth.pdf

The general roles of agencies are:

- **mental health service** – provide specialist mental health triage, risk and mental health assessment, care, and behavioural management
- **emergency department** – provide triage, assessment, emergency care and stabilisation
- **ambulance service** – pre-hospital emergency care, safe transport and stabilisation
- **police** – public safety, assistance with high-risk transportation from the community to a health facility or custodial facility and assistance in the detainment of the patient for the purposes of transport between health facilities where there is a **serious public safety concern**.

The MOU includes a flowchart of the emergency mental health patient journey, and at each stage details the role of each agency (including the ED).

The stages in the flow chart relating to a person with a mental health problem presenting to the ED for the purpose of emergency assessment, is set out below. The preparation of the transfer of the patient is also set out below.

The role of the ED is shown under 'ED' in **Red**. The role of the mental health service (MHS) (**Green**), 'ASNSW' Ambulance (**Orange**) and Police (**Blue**) is also set out.

**Key issues for
Emergency
Department staff**

The responsibilities of ED staff as described in the flow chart include:

- Provision of a safe environment for the patient. It is the hospital management's responsibility to provide for any security issues relating to patients. Early consideration should be given to the need for hospital security presence. Police will remain in the ED if there is a **serious risk** to public safety
- Acceptance of responsibility for the patient brought in by Police and Ambulance, and releasing these staff as soon as practicable
- Notification to Police regarding absconding patients detained under the *Mental Health Act 2007 (NSW)* (the Act) where efforts of staff of the Health Service to locate and return the patient have failed and where there are serious concerns about the safety of the person and/or others, according to the process outlined in the MOU (Appendices F and G of the MOU apply)
- Notification to Police of patients who have been presented under Section 22 of the Act or Section 33 (s33) of the *Mental Health (Forensic Provisions) Act 1990 (NSW)* who have committed an offence but who will not be admitted but who will not be admitted or where Police have requested to be notified if the decision is made not to admit the person. Refer to Section 6.2 of the MOU for detailed guidance regarding Notification to Police
- Assess inter-hospital transport requirements according to risk assessment and optimum clinical care. If NSW Ambulance is required to complete the transport then the Inter-Hospital Transfer Form (Appendix E of the MOU) applies and the assessment of risk associated with the transport is to be made in consultation with attending Paramedics.

Local interagency issues and disputes are to be referred to the Local Protocol Committee (Mental Health) or the Local Health District Inter-Departmental Committee, or equivalent, which operates in all Local Health Districts.

Overarching Response Flow Chart – Transport, Assessment and Care

**RECEIVED AT
EMERGENCY DEPARTMENT**

**ROAD TRANSFER TO
MENTAL HEALTH
INPATIENT FACILITY**

HEALTH ROLE

ED

- ED triage & screening / physical assessment and initial care.
- Provide safe / private environment.
- Provide person with Statement of Rights.
- Contact MH Service to conduct MH assessment.
- Mobilise health security to allow Police to leave ASAP.
- Provide Police and Ambulance if waiting, with regular updates.
- Advise Police if s22 not to be admitted. At Police request, can detain person for 1 hour.
- If person under Mental Health Act absconds refer to Appendices F & G in the MOU.
- Commence Transfer of Care planning.
- Arrange transfer of care / transport in consultation with the MH Service and Ambulance if necessary.
- Notify receiving ED and/or mental health inpatient facility of transfer.
- Ensure care & treatment consistent with Chapter 4 Part 1 of the Mental Health Act..

MHS

- Assist ED with MH & D&A management & provide information.
- Conduct MH assessment on-site / remotely.
- Consultation re transfer of care arrangements.
- Liaise with ED and Ambulance to arrange transfer, if necessary.

- Assess transport options according to risk assessment and optimum clinical care (see Appendix D in the MOU).
- Discuss transport safety needs with Ambulance, Police and Mental Health Service.
- Mobilise health security if necessary, to allow Police to leave.
- Provide information to Ambulance Ops Centre (see Box 1 on IHT Appendix E in the MOU).

AMBULANCE ROLE

- Complete Patient Health Care Record.
- Complete s20 and leave form with ED clinician.
- Contact Ambulance Operations Centre if further transport likely.

- Discuss transport safety needs with ED clinician, Police and Mental Health Service.
- Provide transport (see Appendix D in the MOU).
- Provide clinical care.
- Notify receiving ED and mental health inpatient facility of ETA, risk, security needs.

POLICE ROLE

- Transfer from police vehicle promptly and as soon as practicable.
- Remain at ED until serious risk dissipates / health security in place & situation is able to be safely managed within the resources available to the ED.
- Complete s22 and leave form with ED clinician.

- Attend where there is a public safety risk and assist in the detainment and application of restraint for the purposes of sedation / transport.
- Discuss transport safety needs with ED clinician, Ambulance and Mental Health Service and provide escort where public safety risk.

MANAGEMENT OF ACUTE SEVERE BEHAVIOURAL DISTURBANCE

REMEMBER SACCIT

THIS CHAPTER IS TO BE READ IN CONJUNCTION WITH:

- **CHAPTER 5 AGGRESSIVE OR THREATENING VIOLENCE PRESENTATIONS**
- **PD2015_004 PRINCIPLES FOR SAFE MANAGEMENT OF DISTURBED AND /OR AGGRESSIVE BEHAVIOUR AND THE USE OF RESTRAINT**

Management of acute severe behavioural disturbance includes the following:

- Assessment in a safe environment
- De-escalation/distraction
- Legal issues
- Medication/sedation
- Physical restraint (manual and/or mechanical)
- Calling for Security or Police assistance

Often a combination of these means will be necessary.

(SEE CHAPTER 5 FOR INFORMATION ON CLINICAL ASSESSMENT)

ASSESSMENT IN A SAFE ENVIRONMENT

Physical threat of immediate injury to the person or others should be treated as an emergency requiring immediate intervention. People who have carried out an act of violence prior to hospital arrival should be considered very high risk even if they appear calm on initial presentation to the hospital.

- Confirm with Police that they have searched the patient for weapons or other potentially dangerous objects prior to Police handing over the person.
- If a patient has a weapon call Police/Security. Never attempt to disarm an armed person yourself.
- If Police are required to assist in restraint, they may need to remove their weapons for safety. An approved gun safe will be required. The removal of weapons is at the discretion of the individual police officer. (See GL2013_002 *Management of NSW Police Force Officers' Firearms in Public Health Facilities and Vehicles* http://www0.health.nsw.gov.au/policies/gl/2013/pdf/GL2013_002.pdf)
- Ensure that adequate back up is available in case the situation escalates (i.e. that other staff know where you are, can observe you and the person and know that they may need to intervene).
- Never approach an aggressive patient on your own.
- If possible, have a duress alarm at hand.
- Always maintain a safe distance when talking to an aggressive patient; this should be a minimum of two metres. Keeping at a safe distance may protect you from a sudden attack.
- The best environment is an open area with at least two exits that can also be observed by other staff.
- Ensure there are no potentially dangerous items in the vicinity such as IV Poles, needles or scissors.
- Alert Security (or Police or other staff depending on local arrangements) and, if possible, have them located nearby.
- Remove any items that could be used to grasp you, especially those that could be used to choke, such as ties, necklaces, stethoscopes or lanyards. Remove hoop-style earrings as they could injure you if grabbed by the person.

DE-ESCALATION/ DISTRACTION

Interviewing strategies

- Remove any items that could be used as weapons such as pens or mobile phones.
- Remain near an exit, but avoid placing yourself between the patient and the exit (often, angry people will wish to leave rather than attack).
- Never turn your back on a potentially violent patient until well clear.
- The possibility of hidden weapons should always be considered.
- Approach in a calm, confident manner and avoid sudden or violent gestures.
- Have a non-aggressive stance with arms by your side and palms facing outward.
- Allow the patient ample personal space.

The initial approach to a patient with disruptive behaviours should be de-escalation, de-stressing, distraction and other strategies that focus on engagement of the patient.

- Only one staff member should talk to the patient.
- Approach in an empathic, confident manner and avoid sudden or violent gestures.
- Present yourself as being calm and in control; this is a powerful de-escalation skill. Consider self-calming techniques – such as slowing your breathing and counting to three.
- Have a non-aggressive stance with arms relaxed.
- Avoid prolonged eye contact, do not confront, and do not corner or stand over the patient.
- Emphasise your desire to help.
- Offer the patient time to state their concerns; react in a non-judgemental way explaining your desire to help sort out their current difficulties. Focus on the here and now, and do not delve into long-term grievances or issues.
- Attempt to ascertain the cause of the violent behaviour. Try to calm the patient by responding calmly and evenly. Do not become aggressive or threatening in response.
- Some people will often settle if time is spent calmly discussing their concerns and offering suitable support.
- Try to identify the problem and seek a solution.
- Encourage the patient to think rather than act on the situation.
- Courtesies, such as offering a cup of tea (lukewarm), sandwich, access to a phone, attending to physical needs, providing an opportunity to rest, can be very helpful as is regular orientation to place/person/situation.
- Getting relatives or trusted staff to talk with the patient may help, although they must be protected from attack. Be cautious, though, that the presence of relatives may exacerbate the patient's behaviour.
- Do not touch the patient without their permission to do so.
- Encourage the patient to choose help such as agreeing to talk to a mental health clinician or accepting medication voluntarily (e.g. *'It seems to me things are a bit out of control. Will you let us help you? This medication will help you.'*).
- If further intervention (such as medication) is required, having a number of staff backing up the nominated clinician speaking to the patient (sometimes known as a show of force) may facilitate the patient's co-operation. One person should lead the staff and negotiate with the patient.
- If aggression escalates and violence seems imminent, withdraw from the person and mobilise help. If trapped, a submissive posture with eyes averted, hands down and palms toward patient may help. **If all else fails, lift arms to protect head and neck, shout 'NO!' very loudly and try to escape.**

LEGAL ISSUES

Also see Chapter 10 for legal information.

Under the common law principal of 'Duty of Care', involuntary sedation of a patient with acute severe behavioural disturbance can be given in an emergency situation to save the person's life or to prevent serious danger to the health of others. This includes children and those with alternative consent providers.

Consent for emergency sedation should be sought from children and adolescents (even though it is unlikely to be given) and their parents whenever possible. The consent of a parent or guardian is required for treatment for children under the age of 14 years. After this age, children may seek treatment and give consent on their own behalf, provided they fully comprehend what is proposed. The decision to give consent can be made jointly with parents. Usually, unless the child objects, a parent or legal guardian is asked for consent where a child is 14 or 15 years old. In most cases a person aged 16 and over is capable of providing informed consent.

SEDATION

(Note that state-wide guidelines for the sedation of patients with acute severe behavioural disturbance in Emergency Departments are in development and the medication guidelines below, may be subject to amendment).

If it appears the aggression is related to a medical or psychiatric condition (e.g. delirium or psychosis) AND there are sufficient staff to safely deal with the patient AND it is an emergency, restraint and sedation may be appropriate.

These guidelines are based on the best currently available evidence and clinical advice and will regularly be reviewed and modified.

These guidelines have six parts:

1. Indications
2. General principles
3. Medication for sedation of acute severe behavioural disturbance
4. Sedation for transport
5. Post-sedation management
6. Documentation and reporting.

1. Indications

Sedation may be required for patients whose behaviour puts them or others at immediate risk of serious harm, and which is unable to be contained by other means. Sedation should only be used when other methods of settling the person have failed.

The most common indication for sedation is acute severe behavioural disturbance manifested as threatening or aggressive behaviour, extreme distress, self-harming behaviour or imminent suicide.

2. General principles

- This is a guide, not a prescription.
- There should only be two sedation events in 24 hours.
- If the patient has a documented individual management plan, this should be followed.
- For children and adolescents, consult with their treating psychiatrist or the child and adolescent psychiatrist on call, if such a service is available.
- **Speed of onset and reliability** of delivery are the two most important factors to consider in choosing a route of administration of sedation in the behaviourally disturbed patient.

The clinical endpoint of oral sedation is relief of distress and agitation

Oral sedation is indicated when the patient:

- can be safely and quickly talked down
- is not at imminent risk of harm to themselves or others
- can be safely managed in the ED environment
- AND they agree to take oral medications.

The clinical endpoint of parenteral sedation is rousable sleep

Patients considered for parenteral sedation should be discussed with a mental health clinician first, where practicable.

Parenteral sedation:

- Is indicated to control dangerous behaviour and to facilitate assessment and management
- The advantages of intravenous sedation are that the effect is immediate and the dose can be titrated.
- The intramuscular route is preferred by some clinicians as it may be quicker to administer, or, particularly, where venous access is limited or difficult.
- Should generally be titrated to the point of rousable sleep, not unconsciousness
- Benzodiazepines are generally the medications of first choice as they are more sedating and have fewer side effects than antipsychotics
- For more disturbed patients, a combination of benzodiazepine and antipsychotic, at the outset, is recommended
- Aim to achieve an appropriate level of sedation quickly by using sufficient medication. This requires clinical judgement. Repeated sub-therapeutic doses may lead to inadequate control of behaviour and greater total doses of medication
- If doses outside the guidelines are required, consult the on-call consultant psychiatrist, emergency physician or other appropriate consultant such as an anaesthetist or toxicologist
- The use of droperidol has been questioned since 2002 because of a Black Box warning in the USA which related to its use as an oral antipsychotic. There is no evidence in the literature that the use of parenteral droperidol in emergency situations is associated with an increased clinically significant risk of torsades de pointes or other dysrhythmias
- If droperidol is unavailable, haloperidol can be used in similar doses. Haloperidol causes less sedation but has increased extrapyramidal side-effects when compared to droperidol. It also has a similar, if not greater, risk of dysrhythmia
- Parenteral lorazepam is now available in Australia and may be available in some Local Health Districts (contact your Hospital Pharmacy). It is an effective parenteral sedative, with fewer side effects and a duration of action between that of midazolam and diazepam
- **Use lower doses, and caution, in patients who are frail or medically compromised**
- Wherever possible, parenteral sedation should be carried out at a location that will be safe (resuscitation equipment available) and provides protection of patient's dignity and confidentiality
- Appropriate levels of competence as well as monitoring and resuscitation equipment are required wherever parenteral sedation for acute severe behavioural disturbance occurs
- During the intervention it is important to maintain communication with the patient, explaining what is happening in a sensitive and professional manner. Only one staff member to talk to the patient to avoid negotiation breakdown, 'splitting' and confusion amongst staff. **Explain that the medication is to help calm the situation.**

3. Medication for sedation of acute severe behavioural disturbance

Post Sedation:

- The sedated patient is to be monitored in an appropriate clinical area with resuscitation facilities available until:
 - They are able to maintain oxygen saturation greater than 95% on room air
 - They have intact airway reflexes
 - Their systolic blood pressure is greater than 100 mmHg (see **Post Sedation Management** below)
- **Always** check for pregnancy, allergies, previous adverse drug reaction and intoxication with substances
- All staff to remove potentially hazardous articles/possessions and be equipped with protective gloves and eyewear
- It may be useful for the ED to maintain an emergency sedation kit containing the necessary equipment and medication
- Be aware of the risks associated with parenteral sedation for behavioural emergencies:
 - Respiratory depression, hypotension and dystonia
 - Excess pressure on neck/chest/abdomen
 - Biting, spitting, scratching and flailing limbs
 - Needle-stick injury.

Repeated sedation over a short period (hours to several days) may cause delirium and other complications, and should be avoided if possible.

If repeated sedation cannot be avoided, a comprehensive clinical review by a senior clinician should be performed to guide an appropriate plan of management.

READ THE GENERAL PRINCIPLES ON SEDATION ABOVE BEFORE USING THIS MEDICATION GUIDELINE

Note that state-wide guidelines for the sedation of patients with acute severe behavioural disturbance in Emergency Departments are in development and the medication guidelines below may be subject to amendment.

When parenteral sedation is indicated, IV titration is preferred if IV access can be safely established/secured without additional risk to staff and patient. IM sedation may be necessary to safely achieve IV access. The clinical end-point for parenteral sedation is rousable sleep.

Where distress and agitation is less, it may be possible to intervene early and offer oral sedation to prevent the need for later parenteral sedation.

Parenteral medication is rarely indicated in the elderly and only after specialist consultation.

ADULTS

ADULTS ROUTE	MEDICATIONS		INITIAL DOSE	NOTES	CAUTION
ORAL	BENZODIAZEPINE (preferred) Or	Diazepam	5–20 mg	Diazepam (up to 60 mg total per event)	Diazepam: Respiratory depression & it may take 20–40 minutes until desired effect
		Or	Lorazepam	2–4 mg	
	ANTIPSYCHOTIC ⁴	Olanzapine wafer	5–10 mg	Max dose 20 mg total per event	
IM ⁷	BENZODIAZEPINE (preferred) ⁷ Or	Midazolam ⁶	5–10 mg	Repeat q 20 min (up to 20 mg total per event)	Respiratory depression
		Or	Lorazepam	2–4 mg	
	BENZODIAZEPINE & ANTIPSYCHOTIC ⁴	Midazolam ⁶	5–10 mg	Repeat q 20 min (up to 20 mg total per event)	Respiratory depression
		Droperidol	5–10 mg	Repeat q 20 min (up to 15 mg total per event)	Hypotension Dystonic reactions
IV ¹	BENZODIAZEPINE (preferred) Or	Diazepam ³	5–10 mg	Titrate 5 mg boluses every 3–5 min (up to max 60 mg total per event)	Respiratory depression
		Or	Lorazepam	2–4 mg	
	And/or BENZODIAZEPINE & ANTIPSYCHOTIC ²	Diazepam ³	5–10 mg	Titrate 5 mg boluses every 3–5 min, (max 60 mg total per event)	Respiratory depression
		Droperidol ⁴	5–10 mg	Repeat after 20 min (max of 15 mg total per event)	Hypotension Dystonic reactions

Precautions:

- ¹ IV droperidol should be diluted (1 mg/1 ml of normal saline [NS]).
- ² Benzotropine 2 mg IV or IM should be used to manage acute dystonia caused by antipsychotics.
Note: Use with caution in the elderly as benzotropine may cause an anticholinergic delirium.
- ³ Diazepam should not be diluted for IV administration. Flush with 10–20 ml NS between titrations.
- ⁴ Haloperidol (up to 15 mg per event) can be substituted if droperidol is not available.
- ⁵ If maximum doses have been given as above without achieving control, consult with appropriate specialist.
- ⁶ IV Midazolam is associated with a significant risk of respiratory depression and is not recommended.
- ⁷ Diazepam IS NOT to be used IM due to unreliable absorption when given by this route.

OLDER PERSONS

OLDER PERSONS ROUTE	MEDICATIONS		INITIAL DOSE	MAXIMUM DOSE IN 24 HOURS	CAUTION
ORAL	BENZODIAZEPINE (preferred)	Lorazepam	0.5–1.25 mg	Max dose 7.5 mg (total per event)	Respiratory depression, confusion, ataxia
	And/or	Olanzapine wafer OR	2.5–5 mg	Max dose 10 mg (total per event)	Confusion, hypotension, bradycardia, ataxia
	ANTIPSYCHOTIC ¹	Risperidone	0.5–1 mg	Max dose 4 mg (total per event)	Hypotension, sedation, ataxia
IM ³	Antipsychotic	Olanzapine ²	2.5 mg	2.5 mg increments to max dose of 7.5 mg (total per event). DO NOT use if delirious; seek specialist advice	Confusion, hypotension, bradycardia, ataxia

Precautions:

- ¹ Benzotropine 2 mg IV or IM should be used to manage acute dystonia caused by antipsychotics. **Note: Use with caution in the elderly as benzotropine may cause an anticholinergic delirium.**
- ² Do not use Olanzapine IM within two hours of parenteral benzodiazepines due to the risk of respiratory depression.
- ³ Diazepam IS NOT to be used IM due to unreliable absorption when given by this route.

CHILDREN AND ADOLESCENTS*

*ROUTE	MEDICATIONS		INITIAL DOSE	MAXIMUM DOSE	CAUTION
ORAL	BENZODIAZEPINE (preferred)	Diazepam	0.2 mg / kg	Max dose 10 mg	Respiratory depression, & it may take 20–40 minutes until desired effect
	And/or	Olanzapine wafer	2.5–5 mg for children 20–40 kg 5–10 mg for children > 40 kg	Max dose 10 mg	Hypotension Dystonic reactions
	ANTIPSYCHOTIC ¹ (Usage of already prescribed antipsychotic medication preferred)	Risperidone	0.02–0.04 mg/kg	Max dose 2 mg	Hypotension Dystonic reactions
IV ¹	BENZODIAZEPINE (preferred)	Diazepam ²	0.1–0.2 mg/kg	Administer boluses slowly over 2–3 min, max 10 mg total per dose	Respiratory depression
	Or	Diazepam ²	0.1–0.2 mg/kg	Administer boluses slowly over 2–3 min, max 10 mg total per dose	Respiratory depression
	BENZODIAZEPINE & ANTIPSYCHOTIC ¹	Droperidol ³	0.1–0.3 mg/kg	Max dose 10 mg	Hypotension Dystonic reactions

Precautions:

- ¹ Benzotropine should be used to manage acute dystonia caused by antipsychotics. Acute dystonia in children: Benzotropine 0.02 mg/kg IV or IM in younger children, 1–2 mg IV in older children or adolescents (max 2 mg/dose).
 - ² Diazepam should not be diluted for IV administration. Flush with 10–20 ml NS between titrations.
 - ³ Haloperidol can be substituted if droperidol is not available.
- * The sedation medication guideline for children and adolescents has been endorsed by the Children's Hospital Westmead Drug Committee and Clinical Executive and is included with their permission.

4. Sedation for transport

- Once sedated (rousable sleep), a patient may need transport to a mental health unit or other facility
- Transport should only occur when the patient is stable
- The patient must be able to respond to voice
- If the patient's pulse, blood pressure or respiration is outside normal limits, transport should be re-considered
- Transport should only occur when there is an agreed plan with the receiving facility for the period of transportation
- The sedated patient **MUST** be transported by ambulance, where resuscitation equipment is available
- The patient should be escorted by a clinician with appropriate airway-management skills
- The patient will be constantly observed and vital signs will be regularly monitored en route
- The decision to transport is at the treating doctor's discretion
- Documentation of all medication given prior to transportation and en route **MUST** accompany the sedated patient.

Consideration also needs to be given to:

- The type of transport available
- Duration of the trip
- Possible delays
- Provisions made for repeat sedation and pressure area care if necessary.

DELEGATION OF EXTRA OR RELIEF STAFF ALSO NEEDS TO BE CONSIDERED

- Vigilant monitoring, particularly for signs of airway obstruction, respiratory depression and hypotension during the post-sedation period is mandatory
- It is acknowledged that some flexibility in observations is accepted, so as not to unnecessarily wake/irritate the patient further and to permit sufficient patient rest
- The quality and intensity of aftercare provided to sedated behaviourally disturbed patients should be the same as that provided to any other sedated person
- Prophylactic benzotropine should not be given routinely, particularly in the elderly (greater sensitivity to anticholinergic effects).

5. Post-sedation management

6. Documentation and reporting

Post-parenteral sedation care for patients in 'rousable sleep' state:

- Place in head-down Trendelenburg position if possible
- If not possible, ensure airway is not obstructed
- Support airway and give supplemental oxygen of 6 l/min if necessary. Beware this may obscure the hypoxia of hypoventilation
- Vital signs and continuous pulse oximetry on room air
- Person to be constantly observed until they are able to respond to verbal stimuli
- Suggested frequency of vital sign measurement:
 - every 15 min for 60 min, then every 30 min for 4 hours or until awake
- Watch for early signs of extrapyramidal side-effects (EPSEs) if the patient has been given antipsychotic medication. EPSEs can occur up to 48 hours after administration
- Allocate staff to provide reassurance to other patients and their families in the vicinity of the procedure
- Offer staff the opportunity to review and discuss the procedure.

Video surveillance cannot be used as a substitute for face-to-face observation.

Patients commonly find the process distressing. After the patient is sufficiently alert and well post-sedation, they should be given:

- **An opportunity to express any concerns they may have about the procedure**
- **An explanation of the circumstances surrounding and reasons for the use of, sedation.**

Accurate and timely recording of information related to the management of acute severe behavioural disturbance is essential.

Every time sedation is used, documentation in the patient's medical record should contain:

- **Description** of the events that contributed to the need for sedation
- **Results** of the physical examination of the patient
- The **indication** for the sedation
- A **record of the medications** administered and the response/effectiveness
- A record of **vital signs** made following the use of parenteral sedation using the facility's usual observation charts
- A record that an **explanation of the incident** has been given to the patient and his/her carers if appropriate.

Any patient who has required IM/IV sedation on more than one presentation should have a comprehensive management plan to deal with future behavioural disturbance documented in their file.

Physical restraint is a human or mechanical action that restricts a person's freedom of movement.

The use of **any restraint** on **any patient** in NSW must be in accordance with NSW Health policies including:

- PD2015_004 *Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the use of Restraint* http://www0.health.nsw.gov.au/policies/pd/2015/PD2015_004.html
- *Protecting People and Property Manual*, Chapter 14 'Role of Security Staff in NSW Health' and Chapter 29 'Duress Response Arrangements' <http://www.health.nsw.gov.au/policies/manuals/Documents/prot-people-prop.pdf>
- PD2012_035 *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW*, http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_035.html
- GL2012_005 *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW – Guidelines Focussed Upon Older People*, http://www0.health.nsw.gov.au/policies/gl/2012/GL2012_005.html

The aim is to minimise the ability of the patient to move and injure themselves or others and at the same time to ensure that the patient has a patent airway and circulation is not obstructed.

Brief physical restraint (**manual restraint**) is utilised as part of most acute parenteral sedations for severe behavioural disturbance. Immobilisation of the distressed and/or aggressive patient through control of the limbs and head is the safest mechanism for restricting movement while medication is administered and until sedation is achieved.

Use of devices (**mechanical restraint**) to restrain should only be used in extreme circumstances, and only on the order of the treating doctor. Refer to local policies/protocols for restraint. Chapter 14 of the Protecting People and Property Manual provides guidance on the features of mechanical restraints appropriate to health settings.

Each occasion of any restraint on any patient is to be recorded in the patient's medical record and in the ED's Restraint Register.

The decision to use restraint is a clinical decision that must only be used where a patient's disturbed behaviour simultaneously satisfies four pre-conditions:

1. The patient has a medical or psychiatric condition requiring care, **and**
2. The patient is at the time incapable of responding to reasonable requests from health staff to cooperate, and measures promoting self-control are impractical or have failed, **and**
3. The patient's behaviour is putting themselves or others at serious risk of harm, **and**
4. Less restrictive alternatives are not appropriate.

The principal contraindications to the use of physical restraint are that:

- Due to the health or physical condition of the patient, restraint poses risks that outweigh the benefits to be gained.
- The resources and skills to effect restraint do not exist or are inadequate to ensure restraint can be carried out safely.

**Indications and
contraindications for
use of restraint**

Good practice principles in use of restraint

- **As a last resort** when it is the only means available to prevent imminent harm
- **Proportional** to the antecedent behaviour
- **Applied in a manner that is safe and appropriate**, involves minimal necessary infringement of the patient's right to freedom and dignity
- **Not prolonged** beyond the period that is strictly necessary to gain control of the behaviour deemed necessitating use of the restraint
- Restrained patient at all times is **under care and close and regular supervision** of appropriately qualified medical or nursing staff
- **Not used as a substitute for inadequate staffing, or as punishment**
- **All staff** required to use restraint are to be **trained** in line with NSW Health policy PD2012_008 *Violence Prevention and Management Training Framework for the NSW Public Health System* http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_008.pdf
- All instances of restraint (reasons; nature and extent) are **recorded in the patient's medical record and in the ED's Restraint Register** which is to be regularly reviewed at a senior level
- Patients being mechanically restrained **must** have 1:1 observation under the care of a Registered Nurse.

Health staff are not expected to place themselves at unnecessary risk of harm or injury while carrying out their duties and should discuss any concerns with the restraint team leader or senior treating clinician.

The following steps are intended as a guide for safe manual restraint

- **Safe restraint requires a coordinated team, good timing and practice.** To use this procedure safely, staff **must** be trained, preferably as a team.
- Care is to be taken not to inflict pain or bruising (particularly in the elderly). However, the patient must be held with sufficient firmness to protect the patient and staff from sudden movement, flailing limbs or biting which could be dangerous. (See illustration below.)
- Nominate one person 'in charge' of the procedure. Only one person to talk to the patient to avoid negotiation breakdown, 'splitting' and confusion amongst staff
- Gather sufficient trained staff (five for the actual restraint procedure). Assign each person to a specific limb (e.g. right arm) including one to manage the head of the patient
- Assemble all necessary equipment and medications before approaching the patient
- All staff to remove potentially hazardous articles/possessions and be equipped with protective gloves (and eyewear/face masks where appropriate)
- Approach the patient with the leader talking to the patient with support staff right behind or flanking
- Explain the situation and what is about to happen, reassuring the patient that it will only be a temporary measure and that they will feel better after they have had medication
- Offer the patient the opportunity to accept voluntary restraint.

- At a prearranged signal, each staff member acquires their designated patient limb. The patient should be held firmly and gently moved to a position that facilitates administration of medication for either IM or IV access.
- Face-up restraint should be used where it is safe to do so.
- Face-down restraint should only be used if it is the safest way to protect the patient or others. If face-down restraint is used, it will be time limited. The maximum time a person will be held in face-down restraint is approximately 2–3 minutes to allow sufficient time to administer medication and/or remove the person to a safer environment. **Care must be taken to avoid positional asphyxia that can develop if the patient is placed lying face down**
- As a general principle, clothing rather than limbs should be held to effect restraint. Limbs should be held above and below the joint, not directly on the joint. Do not apply pressure directly on the joint
- One delegated staff member continues to talk calmly to the patient throughout the process, explaining that the medication is to help them calm down
- Documentation of any restraint procedure on any patient must be made in the patient's medical record and in the ED's Restraint Register.

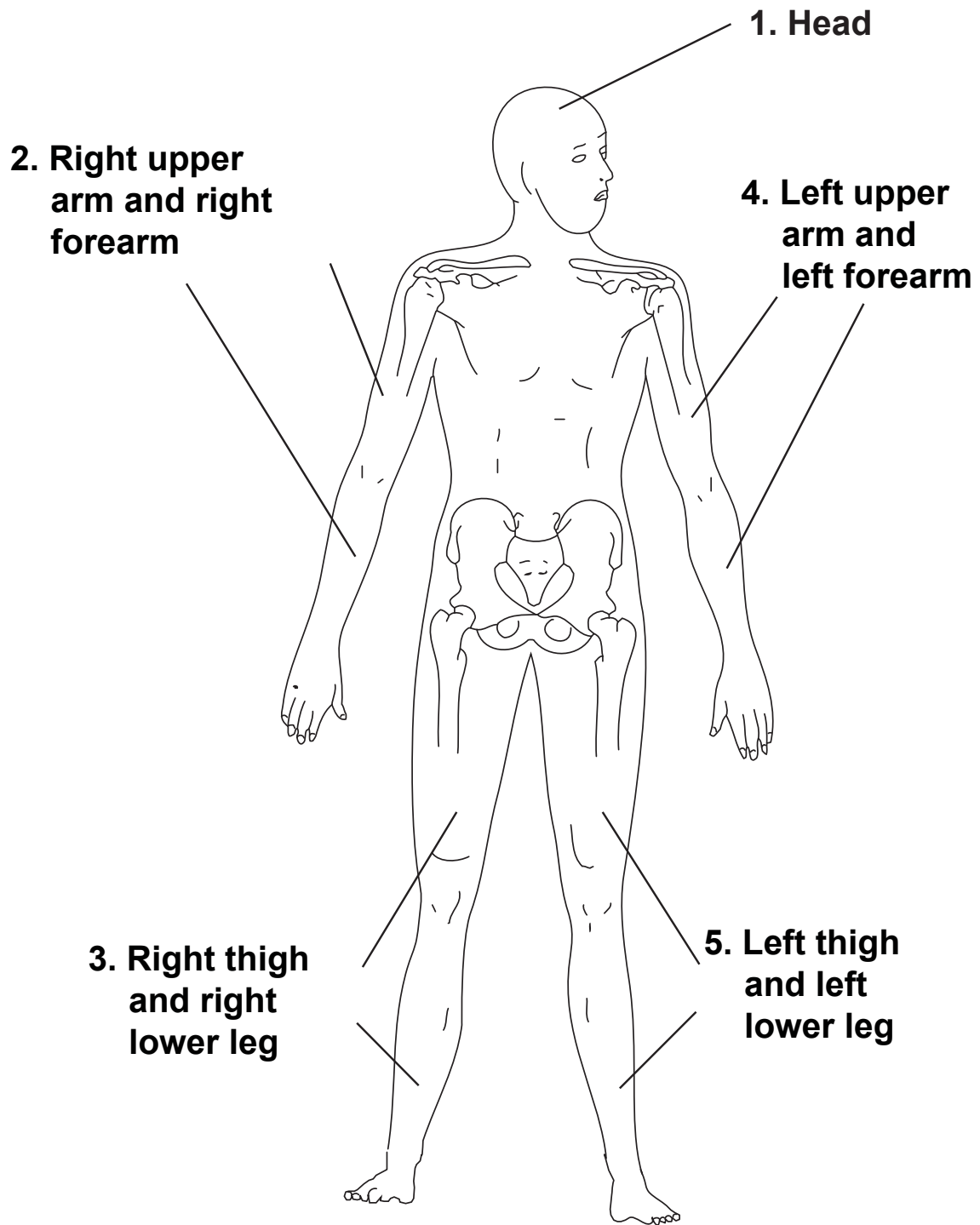
Beware in all restraint situations

- Restraint is a hazardous procedure for both patient and staff
- Biting, spitting, scratching, flailing limbs and needle-stick injury may occur
- Risks to staff include musculoskeletal, injuries, wounds and infectious disease.
- Risks to patients include injuries to limbs, head and neck, falls, internal injuries and suffocation
- Monitor the patient's ability to breathe (check movement, colour and monitor respirations and oxygen saturations). **See Post-Sedation Management** above
- Great care is to be taken to ensure that airway or circulation does not become obstructed. Avoid putting pressure on the chest, abdomen, neck, throat, nerves or occluding venous return from the IV site.
- Protect your own safety
- Have an avenue of escape
- Ensure adequate back up
- Check for weapons (in a non-aggressive manner)
- Retain a calm, non-confrontational approach
- Allow patient time to settle
- Attempt to understand patient's concerns
- All staff are to be trained, in line with NSW Health policies, in managing aggressive patients. Refer to PD2012_008 *Violence Prevention and Management Training Framework for the NSW Public Health System*.

Do not attempt restraint without the adequate number of staff in attendance.

Key points

MAIN POINTS FOR MOBILISATION



Guidelines for mechanical restraint

The use of mechanical restraint devices requires authorisation of the treating doctor and can only occur using a device approved by the Local Health District or Hospital Clinical Governance (or equivalent) committee. The application of mechanical restraint MUST be in line with specifically approved policies and protocols. Staff MUST be trained in procedures for use of the equipment.

Chapter 14 of the *Protecting People and Property Manual* provides guidance regarding features of mechanical restraints for use in health settings, including that they must:

- Be adjustable to reflect the physical frailty of the patient
- Allow the patient to be placed in a sitting or lying position
- Have a wide cuff to prevent tightening and reduced circulation
- Have no sharp edges and not be made from material that is sharp or abrasive
- Be made of a material that is easy to clean
- Be easy to apply, for instance when the patient is moving
- Be difficult for the patient to remove
- Be able to be secured to furniture, i.e. a bed or chair. It is appropriate to pre-prepare a bed with restraints.

NSW Ambulance may use mechanical restraints during transport. Where these restraints have been applied, local protocols must be developed for the safe transfer of the patient onto and off the ambulance trolley.

Operational guidelines in the application of mechanical restraint

The table below summarises the key operational standards to apply in the use of restraint. Refer to local policies.

Indications	<ul style="list-style-type: none">• A clinician believes the patient is soon likely to inflict physical injury to themselves or another person; and restraint is the least restrictive option likely to be effective.
Authorisation	<ul style="list-style-type: none">• Treating medical officer. In an emergency, the senior nurse on duty may authorise, provided the treating medical officer is notified without delay.
Medical Assessment	<ul style="list-style-type: none">• Unless in an emergency, restraint is to commence only after careful assessment of physical and mental health of the patient• In an emergency, medical examination must occur as soon as is practical after the commencement of restraint, but no longer than after 1 hour.
Restraint Procedure	<ul style="list-style-type: none">• Restraints are to be applied in accordance with the specifically developed and approved procedures for manual or mechanical restraint• Guidelines for application of manual restraint, and mechanical restraint are set out below; however, each facility must develop specific procedures and practices that apply to the facility• Ensure any protective equipment or mechanical device likely to be used is clean, safe and available• Patient to be managed preferably in a supine position. Face down restraint should only be used if it is the safest way to protect the patient or others and only for a maximum period of 2–3 minutes to allow sufficient time to administer medication and/or remove the patient to a safer environment. Refer to PD2012_035 <i>Aggression Seclusion and Restraint: Preventing, Minimising and Managing Disturbed Behaviour in Mental Health Facilities</i>.

Observations and vital signs	<ul style="list-style-type: none"> • On initiation of restraint: ideally P, T, RR, BP, GCS. If sedated must have oxygen saturations monitored continuously • Monitor and document vital signs regularly, and P, T, RR, BP, GCS, in addition to oxygen saturation every 15 minutes • Continuous visual observation for the duration of restraint, including observation for adverse effect of restraint (limb circulation, skin condition, consciousness, comfort, pain) • Observation to include verbal communication with the patient.
Care	<ul style="list-style-type: none"> • The patient must receive adequate fluids, food and clothing/bedding. Access to toilet facilities must be offered to the patient at a maximum of two-hourly intervals.
Duration	<ul style="list-style-type: none"> • The minimum time possible with safety, with review at maximum period of one hour. Restraints released every hour for 10 minutes (one limb at time if necessary). If due to safety concerns restraints are unable to be released for brief periods, then MO must be notified and patient must be reviewed.
Completion of episode	<ul style="list-style-type: none"> • The patient may be released from restraint at any time by the treating doctor or senior nurse on duty or as per local policies (e.g. a team decision) • Return to less restrictive care should occur as soon as possible.
Documentation and forms	<ul style="list-style-type: none"> • Authorisation form must detail patient's name and MRN, indication for restraint and alternatives considered prior to restraint, name of authorising officer, time and date of examination and restraint, record vital signs through period of restraint, record time restraint ended, total duration of restraint, any adverse events or medication during restraint • Appropriate documentation must also be made in the patient's medical record and in the ED's Restraint Register.
Training	<ul style="list-style-type: none"> • Staff require adequate and repeated training in managing the care of the agitated patient and in the safe application, use and monitoring of restraints.
Reporting	<ul style="list-style-type: none"> • Every restraint episode on any patient must be recorded in the patient's notes, at a facility level in the ED's Restraint Register, and be monitored at a LHD level.
Facilities / Equipment	<ul style="list-style-type: none"> • Restraint equipment must be approved by the LHD or hospital's Clinical Governance (or equivalent) committee • Restraints are to be easily accessible, clean, in working order, safe (not hard/abrasive/sharp edges). Staff should be provided with suitable protective clothing, gloves and face masks.
Minimum standards	<ul style="list-style-type: none"> • The patient must be examined by the authorising person prior to the restraint • If the authorising clinician is not a medical officer, an examination by a medical officer is required within one hour • A restraint authorisation form must be signed by the authorising clinician • If restraint continues for more than an hour, a medical officer must make an assessment and reauthorise the restraint • Review by medical officer hourly for duration of restraint.

CALLING FOR SECURITY OR POLICE ASSISTANCE

If there does not appear to be a medical/psychiatric cause for the patient's aggression or intimidating behaviour, OR the situation is too extreme to handle safely, call Security and/or Police. Sometimes a show of force (e.g. 3 or 4 Police officers) will have a significant controlling effect.

Be prepared to provide as much information as possible to security staff or Police, including:

- Your exact location within the hospital / department
- Whether you are alone
- History of recent event
- Whether known or unknown patient
- Whether or not the patient has a weapon
- Any medications already given.

The 1800 011 511 Mental Health Line is a state-wide 24-hour mental health telephone access service. Carers, health providers and emergency service workers can use the service for advice about a person's clinical symptoms, the urgency of need for care and local treatment options.

ADDICTIONS

The Ministry of Health has produced Drug & Alcohol Factsheets available via

<http://www.health.nsw.gov.au/mhdao/Factsheets/Pages/default.aspx>

Alcohol and Drug Information Services (24-hours)

Tel: (02) 9361 8000 or 1800 422 599

Alcoholics Anonymous (24-hours)

Tel: (02) 9799 1199

www.aasydney.org.au

Australian Centre for Addiction and Mental Health Research

This site has a web-assisted program to help people reduce their drinking.

<http://www.acar.net.au/index.asp>

Drug & Alcohol Specialist Advisory Service

Tel: 1800 023 687 or (02) 9361 8006

Fax: (02) 9361 8011

Gambling G-Line

Tel: 1800 633 635

TTY: 1800 633 649

Fax: 02 1300 132 304

Narcotics Anonymous (24-hours)

Tel: 1300 652 820 (National) <http://na.org.au/>

LOCAL HEALTH DISTRICT CONTACT NUMBERS

Contact telephone numbers may change and services are advised to regularly update their own records. Your local Mental Health Service should provide you with a list of important contact numbers for your District. Alternatively, Local Health District information and contact numbers can be obtained via the NSW Health Intranet Website by clicking on 'About NSW Health' – then click on 'Health Services'. Click on a service and the information can be viewed. **Other NSW public health service directories are available at the same intranet site:** <http://internal.health.nsw.gov.au/services/>

CHILD ABUSE

Child Care & Family Info Line

Tel: (02) 8594 4244

Outside the metropolitan area: 1800 803 820

TTY: (02) 9557 1410

Hours: Monday to Friday, 9.00am – 5.00pm

(A telephone interpreter service is also available.)

This is a free telephone service which provides comprehensive information to NSW families on children's services as well as other related issues such as family support, child development, health and quality concerns. Limited written resources are available.

Funded by the NSW Department of Family and Community Services (FACS).

Managed by Lady Gowrie Child Centre, Sydney

www.gowrie-sydney.com.au/

Child Protection Unit at the Westmead Children's Hospital may be able to offer advice in more complex cases, after discussion with local specialists, (02) 9845 2434.

Department of Family and Community Services Help Line

24-hour advice regarding child protection issues, and for notification of suspected abuse. This number is for use by health care workers.

Tel: 13 36 27

Department of Family and Community Services – Central Office

164–174 Liverpool Road, Ashfield NSW 2131

Tel: (02) 9716 2222 <http://www.community.nsw.gov.au>

Adult Survivors of Child Sexual Assault and Resource Centre (NSW Rape Crisis Centre)

Tel: (02) 9797 6733

TTY Services: (02) 9716 5100

Early Childhood Intervention Infoline

Tel: 1300 656 865

TTY: (02) 9557 1410

Web: www.eciinfoline.org.au

Hours: Monday to Friday, 9.00am – 5.00pm

(A telephone interpreter service is also available.)

This is a free telephone service which provides information to NSW families on services that support children with a delay in development or a disability. Limited written resources are available.

Funded by the NSW Department of Ageing, Disability and Home Care (ADHC).

Managed by Lady Gowrie Child Centre, Sydney

Child Wellbeing and Child Protection Policies and Procedures for NSW Health provide the tools and guidance for Health Workers to meet their legal and policy responsibilities within the NSW Government Child Protection System – available at http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_007.html

Child Wellbeing and Child Protection Staff are available for consultation in each Local Health District.

The **ED Social Worker** should have contacts for local Family Support Services and Community Health Centres.

Commonwealth Department of Health and Ageing
<http://www.health.gov.au/>

DELIRIUM and BEHAVIOURS ASSOCIATED WITH DEMENTIA

Care of Confused Hospitalised Older Persons:
<http://www.aci.health.nsw.gov.au/chops/guidelines>.

Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A Handbook for NSW health Clinicians: <http://www.health.nsw.gov.au/dementia/Pages/assessment-mgmt-people-bpsd.aspx>

Dementia Behaviour Management Advisory Service
1800 699 799 24 Hour Helpline
<http://dbmas.org.au/>

DISABILITY

NSW Department of Ageing, Disability and Home Care
Central Office Tel: (02) 9377 600
<http://www.adhc.nsw.gov.au/>

FAMILY VIOLENCE

Domestic Violence Advocacy Service
Tel: (02) 8745 6999
TTY Service: 1800 626 267

Domestic Violence Line
Department of Family and Community Services (FACS) – A 24-hour telephone support and referral service.
Tel: 1800 656 463
TTY: 1800 671 442
Fax: (02) 9633 7634

Immigrant Women's Speakout Association
For migrant and refugee women who are victims of violence. Counselling and bilingual workers. Hours: Monday–Friday, 9:00am–5:00pm
Tel: (02) 9635 8022
Fax: (02) 9635 8176
<http://www.speakout.org.au/>

HOMELESSNESS

Aboriginal Homeless People (24-hours)
Tel: (02) 9799 8446
Fax: (02) 9799 8507

Link2Home (24 hours)
A single, state-wide telephone information and referral service for homelessness in NSW. The service is delivered by the FACS Housing Contact Centre.
Tel: 1800 152 152

Mission Australia (24-hours)
Tel: (02) 9641 5000 <https://www.missionaustralia.com.au/>

Salvo Care Line (24-hours)
Tel: (02) 9331 6000
Fax: (02) 8736 3278

Wayside Chapel (24-hours)
Tel: (02) 9358 6577

INTERPRETING AND TRANSCULTURAL SERVICES

Health Care Interpreter Service
Each Local Health District has access to health care interpreters

Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
Tel: (02) 9794 1900
Fax: (02) 9794 1910

Telephone Interpreter for Emergencies (24-hours)
Translating and interpreting service – Department of Immigration
Tel: 13 14 50

Transcultural Mental Health Centre
Information and Clinical Consultation and Assessment Service
Tel: (02) 9912 3851 or Toll free 1800 648 911
Hours: Monday–Friday, 8:30am–5:00pm
<http://www.dhi.health.nsw.gov.au/Transcultural-Mental-Health-Centre/Transcultural-Mental-Health-Centre-Home/default.aspx>

MENTAL HEALTH ACT AND GUARDIANSHIP

Guardianship Tribunal

Free call 1800 463 928

Tel: (02) 9556 7500

Fax: (02) 9555 9049

http://www.gt.nsw.gov.au/gt/guardianshiptribunal_home.html

Mental Health Review Tribunal

Free call 1800 815 511

Tel: (02) 9816 5955

Fax: (02) 9817 4543

Public Guardian

Free call 1800 451 510

TTY: 1800 882 889

Fax: (02) 9688 9797

http://www.publicguardian.lawlink.nsw.gov.au/publicguardian/pg_index.html

NON-GOVERNMENT ORGANISATIONS

Alzheimer's Australia

Tel: (02) 9805 0100

Helpline Tel: 1800 100 500

Association of Relatives and Friends of the Mentally Ill (ARAFMI)

Toll Free 1800 655 198

Mental Health Coordinating Council (MHCC)

Tel: (02) 9555 8388

Fax: (02) 9810 8145

Mental Health Association NSW

This service provides advice about mental health & NGO services.

Tel: (02) 9816 5688

Free Call 1800 674 200 (outside Sydney)

Being – Mental Health and Wellbeing Consumer Advisory Group

Tel: (02) 9332 0200

NSW Institute of Psychiatry

Tel: (02) 9840 3833

Fax: (02) 9840 3838

<http://www.nswiop.nsw.edu.au/>

PARENTAL SUPPORT

Karitane Mothercraft (Parent-Infant Counselling) (24-hours)

Tel: (02) 9794 2300

Relationships Australia

Tel: 1800 654 648

Tresillian (Parent Help line)

Metropolitan Tel: (02) 9787 0800 or 1800 637 357

YOUTH AND FAMILY SERVICES

Aboriginal Children's Services (YConnect) (24-hours)

Tel: (02) 9698 2222

Emergency Youth Accommodation (24-hours)

Free call 1800 424 830

Fax: (02) 9318 2058

Family Support Services Association

Tel: (02) 9692 9999

Fax: (02) 8512 9866 <http://www.nswfamilyservices.asn.au/>

Kids Help Line (24-hours)

Tel: 1800 551 800

<http://www.kidshelp.com.au/>

Legal Aid Helpline (Youth)

Tel: 1800 101 810

Rape Crisis Centre (24-hours)

Tel: 1800 424 017

Salvo Youth Line (24-hours)

Tel: (02) 9360 3000

Youth Line (Lifeline 24-hours)

Tel: 13 11 14

<http://www.lifeline.org.au/>

RAPS and **Touchstone** are the two services run by Relationships Australia NSW. Adolescent Family Therapy and Mediation helps parents and adolescents resolve difficulties and improve family relationships.

RAPS is located in North Parramatta and accepts families across the Sydney area. No referral is required. RAPS does not provide telephone counselling nor is it a crisis service.

Tel: (02) 9890 1500

Toll free on 1800 654 648 during office hours, Monday to Friday.

Touchstone is located in Wollongong and accepts families across the Illawarra area. To find out more, or to book an appointment, call on 1800 240 231 or (02) 4221 2000.

GENERAL NUMBERS

Lifeline 24-hour crisis support and suicide prevention

Tel: 13 11 14

Mensline Australia

For men with family and relationship concerns

Tel: 1300 789 978

Vietnam Veterans' Counselling Service

Tel: 1800 011 046

INTERNET RESOURCES

ACEM Australasian College for Emergency Medicine

<http://www.acem.org.au/home.aspx?docId=1>

CIAP (Clinical Information Access Program)

(NSW Health Sponsored online access to MIMS, electronic databases, journals, Harrison's Online, Therapeutic Guidelines and other resources).

Supporting evidence-based practice at the point of care. The website is available to nurses, doctors, allied health and community health professionals of the NSW Health public health system. The Therapeutic Guidelines Limited: Psychotropic 6th edition, 2008 is available on this site.

<http://www.ciap.health.nsw.gov.au/home.html>

or via NSW Health Intranet: <http://internal.health.nsw.gov.au:2001/>

Clinical Research Unit for Anxiety and Depression (CRUFAD)

<http://www.crufad.com/>

eMedicine Online Text – an American compilation dealing with many medical emergencies. Has a section on psychiatric emergencies. <http://www.emedicine.com/emerg/index.shtml>

headspace is the National Youth Mental Health Foundation which treats young people who have mild to moderate mental health issues.

<http://www.headspace.org.au/>

Medline Search (PubMed) through the National Library of Medicine <http://www.ncbi.nlm.nih.gov/pubmed>

National Institute of Clinical Studies

This site has useful emergency department mental health resources. A password is necessary to access these and can be obtained via the site. <http://www.nhmrc.gov.au/nics/asp/index.asp>

National Institute for Health and Clinical Excellence

UK guidelines on health care including a range of mental health guidelines

<http://www.nice.org.uk/>

NSW Therapeutic Advisory Group Inc

<http://www.ciap.health.nsw.gov.au/nswtag/>

Office of the Public Guardian

http://www.publicguardian.lawlink.nsw.gov.au/publicguardian/pg_index.html

The Society of Hospital Pharmacists of Australia

Details about the Australian Injectable Drugs Handbook, 6th Edition, 2014 may be obtained through this site.

<http://www.shpa.org.au/scripts/cgiip.exe/WService=SHPA/ccms.r?PageId=10022>

APPENDICES

- Appendix 1 Charter for Mental Health Care in NSW
- Appendix 2 Suicide Risk Assessment and Management for Emergency Departments*
- Appendix 3 Geriatric Depression Scale (GDS)*
- Appendix 4 Cognition Screening for Older Adults* (For suspected delirium see Chapter 5 'Confused or not making sense'.)
- Appendix 5 The Edinburgh Postnatal Depression Scale* (Screen for depression in the postnatal period see Chapter 5 'Sad, depressed, withdrawn or distressed'.)
- Appendix 6 Slow Breathing Exercise
- Appendix 7 Sleep Hygiene
- Appendix 8 Guidelines for staff member providing 1 to 1 Observation of the patient
- Appendix 9 Firearms Notification to NSW Police and Firearms Registry
- Appendix 10 Involuntary Drug and Alcohol Treatment Program: Information for Medical Practitioners
- Appendix 11 NSW Emergency Care Institute's Physical Assessment of Mental Health Patients Form and Rationale
- Appendix 12 Mini Mental State Examination
- Appendix 13 Psychiatric terminology

*** Rating scales may be useful to guide assessment but should be interpreted with caution. They may productively be used as a symptom checklist. Without special training, scoring of rating scales cannot be made with precision.**

APPENDIX 1: CHARTER FOR MENTAL HEALTH CARE IN NEW SOUTH WALES

Every person in New South Wales has the right to mental health services that:

- 1. Respect human rights.**
- 2. Are compassionate and sensitive to the needs of the individuals they serve.**
- 3. Foster positive attitudes to mental health in the larger community.**
- 4. Promote positive mental health.**
- 5. Encourage true consumer involvement at all levels of service delivery and policy development.**
- 6. Provide effective treatment and care across the lifespan.**
- 7. Are widely accessible to people with mental health needs.**
- 8. Provide care in the least restrictive environment, consistent with treatment requirements.**
- 9. Provide effective and comprehensive prevention programs across the lifespan.**
- 10. Promote 'living well' with mental illness.**
- 11. Address quality-of-life issues such as accommodation, education, work and income, leisure and sport, home and family and other relationships.**
- 12. Use language that reduces stigma, discrimination, or negativity for those affected and their families.**
- 13. Respect and are responsive to the diversity in lifestyle, sexuality and sexual preference.**
- 14. Are culturally sensitive and appropriate to the needs of the individuals they serve.**
- 15. Encourage and support self-help.**

APPENDIX 2: SUICIDE RISK ASSESSMENT AND MANAGEMENT FOR EMERGENCY DEPARTMENTS

Note that PD2005_121 *Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour* is currently under review and this Chapter may be subject to change.

NSW HEALTH

Suicide Risk Assessment and Management

Emergency Department



NSW DEPARTMENT OF HEALTH

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Further copies of the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* can be downloaded from the:

NSW Health website: www.health.nsw.gov.au

Intranet: internal.health.nsw.gov.au/publications

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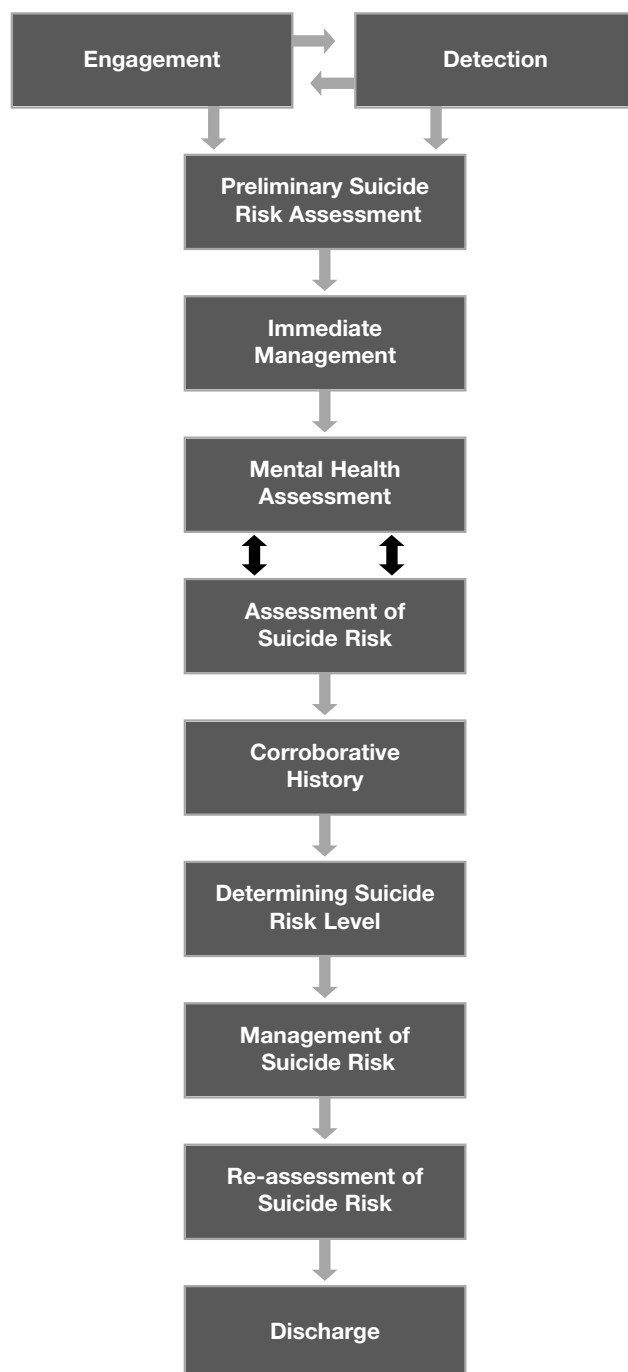
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Related documents

- Framework for Suicide Risk Assessment and Management for NSW Health Staff – SHPN (MH) 040184
- Suicide Risk Assessment and Management Protocols: General Hospital Ward – SHPN (MH) 040185
- Suicide Risk Assessment and Management Protocols: General Community Health Service – SHPN (MH) 040187
- Suicide Risk Assessment and Management Protocols: Community Mental Health Service – SHPN (MH) 040182
- Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit – SHPN (MH) 040183
- Suicide Risk Assessment and Management Protocols: Justice Health Long Bay Hospital – SHPN (MH) 040188

Framework for Suicide Risk Assessment and Management for NSW Health Staff



Introduction

Emergency departments are a key point of contact for people who have attempted suicide or who are at risk of suicide. Emergency departments play an important role in triage, assessment and management of people with mental health problems.

This document supports the NSW Health circular, *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities*¹ and the *Framework for Suicide Risk Assessment and Management for NSW Health Staff*.² Additional information can be found in *Mental Health for Emergency Departments: A Reference Guide*.³

Assessment of suicide risk

Detection

It has been estimated that up to ninety percent (90%) of people who die by suicide suffer from a diagnosable mental disorder.⁴ A number of demographic factors are associated with increased risk of suicide such as unemployment, alcohol and drug use, history of physical and/or sexual abuse, family discord, homelessness, incarceration and mental health problems, particularly depression.

However, the most important factors in assessing a person's **imminent suicide risk** are the **current personal risk factors**.

Examples include:

- 'at risk' mental status, eg hopelessness, despair, agitation, shame, guilt, anger, psychosis, psychotic thought processes
- recent interpersonal crisis, especially rejection, humiliation
- recent suicide attempt
- recent major loss or trauma or anniversary
- alcohol intoxication
- drug withdrawal state
- chronic pain or illness
- financial difficulties, unemployment
- impending legal prosecution or child custody issues
- cultural or religious conflicts
- lack of a social support network
- unwillingness to accept help
- difficulty accessing help due to language barriers, lack of information, lack of support or negative experiences with mental health services prior to immigration.

Protective factors have also been identified that may protect a person from suicide.

These include:

- strong perceived social supports
- family cohesion
- peer group affiliation
- good coping and problem-solving skills
- positive values and beliefs
- ability to seek and access help.

Early warning **signs of depression** should alert the health professional to the need for further assessment of suicide risk. Early warning signs include:

- depressed mood and/or anhedonia (loss of pleasure in usual activities)
- isolated/withdrawn/reduced verbal communication
- difficulty sleeping
- refusing treatment
- reduced appetite
- complaints of pain or physical discomfort not consistent with physical health.

When suicide risk is suspected it is important for the health professional to inquire if the person is feeling suicidal. Suicide risk is not increased by a professional asking about the possibility of suicide risk.

Triage on presentation

People at risk of suicide who present to emergency departments should be triaged according to their risk category. *The Mental Health Triage Scale* developed by South Eastern Sydney Area Health Service can assist in the triage of people presenting with mental health problems. The Australasian College for Emergency Medicine has developed an Australasian Triage Scale⁵ and guidelines for implementing the scale in emergency departments⁶ which include 'behaviour/psychiatric' descriptors that may also be used to assist in triage.*

High suicide risk is suggested by:

- high intent
- definite plan
- hopelessness
- depression
- psychosis
- past attempts
- impulsivity
- intoxication
- male gender
- recent psychiatric hospitalisation
- access to means.

Initial assessment

In general, a medical assessment should be carried out before referral to a mental health service (or other specialty service). However, when a person who is known to the mental health service is showing signs of mental distress at triage, the mental health team can be contacted concurrently with the medical assessment.

The initial assessment should include a brief psychiatric assessment and an initial suicide risk assessment. The purpose of the initial suicide risk assessment is to determine:

- the severity and nature of the person's problems
- the risk of danger to self or others
- whether a more detailed risk assessment is indicated.

*The Australasian Triage Scale can be downloaded from www.acem.org.au/open/documents/triage.htm

There are a number of factors that need to be considered prior to the suicide risk assessment.

- What are the details of the presentation, referral or the circumstances, for example, was there an incident, were they brought in by police, are they accompanied by relative or friend or is it a self-presentation?
- What collateral information is available, for example, medical records, family, accompanying person/s, police, other health providers?
- Is the person likely to leave before being assessed?
- Is the person known to a mental health service?¹

If a person is known to the emergency department and has presented before with one or more suicide attempts, the clinician should refer to the person's management plan.

Brief psychiatric assessment

- Is the person experiencing any current psychiatric symptoms (presence of depressed mood and symptoms of depression such as reduced energy, concentration, weight loss, loss of interest, psychosis, especially command hallucinations)?
- Is there a past history of psychiatric problems? (A history of a mental illness should raise the clinician's concern that the current presentation may be a recurrence or relapse.)
- Mental state assessment (GFCMA: Got Four Clients Monday Afternoon):
 - **G**eneral appearance (agitation, distress, psychomotor retardation)
 - **F**orm of thought (is the person's speech logical and making sense)
 - **C**ontent of thought (hopelessness, despair, anger, shame or guilt)
 - **M**ood and affect (depressed, low, flat or inappropriate)
 - **A**ttitude (insight, cooperation)
- Coping skills, capacity and supports:
 - Has the person been able to manage serious problems or stressful situations in the past?
 - Does the person employ maladaptive coping strategies such as substance or alcohol abuse?
 - Are there social or community supports? Can the person use them?

Assessment of suicide risk

- What collateral information is available, for example, medical records, nursing reports, family, police and other health providers?
- Obtain information from family and friends to establish whether the behaviour is out of character, how long it has been evident, how they deal with crisis.

A hierarchy of screening questions that gently leads to asking about suicidal ideas is a generally accepted procedure for all health professionals (see Figure 1).

Figure 1: Assessment of suicide risk (screening questions)

- Have things been so bad lately that you have thought you would rather not be here?
- Have you had any thoughts of harming yourself?
- Are you thinking of suicide?
- Have you ever tried to harm yourself?
- Have you made any current plans?
- Do you have access to a firearm? Access to other lethal means?

Additional aspects for assessment following an episode of self-harm or attempted suicide:

- What exactly did the person do?
For example, how many tablets were used, length of time in the car, what sort of knife was used, to what was the rope attached?
- What precipitated the self-harm?
Have the causes resolved or are they still present?
- What is the person's intention now?
For example, how does he/she feel about things now? What are their plans?
- Is the person at risk of another suicide attempt?

The person's family, if in attendance, should be informed of the assessment, further assessments required and the management plan. If the person lives with family, the family should be contacted, in particular if the person is being discharged home.

Determination of suicide risk level

There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.^{7, 8, 9} A thorough assessment of the individual remains the only valid method of determining risk.

Assessments are based on a combination of the background conditions and the current factors in a person's life and the way in which they are interacting.

Suicide risk assessment generates a clinician rating of the risk of the person attempting suicide in the immediate period. The person's suicide risk in the immediate to short-term period can be assigned to one of the four broad risk categories: high risk, medium risk, low risk, no (foreseeable) risk.

Refer to the **Suicide Risk Assessment Guide** (p 5) to assist in estimating the current level of suicide risk. It is a guide only, however, and is not intended to replace clinical decision-making and practice.

Changeability

Risk status is changeable and requires regular re-assessment. For people identified as having highly changeable risk status, more vigilant or frequent management may be required.

Assessment confidence

Low assessment confidence may be related to:

- factors in the person at risk, such as impulsivity, likelihood of drug or alcohol abuse, present intoxication, inability to engage
- factors in the social environment, such as impending court case, divorce with child custody dispute
- factors in the clinician's assessment, such as incomplete assessment, inability to obtain collateral information.

When there is a possibility of low assessment confidence, more vigilant management may be required.

- High Changeability Flag**
- Low Assessment Confidence Flag**

Suicide Risk Assessment Guide²

To be used as a guide only and not to replace clinical decision-making and practice.

Issue	High risk	Medium risk	Low risk
'At risk' Mental State – depressed – psychotic – <u>hopelessness</u> , despair – guilt, shame, anger, agitation – impulsivity	Eg. Severe depression; Command hallucinations or delusions about dying; Preoccupied with hopelessness, despair, feelings of worthlessness; Severe anger, hostility.	Eg. Moderate depression; Some sadness; Some symptoms of psychosis; Some feelings of hopelessness; Moderate anger, hostility.	Eg. Nil or mild depression, sadness; No psychotic symptoms; Feels hopeful about the future; None/mild anger, hostility.
Suicide attempt or suicidal thoughts – intentionality – lethality – access to means – previous suicide attempt/s	Eg. Continual / specific thoughts; Evidence of clear intention; An attempt with high lethality (ever).	Eg. Frequent thoughts; Multiple attempts of low lethality; Repeated threats.	Eg. Nil or vague thoughts; No recent attempt or 1 recent attempt of low lethality and low intentionality.
Substance disorder – current misuse of alcohol and other drugs	Current substance intoxication, abuse or dependence.	Risk of substance intoxication, abuse or dependence.	Nil or infrequent use of substances.
Corroborative History – family, carers – medical records – other service providers/sources	Eg. Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	Eg. Access to some information; Some doubts to plausibility of person's account of events.	Eg. Able to access information / verify information and account of events of person at risk (logic, plausibility).
Strengths and Supports (coping & connectedness) – expressed communication – availability of supports – willingness / capacity of support person/s – safety of person & others	Eg. Patient is refusing help; Lack of supportive relationships / hostile relationships; Not available or unwilling / unable to help.	Eg. Patient is ambivalent; Moderate connectedness; few relationships; Available but unwilling / unable to help consistently.	Eg. Patient is accepting help; Therapeutic alliance forming; Highly connected / good relationships and supports; Willing and able to help consistently.
Reflective practice – level & quality of engagement – changeability of risk level – assessment confidence in risk level.	Low assessment confidence or high changeability or no rapport, poor engagement.		– High assessment confidence / low changeability; – Good rapport, engagement.
No (foreseeable) risk: Following comprehensive suicide risk assessment, there is no evidence of current risk to the person. No thoughts of suicide or history of attempts, has a good social support network.			

Is this person's risk level changeable? **Highly Changeable** Yes No

Are there factors that indicate a level of uncertainty in this risk assessment? Eg: poor engagement, gaps in/or conflicting information. **Low Assessment Confidence** Yes No

Management

Maximising safety

- A person assessed to be at immediate risk of suicide should never be left alone.
- The person should be located in a secure area and kept under constant observation/supervision at all times until the arrival of the mental health service.
- Medical staff may invoke the *Mental Health Act 1990* (NSW) by writing a Schedule if there is concern the person cannot be safely managed voluntarily.
- Gaining the assistance of security staff should be considered if there is concern about aggression or the person has displayed aggression that has not been resolved.
- Where the police have brought the person to the emergency department, they may be requested to stay with the person if there is concern for others' safety, until the hospital can safely manage the situation. Local protocols concerning the Memorandum of Understanding between NSW Police and NSW Health¹⁰ should be consulted.
- If possible, provide a calming support person to stay with the person at risk.
- All items that could be used for self-harm (including belts, ties, shoelaces, dangerous objects) should be removed from the person and their immediate environment.

If a person who is considered to be at significant risk **absconds from the emergency department**, the police should be immediately contacted and provided with a description of the patient and the likely areas they may be located. Local protocols concerning the Memorandum of Understanding between NSW Police and NSW Health* should be consulted. A copy of the Schedule is to be provided if relevant. The mental health service should also be contacted if it is known that the person is a client of the mental health service.

*The Memorandum of Understanding between NSW Police and NSW Health was developed and released in 1998 to provide a framework for the effective management of people with a mental illness when the services of NSW Police and NSW Health, mental health services, and the Ambulance Service of NSW are required. The document is being reviewed and revised by an inter-departmental working group overseeing its implementation.

Consultation with and referral to the mental health service

All people presenting with suicide risk to the emergency department should be referred wherever possible to the mental health service for a comprehensive mental health assessment, including a suicide risk assessment. This should occur after initial triage and assessment. At a minimum, a phone consultation with the mental health service should occur.

A **referral to the mental health service** should be made for the following presentations:

- people who present following a suicide attempt or an episode of self-harm:
 - those who report or are reported to be preparing for suicide have definite plans
- people with probable mental illness or disorder:
 - those who are depressed or have schizophrenia or other psychotic illness
- people whose presentations suggest a probable mental health problem:
 - those who report accidental overdoses, unexplained somatic complaints or who present following repeated accidents, increased risk-taking behaviour, increased impulsivity, self-harming behaviours (eg superficial wrist-cutting)
 - co-morbidity (eg with alcohol and other drugs, intellectual disability, organic brain damage)
- people recently discharged from an acute psychiatric in-patient unit, especially within the last month
- people recently discharged from an emergency department following presentation of psychiatric symptoms or repeat presentations for somatic symptoms.

Protocols must be in place for a rapid response from the mental health service in responding to a referral. There may be occasions when unavoidable delays may be experienced by the mental health service in responding due to another mental health crisis occurring simultaneously. However, it is important that the mental health service responds as rapidly as possible to referrals

from the emergency department. After contacting the mental health team the emergency department staff should advise the person and/or family of the expected waiting time to see the mental health team.

A comprehensive management plan for people who repeatedly present with suicidal behaviour should be developed between the mental health service and the emergency department to assist in managing the situation and preventing a crisis. The plan should emphasise:

- consistent treatment by the same primary clinician, wherever possible, with regular scheduled visits and communication among all care providers
- anticipation of crisis – what the person should do if they feel distressed etc.

Joint management plans with key service providers should be developed and discussed at the local mental health/emergency department liaison meeting. Memoranda of understanding between the emergency department, mental health service, police and ambulance services should be developed to ensure better linkages are established and maintained between the services.

A previous suicide attempt is an important indicator for a death by suicide and it is highly possible for an attempt of ambivalent intent and use of non-lethal means to be followed by a fatal attempt. Therefore, these procedures are to be followed on every presentation regardless of previous presentations.

Discharge or transfer from the emergency department

Transfer to an in-patient unit

Patients in acute mental health crises who are at risk of suicide need to be transferred to safe and stable environments as soon as practicable with the involvement of the mental health service.

- While awaiting transfer, there must be appropriate monitoring and observation of the patient in the emergency department.
- When the patient is being transferred from the emergency department to the mental health in-patient unit, there needs to be a clear plan for the safe escort and handover of the person to the in-patient unit.

The following information must be provided to the in-patient unit regarding presentation of the person at risk:

- a verbal report at discharge or an interim summary within one day of discharge
- a written report to follow within 3 days.

Discharge to the community

The assessment and management of suicide risk aims to assist the person through a period of immediate or imminent risk of suicide. When the person's risk can be revised down to low risk or no foreseeable risk, levels of care can be safely and appropriately reduced and the person can be assessed for discharge to the community.

The following requirements need to be met before a patient is discharged from the emergency department to the community.

- The mental health service has been consulted.
- A comprehensive suicide risk assessment has been conducted.
- A management plan has been developed including appropriate follow-up arrangements.
- The person being discharged has a means of returning home or to suitable accommodation.
- The consulting mental health staff have ensured that adequate support and follow-up arrangements have been made, including a follow-up appointment for re-assessment.
- Prior to leaving the emergency department, the person and, where appropriate, their family must be provided with information about how to access urgent help including a 24-hour contact telephone number. They must be provided with written confirmation of the follow-up appointment.
- The following information must be provided to the relevant health provider regarding presentation of the person at risk:
 - a verbal report at discharge or an interim summary within one day of discharge
 - a written report to follow within 3 days.
- If the person is under 16 years of age, contact must be made with the parents or guardian, prior to discharge.
- Significant support people must be contacted, including general practitioner, private psychiatrist, case manager, family and friends about the potential suicide risk and about follow-up arrangements that have been made.

References

- ¹ NSW Department of Health. Circular 98/31 Policy guidelines for the management of patients with possible suicidal behaviour for NSW Health staff and staff in private hospital facilities, May 1998. Note: The policy was being revised at the time of preparation of this framework.
- ² NSW Department of Health. Framework for Suicide Risk Assessment and Management for NSW Health Staff. Sydney: NSW Department of Health, 2004 (in press).
- ³ NSW Department of Health. Mental Health for Emergency Departments – A Reference Guide (Amended May 2002). Sydney: NSW Department of Health, 2001-2002.
- ⁴ Conwell Y, Duberstein PR, Cox C, Herrmann JH, Forbes NT, Caine ED. Relationships of age and axis I diagnosis in victims of completed suicide: a psychological autopsy study. *American Journal of Psychiatry*, 1996;153:1001-1008.
- ⁵ Australasian College for Emergency Medicine. Policy Document – The Australasian Triage Scale. Melbourne: Australasian College for Emergency Medicine, 1993 – updated November 2000. www.acem.org.au/open/documents/triage.htm
- ⁶ Australasian College for Emergency Medicine. Guidelines for Implementation of the Australasian Triage Scale in Emergency Departments. Melbourne: Australasian College for Emergency Medicine, 2000. www.acem.org.au/open/documents/triageguide.htm
- ⁷ Pokorny AD. Prediction of suicide in psychiatric patients: report of a prospective study. *Archives of General Psychiatry*, 1983; 45:249-257.
- ⁸ Goldstein RB, Black DW, Nasrallah MA, Winokur MD. The prediction of suicide. *Archives of General Psychiatry*, 1991;48:418-422.
- ⁹ Rissmiller DJ, Steer R, Ranieri WF, et al. Factors complicating cost containment in the treatment of suicidal patients. *Hospital and Community Psychiatry*, 1994;45(8):782-788.
- ¹⁰ NSW Department of Health, Centre for Mental Health. Memorandum of Understanding between NSW Police and NSW Health. Sydney: NSW Department of Health, 1998. (Updated Memorandum of Understanding between NSW Police and NSW Health Flow Charts 2002 available at: www.health.nsw.gov.au/policy/cmh/publications/mou_police-health.pdf)

APPENDIX 3: GERIATRIC DEPRESSION SCALE (GDS)

Geriatric Depression Scale (short form)

Choose the best answer for how you have felt over the past week:

- | | |
|---|----------------|
| 1. Are you basically satisfied with your life? | YES/ NO |
| 2. Have you dropped many of your activities and interests? | YES /NO |
| 3. Do you feel that your life is empty? | YES /NO |
| 4. Do you often get bored? | YES /NO |
| 5. Are you in good spirits most of the time? | YES/ NO |
| 6. Are you afraid that something bad is going to happen to you? | YES /NO |
| 7. Do you feel happy most of the time? | YES/ NO |
| 8. Do you often feel helpless? | YES /NO |
| 9. Do you prefer to stay at home, rather than going out and doing new things? | YES /NO |
| 10. Do you feel you have more problems with memory than most? | YES /NO |
| 11. Do you think it is wonderful to be alive now? | YES/ NO |
| 12. Do you feel pretty worthless the way you are now? | YES /NO |
| 13. Do you feel full of energy? | YES/ NO |
| 14. Do you feel that your situation is hopeless? | YES /NO |
| 15. Do you feel that most people are better off than you are? | YES /NO |

Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

APPENDIX 4: COGNITION SCREENING FOR OLDER ADULTS



Cognition Screening for Older Adults

This form incorporates the Abbreviated Mental Test scores (AMTS), Delirium Risk Assessment Tool (DRAT) and Confusion Assessment Method (CAM).

Patient Label

Abbreviated Mental Test Score (AMTS)
 Establish baseline cognition by completing the Abbreviated Mental Test OR SMMSE for all presentations 65 years + (45+ ATSI). Repeat with any change in cognition behaviour of LOC. Score 1 for each correct answer.

QUESTION	Time Date	_/_/_	_/_/_	_/_/_	_/_/_
1. How old are you					
2. What is the time (nearest hour)					
Give the patient an address and ask them to repeat it at the end of the test E.g. 42 Market St Queanbeyan					
3. What year is it?					
4. What is the name of this place					
5. Can the patient recognise two relevant persons (eg. Nurse/doctor or relative)					
6. What is your date of birth?					
7. When did the second world war start? (1939)					
8. Who is the current Prime Minister?					
9. Count down backwards from 20 to 1					
10 Can you remember the address I gave you?					
TOTAL SCORE					
Signature					

- A score of 7 or less indicates cognitive impairment
- All patients require a Delirium Risk Assessment using (DRAT) over page

Does the person have a history of any recent / sudden change in behaviour, cognition, loss of consciousness or functional abilities (inc Falls)?

YES - Please do CAM NO - Please do DRAT

Delirium Risk Assessment Tool (DRAT)

Assessment to be completed on admission, pre & post op. and when there is a change in behaviour

Pre morbid RISK factors Tick & add score		Precipitating factors				
<input type="checkbox"/> ≥ 70 yrs PLUS <input type="checkbox"/> Visual impairment (unable to read large print on newspaper with glasses) <input type="checkbox"/> Severe illness (nurses' opinion including mental illness/depression) <input type="checkbox"/> Cognitive impairment AMTS <7/10 or MMSE < 25/30 or past history of memory or cognitive deficit <input type="checkbox"/> Dehydration (scanty, concentrated urine; fever, thirst, dry mucous membranes or raised creatinine/urea)		<p>WARNING: these factors increase risk</p> <ul style="list-style-type: none"> ★ Mechanical restraint ★ Malnutrition ★ 3 new medications added in 24hrs ★ IDC ★ Iatrogenic event (procedure, infection, complication, fall etc) 				
<p>If your patient is ≥ 70 yrs and has at least one of the above risk factors = RISK of Delirium <input type="checkbox"/></p>						
IF CHANGE IN BEHAVIOUR -RECOMMENDED INVESTIGATIONS						
<input type="checkbox"/> CAM	<input type="checkbox"/> Medical review	<input type="checkbox"/> History (incl. family)	<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Medication Review	<input type="checkbox"/> Bloods	<input type="checkbox"/> MSU

CONFUSION ASSESSMENT METHOD (CAM)

The CAM is a validated tool to be used in assisting with the differential diagnosis of Delirium. It should be used for any older person who appears to be disorientated / confused or who has any change in behaviour or LOC. It is important that the CAM is used in conjunction with a formal cognitive assessment (eg AMT/ SMMSE), good clinical and medical assessment, together with baseline cognition information from carers/family or the community or residential aged care service

Delirium Screening Tool

1	Acute onset and fluctuating course	No	Yes	Uncertain, Specify: _____	Is there evidence of an acute change in mental status from the patient's baseline? If so, did the abnormal behaviour fluctuate during the day?	E.g. tend to come and go, or increase and decrease in severity
2	Inattention	No	Yes	Uncertain, Specify: _____	Did the patient have difficulty focussing attention during the interview?	E.g. being easily distracted, or having difficulty keeping track of what was being said?
3	Disorganised thinking	No	Yes	Uncertain, Specify: _____	Was the patient's thinking disorganised or organised?	E.g. Rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from one subject to another?
4	Altered level of consciousness	No	Yes	Uncertain, Specify: _____	Overall, how would you rate the patient's level of consciousness?	Altered E.g. Vigilant, Lethargic, Stupor, Coma, Uncertain.
<p>Delirium is present if features 1 and 2 AND either 3 or 4 are present</p>						
Delirium symptoms:		not present / present		Date: / /		
Medical Officer notified?		Yes / No				

APPENDIX 5: EDINBURGH POSTNATAL DEPRESSION SCALE

(J. L. Cox, J. M. Holden, R. Sagovsky, Department of Psychiatry, University of Edinburgh)

Name: _____

Address: _____

Baby's age: _____

As you have recently had a baby, we would like to know how you are feeling. Please underline the answer that comes closest to how you have felt in the past seven days, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all of the time

Yes, most of the time

No, not very often

No, not at all

This would mean: 'I have felt happy most of the time during the past seven days'. Please complete the other questions in the same way.

In the past seven days:

- | | | | |
|----|---|-----|---|
| 1. | I have been able to see the funny side of things:
As much as I could
Not quite so much now
Definitely not so much now
Not at all | 6* | Things have been getting on top of me:
Yes, most of the time I haven't been able to cope at all
Yes, sometimes I haven't been coping as well as usual
No, most of the time I have coped quite well
No, I have been coping as well as ever |
| 2. | I have looked forward with enjoyment to things:
As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all | 7* | I have been so unhappy that I have had difficulty sleeping:
Yes, most of the time
Yes, sometimes
Not very often
No, not at all |
| 3* | I have blamed myself unnecessarily when things went wrong:
Yes, most of the time
Yes, some of the time
No, not very often
No, never | 8* | I have felt sad or miserable:
Yes, most of the time
Yes, quite often
No, not very often
No, not at all |
| 4. | I have been anxious or worried for no good reason:
No, not at all
Hardly ever
Yes, sometimes
Yes, very often | 9* | I have been so unhappy that I have been crying:
Yes, most of the time
Yes, quite often
Only occasionally
No, never |
| 5* | I have felt scared or panicky for no good reason:
Yes, quite a lot
Yes, sometimes
No, not much
No, not at all | 10* | The thought of harming myself has occurred to me:
Yes, quite often
Sometimes
Hardly ever
Never |

SCORING

The Edinburgh Postnatal Depression Scale (Screen for depression in the postnatal period)

Responses are scored 0, 1, 2, or 3 according to increased severity of the symptoms. Note asterisked items 3, 5, 6, 7, 8, 9, 10, are reverse scored (i.e. 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Score is from 0 to 30, with a score greater than 12 generally thought to suggest depression.

APPENDIX 6: SLOW-BREATHING EXERCISE

PATIENT INFORMATION FOR COPYING AND GIVING TO PATIENTS

To be practised regularly (and at the first signs of anxiety or panic).

1. Hold your breath and count to five slowly (do not take a deep breath).
2. When you get to five, breathe out and say the word 'relax' to yourself in a calm, soothing manner.
3. Breathe in and out slowly through your nose in a six-second cycle. Breathe in for three seconds and out for three seconds. This will produce a breathing rate of 10 breaths per minute. Say the word 'relax' to yourself every time you breathe out.
4. At the end of each minute (after 10 breaths) hold your breath again for five seconds and then continue breathing using the six-second cycle.
5. Continue breathing in this way until all the symptoms of over-breathing have gone.

It is important for you to practise this exercise so that it becomes easy to use any time you feel anxious. It is helpful to time it using the second-hand of your watch or nearby clock.

Reproduced from CRUFAD (Clinical Research Unit for Anxiety Disorders)

APPENDIX 7: SLEEP HYGIENE

Advice includes:

If insomnia is a problem:

1. Go to bed at the same time each day.
2. Get up at the same time each day.
3. Don't nap during the day.
4. Reduce or cut out alcohol and stimulants (coffee, tea, tobacco, soft drinks), particularly at night.
5. Avoid using sleeping tablets.
6. Get regular exercise each day, but not just prior to going to bed.
7. Set aside time during the day to deal with problems (i.e. don't take them to bed where you will ruminate on them).
8. Don't read or watch television in bed.
9. Don't get wound up just before bed.
10. Keep the bedroom comfortable, dark and quiet.
11. Try not to lie in bed worrying about not sleeping.

If not asleep after 30 minutes, get up and do something quiet such as reading or watching TV, and go back to bed when you are sleepy.

APPENDIX 8: GUIDELINES FOR STAFF MEMBER PROVIDING 1 TO 1 OBSERVATION OF THE PATIENT

- The staff member's total concentration must be on the patient at all times. This includes during showering, toileting and when asleep.
The staff member is not responsible for the care or observation of any other patient.
- The staff member must maintain constant visual contact with the patient at all times. The patient must not be left alone at any time. The staff member remains with the patient even during reviews by the medical team and/or other health professionals.
- Issues of privacy and dignity are important but safety and security take precedence.
- Ensure that the patient's immediate environment is safe and check the patient's belongings for hazards, e.g. lighters, matches, dressing gown or pyjama cords, glass bottles, nail files, scissors, razors or blades. Remove all unnecessary equipment such as O2 tubing, nurse-call cord, chairs. Eliminate any ready access to means of self-harm or harm to others. Beware of the ingenuity of people who want to self-harm or suicide. Items such as bin liners, plastic bags and tourniquets can be dangerous. Check the bed and bed linens once each shift to ensure the patient is not hoarding anything that could be used to harm self or others.
- Ensure that the patient actually swallows any medication given to them.
- Check that the patient is actually sleeping, rather than accepting when they appear to be doing so, especially if the patient has pulled bed linen over their head. Check for breathing regularly if sleeping.
- Check any belongings brought in by visitors for hazards before they are given to the patient.
- If the staff member needs to leave the bedside, ensure relief is organised before leaving the patient's bedside for any period of time whatsoever.
- If available, a personal duress alarm should be worn while caring for the patient in order to access help quickly if needed.
- Never leave a patient who is under 1 to 1 observation alone in the care of a relative (unless specifically authorised by a medical officer and documented in the patient's medical record).
- The patient may not always want to talk about their reason for admission, current stressors or past life-events. It should not be assumed that it is always appropriate to engage the patient in discussion of their problems. Sometimes it may be appropriate to provide distraction for the patient by allowing them to read, play cards, listen to music or watch television or engaging them in general conversation not related to their illness. It is not appropriate for the staff member to offer advice to the patient.
- If the patient does want to discuss their current situation, the staff member should listen and be empathic.
- Reassure the patient that they will be safe and protected. Feeling suicidal can be very frightening for people.
- Ask for an urgent clinical review if there is a sudden change in the patient's mental state or if they become more agitated or distressed.
- The staff member must not have their mobile phone with them while they are performing their duties.
- Staff members providing 1 to 1 observations should not read, study or attend to any other activity that potentially distracts them from observing and caring for the patient.
- The staff member must not wear lanyards, a stethoscope or anything else around their neck (e.g. jewellery) if the patient is at risk of harm to others.
- The staff member should position themselves between the patient and the door, but not block the exit.

APPENDIX 9: NOTIFICATION TO NSW POLICE AND THE FIREARMS REGISTRY PURSUANT TO SECTION 79 OF THE FIREARMS ACT 1996

S79 of the *Firearms Act 1996* provides for the notification to the NSW Police Commissioner by certain health professionals if they are of the opinion that a person to whom they have been providing professional services may pose a threat to their own or public safety if in possession of a firearm. In this instance, health professional means a Medical Practitioner, Registered/Enrolled Nurse, Registered Psychologist, Counsellor or Social Worker. Where a high-risk mental health patient is known to have access to firearms, the health professional is to advise Police as soon as practicable before the patient is discharged.

S79 protects the clinician from criminal or civil action in respect of breaching privacy. Nonetheless clinicians should inform patients that if they become aware the patient has access to a firearm and are concerned that the patient may pose a threat to their own safety or the safety of others, Police may be informed.

Process for notifying NSW Police of risk concerns:

1. Ring Local Area Command Duty Officer to discuss the matter
2. Fax this completed form to Local Area Command Duty Officer
3. Fax this completed form to NSW Firearms Registry: (02) 6670 8550
Attention: Manager Review and Assessment NSW Firearms Registry

Patient's Family Name	Given Name(s)	Date of Birth
Residential Address		Telephone
Where is the patient currently located (eg inpatient, emergency department, residential)?		
If an inpatient address to which the patient will be discharged?	Anticipated date and time of discharge? (To ensure safety issues can be addressed at least 6hrs notice must be provided to Police.) Date: / / Time: _____	
Description of circumstances which lead you to believe that the person may pose a threat if in possession of a firearm. (Include: relevant conversation, circumstances, observations, firearm type, effect of medical condition or treatment/medication on person's capacity etc. Use over page if more space is needed.)		
Does the person have access to their own firearm? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Does the person have access to other firearms? (eg that of a spouse, other relatives, friends, neighbours) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Name of person and location of firearm: _____		
Details of person submitting this report:		
<input type="checkbox"/> Medical Practitioner	<input type="checkbox"/> Registered/Enrolled Nurse	<input type="checkbox"/> Registered Psychologist
<input type="checkbox"/> Counsellor	<input type="checkbox"/> Social Worker	
_____	_____	_____
Contact Telephone	Ext	Mobile
Contact Address: _____		
_____	_____	_____
NAME	SIGNATURE	DATE

NOTE: Further details may be required by Police to support legal process or legal action needed to protect persons. The information contained herein is confidential and any action by a practitioner does not give rise to any criminal or civil action or remedy (or breach of privacy laws). If you have any enquiries contact the NSW Firearms Register, Manager Review and Assessment, on 1300 362 562 or the Duty Officer at your nearest NSW Police Local Area Command.

APPENDIX 10: INVOLUNTARY DRUG AND ALCOHOL TREATMENT PROGRAM: INFORMATION FOR MEDICAL PRACTITIONERS

Involuntary Drug and Alcohol Treatment Program Information for Medical Practitioners

What is the Involuntary Drug and Alcohol Treatment Program?

The Involuntary Drug and Alcohol Treatment (IDAT) Program provides short term care, with an involuntary supervised withdrawal component, to protect the health and safety of people with severe substance dependence who have experienced, or are at risk of, serious harm and whose decision making capacity is considered to be compromised due to their substance use.

The IDAT Program is a structured drug and alcohol treatment program that provides medically supervised withdrawal, rehabilitation and supportive interventions for Identified Patients (IPs)

The NSW *Drug and Alcohol Treatment Act 2007* (DAT Act) provides the legislative basis for IDAT. The DAT Act “provides for the health and safety of persons with severe substance dependence through involuntary detention, care, treatment and stabilisation”.

The DAT Act aims to ensure that involuntary treatment is only used when it will be in the best interests of the individual and when no other less restrictive means for treating them are appropriate. The DAT Act also protects the rights of people while they are undergoing involuntary treatment.

The DAT Act is accompanied by:

- A Memorandum of Understanding, which sets out the roles and responsibilities of key NSW Government agencies involved in IDAT
- A Model of Care, which contains specific protocols regarding the medical management and psychosocial interventions during treatment.

Why IDAT?

The establishment of the NSW *Drug and Alcohol Treatment Act 2007* was the result of the 2004 NSW Government Review of the *Inebriates Act 1912*. The *Inebriates Act* was introduced early last century and has been the subject of consistent criticism over many years. Under the *Inebriates Act*, people with severe substance dependence are committed to mental health units, which may not have direct access to the appropriate drug and alcohol facilities and expertise, including withdrawal treatment.

The DAT Act was trialled from 2009 to 2010. A comprehensive independent evaluation of the legislation determined that the new legislation and treatment model is more effective for providing drug and alcohol treatment to the target group and is more consistent with contemporary values regarding human rights and dignities of severely substance dependent people.

Subsequent to the review of the legislation, the Government approved the proposal to implement the Act statewide in the form of the IDAT Program.

The Inebriates Act 1912

The *Drug and Alcohol Treatment Act 2007 (NSW)* is replacing the *Inebriates Act 1912*. The *Inebriates Act* has been suspended and will be repealed.

How do I refer?

Referrals to an *Accredited Medical Practitioner (AMP)* for assessment for a dependency certificate can be made by phone, fax or email and can only be received from Medical Practitioners (MP), such as General Practitioners (GPs), emergency doctors and psychiatrists. A screening and referral form is used that captures as many details as possible. Referrals are logged by a MP, recording the time, date and details of the referral, in line with reporting requirements. A written acknowledgement for the referral must be provided to the referrer within a working day of receiving the referral.

Once the AMP at the Treatment Centre has received a referral from a MP, a determination will be made as to whether there is sufficient information (a local comprehensive assessment) for the AMP to assess the IP for a Dependency Certificate. If not, further screening and a comprehensive assessment at the local level will be requested of the MP and local Involuntary Treatment Liaison Officer (ITLO). Contact details of local ITLOs will be provided to the MP for liaison regarding further drug and alcohol screening and assessment needs.

Involuntary Treatment Liaison Officer may be:

- at the statewide in-patient unit (for patients residing in areas where the in-patient units are located), or
- part of the Referring Person's Network (for patients residing in other areas in NSW).

The role of an ITLO is to assist in the screening and information gathering required to support a referral by a MP to an AMP for assessment for a Dependency Certificate. An ITLO is a qualified professional, including doctors or nurses who are trained, have at least five years experience of providing direct drug and alcohol patient care and skilled to screen persons who may be eligible for a Dependency Certificate under the *Drug and Alcohol Treatment Act (2007)*. An ITLO conducts screening, triage and assessment to a standard of, and in liaison with, the MP, Treatment Centre and AMPs to determine if a person should be recommended for referral for assessment by an AMP for a Dependency Certificate.

What are the criteria for involuntary admission?

A Dependency Certificate, which allows a person to be involuntarily admitted, may only be issued if the AMP at the Treatment Centre is satisfied the person meets the following criteria:

- The person has a severe substance dependence, meaning they:
 - have a tolerance to a substance
 - show withdrawal symptoms when they stop or reduce levels of its use
- Do not have the capacity to make decisions about their substance use and personal welfare primarily because of their dependence on the substance **AND**
- The care, treatment or control of the person is necessary to protect the person from serious harm; **AND**
- The person is likely to benefit from treatment for his or her substance dependence but has refused treatment, **AND**
- No other appropriate and less restrictive means for dealing with the person are reasonably available.

Referrals will be accepted from all over the state as long as the person is 18 years or older.

In deciding whether a person requires involuntary care the AMP may also have regard to any serious harm that may occur to children in the care of the person, or other dependants.

How long can a person remain in involuntary care?

An AMP can issue a dependency certificate detaining the person for treatment under the Act for up to 28 days in the first instance.

Extension for a dependency certificate

There is an option to extend the Dependency Certificate for up to a total treatment period of 3 months, in extreme circumstances, where withdrawal, stabilisation and discharge planning may take longer.

Transportation to the Treatment Centre

Depending on the patient's level of risk of withdrawal or risk of harm to self or others during transport, patient's can be transported to the Treatment Centre via the following options:

- Family member/carer/friend/guardian
- Local Health District staff
- Health Transport Unit, in certain circumstances
- Ambulance, in certain circumstances
- Police, in certain circumstances

What will happen at the Treatment Centre?

While at the Treatment Centre the person will be comprehensively assessed on their capacity to make decisions about their substance abuse, personal welfare and future treatment options. They will undergo medically assisted withdrawal as well as medical treatment for any concurrent physical and/or mental illness.

A comprehensive Treatment Plan will be developed, which includes a structured psychosocial program following a period of medicated withdrawal and a thorough discharge plan for community based care.

The seclusion, restraint and sedation of patients is only permitted if they are of significant risk to themselves or others. Specific protocols are in place if this is necessary.

Clinical Outcomes:

Expected clinical outcomes for patients could include, but are not restricted to:

- Safe completion of the withdrawal episode
- Improved general health through facilitated access to medical care
- Improved nutrition
- Improved social functioning through better management of housing and welfare needs
- Reduced risk of relapse through the establishment of prevention strategies

Community Based Care

Post discharge Community Based Care is a very important component of IDAT due to the high risk of relapse amongst people who have undergone withdrawal.

For this reason participants will be provided with comprehensive community based treatment by the discharge planning and aftercare team. They will:

- comprehensively assess the person's needs including living skills and needs, mental health and cognitive functioning
- develop a discharge and community treatment plan that identifies immediate and long term needs
- provide ongoing case management and active follow up
- engage culturally specific support services where required
- co-ordinate and link to suitable community services in accordance with a person's discharge plans, including medical and psychosocial interventions as well as welfare support such as housing and vocational services
- where required, link to appropriate residential rehabilitation and care.

What are the safeguards for human rights?

IDAT contains provisions to ensure that:

- involuntary detention is a last resort
- the interests of the person are paramount
- the person will receive the best possible treatment in the least restrictive environment
- any interference with the rights, dignity and self-respect of the person is kept to a minimum.

IDAT also contains provisions to ensure that a person and their primary carer are provided with clear information about their legal rights and their rights of appeal.

All Dependency Certificates must be reviewed by a Magistrate as soon as possible after issuing.

Independent Official Visitors have been appointed to inspect the Treatment Centres regularly, to act as an advocate on behalf of patients if required, and to provide reports to the Minister for Health.

Need more information?

If you require additional information, please contact:
ADIS (Alcohol and Drug Information Service) at 9361 8000 or 1800 422 599 (outside Sydney); or

More information can also be found on the Health website along with all the necessary forms required to make a referral.

<http://www.health.nsw.gov.au/mhdao/legislation.asp>

You can also participate in online learning about the IDAT Program by visiting;

<http://lms.acwa.asn.au/login/index.php>
user name: idat password: ccwt1

APPENDIX 11: NSW EMERGENCY CARE INSTITUTE PHYSICAL ASSESSMENT FORM FOR MENTAL HEALTH PATIENTS

Note that state-wide guidelines for the Physical Assessment of Patients Presenting with a Primary Mental Health Problem in the Emergency Department are in development and will include a standardised form.

Physical Assessment for Mental Health Patients Form



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**

Adapted by the ECI from Bankstown and Liverpool Hospital Forms

Prepared March 2012

Supporting evidence for physical assessment of mental health patients



To improve mental health patient flow and care in the ED a rapid clinical assessment tool has been developed by the ECI. Historically the term 'medical clearance' is not an accurate representation of the screening process and may lead to unrealistic expectations of what is achieved by this. The physical assessment for acute medical illness which may be concurrent with or related to the mental health presentation is very important.

This physical assessment is based on vital signs and a rapid appraisal of history to determine if the patient is low risk for acute organic illness. This does not clear the patient from future acute medical illness or change the status of stable chronic conditions.

It is important that there is clear guidance on the purpose of the medical assessment and its limitations.

The evidence as reviewed by the ECI suggests the risk for acute medical problems in psychiatric patients who are admitted to Psychiatric Units is small. The benefits of various investigations in cohorts of patients deemed low risk is very limited.

Using a form and checklist ensures that the vital signs are done. This can be followed by a broad and brief examination and systems review if the patient is not identified as low risk. Further investigations may evolve as indicated from this, such as pathology blood testing, urinalysis and CT scan if indicated from the initial screening exam.

The list of references below have been used to inform the development of the assessment form:


1. [Mental Health for Emergency Departments reference guide](#)
2. Olshaker, J.S., et al. Medical clearance and screening of psychiatric patients in the emergency department. *Acad Emerg Med* 4(2):124, February 1997
3. Korn CS, Currier GW, Henderson SO. "Medical clearance" of psychiatric patients without medical complaints in the emergency department. *Journal of Emergency Medicine* 2000;18 (2):173–176
4. Massachusetts College of Emergency Physicians / Massachusetts Psychiatric Society [Consensus Guidelines on The Medical Clearance](#)
5. Presentation including an algorithm for [Physical Screening of the Mental Health patient](#) by Dr Sue Ieraci, Bankstown ED

With thanks and recognition for work done, presentations used and forms developed by Dr Sue Ieraci, Bankstown ED and Dr Paul Middleton.


Developed by the ECI

Updated May 2012

APPENDIX 12: MINI MENTAL STATE EXAMINATION FORM



SMR060900

 NSW Health <small>GOVERNMENT</small>	FAMILY NAME	MRN
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Facility:	D.O.B: ____/____/____	M.O.
	ADDRESS	
MINI MENTAL STATE EXAMINATION (MMSE) <small>(Folstein MF, Folstein SE and McHugh PR 1975)</small>		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

MEMORY AND COGNITIVE SCREENING TEST

Date Time

Assessor's Name Assessor's Signature

PATIENT/CLIENTS DETAILS

Occupation Education Level

Hearing Vision

RECORD EXACT REPLIES. ENTER SCORES OUT OF MAXIMUM SHOWN. NO HALF MARKS AWARDED.

	SCORE	POINTS
1. ORIENTATION		
<i>What is the ?</i>		
Year	_____	1
Season	_____	1
Date	_____	1
Month	_____	1
Day of Week	_____	1
<i>Where are we ?</i>		
HOME	HOSPITAL	
Country	Country	1
State	State	1
Town / Suburb	Town / Suburb	1
Street	Place	1
Number	Floor / Room	1
2. REGISTRATION		
Name three objects, taking one second to say each, then ask the patient to repeat them (Score number correct at first attempt).		
Apple	Table	Coin
Repeat them until the person learns all three		_____ 3
Inform patient that you will ask for patient to recall them		
Number of trials (up to 6) required to learn the answers _____		
<i>Alternate words for subsequent tests - Ball, Car, Man, Cake, Book, Tie</i>		
3. ATTENTION AND CALCULATION		
(A) Serial Sevens (Take 7 away from 100 and keep taking 7 until I say stop - stop after five answers) Answers - 93, 86, 79, 72, 65		
(B) Spell WORLD backwards (score is the number of letters in correct order)		
NOTE - Complete both (A) and (B) and record the higher score.		_____ 5
4. RECALL		
Ask the person to name the three objects in Question 2.		_____ 3
5. LANGUAGE		
(A) Ask the patient to name the following as you point to them		
Pen	Watch	_____ 2
(B) Have the patient repeat		
"No ifs, ands or buts."		
		_____ 1
(C) Have the patient follow a three stage command (Ask the patient what their dominant hand is and frame the question to indicate their non-dominant hand).		
'Take this paper in your right/left (non-dominant) hand. Fold the paper in half. Put the paper down in your lap.		_____ 3

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR060900

MINI MENTAL STATE EXAMINATION (MMSE)

SMR060.900

NO WRITING

Page 1 of 2



Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

MINI MENTAL STATE EXAMINATION (MMSE)
(Folstein MF, Folstein SE and McHugh PR 1975)

(D) Have the patient read and obey the following

SCORE POINTS

close your eyes

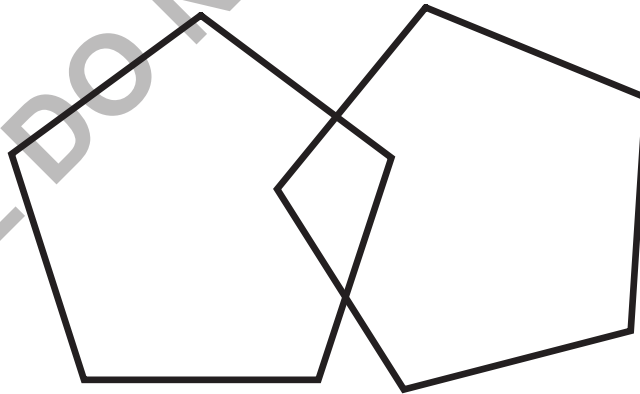
_____ 1

(E) Ask the patient to write a sentence below ★

_____ 1

6. CONSTRUCTION

Ask the patient to copy this design ★ ★



_____ 1

TOTAL SCORE

_____ **30**

★ To score section 5E. The sentence must have a subject, a verb and make sense. Correct grammar and punctuation are not necessary.

★ ★ To score section 6: The two diagrams must have 5 sides, with the intersecting shape having 4 sides.

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING



APPENDIX 13: PSYCHIATRIC TERMINOLOGY

Adjustment disorder: a disproportionate reaction to an identifiable psychosocial stress, which may include depressed mood, anxiety or volatile mood states/swings, behavioural disturbances and somatic complaints.

Affect: objective assessment of a person's emotional state. Described in terms of range and reactivity (from flat to blunted to restricted to normal to labile) and appropriateness (appropriate to inappropriate to the content of speech or ideation) and congruence to mood. Descriptors include euphoric, elevated, angry, irritable, and sad.

Agoraphobia: avoidance of places which the person associates with severe anxiety. It usually arises as a result of fear that they may have a panic attack and be unable to get help, and so be overwhelmed, humiliated or die.

Akathisia: a severe sense of internal agitation, most commonly in the legs, usually associated with neuroleptic medication. Akathisia may be very distressing with movements such as fidgeting, pacing, or inability to stay still.

Alcohol hallucinosis: auditory hallucinations occurring in a clear sensorium (i.e. not DTs) associated with cessation of alcohol consumption in a heavy drinker.

Alogia: an impoverishment in thinking that is inferred from observing speech and language behaviour. There may be brief and concrete replies to questions and restriction in the amount of spontaneous speech.

Ambivalence: simultaneous presence of contradictory emotions, attitudes, ideas or desires with respect to a particular person, object or situation.

Amnesia: loss of memory. Anterograde (inability to lay down new memories); retrograde (loss of memory for events preceding the condition presumed responsible for the amnesia).

Anhedonia: inability to enjoy activities that are usually pleasurable.

Anorexia nervosa: eating disorder with weight 15% or more below normal, intense fear of gaining weight, denial of the problem, preoccupation with body image and, in females, amenorrhea.

Antisocial behaviour: irresponsible behaviour which demonstrates a lack of respect for the rights of others, e.g. dishonesty, deceitfulness or abuse.

Anxiety: unrealistic worry, tension, or uneasiness resulting from anticipation of danger.

Anxiolytics: medications with a marked antianxiety effect (e.g. benzodiazepines).

Arousal: the physiological and psychological state of being awake or reactive to stimuli.

Attention: sustained focus on a particular activity.

Avoidance: the act of staying away from stress-related circumstances.

Avolition: lack of initiative or goals.

Behaviour therapy: a variety of techniques that aim to modify behaviour by analysing the factors which increase or decrease the frequency of the behaviour, and altering those factors to reduce the unwanted behaviour.

Bereavement: normal feelings of deprivation, desolation and grief at the loss of a loved one.

Binge-eating: distinct periods of overeating which the person feels unable to control, followed by depression, guilt, and self-loathing.

Bipolar disorder: mood disorder characterised by at least one manic or hypomanic episode (previously known as manic depressive disorder).

Bulimia nervosa: an eating disorder characterised by recurrent episodes of binge eating and behaviour to control weight (over-exercise, inducing vomiting, using laxatives and/or diuretics).

Catatonia: unusual motor abnormality associated with psychiatric illness. May be associated with reduced activity as in catatonic stupor or immobility; or excessive motor activity as in catatonic excitement; or marked negativism (purposeless resistance to attempts to move the patient's limbs) or posturing (maintaining bizarre postures or stances); or waxy flexibility (maintaining postures after the person's limbs have been moved by another person).

Catharsis: a sudden therapeutic release of emotion associated with attaining an insight, or following the release of repressed material.

Circumstantiality: speech that is long-winded and full of excessive or irrelevant detail, but which eventually gets to the point.

Clang associations: words are strung together according to their sound rather than their meaning (e.g. punning or rhyming which does not make logical sense).

Cognition: process of thinking, knowing and reasoning.

Cognitive: the mental process of comprehension, judgement, memory, and reasoning, in contrast to emotional and behavioural processes.

Coma: state of complete loss of consciousness.

Command hallucinations: hallucinations instructing the patient to perform a certain action. The patient may feel compelled to act on these instructions. Command hallucinations instructing the person to self-harm or harm others are indicators of extremely serious risk.

Co-morbidity: coexistence of any two or more illnesses. Commonly used to refer to co-existing mental illness and substance-use disorder, but can equally be a mental illness or intellectual disability or a physical illness (see dual diagnosis).

Community Treatment Order (CTO): an order made under the *NSW Mental Health Act 2007* that allows limited compulsory treatment in the community.

Compulsions: repetitive voluntary behaviours (e.g. checking, ordering, hand washing) or mental acts (e.g. counting, praying) coupled with a sense of compulsion, and (at least early on) a desire to resist the behaviour or mental act. They are performed with the intention of reducing distress or preventing some future catastrophe.

Concrete thinking: literal thinking, with limited ability to use metaphors or abstractions.

Confusion: disturbed orientation, inattention and reduced comprehension, often with emotional and behavioural disturbance.

Consultation-liaison psychiatry: sub-specialty of psychiatry with expertise in the psychiatric and psychosocial aspects of medical care.

Conversion: abnormality of motor or sensory neurological function for which no physical explanation can be found, unconsciously enacted to solve a strong emotional conflict (note that up to 50% of 'conversion symptoms' later turn out to have some organic component).

Coping mechanisms: a person's usual means of dealing with stress.

Counter-transference: feelings or emotions invoked in the therapist by the patient which arise as a result of the therapist unconsciously associating events from their own past with the current patient.

Crisis intervention: brief interventions aimed at helping the person deal with acute distress.

Defence mechanisms: a range of unconscious psychological processes, which protect the individual from dealing with distressing emotional conflict or anxiety. May be classified as immature (e.g. denial) or mature (e.g. humour); or as maladaptive or adaptive.

Delirium: an acute cognitive disorder characterised by acute onset of confusion, disorientation, inattention, incoherent speech and fluctuating level of consciousness.

Delusion: a fixed false belief, which is not culturally appropriate, and which is sustained despite evidence that it is false. Delusions are not amenable to rational persuasion. Types of delusion include grandiose, persecutory, religious, jealousy, somatic, nihilistic or bizarre.

Delusions of control: the belief that one's feelings, impulses, thoughts or actions are not one's own but have been imposed by some external force.

Delusions of reference: delusion that things, actions or events have a particular significance for the person, or are being staged in order to communicate with them (e.g. the delusion that every car with a number plate with a six in it belongs to the devil). Ideas of reference have a similar theme but do not reach delusional intensity.

Dementia: an acquired decline in memory and cognition (language, judgement, reasoning, information processing, visual-spatial ability, orientation, calculating skills) that results in significant impairment of personal, social or occupational function.

Dependence, substance: the person has tolerance; withdrawal symptoms when use ceases; persists with use despite knowledge of harm, or that functioning is adversely affected.

Depersonalisation: altered perception of self such that the person feels they are outside themselves, observing rather than participating, or are otherwise unreal.

Depression (common usage): feelings of sadness, despair, and discouragement, which are part of normal experience.

Disinhibition: orientation towards immediate gratification, leading to impulsive behaviour driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.

Disorientation: impaired awareness of the location of the self in relation to time (time of day, date or season), place (person's location), or person (who one is).

Derealisation: altered perception such that the external world seems unreal.

DSM 5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: Published by the American Psychiatric Association and contains a comprehensive classification system of psychiatric disorders, with clear diagnostic criteria.

Detachment: aloofness from interpersonal contact.

Devaluing: attribution of exaggeratedly negative qualities to oneself or others.

Disability: is the restriction of function occasioned by the impairment (e.g. disorganisation affecting work performance).

Dissociation: the splitting of clusters of mental contents from conscious awareness, altering the sense of self of the person. Derealisation and depersonalisation are examples.

Distractibility: difficulty concentrating and focusing on tasks.

Dual diagnosis: co-existence of two disorders commonly psychiatric and substance abuse; also refers to co-existence of psychiatric disorder and intellectual disability.

Dyskinesia: distortion of voluntary movements with involuntary muscle activity.

Dysphoria: a mental and emotional conditions in which a person experiences intense feelings of depression, discontent, and in some cases indifference to the world around them.

Dystonia: involuntary muscle contraction resulting in sustained abnormal movement or posture. May be drug-induced, hereditary or idiopathic, and local or generalised.

Acute dystonias: secondary to neuroleptic medication are extremely distressing and potentially fatal. Specific types include laryngospasm, oculogyric crisis ('look-ups') and opisthotonos.

Dysthymia (dysthymic disorder): chronic depressed mood over at least two years, with some mild symptoms of depression (but not severe enough to be major depression).

Echolalia: 'parrot-like' repetitive echoing of other people's words or phrases, often with mocking or staccato intonation.

Echopraxia: mimicking the movements of others.

Electroconvulsive therapy (ECT): therapeutic use of electric current to induce convulsive seizures (a very effective treatment for some psychiatric illnesses, particularly severe depression).

Emotional lability: instability of emotional experiences and mood.

Empathy: insightful and objective understanding and awareness of the feelings and behaviour of another person, combined with concern for the welfare of the person. By contrast sympathy is usually non-objective and non-critical.

Entitlement: an unreasonable expectation of special attention, status or treatment.

Euphoria: where a person experiences intense feelings of wellbeing, elation, happiness, excitement and joy.

Factitious disorders: disorders characterised by intentional production or feigning of physical or psychological symptoms; related to a need to assume the sick role rather than for obvious secondary gains such as financial reward.

Fatigue: weakening or depletion of one's physical and mental resources.

Fear: an emotional response to perceived imminent threat or danger associated with urges to flee or fight.

Flashbacks: a dissociative state during which aspects of a traumatic event are re-experienced as though they were occurring at that moment.

Flight of ideas: extremely rapid speech with abrupt changes from one topic to another. The person cannot express ideas as quickly as they come into his or her head.

Formal thought disorder: an inexact term referring to a disturbance in the form of thinking rather than to abnormality of content.

Formication: the sensation of something crawling under one's skin, e.g. ants or insects.

Fugue: a dissociative disorder marked by sudden, apparently random travel away from home, inability to recall their personal history, and often assumption of a new identity.

Grandiosity: exaggerated sense or claims of one's importance.

Hallucination: a sensory perception in the absence of an actual external stimulus. Types include auditory (voices, music, other noises); olfactory; somatic (physical sensation within the body); tactile (sensation of something on or under the skin); and visual.

Hallucinosi: hallucinations in which reality testing is not impaired (i.e. the patient realises they are hallucinating).

Hyperventilation: rapid breathing usually associated with anxiety, producing complaints of light-headedness, faintness, tingling of the extremities, and palpitations.

Hypervigilance: an enhanced state of sensory sensitivity accompanied by an exaggerated intensity of behaviours whose purpose is to detect threats.

Hypomania: elevated mood, unrealistic optimism, pressure of speech and activity, and a decreased need for sleep, which is not quite as extreme as mania.

Idealisation: attribution of exaggeratedly positive qualities to the self or others.

Ideas of reference: incorrect interpretation of casual incidents and external events as having direct reference to oneself.

Identity: sense of self and unity of personality over time.

Illusion: misperception of a real external stimulus (e.g. a shadow is seen to be a figure walking toward you). Found in delirium.

Impairment: any loss or abnormality of psychological, physiological, or anatomical structure or function (e.g. hallucinations resulting in distorted perception).

Impulse control disorders: inability to resist an impulse, drive, or temptation to perform some act that is harmful to oneself or to others (e.g. pathological gambling, kleptomania, and trichotillomania).

Incoherence: communication is so disorganised and senseless that the main idea cannot be understood.

Insight: the extent of an individual's awareness of his or her situation and illness. There are varying degrees of insight. For example, an individual may be aware of his or her problem but may believe that someone else is to blame for the problem. Alternatively, the individual may deny that a problem exists at all. The assessment of insight has clinical significance since lack of insight generally means that it will be difficult to encourage the individual to accept treatment.

Insomnia: a subjective complaint of difficulty falling or staying asleep, or poor quality of sleep.

La belle indifference ('beautiful indifference'):

inappropriate lack of concern about a disability, classically seen in conversion disorder.

Lability: rapidly shifting or unstable emotions.

Limit setting: providing external containment of a person's distress by agreeing on the 'limits' of acceptable behaviour, and agreeing on the negative consequences if behaviour exceeds those limits. Limit setting is used by experienced therapists as a tool to reduce acting-out behaviours.

Loosening of associations: thought disorder in which ideas continually shift from one unrelated subject to another.

Magical thinking: belief that thoughts, actions or words may have power to affect events directly.

Mania: a mood disorder characterised by excessive elation, inflated self-esteem and grandiosity, hyperactivity, agitation, and accelerated thinking and speaking.

Mannerisms: a peculiar and characteristic individual style of movement, action, thought, or speech.

Melancholia: a mental state characterised by very severe depression.

Mental disorder: mental disorder may be defined as a significant impairment of an individual's cognitive, affective, and/or relational abilities which may require intervention and may be a recognised, medically diagnosed illness or disorder.

Mental health: state of being that is relative rather than absolute. The best indices of mental health are simultaneous success at working, loving, and creating, with the capacity for mature and flexible resolution of conflicts between instincts, conscience, important other people, and reality.

Mental status examination: process of estimating psychological, behavioural and cognitive function by observing and talking with the patient.

Mood: subjective experience of emotion as reported by the person.

Mood disorder: illness with disturbance of mood as the primary symptom. Includes depressive disorders as well as those with mania and hypomania.

Munchausen's syndrome: a severe chronic factitious disorder in which the patient attends many different hospitals with fabricated symptoms, often under different names, and often undergoes multiple invasive procedures and operations. It is thought the motivation is to assume the sick role.

Munchausen's by proxy: seeking treatment for symptoms, which they have fabricated in another (usually a child; but without intention of seeking external gain).

Mutism: refusal to speak; maybe for conscious or unconscious reasons.

Narcissism: excessive self-love.

Negative symptoms: symptoms characteristic of schizophrenia that are associated with a loss of functioning of some kind (e.g. alogia, reduced initiative and motivation, social withdrawal, cognitive impairment, blunted affect and anhedonia).

Neologism: an invented new word or expression that has no meaning to anyone other than the individual for example, 'I have a helopantic under my foot'.

Nightmare disorder: repeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to survival.

Obsessions: recurrent, intrusive unwanted mental thoughts, ideas, images, fears or impulses that the patient knows are absurd or unreasonable, but recognises as coming from their own mind. They are often of an aggressive, sexual, religious, disgusting or nonsensical nature, and cause distress to the patient.

Obsessive compulsive disorder (OCD): obsessions and/or compulsions which cause marked distress, are time-consuming or significantly interfere with the person's normal routine, occupational functioning, social activities or relationships.

Oppositional defiant disorder: a pattern of excessive negativistic and hostile behaviour in a child that lasts at least six months.

Organic mental disorder: mental illness, or symptom suggestive of mental illness, caused by an underlying physical or structural abnormality (such as a brain tumour or an endocrine disorder). There is general agreement that it is difficult, if not impossible, to make clear distinctions between 'organic' and 'non-organic' (functional).

Orientation: awareness of one's self in relation to time, place, and person.

Overvalued ideas: an unreasonable and sustained belief that is maintained with less than delusional intensity.

Panic: sudden, overwhelming anxiety of such intensity that it produces terror and physiological changes.

Panic disorder: recurrent, unexpected panic attacks.

Paranoia: an intricate, complex, and elaborate delusion based on misinterpretation of an actual event. Other signs of psychosis are minimal, and the person often functions well.

Parasomnia: disorders of sleep involving abnormal behaviours or physiological events occurring during sleep or sleep/wake transitions .

Perseveration: excessive repetition of the individual's own words or ideas in response to different stimuli.

Personality: the long-standing and characteristic way in which a person thinks, feels, and behaves. A widely used model identifies five dimensions to classify personality style: neuroticism versus emotional stability; extraversion versus introversion; openness versus closedness to experience; agreeableness versus antagonism; and conscientiousness versus negligence.

Personality traits: imprecise term to describe aspects of a person's personality. Often used to describe consistent maladaptive responses, which do not reach full diagnostic criteria (e.g. the patient has antisocial and borderline personality traits).

Personality disorder: characteristic patterns of feeling, behaving and thinking about the environment and oneself that are inflexible and maladaptive, and result in distress or impaired functioning. Three clusters are identified: (a) paranoid, schizoid, schizotypal; (b) antisocial, borderline, histrionic, narcissistic; (c) avoidant, dependent, obsessive-compulsive.

Phobia: severe anxiety related to a specific object or situation, even though the subject recognises that the fear is excessive or unreasonable. The object or situation is avoided or endured with marked distress.

Positive symptoms: symptoms of psychosis that are thought of as an exaggeration or distortion of normal processes (e.g. hallucinations, delusions, or tangentiality).

Posturing: spontaneous and active maintenance of a posture against gravity.

Poverty of speech: restriction in the amount of speech. Pressured speech: rapid, accelerated, frenzied speech. Primary gain: reduction of psychological distress as a result of the use of an unconscious defence mechanism (e.g. somatisation).

Projection: primitive defence in which one attributes one's own conflicted feelings and wishes onto another person.

Prodrome (Precursor): an early or premonitory symptom or set of symptoms of a disease or a disorder.

Psychomotor retardation: slowing of physical movements and emotional reactions commonly secondary to depression.

Psychosis: gross impairment in reality testing, typically shown by delusions, hallucinations, or thought disorder, or bizarre or disorganised behaviour.

Racing thoughts: a state in which the mind uncontrollably brings up random thoughts and memories and switches between them very quickly.

Rapid cycling: the presence of at least four mood episodes in the previous 12 months.

Repetitive speech: morphologically heterogeneous iterations of speech.

Restless leg syndrome: an urge to move the legs, usually accompanied or caused by uncomfortable and unpleasant sensations in the legs.

Risk taking: engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences.

Schizophrenia: one category from the broader group of psychotic disorders. Diagnosis requires that symptoms be present continuously for at least six months, that there be at least one month of active psychotic symptoms, and that there is significant occupational or social dysfunction. Course is variable, with complete remission, episodic relapse and continuous symptoms all described. It is usually not possible to make a definitive diagnosis from a first assessment of someone presenting with psychotic symptoms – diagnosis requires observation over a sustained period. Do not assume that a person with psychotic symptoms has schizophrenia. See DSM 5 for full diagnostic criteria.

Schizophreniform disorder: psychotic symptoms present for between one and six months. It is preferable to use the more generic and less stigmatising term 'psychotic disorder'. See DSM 5 for full diagnostic criteria.

Schizoaffective disorder: a disorder in which there are clear affective episodes (major depressive, manic, or mixed episodes) coexisting with symptoms of schizophrenia. See DSM 5 for full diagnostic criteria.

Social phobia (social anxiety disorder): persistent fear and avoidance of social situations that might expose one to scrutiny by others and induce one to act in a way or show anxiety symptoms that will be humiliating or embarrassing.

Somatisation: the conversion of mental states or experiences into bodily symptoms, presenting as multiple physical complaints with no objective evidence of organic impairment.

Stress reaction: an acute, maladaptive emotional response to industrial, domestic, and other calamitous life situations.

Suicidal ideation: thoughts about self-harm, with deliberate consideration or planning of possible techniques of causing one's own death.

Suicide: the act of intentionally causing one's own death.

Suicide attempt: an attempt to end one's own life, which may lead to one's death.

Sundowning: worsening of symptoms of delirium at night. Also used to refer to the emergence at night of disruptive behaviours in dementia patients.

Suppression: the conscious effort to control and conceal unacceptable impulses, thoughts, feelings or acts.

Suspiciousness: expectations of and sensitivity to signs of interpersonal ill intent or harm; doubts about loyalty or fidelity of others; feelings of being mistreated, used or persecuted by others.

Tangentiality: replying to a question in an oblique or irrelevant way.

Tarasoff decision: a California-court decision that essentially imposes a duty on the therapist to warn the appropriate person or persons when the therapist becomes aware that the patient may present a risk of harm to a specific person or persons. Widely seen as (an untested) standard for Australian therapists.

Tardive dyskinesia: neuroleptic-induced / medication-induced movement disorder consisting of involuntary choreiform, athetoid, or rhythmic movements of the tongue, jaw, or extremities developing with long-term use (usually a few months or more) of neuroleptic medication. Over a 10-year period, up to one-third of patients on a long-term antipsychotic medication may develop tardive dyskinesia.

Thought-blocking: a sudden obstruction or interruption in spontaneous flow of thinking or speaking, perceived as an absence or deprivation of thought.

Thought-broadcasting: delusion that your thoughts can be heard by others.

Thought insertion: delusion that other people are putting thoughts inside the person's mind.

Thought disorder: disruption in the sequence, order and logic of thought, as reflected in speech and in the execution of actions. Formal thought disorder is a disturbance in the form rather than in the content of thought (e.g. loosening of associations).

Tic: an involuntary, sudden, rapid, recurrent, nonrhythmic motor movement or vocalisation.

Tolerance: a situation that occurs with continued use of a drug in which an individual requires greater dosages to achieve the same effect.

Transference: the unconscious assignment to others of feelings and attitudes that were originally associated with important figures (parents, siblings) in one's early life. Transference may affect the patient/clinician/relationship either positively or negatively.

Waxy flexibility: slight, even resistance to positioning by examiner.

Word salad (verbigeration): a mixture of words and phrases that lack comprehensive meaning or logical coherence.

For a full range of mental health terms see the Glossary of Technical Terms section of the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5).

AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FIFTH EDITION DSM-5. WASHINGTON, DC. AMERICAN PSYCHIATRIC PUBLISHING, JUNE 2013

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