Patients with Mental Health Problems

Always use a calm empathic approach to patients with mental illness –they respond best to someone who listens to them properly. Common conditions that you will encounter are self harm, substance abuse, depression with suicidal ideation and panic attack disorder. Many of these presentations are commonest during the night.

Your first task is to exclude psychosis:

Is there any evidence of rational thinking loss?

If the patient is psychotic, your second task is to exclude organic disease requiring medical treatment (until an organic cause is excluded the patient must remain under your care).

Are there any Features that suggest Organic Psychosis?

- **Sudden onset**
- **Fluctuation**
- **Non-auditory hallucinations**
- **Clouding of Consciousness (Orientation must be assessed and documented properly)**
- **Disturbed cognitive function –eg serial 7s**
- **Identifiable cause of confusion eg alcohol or drug misuse, sepsis, head injury, metabolic or electrolyte disturbance**

Your third task is to decide if the patient poses an immediate threat to themselves or other people.

Is there a reasonable suspicion that he/she may harm someone?

All patients presenting with self harm (either self poisoning or self cutting etc) will require an early suicide risk assessment. This is carried out by the Emergency Department doctor and the patient recorded as "high" or "low" risk. No one can carry out an adequate psychiatric assessment on an intoxicated patient but you are still obliged to carry out a risk assessment. It is comforting that virtually all self-harming patients become less suicidal as they sober up.

High Risk Features following self harm

- **Patient expected they would die and made no provision for own safety**
- **Firm Evidence of planning**
- **Patient still clearly articulates suicidal plans (note that some patients with personality disorder also do this)**
- **Patient has easy access to choses means of suicide**
- **May be uncommunicative, refusing to discuss self harm event**
- **Unwilling or reluctant to accept medical treatment**
- **APPEARS ACUTELY DISTURBED, PSYCHOTIC OR INAPPROPRIATELY CALM**

If high-risk patients leave before examination or treatment you must notify the Police that they have left contrary to advice and may be at risk of further self harm. They will probably need to be detained under Mental Health Order.

If you conclude that the patient has a non-organic psychosis that puts him/herself or others at immediate risk the patient should be detained form psychiatric assessment under the Mental Health (NI) Order 1986 (see below). He or she MUST be discussed with the RAID team and if formal section reqi=uired they will help you to facilitate this

DO NOT KEEP PATIENTS WHO ARE MEDICALLY FIT FOR DISCHARGE IN ANY PART OF EMERGENCY DEPARTMENT OR ANTRIM OVERNIGHT TO AWAIT MENTAL HEALTH ASSESSMENT – SEEK EMERGENCY DEPARTMENT SENIOR HELP IF NECESSARY

(see Legal Issues, Deliberate Self Harm, Drug and Solvent Abuse Poisoning, Violent psychotic patient)

THE MENTAL HEALTH ORDER ONLY APPLIES TO CONDITIONS THAT ARE CAUSED BY MENTAL ILLNESS. IT DOES NOT PERMIT YOU TO DETAIN PATIENTS IN ANTRIM HOSPITAL OR TO TREAT PATIENTS WITHOUT CONSENT. IF YOU DECIDE THAT A PATIENT DOES NOT HAVE THE CAPACTIY TO CONSENT AND THAT IT IS IN HIS/HER BEST INTERESTS TO RESTRAIN AND TREAT THEM YOU ARE RELYING ON COMMON LAW.
(see GMC Publication "Seeking Patient's consent: the ethical considerations" 1998, available online at www.gmc-uk.org)

Field Code Changed

Use of the Mental Health Order

Mental illness is defined as a "state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he requires care or medical treatment in his own interests or the interests of other persons."

Compulsory admission for assessment of a patient can only occur when:

1. He or she is suffering from a mental disorder of a nature or degree which warrants detention in hospital for assessment (or for assessment followed by medical treatment)

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AND

2. Failure to detain the patient would create a substantial likelihood of serious physical harm to him or herself or to other persons

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ie the questions in mind are:
Is there any possible evidence of mental illness?

AND
Is there a substantial risk of serious physical harm to the patient or others?

Criteria for likelihood of serious physical harm are evidence of one of the following:

1.
2. **The patient has inflicted, or threatened or attempted to inflict, serious physical harm on him/herself**
3. **The patient's judgement is so affected that he or she is, or would soon be, unable to protect him/herself against serious physical harm and that reasonable provision for his/her protection is not available in the community or**
4. **The patient has behaved violently towards other persons or so behaved him or herself that other persons are placed in reasonable fear of serious physical harm to themselves**

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HOW TO ARRANGE A MENTAL HEALTH ORDER ASSESSMENT

Always discuss with the duty psychiatrist in Holywell (2nd on call) or the Emergency Department consultant on-call. To obtain compulsory psychiatric assessment Forms One and Three must be completed.

Form One

An application for compulsory admission needs to be made by either the *nearest relative* (on form 1) OR an *Approved Social Worker*) (on form 2). Guidance on who is considered to be the "nearest relative" is on the back of Form 1. You must discuss the case in private with the relatives and explain what is needed and take them through the form. An approved social worker can be contacted by our hospital SW team or, out-of-hours by Ambulance Control.

Form Three

There must also be a *Medical Recommendation* for psychiatric assessment made on Form 3 either by the patient's GP or someone acting on behalf of the GP. Form 3 is the only Doctors' form that applies in the Emergency Department setting and when you complete it you are acting in place of the patient's GP (always try to contact the GP or deputy first). Note that this only applies to patients with mental illness, not organic psychosis, intoxication, drug abuse and so on.

The application is usually addressed to Homefirst Community Trust, The Cottage, Ballymena (Holywell Hospital is part of that Trust). Your application on the form must include the following information: the grounds (including a clinical description of the mental condition of the patient) for the opinion that the detention is warranted; the evidence for the opinion that failure to detain the patient would create a substantial likelihood of serious physical harm.
A diagnosis of the specific form of mental disorder is not required .

When a patient is detained via Mental Health Act Forms, they are legally binding documents, they cannot be disregarded. They can only be "cancelled" after an assessment by *a psychiatrist*. YOU MUST NEVER DISREGARD, TEAR UP OR LOSE A COMPLETED MENTAL HEALTH ACT APPLICATION.

As already discussed we have access to mental health professionals 24hr a day via the RAID team refer via 331286 which is a 24 hr referral number. The Raid team will also regularly round in the ED to look for any suitable patients for them. Dual medical and psychiatric assessment is encouraged, that is to say there is no expectation that medical treatment should be complete prior to psychiatric assessment commencing.

If high risk patients leave before examination or treatment you must notify the Police that they have left contrary to advice and may be at risk of further self harm. They will probably need to be detained under Mental Health Order.

Drug and Solvent Abuse (see also Poisoning, Legal Issues)

This may present with acute poisoning or with the consequences of chronic abuse. Children as young as 10 have presented to this department with drug related symptoms. Substance abuse is often concealed by the patient and you have to have a high index of suspicion:-

Look out for the following:-

- muscle twitching & jaw spasm - Ecstasy
- peri-oral rash - glue sniffing
- minor psychiatric illness - any
- panic attacks/palpitations – any
- pin point pupils/marks on forearms etc - opiate

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Acute presentations of non-opiate drug abuse do not automatically require admission, even if the patient is distressed. Admit if significantly altered vital signs and/or mental state. A responsible adult must supervise discharges.

All patients who have collapsed/overdosed on Heroin or other opiates must be admitted even if apparently recovered.

The signs of opiate withdrawal include agitation, nausea & vomiting, diarrhoea, shivering & "goosebumps", muscle cramps and dilated pupils. Oral benzodiazepines are the sedation of choice. You should seek advice from the addiction team at Holywell hospital urgently.

National guidelines for:

- the investigation/management of iv drug abusers who present with systemic sepsis or marked local reactions
- management of ivda in general

are available in the computer room. The former were produced after a number of unexplained deaths involving ivda patients in Glasgow and Dublin.

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The Violent Psychotic Patient (see Section One 'Arguments', Legal Issues and Mental Health Act

- Refer to the hospital and college of emergency medicine protocols on rapid tranquilisation

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You must take reasonable steps to exclude a physical cause for violence/confusion – consider hypoxia, metabolic upset, CNS lesion etc

Alcohol Withdrawal Syndrome and Dealing with the Problem Drinker

Alcohol withdrawal syndrome (AWS) is a set of symptoms caused by ABRUPTLY stopping drinking after prolonged heavy consumption. Because of its affect on the brain and autonomic nervous system, it carries the risk of death or permanent neurological disability so it requires careful management. Unfortunately, most patients who are problem drinkers are difficult to assess and very difficult to manage. Their relatives and GPs are often at their wits' end, adding to the pressure on you.

MENTAL HEALTH PROBLEMS

Some patients who require admission for another condition develop AWS in the ward necessitating treatment–this is *secondary* detox. This section considers *primary* detox only ie patients for whom AWS or a detox request is the presenting problem.

Medical Evidence now suggests that

- Reducing intake gradually rather than total abstinence may be more effective for many patients and it should avoid AWS
- Repeated failed detox (often requested impulsively by patients due to psychosocial pressures) is harmful to the patient leading to seizures and more severe AWS in the future
- Most patients requiring detox can be managed solely in the community
- Refer patients to RAID team for a brief intervention and onward referral to Community addictions team

Guideline for the Community Management of AWS

- **Identify the patient's suitability using pre-admission assessment flowchart**
- **Document baseline examination for WKS: confusion?, ataxia?, opthalmoplegia?: if present admit SSW**
- **Carry out brief intervention using FRAMES method (box below)**
- **Dispense maximum of chlordiazepoxide 15mg qid for two days, chlordiazepoxide 10mg tid for two days pending GP assessment**
- **Dispense Thiamine 100mg bd**
- **Advise that some sleep disturbance is inevitable during the recovery process**
- **Advise NOT to drink while taking chlordiazepoxide!**
- **Advise to see GP at first available appointment**
- **Advise to re-attend Emergency Department for re-assessment if becomes acutely unwell on this regime**

Guideline for the initial observation ward management of patients with alcohol dependency (admitted for other reason)

- **Identify patients suitability using pre-admission assessment flowchart on next page**
- **Place on GMAWS chart**
- **Prescribe chlordiazepoxide 40-60mg orally at *6,12,6 & 12* (if necessary seek advice re dose)**
- **Prescribe Chlordiazepoxide 30mg orally prn hourly for persistent agitation**
- **Prescribe lorazepam 1-2.5mg iv prn 2 hourly with close medical monitoring for severe breakthrough agitation requiring restraint**
- **Resistant severe agitation may require administration of phenobarbitone on an anti-psychotic preparation – speak to a consultant**
- **Advise that some sleep disturbance is inevitable during the recovery process. Minimise risk of delirium by avoiding monitors, drips and disturbances overnight**
- **Prescribe Pabrinex Twin Amps three times daily by iv infusion (NB Check for HYPOGLYCAEMIA & correct <u>after</u> Pabrinex given)**

BRIEF INTERVENTION

- **<u>F</u>EEDBACK: of your assessment of the situation**
- **<u>R</u>ESPONSIBILITY is the patient's alone**
- **<u>A</u>DVICE to stop drinking**
- **<u>M</u>ENU of options to help**
- **<u>E</u>MPATHY ie. Show warmth and understanding**
- **<u>S</u>ELF-EFFICACY ie encourage the patient to believe that abstinence or reduction is achievable**

ALCOHOL & THE LAW

Not infrequently, patients with alcohol withdrawal syndrome or other alcohol-related disorder will try to leave hospital or will refuse treatment. For example, during rapid sedation of the agitated patient some level or temporary restraint is often employed. It is important for staff who treat such patients to understand both their duty of care and their legal position in relation to these issues.

Firstly, doctors should be aware that the Mental Health (NI) Order 1986 can NOT be used to detain patients with alcohol problems for compulsory assessment unless they have an intercurrent mental illness that mandates compulsory assessment

Secondly, the law presumes that all registered medical practitioners are qualified to make an assessment of a patient's capacity to consent of refuse medical treatment. Patients with alcohol-related problems MAY have impaired capacity (see capacity checklist below) and in this event a doctor may impose restraint or treatment under the authority of Common Law providing that all the following stringent conditions apply:
-That there is the *urgent necessity* for treatment
-That the intervention is in the patient's *best interests*
-That the doctor is acting in *good faith* in line with what a responsible body of medical opinion would do in the situation

Capacity Checklist

Patient understands what the proposed treatment is and its purpose
Patient understands the main risks, benefits and alternatives
Patient understands the consequences of refusing treatment
Patient believes the information
Patient can retain the information long enough to make a judgement

If a patient has the capacity to withhold consent for treatment (this includes leaving the hospital contrary to advice), treatment MUST not be imposed on the patient irrespective of the consequences. The practice of notifying PSNI that a patient has left contrary to advice is rarely appropriate and a medical practitioner should always be involved in this decision for the reasons explained above.

DEPARTMENT OF EMERGENCY MEDICINE HELPLINE 9446 6446

FAX TO GP FOR COMMUNITY DETOXIFICATION FROM ALCOHOL

Name: _____ ***Address:*** _____

Date of Birth: _____ ***ED Number***: _____

Date of Attendance: _____

Your patient attended Antrim Emergency Department today with a primary detoxification request due to prolonged heavy alcohol consumption. He/she did not fulfil our inpatient detoxification criteria* and he/she has been discharged with the following medication:-

☐

Day One	Chlordiazepoxide 30mg qid
Day Two	Chlordiazepoxide 20mg qid
Day Three	Chlordiazepoxide 10 mg qid
Day Four	Chlordiazepoxide 10mg bd
Day Five	Chlordiazepoxide 10mg nocte

☐

Day One	
Day Two	
Day Three	
Day Four	
Day Five	

3

Vitamin Supplements

Thiamine 100mg bd for 28 days

and

Ascorbic Acid 500mg mane for 14 days

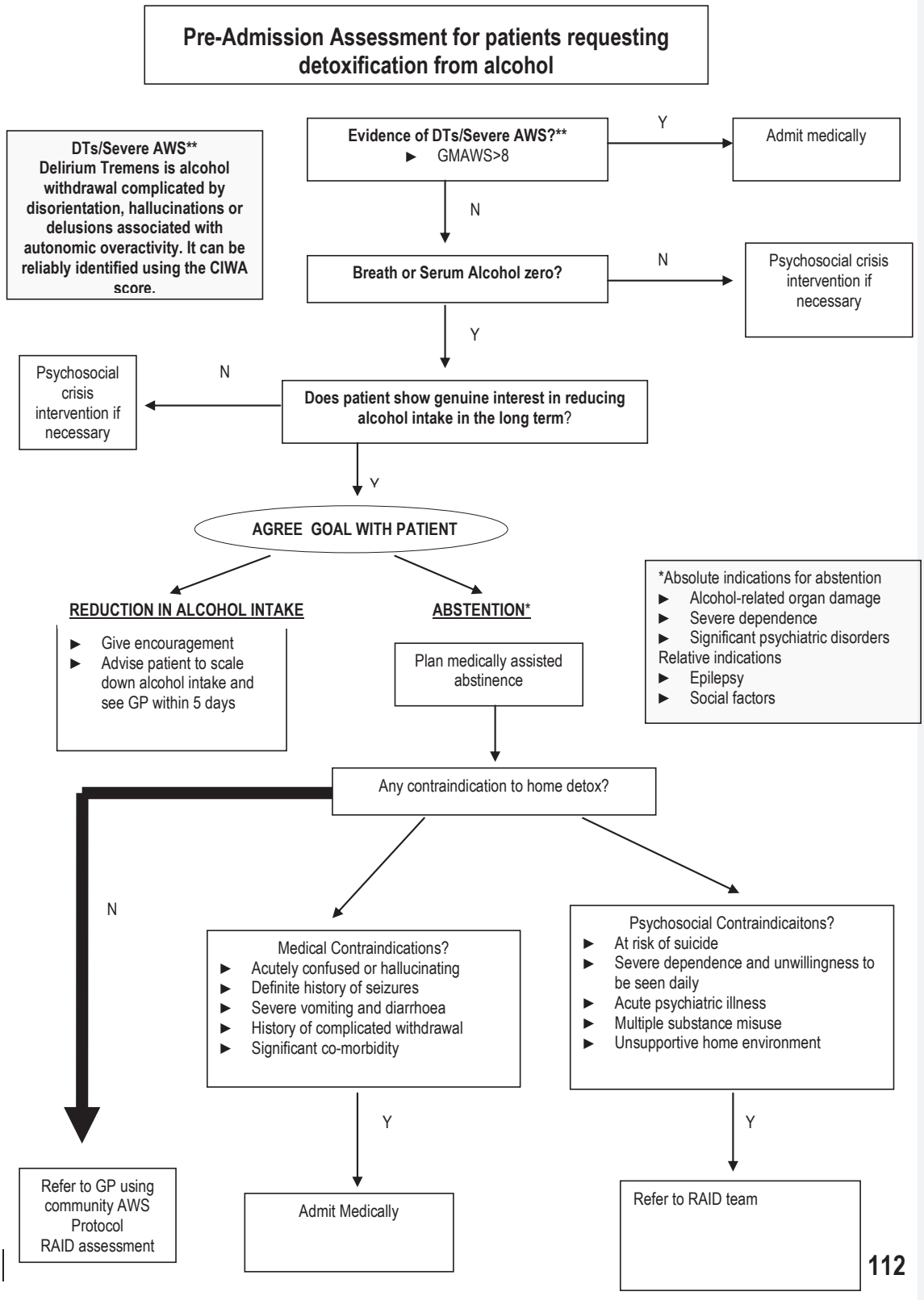
Your patient has been advised to contact your surgery to request a review around 48 hours after discharge from the Emergency Department. Please consider referring to the Addictions Team for follow up. He/she has also been advised to attend either Antrim Emergency Department or yourself should there be any further problems.

Additional Comments _____

_____

Signed _____ **ED Doctor** _____ **PRINT**

Always fax this with Emergency Department Detox Fax Cover Sheet and retain the original in the patient's Emergency Department notes


Pre-Admission Assessment for patients requesting detoxification from alcohol
DTs/Severe AWS**
Delirium Tremens is alcohol withdrawal complicated by disorientation, hallucinations or delusions associated with autonomic overactivity. It can be reliably identified using the CIWA score.
Evidence of DTs/Severe AWS?**
► GMAWS>8
Y
Admit medically
N
Breath or Serum Alcohol zero?
N
Psychosocial crisis intervention if necessary
Y
Psychosocial crisis intervention if necessary
N
Does patient show genuine interest in reducing alcohol intake in the long term?
Y
AGREE GOAL WITH PATIENT
REDUCTION IN ALCOHOL INTAKE
► Give encouragement
► Advise patient to scale down alcohol intake and see GP within 5 days
ABSTENTION*
Plan medically assisted abstinence
*Absolute indications for abstention
► Alcohol-related organ damage
► Severe dependence
► Significant psychiatric disorders
Relative indications
► Epilepsy
► Social factors
Any contraindication to home detox?
N
Medical Contraindications?
► Acutely confused or hallucinating
► Definite history of seizures
► Severe vomiting and diarrhoea
► History of complicated withdrawal
► Significant co-morbidity
Psychosocial Contraindicaitons?
► At risk of suicide
► Severe dependence and unwillingness to be seen daily
► Acute psychiatric illness
► Multiple substance misuse
► Unsupportive home environment
Y
Y
Refer to GP using community AWS Protocol
RAID assessment
Admit Medically
Refer to RAID team

Glasgow Modified Alcohol Withdrawal Score	
Tremor 0) No tremor 1) On movement 2) At rest	
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats	
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable	
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact	
Agitation 0) Calm 1) Anxious 2) Panicky	
Score	
Treatment	

Score

Do not use scoring tool if patient is intoxicated; must be at least eight hours since last drink.

0	Repeat score in two hours (discontinue after scoring on four consecutive occasions, except if less than 48 hours after last drink)
1–3:	Give 10mg diazepam: repeat score in two hours
4–8:	Give 20mg diazepam: repeat score in one hour
9-10:	Give 20mg diazepam : repeat score in one hour; discuss with medical staff

This screening tool provides a simple way of scoring the level of alcohol withdrawal and matching this with recommended diazepam doses

We use chlordiazepoxide instead of diazepam GMAWs charts are available on symphony