



# **Emergency Mental Health**

Educational Manual

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## Foreword

The safe and effective management of mental health emergencies is a very important component of a comprehensive system of services to individuals with mental illness and their families. Often, that is the point of entry to treatment, and frequently, it is a time of distress and turmoil. Good quality care at this point prepares a path for recovery and constitutes a critical opportunity to effect both immediate and long term benefits.

So important is this component of treatment, that it has been recognized as one of the key areas in mental health reform in the document "Best Practices in Mental Health Reform" prepared by the Clarke Institute Health Systems Research Unit for the Federal/Provincial/Territorial Advisory Network for Mental Health. Similarly, the British Columbia Ministry of Health's Adult Mental Health Division have signalled the importance of emergency mental health services. Consequently, the Ministry of Health requested that the Mental Health Evaluation and Community Consultation Unit (Mheccu) at the University of British Columbia, undertake a project to support a number of British Columbia communities in their education of health professionals delivery of emergency mental health care. This project was undertaken in conjunction with facility improvements to a number of hospitals, in order to create safe environments for the provision of such care.

This education manual is a testament to the excellent work done by the project team, headed by Joe Noone and Alice Chan at Mheccu. Their work has been done in collaboration with many devoted individuals in the communities of: Creston, Fort Nelson, Fort St. John, Hazelton, Nelson, Prince Rupert, Princeton, and Saltspring, B.C. Furthermore, Gulrose Jiwani, of the Ministry of Health, Adult Mental Health Division, contributed substantially to the project.

With the appreciation of the good work of all those involved with the project, I am pleased that Mheccu has been able to support these efforts to provide good quality emergency mental health in our British Columbia communities.

Elliot Goldner  
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## Introduction

In the spirit of mental health reform in the province of British Columbia, the recognized scarcity of emergency mental health services in the rural and remote regions presents quality of care issues for the clients and you, the health care providers. The Hospital – Based Emergency Psychiatry Services: Observation Units Initiative sponsored by the Adult Division, Ministry of Health, is one attempt to address the complex service delivery issues in non-urban communities. The Observation Units Initiative is comprised of two components: (1) the construction of up to ten seclusion rooms in the rural and remote community hospitals, and, (2) the education and training of interdisciplinary staff who assess, manage, and treat clients requiring emergency mental health care.

This education manual is a core component of that education and training. To appropriately support and offer interdisciplinary staff the knowledge, skills, and attitudes necessary to safely and humanely manage these clients, the training involves many interactive elements that complement this manual.

The definitions for "crisis intervention" and "psychiatric emergency" are explained in the text. The term "emergency mental health" is also used. A crisis (and the need for crisis intervention) and a psychiatric emergency (and the need for psychiatric emergency care) form a continuum. In other words, a crisis can develop into a psychiatric emergency or a psychiatric emergency can resolve to become a crisis. "Emergency mental health" is a term that seems to best represent both concepts at this stage.

The term "client" or "patient" is used to represent a consumer, a resident, or a family member. The term "health care provider" or "clinician" is used to represent a member of the interdisciplinary staff (physician, nurse, psychologist, social worker, occupational therapist, physiotherapist, or other professional) within a hospital setting or a community health/mental health setting.

In the spirit of mental health reform and improved quality of care, the authors believe that emergency mental health will become increasingly interdisciplinary in practice. Integration between a hospital and its community is therefore a critical aspect in the provision of continuity of care.



# 1 Development of Emergency Mental Health Services



# Development of Emergency Mental Health Services

## Introduction

Emergency mental health services encompass both emergency psychiatry and crisis response. These are needed when urgent or emergency mental health intervention is required.

As a start, it might be helpful to explore the question, "what is emergency psychiatry?"

One approach is to attempt to define this term and then look at its development.

The preface to the 1990 *Manual of Clinical Emergency Psychiatry* (1) edited by Dr. Randy Hillard begins with: "Emergency psychiatry is about caring for people who need help right now."

Dr. Andrew Slaby, an early pioneer in emergency psychiatry in the United States, makes the point: "Emergency psychiatry care is the foundation upon which all further psychiatric care is predicated."

Definitions of emergency psychiatry vary and an adequate definition is one that involves both a statement of who defines the problem as well as an understanding of the biological, social, psychological and existential forces which converge upon the person to create a change in behavior requiring immediate intervention. An American Psychiatric Association task force in 1982 suggested the following definition: "A psychiatric emergency is an acute disturbance of thought, mood, behavior or social relationship as defined by the patient, family or the community."

A number of conditions are usually present:

1. An acute disturbance of mental function
2. A state of unpredictability, usually combined with a lack of response to social controls
3. Confirmation that the above criteria are caused by a psychiatric disorder

P.M. Kleespies, in *Emergencies in Mental Health Practice (2)* (1998), identifies the following related characteristics:

1. Acuteness or intensity
2. Seriousness or a high level of danger
3. Need for immediate treatment, without which irreversible harm or death might occur

A psychiatric emergency is therefore:

"an acute clinical situation in which there is an imminent risk of serious harm or death to self or others unless there is some immediate intervention" (Kleespies 1998)

There are relatively few situations in clinical practice that meet this threshold. These include serious suicidal states, violent states, and states of seriously impaired judgement in which an individual is endangered (delirium, dementia, acute psychosis, severe dissociative state, etc.).

The concepts of psychiatric (or psychological) "emergency" and "psychological crisis" have been "frequently confused or erroneously used interchangeably." (3)

A "crisis" is a serious disruption of the individual's baseline level of functioning, such that coping strategies are inadequate to restore equilibrium (a loss of psychological equilibrium). It is an emotionally significant event in which there may be a turning point for better or worse. It does not necessarily imply danger of serious physical harm or life threatening danger (as in an "emergency").

Those who work in emergency mental health services assess a variety of psychological crises and an important task is to distinguish between crises that may also be emergencies, and those that are not.

## Historical development of emergency psychiatry

Emergency psychiatry as a discernable strand in the development of psychiatry itself probably began to emerge after the Great War (1914-18) and evolved along separate and independent tracks until the 1960's when these began to merge.

### **Emergency ward of the general hospital**

In the 1920's psychiatric emergency care developed from the emergency response of large general hospitals in metropolitan areas. Heavily utilized city emergencies began to serve as a generalized "family doctor" to many patients. An increasing volume of psychiatric emergencies became the responsibility of psychiatric residents on call. This was usually an expedient arrangement to siphon off the mental patients from the more usual and "acceptable" flow of surgical/medical emergencies. Remnants of an uneasy quality to this adaptation persists in many emergencies where mental cases tend to be shunned, (along with other stigmatized patient groups such as the "sinful" patient [alcohol and drug intoxication/abuse, HIV disease]) both by emergency medicine and by traditional psychiatry.

### **The mental hospital**

In the large mental hospitals of the 1930's there was the creation of an "aftercare emergency" adjunct of the hospital for recently released patients handling the transition to post-hospital life. Former inpatients who were not sick enough to be reinstitutionalized but not well enough to survive in the community without professional support were the focus.

## Other developmental influences

### **Community psychiatry**

After World War II the development of community psychiatry blended the above mentioned origins of emergency psychiatry and increasingly influenced its development with non-hospital based urgent psychiatric responses and an as yet unfulfilled promise of replacing institutional care.

### **Deinstitutionalization**

Deinstitutionalization has been a major developmental influence that has changed emergency psychiatry over the last thirty or more years. Initially, deinstitutionalization promoted a shift in the focus of care from mental hospitals to the psychiatric units of general hospitals. These psychiatric units previously tended to serve a somewhat different patient population. Readmission rates spiraled and a new class

of roving indigent mentally ill surfaced, first in the U.S. where they are euphemistically and somewhat quaintly called the "homeless." These "dispossessed" patients reflect the reality that adequate resources did not follow patients from the institution to the community.

### **Emergency medicine**

A more recent development occurred after the U.S. war in Vietnam with the professional growth of emergency medicine itself to a specialty status.

## Implications

As a result of the development of emergency psychiatry, a number of findings are particularly pertinent to service delivery in this area. These include:

- The emergency departments of general hospitals increasingly tended to become the gate keeper to the mental health system.
- Improved quality of assessments by psychiatric emergency services should lead to more clinically appropriate decisions about who needs to be admitted and who does not need to be admitted.
- Many of the diagnostic groups that contribute to the problem of "chronic crisis patients" may not be best dealt with by traditional hospitalization.
- The orientation of psychiatric emergency services should develop from an emphasis on triage to incorporate crisis resolution, based on thorough assessment of available patient coping resources and of environmental supports.
- Psychiatric emergency services are uniquely positioned at the interface between the community and hospital and between in-patient and out-patient services and thus, can sensitively mirror changes in the philosophy and provision of mental health services.

The literature on emergency psychiatry tends to be conceptualized from the perspective of emergency psychiatry (generally by physicians) and emphasizes the acute reactions of patients with diagnosed psychopathology.



## Historical development of crisis intervention

The literature on crisis intervention tends to be found in psychology, social work and nursing and emphasizes disruptions in living experienced by relatively normal individuals who are treated in out-patient settings.

Crisis intervention literature rarely describes "emergencies."

Psychiatric emergency literature rarely defines or discuss "crisis."

The historical origins of crisis intervention differ from that of emergency psychiatry.

Influences in crisis intervention include the work of Erich Lindemann (1944) in describing the reactions of survivors of the 1942 Cocoanut Grove nightclub fire in Boston in which almost 500 perished ("stages of grief").

World War II and the Korean War were also influential where soldiers with "shell shock" or "traumatized neurosis" were treated close to the front line as opposed to being hospitalized at home. Crisis intervention principles include proximity, immediacy, expectancy and brevity (P.I.E.B.).

The concept of crisis as a "turning point" and as providing danger and opportunity comes largely from the work of Erik Erikson and his work outlining normative developmental crises throughout life.

A central influence was the work of Gerald Caplan on preventative psychiatry and on community mental health.

Another influence was the suicide prevention movement commencing in late 1950 in Los Angeles (Shneideman, Farberow, etc.) who originated the term "psychological autopsy."

## Recent history of psychiatry planning in British Columbia

By 1990, evolutionary or ad hoc planning, which is an adaptation to maintain the status quo, gradually gave ground to more formal organizational or systems planning.

Some organizing principles began to emerge including that accountability and coordination equals responsibility. With regard to psychiatric units in general hospitals, an adult bed capacity of 25 beds per 100,000 population was suggested (In 1990 in B.C. this would have represented some 750 beds, functioning in a "modern" as opposed to "traditional" model).

The "modern" alternative emphasizes capability for certified patients, day and other partial hospitalization programs, crisis intervention programs and specialized psychiatric emergency services with emergency holding beds.

Tertiary centres, including the provincial mental hospital component, would comprise programs for specialized patient populations. 15 beds per 100,000 was suggested for tertiary programs. In B.C. in 1990, this would have translated to approximately 450 beds. Combined secondary and tertiary psychiatric beds would comprise 45 beds per 100,000.

In the 1950's, Riverview had over 4,000 beds.

By 1990 the bed count was down to 1,270.

By 1993 Riverview had 921 beds.

In contrast, the population of B.C. almost tripled during that period (1.1 million to 3.2 million).

In 1993 at the 3rd International Congress in emergency psychiatry in Quebec City, Dr. John Talbott highlighted deinstitutionalization, which he referred to as 'transinstitutionalization'. The Congress also reviewed how emergency psychiatry worked in Vancouver, Toronto and Montreal. Dr. Madeleine Tremblay did an excellent job of representing Vancouver, particularly Vancouver General Hospital's Psychiatric Assessment Unit (PAU). Toronto advised of plans there to reduce psychiatric beds from 58 to 30 per 100,000 population and to shift hospital/community funding from 80/20 to 40/60.

In 1997 "Review of Best Practices in Mental Health Reform" (4) (prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health) by the Clarke Institute of Psychiatry was influential in refining planning for mental health service delivery.

This document identified seven core services in a comprehensive mental health system:

1. Case management/assertive community treatment
2. Crisis response systems/psychiatry emergency services
3. Housing/community support
4. Inpatient/outpatient care
5. Consumer self-help and initiatives
6. Family self-help
7. Vocational/educational services

The document provided minimal guidance regarding crisis response systems/psychiatric emergency services.

"Non-experimental and descriptive studies suggest that:

- crisis housing provides a viable alternative to hospitalization for persons with SMI (serious mental illness)
- diversion programs are effective
- crisis centres can serve persons with psychosocial problems"

And for,

### Key elements of best practice

- "Services are established that resolve crises for persons with serious mental illness using minimally intrusive options
- Crisis programs are in place to divert people from inpatient hospitalization
- Evaluation/research protocols are incorporated into crisis programs"

In 1998, "Revitalizing and Rebalancing British Columbia's Mental Health System" (5) (the 1998 Mental Health Plan) adopted the seven core services outlined in the Best Practices document of 1997 and set up a best practice group for each core service, each with two co-chairs and five members, and an adult mental health division staff person.

The crisis response and emergency services best practice group met for some five one day planning sessions between March and mid-September 1999. The group addressed the core components of a "crisis response/psychiatric emergency" system.

The components of a crisis response and emergency system that were worked on comprised:

1. Crisis lines
2. Mobile crisis outreach
3. Walk in crisis stabilization services
4. Community crisis stabilization services
5. Hospital based psychiatric emergency services

These components (or functions) form a continuum of services that are needed for crisis intervention and emergency response.

"A hospital based psychiatric emergency service (PES) was seen as providing specialized emergency mental health assessment, treatment and management services to persons referred via a hospital emergency department."

The components (or functions) were restricted to consideration of:

- Consultation to the emergency department
- Brief stay units (average length of stay ALOS 3-5 days)

### **Rationale**

A model is needed to deliver hospital based emergency psychiatric care for a number of reasons:

- To provide treatment. In the first place, a model is necessary to provide treatment. A comprehensive theoretical model is necessary for the provision of systematic treatment.

e.g.,

- i.) To guide how one obtains a history and perform a relevant physical examination
  - ii.) To allow one to arrive at a psychiatric diagnosis
- To organize services. For instance, with a biopsychosocial model, appropriate laboratory and clinical facilities are necessary.

- To teach. A model is needed to provide effective education in all aspects of the interaction of the biological, psychological, social, and existential factors which determine illness.
- To do research. Finally, a model is necessary for research in emergency psychiatry. A model allows one to state a hypothesis which subsequently can be tested. Program delivery is thus enhanced and can evolve.

### **Approach**

#### **Biopsychosocial**

All illness is determined by an interaction of biological, psychological, social and existential factors, so that models employing an understanding of how these forces converge upon a person in health and illness is necessary.

### **Models**

#### **The triage model**

This is based on the model used in times of war in which decisions are made as to who will be treated and who will be left until the pressure of numbers lessens. Those with less severe problems are seen briefly and/or referred on. The assumption underlying the triage model is that there are limited resources and that the priority for treatment is for those most in need, or those most able to obtain benefit from a brief therapeutic intervention. Therefore, individuals with less severe presentations and those with refractory conditions may be ignored. The greatest risk with the triage model is one of inadequate assessment. Use if made of the "least restrictive alternative" (or most therapeutic one!) in disposition, both to optimize patient responsibility and competence ("needs versus rights") and for best utilization of scarce resources.

## The crisis intervention (C.I.) model

The Chinese characters for crisis, Wei Ji (Mandarin) represent "danger" and "opportunity" respectively.

The C.I. model emphasizes the crisis as an opportunity for growth.

### **A crisis is seen as a turning point**

The role of long term hospitalization is de-emphasized and briefer psychotherapies and treatment outside hospital are highlighted. The triage model and the crisis intervention model are not incompatible and are also consistent with the biopsychosocial approach. The challenge in emergency psychiatry is to integrate as effectively as possible the "triage" model of traditional hospital based psychiatric emergency care with the community based model of "crisis intervention." This integration will probably look somewhat different even in similar settings. The development of different models will certainly be most evident across different urban, rural and remote regions of B.C. The crucial need to integrate the previously separate models of "emergency psychiatry" and "crisis intervention" is reflected in this manual by our preference, at this stage, for the term "emergency mental health."

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## 2 Management of Psychiatric Emergencies





## Management of Psychiatric Emergencies

The management of a psychiatric emergency is one of the most demanding aspects of health care. Traditional psychiatric training largely ignores the skills needed to successfully manage the mental health emergency. However, much can be learned in a relatively short time.

One needs certain skills to deal with this population. Decisions must be made rapidly and accurately. Diagnosis and management of the patient may change drastically as further information comes to light. A considerable amount of physical illness may appear primarily as a psychiatric disorder. The clinician needs to be comfortable with physical diagnosis and the basic treatments of medical illnesses. One needs to work independently with confidence, yet recognize the need for help, and seek out various resources that are available. It is very easy to feel helpless and overwhelmed, when there is a shortage of hospital beds and yet another acute psychiatric patient arrives. It is easy to become frustrated when a chronic patient returns for the nth time. Such experiences can frustrate and anger clinicians.

Each referral must be carefully and rigorously assessed for medical and psychiatric disorders, no matter how frequently they reappear in the emergency department. Hospital clinicians must also learn to negotiate conflict situations with patients, family and community resources. The problems of violence, suicide risk, bizarre behaviour and non-compliance are particularly difficult and common in emergency. These can naturally produce emotional reactions in inexperienced clinicians. However, with moderate exposure and some supervision one can gain a working competence in dealing with these areas.

### Why now???

Mental health emergencies are not defined by a clinician, but rather by the patient and those around them. It is therefore important to know who made the decision to bring the patient and what factors influenced them. Often the patient has little to do with the decision. They are brought by police, ambulance, community mental health workers, family members, landlords, and occasionally a family doctor or psychiatrist.

## Reasons for referral to hospital for mental health emergencies

### 1. Violence

- a) Outward directed - Threatening or actual. If a person is violent because of mental illness, they will often be brought to hospital, not jail. It should be remembered that behavior is not a consistent result of an individual's psychological makeup. Social, situational, and environmental factors combine with personality structure to generate behaviour and muddy the predictive waters.
- b) Self directed - Anyone threatening, or after an attempt of suicide, is almost always assumed to be acutely mentally ill and is brought to the hospital.

### 2. Psychosis

Deterioration or increased symptoms of psychosis which produces a lack of self-care or a refusal of treatment often prompts concerned family or friends to bring the person to hospital.

### 3. "Bizarre" behaviour

Anyone who displays objectionable or unusual behaviour in a public place which is thought to be due to mental illness may be brought to the hospital.

### 4. Medication problem

Either side effects of prescribed medications or a search for drugs to abuse may produce a visit to the emergency department of the hospital. Often overlooked are depot, anticholinergic, over-the-counter (OTC), and illicit drugs.

### 5. Change in social support

Many individuals with serious mental illness do well as long as they are cared for by others. Any change ranging from vacation or illness to death may create a mental health emergency.

### 6. Socioeconomic crisis

A person may need housing, financial help or legal aid and turn to the hospital for help.

## Self Referrals

Frequently it is easy to determine why a person is brought to the hospital. Sometimes it is very difficult to determine why self referrals present to the emergency. Self referrals may not disclose the real problem early in an interview, and may complain with symptoms of a past mental illness.

We must know what the patient and others expect from the hospital. Often the expectations of the patient, family, and community agencies are different from each other and can not be satisfied in the hospital setting. Negotiation begins during the assessment so all concerned parties are aware of the resources of the mental health emergency service. Collateral information is very important as is the need to always *respond quickly* to the referral.

## Goals in handling a mental health emergency

The goal of psychiatric emergency care delivery is not only to restore functioning at the time of a crisis, but also to help an individual be better for having experienced crisis. In a crisis, psychological mechanisms stand out in bold relief and the person may present as a caricature of their "normal" self. Crises are usually time limited and increase the potential for change.

### **1. Immediate stabilization of the situation**

Stabilization requires that steps be taken immediately to protect the staff and the patient from harm. Violence is a very immediate concern. Suicide, substance abuse, and psychosis must also be quickly dealt with.

### **2. Rule out life threatening medical conditions**

A number of life threatening conditions mimic psychiatric illness, and the clinician must be constantly on the look out for them, such as hypoglycemia and closed head injury, etc.

### **3. Psychiatric diagnosis**

A careful history and mental status should be done. The clinician should ask why the patient is in the emergency department today and who brought them; and in addition, determine the expectation of both the patient and their friends or relatives who brought them there.

#### 4. Medical diagnosis

As 10% - 30% of all psychiatric admissions have physical conditions that are often undiagnosed, a functional inquiry and physical examination should be performed on each patient.

The psychiatrist fears the medical aspects, the internist fears the behavioral aspects and the neurologist says "no focal findings." "Medically cleared" should mean "everything done and nothing found" but may really mean that the patient is breathing and that the heart is beating. You need to know who does the medical clearance.

Maintain a high index of suspicion as there is often too rapid a transfer to mental health emergency services if there is the presence of:

- Hallucinations or disorganized thinking
- Agitation
- Patients who create their own problems - alcohol, drugs, etc.
- A psychiatric history

With regard to Delirium, watch out for shallow rapidly changing delusions, visual hallucinations, and illusions.

Refer to medicine first (or to the emergency physician for medical clearance) if any of the following are present:

- Disorientation
- Clouded consciousness
- Abnormal vital signs (indicative autonomic dysfunction)
- No prior psychiatric history
- Visual hallucinations
- Illusions

#### 5. Treatment

A holistic approach is best and includes pharmacological, psychological, and social treatments that contribute to the total management of the patient.

#### 6. Disposition

This refers to the ultimate placement of the person back in the community - whether in an institution, halfway house, or private home, etc. Disposition planning starts when the person arrives in the emergency and remains an important goal throughout the patient's stay. Observe clues (e.g., the borderline personality organization patient with bags packed i.e. communicating intent to move in). You may need to reframe what you can provide. Use of *empathy* is important. You may have to work on shifting the patient's perception during the emergency mental health intervention.

## The emergency mental health interview

The information gained during the initial interview provides the data base for diagnosing and treating the patient. In emergency work, this data base is necessarily streamlined because of time constraints and the difficulties in obtaining a complete and accurate history from an irrational patient in crisis.

### Assessment guidelines

#### **Structure the interview**

Follow standard structure beginning with the patient's chief complaint and history of the present illness, followed by brief but pertinent inquiries as to past psychiatric and medical history and family and social history.

An over-the-counter (OTC), psychiatric, and medical medication, alcohol/drug and legal (charge/conviction) history is often important.

Identifying data and the mental status exam data are gathered through the interview. Any formal mental status is best done towards the end. If the patient is disoriented, do a formal mental status exam first. Standardize the formal mental status. This will allow you to pick up nuances and will facilitate your acquisition of clinical experience.

You need to be open and curious to be a good clinical interviewer.

You need to identify and control countertransference feelings.

*Be descriptive, not judgmental.*

**An outline type reporting format can serve as a guide:**

Identifying data:

Chief complaint:

History of present illness:

Past history:

Psychiatric

Family psychiatric

Medical

Personal/Social

Mental status exam:

Appearance and behaviour

Clinical testing of sensorium and cognitive functions (helps differentiate functional and organic problems)

Orientation

Memory

Attention and concentration

Intelligence and abstraction

Mood (inquired, manifest, vegetative concomitants, suicide risk)

Perceptual (auditory, visual, olfactory, gustatory, tactile)

Thought (content, process)

Insight/Judgment

Other exam data:

Diagnosis and differential:

Treatment plan:

**Get a convincing story**

The history should make sense chronologically and in terms of general psychiatric and medical knowledge.

It should include information that supports a leading diagnosis or two and excludes others. For example, in an acutely psychotic paranoid patient one wants data on recent drug use (possible amphetamine psychosis) and family history (possible Schizophrenia).

**Define the problem with the patient**

Once an understanding of the problem has been determined, be sure to discuss it with the patient. Even the most disorganized patient may profit from a simple explanation of his/her condition. If you suspect a hidden agenda, ask the patient what he/she wants and show non-judgmental concern. *Remember that precipitous discharge breaks trust.*

## The decision to admit to hospital

Despite considerable research, clinicians are not agreed upon explicit criteria for hospitalization. Some individual factors have been identified that contribute to the decision to admit a patient. There is much disagreement about the relative importance of these variables. Many "obvious" variables explain very little of the variance in the decision to admit. Some clinicians proceed intuitively, without spelling out the criteria they use to make this key decision.

There is a need for further research to find criteria and predictors which determine the decision to hospitalize:

### Variables

- Patient variables
- Therapist variables
- Patient/therapist variables
- System variables

### Admission indicators

- Diagnosis of psychotic disorder
- Dangerousness
- Prior hospitalization
- Lower social strata
- Lives alone
- Presents at night
- Not self referred
- Police referred

These classical variables account for only about 25% of the variance, even for the psychotic group.

### Other factors

- Stress
- Social support
- Coping models

Coping models as the most powerful discriminating factor between hospital versus community disposition (U. Schnyder, 1993).

## Criteria

The following represents a description of the more common factors involved in the decision to admit a patient. They are listed in descending order from most important to least important.

### 1. Danger to self or others

Dangerousness represents the most unequivocal reason for admitting any patient. A patient with a plan to harm someone else or themselves, plus evidence of advance preparation for this act, should certainly be admitted if the behaviour is due to "mental illness." In this situation, "mental illness" is generally defined as psychosis, intoxication or depression. A patient who meets any of these criteria for "mental illness" is eligible for certification under the Mental Health Act.

### 2. Severity

Severe psychopathology of a psychotic nature can impair functioning to the point that feeding and clothing oneself can become neglected. Mistakes of judgment, including accidents, spending sprees, sexual promiscuity, and confrontation with the police, are common in this situation. Compliance to medication and attendance to outpatient services are unlikely if the patient is experiencing this type of functional impairment. The patient is generally admitted. This patient may also be eligible for certification.

### 3. Disengagement

Occasionally a family or caretaker has reached the limit of tolerance for bizarre or unusual behaviour in a patient and needs a period of relief. The patient may need removal from an obnoxious environment which may or may not be produced by the patient's illness. Admission is recommended if it is clear that irreparable damage will be done to his or her reputation and relationships unless hospitalization is undertaken. This situation is generally not an indication for certification.

### 4. Diagnosis

A patient should be held for observation if the accounts of recent events given by the patient and the individual who brought him/her vary significantly. If criteria 1 and/or 2 are involved, then certification may be in order.



Occasionally a patient presents with complicated medical, neurological, and psychiatric symptoms, making accurate diagnosis impossible without extensive investigation. Admission is recommended in this instance.

Ideally, the decision to admit should be made before one inquires as to the availability of beds. With an awareness of alternative dispositions, the clinician can hopefully find a place for any patient that needs to be admitted. Once the decision to admit and/or certify has been made, there should be no turning back from this and no room for negotiation. The vast majority of patients and families desire a clear cut dispositional decision rather than one filled with uncertainty and ambiguity. The patient who vehemently opposes admission and/or certification may be requesting more structure and a clear idea of what the plans are for him or her.



## **3** Multiaxial Assessment



## MultiAxial Assessment

How does your health care provider know what diagnosis to give you when you visit about a particular concern? How does your provider know that you have a type of hepatitis rather than a type of liver cancer? You are likely the main source of information as you report what physical symptoms you have been experiencing. Your provider probably has your previous history to be guided by as well as observing how you present during this particular visit. You may be accompanied by a spouse, a relative or a friend who may also be able to provide additional information as to how you have been functioning.

In coming up with an accurate diagnosis, your provider will likely be guided by the classifications and categories contained in the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD 10). This is a diagnostic manual that lists the known diseases and diagnostic categories for medical and psychiatric disorders. Earlier versions of the ICD did not provide adequate consideration of the full range of psychiatric disorders. To bridge this gap the Diagnostic and Statistical Manual of Mental Disorders (DSM) was developed. The DSM, currently the fourth edition (DSM IV), has, over the years been developed to be collaboratively used with the ICD.

Why a separate diagnostic and classification system for mental disorders? The original motivation was to collect incidence and prevalence information on mental disorders. Over the years, the DSM has evolved into much more than a statistical gathering tool. The DSM IV now contains a diagnostic and classification system that attempts to capture in a holistic way, the client's major psychiatric illness or main clinical issue, the personality attributes and/or the intellectual capability that may contribute to the client's dynamics, any underlying medical illness that may influence the clinical picture, short and long term psychosocial issues that would impact the client's ability to function, and the client's overall ability to manage day to day events. In other words, the DSM can now provide a more complete biopsychosocial profile of the client, for clarity of diagnosis and treatment, and for education and research.

A multiaxial assessment contains five sections which, together, provide a complete clinical profile of the client (e.g.: presenting problems and contextual elements).

## MultiAxial assessment

- Axis I    Clinical disorders/Other foci**
- Axis II    Personality disorders/Mental retardation**
- Axis III    General medical conditions**
- Axis IV    Psychosocial and environmental problems**
- Axis V    Global assessment of functioning**

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), (p. 25). Washington, D.C.: Author.

### **Axis I    Clinical conditions:**

Disorders usually first diagnosed in infancy, childhood, or adolescence (excluding Mental Retardation, which is diagnosed on Axis II)

Delirium, Dementia, and amnesic and other cognitive disorders

Mental disorders due to a general medical condition

Substance-related disorders

Schizophrenia and other psychotic disorders

Mood disorders

Anxiety disorders

Somatoform disorders

Factitious disorders

Dissociative disorders

Sexual and gender identity disorders

Eating disorders

Sleep disorders

Impulse-control disorders not elsewhere classified

Adjustment disorders

Other conditions that may be a focus of clinical attention

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), (p.26). Washington, D.C.: Author.

The presenting problem or the reason why the client comes for medical attention is coded on Axis I. This is where an accurate and thorough assessment becomes essential. Medicine, nursing, social work, psychology, occupational and physiotherapy generally conduct their assessments according to frameworks specific to each discipline. What is of importance is that a comprehensive profile of the client is documented on the health record and accessed by the relevant health providers in a timely and appropriate manner. The discussion that follows further elaborates on the sections contained in a complete mental health assessment. There will be more information pertinent to a specific axis in some sections than in others and this will be pointed out.

### Mental health assessment

- **Demographic or identifying information:** the client's name, address, date of birth, next of kin, or other relevant identifying data may already be obtained during the procedure through the admitting department of the hospital or through RCMP, police, or the ambulance services if the client has been brought in by them. If there are gaps in this information, it can be obtained during the assessment interview or from collateral information such as hospital files or other sources such as community health/mental health informants.
- **Reason for referral or "Why now?":** ask the client why s/he has come to the hospital at this point in time. When you document, use the words of the client, as much as possible.
- **History of present illness:** Ask the client how long s/he has been experiencing these specific symptoms, the effects these symptoms are having on ability to function in relation to activities of daily living, and is this the first time these symptoms have occurred. Ask about both physical and psychiatric components of the symptoms. Are there any chronic physical or psychiatric conditions? The client may be able to answer you in varying degrees of completeness. This variability is often a beginning clue as to what might be going on either physically or psychiatrically for the client.
- **Current treatment:** includes all relevant health care providers the client is presently seeing. Try to get the client to be as specific as possible about who, for how long, medications, alternative remedies, etc. The client's pattern of health seeking and continuity with health care providers or adherence with recommendations may give you clues relevant to clinical conditions (Axis I), personality (Axis II), or medical conditions (Axis III).
- **Psychiatric history:** the client may or may not have a previous history; depending on the client's demographics, this information may also give you clues related to possible underlying medical causes. For example, a first psychotic episode in a late adoles-

cent-young adult male with no previous history vs. a first psychotic episode in a mid-fifties male, will not only present differently but will also be assessed with different diagnostic possibilities in mind by the healthcare provider. This history also provides some context relevant to the reason for referral. This section may be examined after the history of present illness.

- **Family psychiatric history:** many psychiatric disorders have a strong familial predisposition such as schizophrenia, mood disorders, or anxiety disorders. Adoption issues may be brought up by the client at this time and this is information the interviewer would need to explore further along in the assessment. Contextual elements relevant to personality (Axis II) or psychosocial/environmental factors (Axis IV) may often be revealed in this section.
- **Medical surgical history/Substance use:** Be aware of pertinent information that will have diagnostic implications. For example, endocrine disorders, most commonly thyroid conditions, may present with changes in mood and energy level. Patterns of substance use also have a strong familial determinant and many clients use substances to self medicate.
- **Current life situation:** this area may be covered or partially covered in the demographics/identifying information section. Details such as employment, area of residence, education, legal issues, or other may be elaborated upon. This information is significant in that it may identify some of the psychosocial/environmental realities (Axis IV) that may influence the clinical picture. As well, some of the more functional aspects of the client's lifestyle may be revealed. Is the client able to perform activities of daily living with assistance or independently (Axis V)?
- **Personal history:** this information is relevant and important because it reveals the quality of significant relationships early in the client's life. The family of origin's socioeconomic, cultural, and religious history is explored. Family secrets such as adoptions, extramarital relationships, or legal problems can be tracked. It is often helpful to depict familial relationships and significant events by drawing a genogram, which is a pictorial representation of "who's who." The personal and developmental aspects of the client's life can be revealing in relation to the personality characteristics of the individual. How the client performed in school, how much education the client completed, the work history of the client, and the socioeconomic history of the client are important determinants of level of functioning prior to onset of illness. You will find much information related to personality (Axis II) in this section.



- **Mental status:** this information begins with some of the physical identifiers of the client. More importantly, it is a window to access the cognition, mood/affect, perception, thought form and content, judgement, and insight of the client. This information is valuable to make an accurate diagnosis related to clinical condition (Axis I) or medical condition (Axis III). More specific details can be elicited in this section related to suicidal thoughts or homicidal thoughts.
- **Physical examination:** this is a very important area which can be overlooked if the client presents with acute psychiatric symptoms. Never underestimate the value of a thorough physical examination, with accompanying blood/urine workups, as deemed appropriate. This is especially the case when dealing with the geriatric client, the substance intoxicated client, the medically compromised client, or the client who has attempted suicide. Remember that medical conditions are coded on Axis III.
- **Brief Psychiatric Rating Scale (BPRS):** it might be helpful for the interviewer to conduct a "pre" and a "post" treatment assessment using this well validated scale measuring aspects of psychiatric symptoms. (An abbreviated version is presented on page 52.)
- **Diagnosis and formulation:** by conducting a thorough assessment of the client (directly from the client, from collateral sources), the interviewer is now able to make an initial diagnosis. The formulation is a hypothesis the interviewer has made about the client and can serve as a "road map" that can help guide relevant treatment/discharge recommendations.
- **Treatment/Discharge recommendations:** only by arriving at a diagnosis and a formulation can an appropriate set of plans be drawn up in the best interests of the client (and family, if appropriate).

<b>Axis II      Personality Disorders: Mental Retardation</b>	
Paranoid Personality Disorder	Dependent Personality Disorder
Schizoid Personality Disorder	Obsessive-Compulsive Personality Disorder
Schizotypal Personality Disorder	Personality Disorder not otherwise specified
Antisocial Personality Disorder	Mental Retardation
Borderline Personality Disorder	
Histrionic Personality Disorder	
Narcissistic Personality Disorder	
Avoidant Personality Disorder	

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), (p. 27). Washington, D.C.: Author.

As providers are fully aware, clients are not a collection of symptoms or diagnoses. To determine how the Axis I diagnosis or clinical symptoms affect the client's ability to function as well as to obtain a true sense of "who" your client is, it is important to clarify if there are significant personality characteristics or intellectual limitations that may have an influence in determining the Axis I diagnosis as well as the course of treatment recommendations. For example, if the client is intellectually impaired because of Mental Retardation, the provider would put a diagnosis of "Mental Retardation" (specifying severity) on Axis II. If the client is determined to possess a set of fairly significant character traits that would have important diagnostic, treatment, and discharge implications, the provider would code this information on Axis II.

**Axis III: Medical Conditions**

Axis III refers to medical conditions. These medical conditions are coded on Axis III if their clinical significance has potential to impact on the Axis I diagnosis. For example, the client has cancer and is engaged in treatment for it or the client has a significant organ system condition such as Hepatitis or Tuberculosis. If the medical condition is directly affecting the Axis I diagnosis, then the medical condition should be coded on Axis I and Axis III, for example, a Delirium due to a severe infection, Post Traumatic Stress Disorder due to trauma, or an Adjustment Disorder due to a recent diagnosis of AIDS. Treatment for the Axis I psychiatric condition is also influenced by any significant medical conditions. Some classes of antidepressants may not be prescribed if there exist certain heart conditions, there may be pharmacological interactions with anti-neoplastic therapies, some liver conditions may not allow safe prescription of certain medications.

**Axis IV      Psychosocial and environmental problems:**

Problems with primary support group  
 Problems related to the social environment  
 Educational problems  
 Occupational problems  
 Housing problems  
 Economic problems  
 Problems with access to health care services  
 Problems related to interaction with the legal system/Crime  
 other psychosocial and environmental problems

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), (p. 30). Washington, D.C.: Author.

Axis IV refers to contextual elements, namely psychosocial and environmental issues. These contextual elements can also have an influence on making the Axis I symptoms worse or facilitate recovery. They also impact on any Axis II and Axis III diagnoses. Let's take the case of a client who presents to you. You determine from the client's current/past history and collateral information, along with observation of the client, that the most likely diagnosis is Schizophrenia (paranoid type). From the client's current history, you find out s/he has been living either on the street or in homeless shelters in the most socioeconomically deprived part of your community. The client has also relocated from another part of the province to your community only two months prior. By putting this information down on Axis IV, these specific contextual elements of homelessness and recent relocation would most likely be contributing factors that would exacerbate the client's current episode of illness. This information is important in terms of appropriate treatment and discharge planning.

**Axis V**

**Global assessment of functioning:**

- 100 – 91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
- 90 – 81 Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
- 80 – 71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors, no more than slight impairment in social, occupational, or school functioning.
- 70 – 61 Some mild symptoms **or** some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
- 60 – 51 Moderate symptoms **or** moderate difficulty in social, occupational, or school functioning.
- 50 – 41 Serious symptoms **or** any serious impairment in social, occupational, or school functioning.
- 40 – 31 Some impairment in reality testing or communication **or** major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood.
- 30 – 21 Behaviour is considerably influenced by delusions or hallucinations **or** serious impairment in communication or judgement **or** inability to function in almost all areas.
- 20 – 11 Some danger of hurting self or others **or** occasionally fails to maintain minimal personal hygiene **or** gross impairment in communication.
- 10 – 1 Persistent danger of severely hurting self or others **or** persistent inability to maintain minimal personal hygiene **or** serious suicidal act with clear expectations of death.
- 0 Inadequate information

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), (p. 32). Washington, D.C.:

Author

Axis V is Global assessment of functioning (GAF). Here, the provider analyzes and synthesizes the information derived from the client's history and collateral together with observation and experience, makes a clinical judgement about how the client is functioning overall in the current context. The GAF captures the "psychological, social, and occupational functioning" of the individual (DSM IV, 4th edition, American Psychiatric Association, 1994, p. 30). This scale does not take into account "impairment in functioning due to physical (or environmental limitations)" (DSM IV, 4th edition, American Psychiatric Association, 1994, p. 30). The GAF is also redone at the time of discharge. The significance of the score on the other four axes will contribute to treatment and discharge planning.

The amount and quality of information obtained during a thorough history taking can vary. The multiaxial diagnostic classification system provides a succinct way to capture the clinical presentation in a clear manner. Another important consideration is that diagnoses tend to persist and follow the client to other health care providers and treatment contexts. In other words, there is still very much a stigma attached to some of the Axis I, Axis II, and Axis III diagnoses. For example, the client with an Axis I diagnosis of a Substance Related Disorder, the client with an Axis II diagnosis of Borderline or Antisocial Personality Disorder, or the client with an Axis III diagnosis of AIDS or Hepatitis B or C, may, during various treatment episodes, encounter providers who may be less than understanding, empathic, or compassionate. Once these diagnostic labels are applied to a client, there needs to be consideration if any harm may be done. This is not to take away from the need for a comprehensive and accurate diagnosis in order to facilitate appropriate and efficacious treatment. However, the worth and usefulness of any diagnosis is in its accuracy. Therefore, the provider really does need to take the time and effort to do as thorough and complete a mental health assessment as possible. Providers need to be descriptive rather than judgmental in their documentation.

Remember, *how* you ask the questions will largely determine the amount and quality of the information you obtain. Depending on the client's presentation and condition, you may only be able to obtain some very basic information, initially. Here are examples of some of the ways to ask questions during the mental health assessment:

**Demographic or identifying information:**

- What is your name? Tell me your name?
- When were you born? What is your birth date?
- Where do you live? What is your address?
- Who is your next of kin? Who is your closest family member?  
Who would you like to know (or notify) that you are here?

(Remember, that the next of kin may not be the same as the person the client would like to notify)

**Reason for referral or "Why now?":**

- Tell me what brought you here, today?
- What made you come in, today?

**History of present illness:**

- Tell me how long this has been going on? How long has \_\_\_\_\_ been happening?
- Has this (or \_\_\_\_\_) happened before now?
- Tell me more.

**Current treatment:**

- Are you seeing anybody about this? (or about \_\_\_\_\_)
- Have you seen anybody about this?
- Who is your family doctor?
- Are you being seen (treated) for anything else? How long have you been seen for this?
- Tell me about any medications you might be taking? How long have you been taking these?
- Is there anything else you would like to tell me about \_\_\_\_\_?

**Psychiatric history:**

- Tell me if you have ever seen anybody for this (or \_\_\_\_\_) before today?
- Can you remember if you have ever seen anybody for this before?
- Have you ever been in hospital? For what? Tell me more?
- Was that the only time? How long were you in? Which hospital?
- Tell me about the other times?

**Family psychiatric history:**

- Can you tell me if anyone in your immediate family (biological parents, biological siblings, biological grandparents, biological aunts/uncles/cousins, etc.) has experienced this? (or \_\_\_\_\_) Please say more.
- Do you know if (above relative) has received treatment for \_\_\_\_\_?

**Medical surgical history/Substance use:**

- Are there any medical conditions you have?

- How long have you had them? (or \_\_\_\_\_)
- Have you had any hospitalizations, surgeries, etc. for medical conditions?
- The following are questions I ask everyone. Do you drink alcohol? Smoke cigarettes or other substances? Are there substances you snort, inhale, inject, etc.?
- How much/how often do you (drink, smoke, inhale, snort, inject, etc.)?
- How long have you (drank, smoked, inhaled, snorted, injected, etc.)?
- Have there been periods when you have tried to cut down or quit? For how long? Have you tried to do this on your own? With help? What kind of help?

**Current life situation:**

- Who lives with you? How long have you lived together?
- How long have you been living at \_\_\_\_\_?
- How are you supporting yourself? Are you working? At what? For how long? Tell me more about your work?
- Are there any legal concerns or issues that currently involve you? Any in the past?

**Personal history:**

- Where were you born? Where did you grow up?
- Tell me about your parents. Where were they born and raised? When did they come to (country, province, community)? Can you tell me about how long they have been married to each other? (or living together) Were there previous relationships/marriages, etc.?
- What did your father/mother work at? (Explore periods of time away, preoccupied with work, etc.)
- Do you have any brothers or sisters? Tell me about them, beginning with the oldest/youngest.
- Who did you grow up with? Were there any other people living in the house? (grandparents, other relatives, boarders, etc.)
- What can you tell me about growing up in your home? (Explore the quality of the relationships the client is able to share with you: any strong attachments, any weak attachments, frequent moves, significant religious or cultural influences, practices, etc.)
- Tell me about elementary school? How did you do academically? Were there subjects you found difficult? (Explore relationships with teachers, significant others in the school system, etc.)
- Tell me about some of the friends you had in elementary school? What did you do? Extracurricular activities, etc.

- What was high school like for you? How did you do? What did you like, not like?
- What kinds of friends/groups did you hang out with? Social activities, etc.
- Any university or college? Tell me about your experiences there.
- When did you start dating? (same sex, opposite sex, both sexes)
- When was your first serious intimate relationship? With whom? For how long? Why did it end? Who did you become involved with next?
- How long have you been \_\_\_\_\_ ? (single, married, cohabitating, divorced, widowed, etc.)
- Share with me a little more about your relationship. (as in above)

### **Mental status**

#### **Observe the client carefully:**

- How does s/he appear from a health status point of view? Skin colour, condition, general hygiene. Condition of extremities, general body odour, hair, grooming, etc. Is the client's body weight in proportion to height and size? How is the client dressed? Is it appropriate to the weather, situation, etc. Are there obvious scars, wounds, prostheses, aids, or other aspects of the client that are notable? Does the client seem anxious, ill at ease, nervous, suspicious, indifferent, slow, lethargic, speedy, etc. Is there eye contact? What is the degree of rapport or connection during the interview?

#### **Cognition:**

- Throughout the interview, you will have opportunities to determine how well the client is able to think and respond to your questions. Are there delays in time for responses or can you barely get a word in? Do the responses or the client's questions to you make sense?
- Is it obvious or is it subtle the client is having difficulty answering even basic information related to who they are, where they live, etc. This is important in the case of geriatric clients, as you may be dealing with Alzheimer's or other types of dementia. There may be obvious cognitive deficits or the client may attempt to cover by confabulating (making up answers that sound "right," but really have no basis in fact or the "facts" don't add up)

#### **Mood/Affect:**

- What is the client's observable affect (what is the facial expression)? Is the affect congruent with how they are feeling or with what may be happening with the client? How does s/he describe their mood (how do they describe how they are feeling)?



**You may want to ask:**

- Tell me how you have been feeling? How long have you been feeling this way? Have you ever felt this way before? When was that?

**Perception:**

- Observe if the client is responding to internal or external stimuli. The client may be responding to hallucinations or illusions. Hallucinations most commonly tend to be auditory. The client who is hearing voices (most commonly during a psychotic episode) may be seen as talking back to the voices, covering their ears, hitting their head with their hands or fists, in attempts to deal with or get rid of the voices. Clients may be responding to visual hallucinations (most commonly in withdrawal) by attempting to attack the hallucinations or to escape them. Illusions are the client's misperceptions of actual objects or aspects of the environment. For example, if the lighting is poor in a room, the client may think the bed curtains are the clothing of a ghost.

**Some ways of inquiring are:**

- Sometimes people tell me they hear voices. Is that (has that happened) happening to you?
- Tell me what you are hearing? Who are you talking to? What is it you are seeing?

**Thought form and content:**

- The form of a thought is how the thought is presented (in a phrase, complete sentence, within the proper syntax, sequencing of the language and culture).
- The content of a thought is what the thought says or expresses (the actual words, meanings, what the thought conveys).
- Clients, having a psychotic episode may demonstrate a thought disorder of both form and content. For example, "my name is John, Joe, Jack...Jack and Jill went up the hill and joke....the Joker...Batman and Joker ..."

**Judgement and insight:**

- The ability of the client to anticipate and understand consequences is a large indicator of how intact or impaired the client's judgement is.
- Whether the client is able to tell you that s/he is ill, or how the illness impacts on ability to function is an indicator of the degree of insight or awareness the client has.

**Mini Mental Status (MMS)****and Brief Psychiatric Rating Scale (BPRS):**

- MMS is useful if there are questions about gross cognitive deficits
- BPRS is useful to provide a snapshot as to the client's gross level of reality testing

The Annotated Mini Mental State Examination (AMMSE)

MiniMental LLC

Name of Subject \_\_\_\_\_ Age \_\_\_\_\_
Name of Examiner \_\_\_\_\_ Year of School Completed \_\_\_\_\_

Approach the patient with respect and encouragement. Date of Examination \_\_\_\_\_
Ask: Do you have any trouble with your memory? Yes [ ] No [ ]
May I ask you some questions about your memory? Yes [ ] No [ ]

SCORE ITEM

5 ( ) TIME ORIENTATION

Ask:
What is the year? \_\_\_\_\_ (1), season \_\_\_\_\_ (1)
month of the year? \_\_\_\_\_ (1) date \_\_\_\_\_ (1)
day of the week \_\_\_\_\_ (1)

5 ( ) PLACE ORIENTATION

Ask:
Where are we now? What is the state \_\_\_\_\_ (1), city \_\_\_\_\_ (1)
part of the city \_\_\_\_\_ (1), building \_\_\_\_\_ (1)
floor of the building \_\_\_\_\_ (1)

3 ( ) REGISTRATION OF THREE WORDS

Say: Listen carefully. I am going to say three words. You say them back after I stop.
Ready? Here they are...PONY (wait 1 second), Quarter (wait 1 second), ORANGE (wait one
second). What were those words?
\_\_\_\_\_ (1)
\_\_\_\_\_ (1)
\_\_\_\_\_ (1)

Give 1 point for each correct answer, then repeat them until the patient learns all three.

5 ( ) SERIAL 7s AS A TEST OF ATTENTION AND CALCULATION

Ask: Subtract 7 from 100 and continue to subtract 7 from the subsequent remainder
until I tell you to stop. What is 100 take away 7? \_\_\_\_\_ (1)
Say:
Keep Going \_\_\_\_\_ (1) \_\_\_\_\_ (1)
\_\_\_\_\_ (1) \_\_\_\_\_ (1)

3 ( ) RECALLING OF THREE WORDS

Ask:
What were the three words I asked you to remember?
Give one point for each correct answer \_\_\_\_\_ (1)
\_\_\_\_\_ (1) \_\_\_\_\_ (1)

2 ( ) NAMING

Ask:
What is this? (show a pencil) \_\_\_\_\_ (1). What is this? (show a watch) \_\_\_\_\_ (1)

1 ( ) **REPETITION**

Say:

Now I am going to ask you to repeat what I say. Ready? No ifs, ands or buts.

Now you say that \_\_\_\_\_ (1)

3 ( ) **COMPREHENSION**

Say:

Listen carefully because I am going to ask you to do something:

Take this paper in your left hand (!1), fold it in half (1), and put it on the floor. (1)

1 ( ) **READING**

Say: Please read the following and do what it says, but do not say it aloud. (1)

## Close your eyes

1 ( ) **WRITING**

Say:

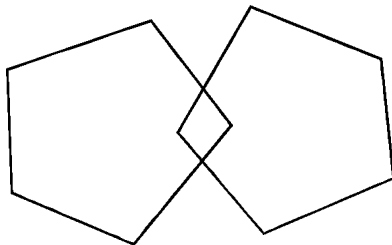
Please write a sentence. If patient does not respond, say: Write about the weather. (1)

\_\_\_\_\_

\_\_\_\_\_

1 ( ) **DRAWING**

Say: Please copy this design.



**TOTAL SCORE** \_\_\_\_\_ Assess level of consciousness along a continuum

Alert      Drowsy      Stupor      Coma

	YES	NO
Cooperative:	<input type="checkbox"/>	<input type="checkbox"/>
Depressed:	<input type="checkbox"/>	<input type="checkbox"/>
Anxious:	<input type="checkbox"/>	<input type="checkbox"/>
Poor Vision:	<input type="checkbox"/>	<input type="checkbox"/>
Poor Hearing:	<input type="checkbox"/>	<input type="checkbox"/>
Native Language:	<input type="checkbox"/>	<input type="checkbox"/>

Deterioration from  
previous level of  
functioning:  YES  NO

Family History of Dementia:  YES  NO

Head Trauma:  YES  NO

Alcohol Abuse:  YES  NO

Thyroid Disease:  YES  NO

**FUNCTION BY PROXY**

Please record date when patient was last able to perform the following tasks.

Ask caregiver if patient independently handles:

	YES	NO	DATE
Money/Bills:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transportation:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Telephone:	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Brief Psychiatric Rating Scale (BPRS):

SYMPTOMS	Not Present	Very Mild	Mild	Moderate	Mod. Severe	Severe	RATING
<b>Depressive Mood</b>	0	1 ↓	2	3 ↓	4	5 ↓	0 1 2 3 4 5 N/A
States discouragement, not depression; face does not show depression.			Reports depressed; some episodes of crying, sad tone throughout interview		States despair & pessimism; shows extreme sadness.		
<b>Suicidal Ideation</b>		Pt reports some passive thoughts of suicide but has made no plan.		Pt reports some active thoughts of suicide but has made no plan.		Frequent active thoughts of suicide and has made a plan.	0 1 2 3 4 5 N/A
<b>Elation</b>		Seems unaccountably happy, too cheerful.		Unrealistic high feeling, giddy, demands contact.		Seems almost intoxicated. Laughing, giggling, euphoric.	0 1 2 3 4 5 N/A
<b>Grandiosity</b>		Mildly arrogant or boastful but in good contact with reality.		Inflated self-opinion, but not delusional.		Delusions of grandeur	0 1 2 3 4 5 N/A
<b>Hostility</b>		Reports minor irritation.		Reports animosity toward others.		Expresses intense unjustified animosity toward others.	0 1 2 3 4 5 N/A
<b>Suspiciousness</b>		Expresses mild suspiciousness of others.		Pervasively suspicious & tends to blame others but nondelusional.		Extreme suspiciousness, delusions of persecution or ideas of reference.	0 1 2 3 4 5 N/A
<b>Unusual Thought Content</b>		Hint of unusual or idiosyncratic beliefs, but are not delusional.		Unusual or bizarre ideas; if delusional, distortions can be corrected		Pt. expresses bizarre and delusional ideas	0 1 2 3 4 5 N/A
<b>Hallucinatory Behaviour</b>		Reports one equivocal hallucinatory experience in past 24 hours.		Define hallucinations in past 24 hours, but describes them as unreal.		Definite hallucinations in past 24 hours and describes them as real.	0 1 2 3 4 5 N/A
<b>Conceptual Disorganization</b>		Minor difficulty following Pt's train of thought.		Much difficulty following thought when interview unstructured		TF disorder, loose, illogical, etc.	0 1 2 3 4 5 N/A
<b>Disorientation</b>		Hint of confusion about person, place or time.		Clear confusion re: person, place or time, can be corrected.		Clear confusion in identifying 2 of the 3, can't be corrected.	0 1 2 3 4 5 N/A

**Diagnosis and formulation:**

- Axis I – V: it is here, in the diagnosis, that you have the opportunity to pull together all the pieces of the mental health assessment. The formulation is a succinct summary of the key themes, significant events, personality and coping style in the client's history. It can serve as a guide for treatment and discharge recommendations.

**References:**

1. American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, D.C.: Author.
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# 4 Psychopharmacology in Emergency Psychiatry

The contents of this section are best considered under the following headings:

Antipsychotics or Neuroleptics

The Atypical Antipsychotics (SDAs)

Antiparkinsonian Agents (Anticholinergics)

Anxiolytics, Sedatives and Hypnotics (Benzodiazepines)

Considerations in the Treatment of Acute Psychosis



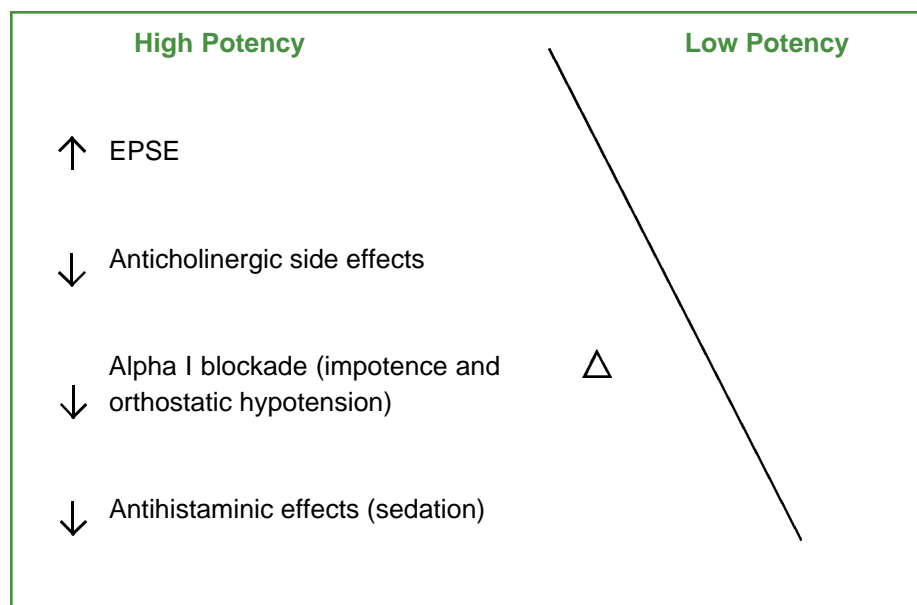


## Antipsychotics or Neuroleptics

These are used to treat psychotic symptoms in patients with Schizophrenia and other conditions. Symptoms may include delusions, hallucinations, paranoia, thought broadcasting, catatonia, bizarre behavior and associated symptoms such as hypervigilance, agitation and irritability.

They work via central blockade of dopamine receptors (especially D2), which in limbic areas leads to antipsychotic effects; in basal ganglia, to extrapyramidal side effects (EPSE); in the brainstem chemoreceptor trigger zone, to antinausea and antiemetic effects; and in the hypothalamus, to increased prolactin release.

Lower potency agents, such as chlorpromazine and thioridazine, tend to be high in anticholinergic side effects, sedation, orthostatic hypotension and decrease seizure threshold. Higher potency agents, such as haloperidol and fluphenazine tend to be high in pseudoparkinsonism, akathisia and acute dystonic side effects.



## Neuroleptic dose-equivalence guidelines

Name		Equivalence		Recommended doses (mg)*		
Generic	Brand	mg	CF**	Initial	Maintenance	Maximum
<b>Typical Neuroleptics</b>						
Chlorpromazine	Largactil	100	1:1	75	200 - 400	1000
Flupenthixol	Fluanxol	5	1:20	3	3 - 6	12
Fluphenazine	Moditen	2	1:50	2.5 - 10	1 - 5	20 up to 40
Haloperidol	Haldol	2	1:50	2 - 6	12 - 18	30 - 40
Loxapine	Loxapac	15	1:6.6	20 - 50	60 - 100	250
Mesoridazine	Serentil	50	1:2	75 - 150	100 - 200	400
Methotrimeprazine	Nozinan	70	1:1.4	50 - 100	100 - 200	1000
Pericyazine	Neuleptil	15	1:6.1	15 - 60	7.5 - 45	60
Perphenazine	Trilafon	10	1:10	12 - 24	+/- 24	64
Pimozide	Orap	2	1:50	2 - 4	2 - 12	20
Thiopropazine	Majeptil	5	1:20	5	30 - 40	90 or more
Thioridazine	Mellaril	100	1:1	25 - 150	75 - 400	800
Thiothixene	Navane	5	1:20	5 - 10	15 - 30	60
Trifluoperazine	Stelazine	20	1:20	2 - 15	6 - 20	40 up to 80
Zuclopenthixol	Clopixol	20	1:5	10 - 50	20 - 40	100
<b>Atypical Neuroleptics</b>						
Clozapine	Clozaril	50	1:2	12.5 - 25	300 - 600	900
Olanzapine	Zyprexa	5?	1:20?	5 - 10	10 - 20	20
Risperidone	Risperdal	2	1:50	2	4 - 8	16
Name		Recommended doses (mg)				
Generic	Brand	Initial	Maintenance	Maximum		
<b>Depot Neuroleptics</b>						
Flupenthixol decanoate	Fluanxol	5 - 20	20 - 40/2 - 3 x wk	100/2 - 3 wk		
Fluphenazine decanoate	Modecate	2.5 - 12.5	25/2 - 3 wk (or 3 - 4 wk)	50 - 100/2 - 3 wk (or 3 - 4 wk)		
Fluspirilene	Imap/Imap Forte	2 - 3	2 - 10/1 wk (or 1.5 wk)	15/5 - 6 days		
Haloperidol decanoate	Haldol LA	50 - 150	100 - 300/4 wk (or 3 - 4 wk)	300 or +/- 4 wk		
Pipotiazine palmitate	Piportil L4	50 - 100	75 - 150/4 wk (or 3 wk)	250/4 wk		
Zuclopenthixol decanoate	Clopixol Depot	100 - 400	150 - 300/2 - 4 wk (or 1 - 3 wk)	400/2 wk		

\* Based on references number 1, 2, 3, 7, 10 and 14. Lower or higher doses may be used occasionally.

\*\* Conversion Factor – Chlorpromazine : Neuroleptic

## Side effects of antipsychotics

### a) Dopaminergic side effects

#### 1. Pseudoparkinsonism

- cogwheel rigidity
- shuffling gait
- pill-rolling tremor
- masked facies

#### 2. Acute dystonia

- opisthotonus
- torticollis
- laryngospasm (potentially dangerous airway obstruction)
- oculogyric crisis

#### 3. Akathisia

- subjective or observable restlessness ("thorazine shuffle")

#### 4. Galactorrhea secondary to increased prolactin secretion

#### 5. Tardive dyskinesia (TD)

- Abnormal involuntary orobuccofacial choreathetoid movements affecting 15 – 20% of patients receiving chronic neuroleptic treatment because of dopamine receptor supersensitivity (cumulative dose). Curiously, it is masked by antipsychotic doses and tends to worsen acutely with decreased doses. Patients should be examined for abnormal involuntary movements before initiating therapy and every six months. (Abnormal Involuntary Movement Scale) (AIMS)

#### Risk factors

- elderly
- female
- affective disorder
- antiparkinsons agents
- depot neuroleptics

#### Treatment

- no effective treatments
- use lowest dose
- switch to atypical antipsychotics (risperidone/clozapine)
- vitamin E 400 I.U. t.i.d. to q.i.d.

**6. Neuroleptic Malignant Syndrome (NMS)**

- fever (up to 42°C)
- lead pipe rigidity
- autonomic dysfunction (tachycardia, labile hypertension, diaphoresis)
- mental status changes (mild obtundation to stupor and coma)
- possibly rhabdomyolysis with ↑ CPK and ARF
- 15 - 20% mortality rate
- evolves over 24 - 72 hours and lasts 5 - 10 days

**Treatment**

supportive treatment (transfer to ICU)  
internal medicine/neurology consult  
discontinue neuroleptic  
administer dantrolene or bromocriptine

**b) Anticholinergic side effects**

- dry mouth
- blurred vision
- constipation
- urinary retention
- memory and concentration difficulties

**c) Alpha-adrenergic blockade**

- orthostatic hypotension
- erectile impotence

**d) Anti-histaminic side effects**

- sedation, drowsiness
- weight gain

**e) Others**

- agranulocytosis
- EKG changes (prolonged QT interval)
- elevated LFTs
- elevated CPK in the absence of NMS
- photosensitive skin rashes
- pigmentary retinopathy (avoid doses of thioridazine > 800 mg/day)
- seizures (decreases seizure threshold)
- sexual dysfunction (erectile impotence; delayed, absent or retrograde ejaculation)
- priapism

## The atypical antipsychotics (SDAs)

1. Low propensity to cause extrapyramidal side effects (EPSE) because of high affinity for both D2 and 5HT2 receptors
2. Does not cause increased prolactin release (or minimally)
3. Effective in both positive and negative symptoms
4. Decreased risk of causing tardive dyskinesia or neuroleptic malignant syndrome
5. Effective in patients who do not respond to traditional neuroleptics.

## Four new atypical agents

### a) Clozapine (Clozaril)

- dibenzodiazepine
- very effective in treatment-resistant Schizophrenia
- improves cognition in chronic Schizophrenia
- side effects include sedation, sialorrhoea, increased risk of seizures (5 -10% risk if > 600 mg/day)
- weight gain, orthostatic hypotension, 1 - 2% risk of fatal agranulocytosis
- provincial distribution only from Riverview Hospital
- costs \$3,000 - \$5,000 per year, plus weekly blood tests; starting dose is 25 - 50 mg b.i.d.
- usual dose is 300 - 600 mg/day
- needs a compliant insightful patient with good support and follow-up

### b) Risperidone (Risperdal)

- similar efficacy compared to clozapine
- has minimal EPSEs if < 6 mg/day
- some U.S. centres (Boston) advocate its use in acute psychosis
- inadvisable to > 12 mg/day because of increased EPSEs and risk of cardiac toxicity
- often leads to akathisia without first passing through dystonia or parkinsonism
- expensive at approximately \$1.00 per mg.

**c) Olanzapine (Zyrex)**

- thienobenzodiazepine
- effective in both positive and negative symptoms
- side effects include dizziness, constipation, akathisia, weight gain, postural hypotension, ↑ ALT
- starting dose is 5 - 10 mg Hs p.o.
- usual maintenance dose is 5 - 20 mg/day

**d) Quetiapine (Seroquel)**

- dibenzothiazepine
- side effects include dizziness, dry mouth, weight gain, ↑ ALT, postural hypotension, cataracts in dogs (advise to have pretreatment eye exams and at 6 - month intervals)
- starting dose is 25 mg b.i.d., increasing by 25 - 50 mg b.i.d. as tolerated
- usual maintenance dose is 300 - 600 mg/day

**e) Zuclopenthixol (Clopixol)**

- very versatile agent effective in both positive and negative symptoms
- available in a short-acting aqueous (acetate) formulation and depot (decanoate) formulation. Both can be mixed in the same syringe. Short-acting aqueous injection (Acuphase) is useful in acute psychosis (effects last 72 hours), 50 - 150 mg, and ensures smooth conversion to depot thereafter.

**Antiparkinsonian agents (anticholinergics)**

**1) Pseudoparkinsonism and acute dystonias**

Five commonly used antiparkinsonian agents:

- a) Diphenhydramine (Benadryl) - IV/I.M./p.o. 25 - 50 mg up to 4 times/day
- b) Benztropine mesylate (Cogentin) - IV/I.M./p.o. 1 - 2 mg up to 3 times/day. Abuse potential and arrhythmogenic when given IV.
- c) Procyclidine (Kemadrin) - p.o. 5 mg b.i.d. to q.i.d.
- d) Trihexyphenidyl (Artane) - p.o. 2 - 5 mg b.i.d. to t.i.d.

e) Amantadine (Symmetrel) - p.o. 50 - 100 mg b.i.d.

In acute dystonias, Benadryl IV 50 mg or Cogentin IM 2 mg are most effective, may repeat because of short half life.

## 2) Akathisia

Benzodiazepines (Clonazepam) and low dose propranolol are more effective than antiparkinsonian agents here.

## Anxiolytics, Sedatives and Hypnotics

Drug name	Onset of action	Elimination half life (hrs)	Equivalent dose (mg)
Midazolam (Versad)	fast	1	1 mg
Triazolam (Halcion)	intermediate	2	1 mg
Alprazolam (Xanax)	fast	6 - 20	2.5 mg
Clonazepam (Rivotril)	intermediate	34	5 mg
Lorazepam (Ativan)	intermediate	10 - 20	10 mg
Diazepam (Valium)	fast	30 - 100	50 mg
Chlordiazepoxide (Librium)	fast	30 - 100	100 mg
Oxazepam (Serax)	slow	?	150 mg
Temazepam (Restoril)	slow	?	150 mg

- a) Indications**
- anxiety
  - insomnia
  - seizures
  - muscle relaxant
  - alcohol withdrawal
- b) Mechanism of action**
- Enhances the effects of GABA or the reticular activating system (RAS) (postsynaptic) by opening chloride channels
- c)** Abuse potential is proportional to the rate of onset of action, elimination half life and potency. Tapering and discontinuation most problematic with Alprazolam because of potency
- d)** Additive effects with other CNS depressants (alcohol, barbiturates, narcotics, etc.)
- e) Side effects**
- tolerance
  - psychological and physiological dependence
  - abuse potential
  - paradoxical disinhibition (especially in demented patients)
  - sedation
  - drowsiness
  - increased risk of cleft lip and palate in pregnancy



## Considerations in the treatment of acute psychosis

1. The first step is to ensure your own safety and have adequate staff to deal with the problem. A restraint team typically has a designated leader who directs application of restraints as well as talks with the patient as the restraints are applied. Chemical restraints may be used after verbal and behavioral interventions have failed, either alone or in combination with physical restraint and/or seclusion. All patients should be given an opportunity to take the medication voluntarily, in either oral or intramuscular form.

Although the antipsychotic effects of neuroleptics may be beneficial in treating psychotic patients who are assaultive, such effects may not take place for up to one week or more. It is more likely that the tranquilizing properties of the neuroleptics are responsible for the sedative effects.

Benzodiazepines usually have a calming effect and may provide a speedy and effective response, especially when administered intramuscularly. Close observation of the patient is essential, with frequent monitoring of vital signs because of the potential for respiratory depression. Paradoxical agitation may also occur, especially in those with pre-existing brain damage, e.g. demented elderly patients.

2. Initial dose followed by repeat if there is no response after 20 - 30 minutes post intramuscular dose or 60 minutes post oral dose.
3. **Neuroleptics**  
Haloperidol 2.5 - 5 mg p.o./I.M. t.i.d. to q.i.d.  
Loxapine 10 - 25 mg p.o./I.M. t.i.d. to q.i.d.
4. **Benzodiazepines**  
Clonazepam 0.25 - 1 mg p.o. t.i.d. to q.i.d.  
Lorazepam 0.5 - 2 mg p.o./I.M. t.i.d. to q.i.d.
5. Some USA centres (Boston) use Risperidone 2 - 6 mg in conjunction with Lorazepam 0.5 - 2 mg p.o./I.M. t.i.d. to q.i.d. as first line treatment.
6. Use PRNs liberally. Always state a maximum total PRN per 24 hours quantity, e.g. Lorazepam 1 mg p.o./I.M. q4 - 6h (not to exceed 4 doses/24 hours).

7. Monitor regularly for akathisia, dystonic reactions, and extrapyramidal side effects and treat with anticholinergics and propranolol accordingly.
8. Benzodiazepines are the drugs of choice in Delirium Tremens (Loading Technique).
9. Employ lower doses in the frail elderly, hepatic/renal dysfunction, pre-existing brain disease.

## **5** The Violent Patient



# THE VIOLENT PATIENT

## Introduction

Aggression and violence are of increasing concern to all of us.

The very pervasiveness of aggression and violence leads to responses of expectation, acceptance, and in some cases, denial. Denial can only be somewhat effective as a psychological defence, when it remains total and firmly in place. Reality however has a way of breaking down denial. As awareness develops more adaptive responses and defences are needed.

Aggression and violence are progressively becoming more important reasons for referral for hospital emergency management. A high level of professional skills in the assessment and management of violence is crucial for the emergency department and mental health professionals responding to persons in crisis or who present as psychiatric emergencies.

Some general observations can help shape our approach to aggression and violence:

- Violence is a behaviour, not a diagnosis
- Violence has multi determined origins
- Violence is situation specific
- Violence involves perpetrator and victim (victim is "interactional") (1)
- Aggressive people can act out verbally or physically

Anxiety is central and must be addressed both in ourselves as health care providers, and in our patients as potential aggressors (2). Anxiety, anger and fear drive most incidents of interpersonal violence and engender similar feelings in victims and witnesses. Our arousal and how we cope with it is central (3) (4). An intellectual understanding of violence is not enough, we need to internalize and to manage our emotions.

Through training and experience you can acquire the knowledge, skills, and attitude necessary for non violence crisis management. With crisis management you can prevent or defuse a significant number of potentially violent situations which is always the goal of management. When aggression occurs, whether verbal or physical, you are able to deal with it in a safe, professional and therapeutic manner. When face-to-face with a potentially violent person, who is often unknown to you, your best and only information source is that person. Rapid assessment of the violence prone individual will guide the management in any given situation.

The majority of assaults are preceded by an observable change in verbal behaviours.

The majority of assaults are also preceded by an observable change in activity level (non verbal behaviours).

Therefore the chance of a totally unpredictable assault is relatively small. To maintain safety you need to organize your thoughts and heighten your awareness to violence in its infancy. Start with building knowledge on observable behaviour changes as a person escalates in a behavioral crisis.

## Definitions

We can consider three terms in helping to define the area of aggression and violence.

These are:

1. Assertion (L. asserera; claim, affirm )
2. Aggression (L. aggressio; a going toward, attack)
3. Violence (L. violentia; vehemence, ferocity)

Assertion is a generic term for all behaviour, with or without hostile intent, which is designed to gratify a need.

Aggression is a specific form of assertion that has hostile intent.

Violence pertains to the use of physical force and is the exertion of physical force so as to injure or abuse.

## Data on health care violence

Currently there is sparse research in the area of workplace violence, including in health care.

### Regarding violence in the medical workplace

- a) A survey of health care workers in Canada (from Ontario, Manitoba and Saskatchewan) indicated a high prevalence of self-reported physical assault during the professional career of staff (from 20 - 80%). For example in Ontario, 59% of nurses reported being assaulted during their career and 35% reported assault in the last twelve months. For health care workers percentages were higher for assaults in institutions rather than the community. In hospitals percentages were higher in psychiatry and in emergency departments than elsewhere (5).
- b) A report on two years data (fiscal 1991 and 1992) from Winnipeg's Health Sciences Centre (6) showed that there were 242 reported abuse related injuries. The majority of these were reported by nursing (80.2%). Nurses in psychiatry had the highest rate of injury for nursing staff. Security staff had the highest rate of reported injuries (>50%). The study concluded that abuse related injuries to health care workers in an urban hospital are prevalent, serious and can be costly in terms of time off work and compensation. Under-reporting is likely, especially among physicians...."Physicians were not "employees" of the hospital and therefore did not observe corporate policies and procedures applicable to all other staff. This is being rectified...."

In the Winnipeg study the percentage of employees abused *each year* was:

Overall	4%
Psychiatry nurses	13%
Security	34%

95% of injuries were caused by patients. There were 646 reports of verbal threats and abuse in the same time frame (c.f. 242 injured). Verbal abuse usually precedes physical assault.

- c) The Workers' Compensation Board of British Columbia claims resulting from workplace violence more than doubled from 1982 (539) to 1991 (1,158). For health care workers the claim rate quadrupled (7). Nurses have the same risk of workplace violence in British Columbia as police officers, i.e. four times the rate of

any other occupations. Health care workers lose more days to injury-than workers in any other industry in B.C., including loggers (8).

### Some useful constructs

The literature on violence is voluminous and difficult to organize in any unifying or integrated way. Much of the early biological literature is now only of historical interest. In the psychosocial area, a few basic constructs are of help in understanding interpersonal violence. These include: dehumanization, the frustration-aggression hypothesis and mood versus predatory aggression.

### Dehumanization

Warfare is traditionally conceptualized as "holy war": the enemy is massively dehumanized, thus allowed, at least in theory, unfettered aggression. To the extent that we dehumanize or marginalize or distance people, on whatever basis - race, culture, religion, prejudice, fear, etc., - we increase the risk for violence in society. In the same way that the three most important words in real estate are "location, location, location," the key words to living in peace and harmony are "respect, respect, respect."

### The modified frustration-aggression hypothesis

The links between frustration, anxiety and anger have been described as the frustration-aggression hypothesis. Consider the following,

- perceived need/threat
- feeling inadequate
- feeling expectations are not being met
- anxiety
- frustration
- obstacle blocking goal
- anger
- aggression

Frustration does not necessarily always lead to aggression. Likelihood is increased if social learning reinforces aggression. Although frustration and pain are considered as major causes of aggression, there are many factors that can interfere and increase or decrease an aggressive response. These factors are the result of social learning (9). One of the primary modifiers of aggression is the



intention attributed to the frustrator. The influence of social learning has modified the original frustration-aggression hypothesis.

## Mood versus predatory aggression

Animal models of aggression can be divided very simply into mood aggression and predatory aggression.

### **Mood versus predatory aggression**

- intense autonomic arousal
- threatening or defensive postures
- menacing vocalization
- may be intra species
- not usually related to feeding
- often hormonally responsive

### **Predatory aggression characteristics**

- little autonomic arousal
- utilization of stalking postures
- minimal vocalization
- primarily inter species
- related to feeding
- minimally hormonally responsive

Human interpersonal violence, in the majority of instances, involves mood rather than predatory aggression.

Predatory aggressors tend not to get mad but to get even. Such predatory violence is more difficult to avoid given its more random nature. The lack of autonomic arousal is deceptive and ensures that victims receive little or no warning, and also improves the predator's chances of avoiding subsequent detection and apprehension. Predatory aggressiveness is sometimes referred to as "instrumental" while mood aggression is sometimes referred to as "reactive" or "affective."

Mood aggression is much more common. Therefore, if we can assess emotional reactivity in others and (no less important) in ourselves, we should be ahead of the game in predicting violence. If we can predict it, then we can help prevent violence. Prevention is key and should be our primary goal both personally and professionally.

There may be mixed mood and predatory aggressive incidents. Interpersonal violence generally promotes a state of emotional crisis and our responses can vary. Studies of arousal and acute stress indicate a number of crisis options that are available to us. These include fight, flight, posturing (the illusion of violence) and submission. (10)

## Risk factors

**As clinicians we are already quite familiar with the major risk factors for violence. These include:**

- A history of violence
- Age (younger, majority age 20-40)
- Gender (males more than females)
- Alcohol/drugs (dependence/intoxication/withdrawal)
- Socioeconomic status (low more than high)
- Estimated IQ (low more than high)
- Residential mobility
- Marital status (lack of)

A record of past violence is the best indicator of future violence.

Mental illness does not generally appear to be related to violence in the absence of a history of violent behaviour.

"However, the belief that mental disorder bears some moderate association with violent behaviour is both historically invariant and culturally universal." (11)

In our individual assessment of persons with mental disorder, our index of suspicion for violence risk is increased with psychotic patients who exhibit imperative hallucinations or persecutory delusions, with organic patients exhibiting confusion, hostility or delirium, etc., and in certain personality disorders in crisis, e.g. paranoid, borderline and antisocial. We tend to view as an even more acute risk, patients with "comorbidities" or "concurrent" diagnoses. These include alcohol/drug abuse or personality disorders and mental retardation.

Although consideration of such risk factors alerts us to various potential available fuels for violence, these usually remain at the level of predisposing factors and require a trigger, or precipitant, for ignition.

Just as many patients with pre-assaultive behaviours (verbal aggression, high activity level and invasion of personal space) never go on to assault staff as those that do. So what is it that drives 50% of these violence prone clients to assault staff? What is the "trigger" that sets off the physical aggression? It is important that you have an awareness of common "triggers" in the environment that you work. One of the strongest triggers is activated when the client perceives that they are being treated with disrespect or unfairly. When you are tired and overworked you may become insensitive to clients' needs. Your interactions with clients may become argumentative, authoritarian and in some cases threatening. To stay safe you must be able to conduct a self assessment and identify when you are also displaying verbally aggressive behaviour and are becoming part of the problem, rather than part of the solution.

Attention to the situational variables therefore and to state characteristics rather than only to trait characteristics is essential during our clinical assessment of the potentially violent patient.

**Triggers can include:**

- intoxication
- loss of a central love relationship
- acute emotional crisis
- loss of personal power
- loss of face
- fear
- pain
- physiological states, e.g. hunger, thirst, lack of sleep
- staff reactions
- rejection
- disrespect, etc.

# Communication

## General attitude and approaches

### A. Attitude or feeling state

- Remain calm. ("mirror calm")
- Be non judgmental.
- Avoid threatening words or actions.
- Do not enter a power struggle.
- Use "soft focus" eye contact and an expression that says "I'm your friend, not your enemy."
- Show concern without anger.
- Be in firm but kindly control.
- Be empathetic. (remember "hurt people hurt people")
- Recognize and reinforce steps to regain control. Use positive gestures and language.
- Trust your intuition and feelings. Ask the person if you are correct. For example, "I have the feeling you are upset because your daughter couldn't visit today. Am I right about that?"
- Be aware of personal responses to aggressive behaviour. Caregivers who project their own feelings of rage and fear onto the impaired will overestimate the potential for violence and resort to excessive use of restraints, physical or chemical.
- Heed inner dialogue. (an awareness of countertransference reactions is necessary)
- Avoid the "saviour" or "macho" attitude in an effort to live up to expectations of on lookers or to compensate for personal fears.
- Avoid the extremes of "therapeutic nihilism" and the "Midas touch."

### B. Speech

- Use simple, concrete, positive statements. Say what you want them to do, not what you don't want them to do. For example, "please sit over here" instead of "don't pace in the dining-room."
- State instructions or questions one at a time. When they can respond appropriately, they are regaining control.
- Keep voice volume appropriate for distance and the person's ability to hear. Raising the voice raises the pitch. This is the hardest range for the elderly to hear.
- Use a smooth supportive tone.

- Use normal speech rhythm. Speaking too fast, too slowly or in a jumpy excited manner can irritate the person and escalate the problem.
- Address persons by name (e.g. "John") providing you have permission. Otherwise, use "Sir," "Ms.," etc.
- Pay attention to the response. Do not assume your message is understood. Remember that silence is not consent.
- Do not use jargon.
- Avoid giving advice.
- Listen and learn, use open and active listening. (nod and say "yes, yes") What does the client see as the problem and what do they expect of you?
- Use silence and restatement to clarify the message.
- Ask questions to seek information, a favour or to distract the person.
- Avoid sarcastic or insulting remarks. Be careful of using humour. When in doubt, don't try to be funny. Humour is a high risk, high gain technique.
- Reassure acting out and frightened individuals that you, the care-giver, do not intend to be a threat.
- Telling aggressive people their behaviour frightens, worries or upsets you can be appropriate. They may not see their behaviour this way and may attempt to change it.
- Asking individuals who are aware of their aggressive urges to tell you when something you do or say makes them angry may defuse a touchy situation.
- Verbal abuse is not a safety valve and may aggravate assault. It can provide justification by way of dehumanization. Use a "strip phrase," e.g. "I appreciate that, but," etc. as a deflector. Remember, the majority of physical assault is preceded by verbal abuse.

### **C. Non verbal messages**

- Be aware of non verbals. Non verbal leakage provides your best information in a crisis.
- Avoid exaggerated gestures which may startle or threaten.
- Reduce nervous mannerisms and avoid overactivity. You will appear in control even though you may not feel that way.
- Portray a confident non anxious manner. Keep your hands in view and not behind the back or in the pockets. The person may believe you are hiding something.
- Approach with the palms open. This is the handshake or welcoming position.

- Honour "personal space." Remember the variables involved include the sex, size, familiarity and the speed of the approaching helper. Remember this distance may double or triple when a person is in a crisis state.
- Use a "tactical interview stance." Standing at least one leg length distance (about 3 feet), and turned approximately 45 degrees to the side with hands in plain sight is less threatening and offers individuals a "perceived" route of escape. Keep hands open and above waist line. Standing squarely face to face is issuing a challenge and is also unsafe.
- Avoid standing over people who are upset. Use eye level. Use increased distance to decrease angle of eye contact.
- Isolate the situation. Do not have an audience when dealing with a crisis situation.

**D. Setting priorities**

**a) Caregiver safety**

- Never turn your back on acting out people.
- Leave and go to a safe, pre-arranged place.
- Always have access to an avenue of escape. Don't talk yourself into a corner.
- Know your limits. Get help. If you think you may need help.... get it!

**b) Care recipient safety**

- Violent people are often basically frightened people.

**c) Protection of property**

## Personal safety training

If you are in a relatively high risk group regarding violence in your medical workplace whether in your office (community) setting or in hospital (e.g. emergency department), participate in at least a basic one day Management of Aggressive Behaviour course that includes personal safety training followed by annual refresher training of at least half a day. If you are part of a designated team for responding to behavioral emergencies, team training of at least four days annually is needed.

The background of your attitude, your skills, and your knowledge needs to integrate with the 3 "A's" of personal safety, awareness, assessment and action. Action skills involve stance, movement and other physical techniques to avoid or minimize physical injury from assaults, including strikes and grabs. You require hands on training and practice. You can't learn physical skills from a book or video alone.

Physical aggression can be against one's self, another person, or the environment. Our personal safety comes first when dealing with violence. To stay safe in a physically aggressive (i.e. violent) encounter we need personal safety training and/or self defence skills and also pre-planned guidelines and the ability to call for assistance.

A basic and practical personal safety class format would be conducted along the following lines:

- a)** warm up
- b)** stance
  - angle
  - distance
  - hands

The following principles would be incorporated:

"balance," "deception," "reactionary gap," "action beats reaction"

- c)** exercises in approach and stance
- d)** dealing with strikes
  - evasive sidestep
  - deflection
  - practice "getting off the line" and "swat the bug"
- e)** dealing with grabs
- f)** the importance of mental set

## Putting it all together

In a crisis our emotions surface and we apply the techniques we are most familiar with (i.e. over learned). Violent people are often frightened by their hostile urges and seek help in preventing a loss of control. They create feelings of anxiety, fear and anger. The issue of anxiety, stress and arousal is central.

### **Approach:** ("before")

A consistent non judgmental approach without provocation is required.

We need both skill and courage to decide and monitor a useful intervention.

A premium is placed on an attitude of directness and honesty.

Our philosophy reflects acceptance that violence will occur and be competently dealt with. Forget the "zero tolerance" approach. Avoid extremes, they are both reflections of one reality. The true enemies are not people "but ideology, hatred and ignorance." (11)

The emphasis is on prevention with attention to situation specific factors.

We ally with the client and highlight positive personality features (empathy building). Not "psychopath," "wife beater," "drunk" but rather "music lover," "dog lover" etc.

We deal with our anxiety. The client has fears of losing control and may escalate if they note staff are afraid. Practice stress management on a daily basis. We portray a confident non-anxious manner. Our underlying philosophy is one of professionalism and respect.

Consider male:female ratios. Generally female staff is an advantage though individual assessment may indicate otherwise. If there is an outbreak of violence an adequate trained back up team is required immediately.



**Management:** ("during")

The importance of mental set:

"Staff do not come to work to be assaulted."

The overriding authority for the use of force is the Criminal Code of Canada.

"Everyone is justified in using as much force as is reasonably necessary...to prevent assault."

insufficient force	reasonable force	excessive force
staff injury	goal is no injury to staff or patient	patient injury

The force options continuum:

1. presence
2. dialogue
3. empty hand control
4. intermediate weapons
5. firearms

The "three rules":

Be prepared (expect the unexpected)

Isolate the situation (do not have an audience)

Be nice ("a kind man turneth away wrath") (12)

The sequence for management of behavioral emergencies is the CAT approach:

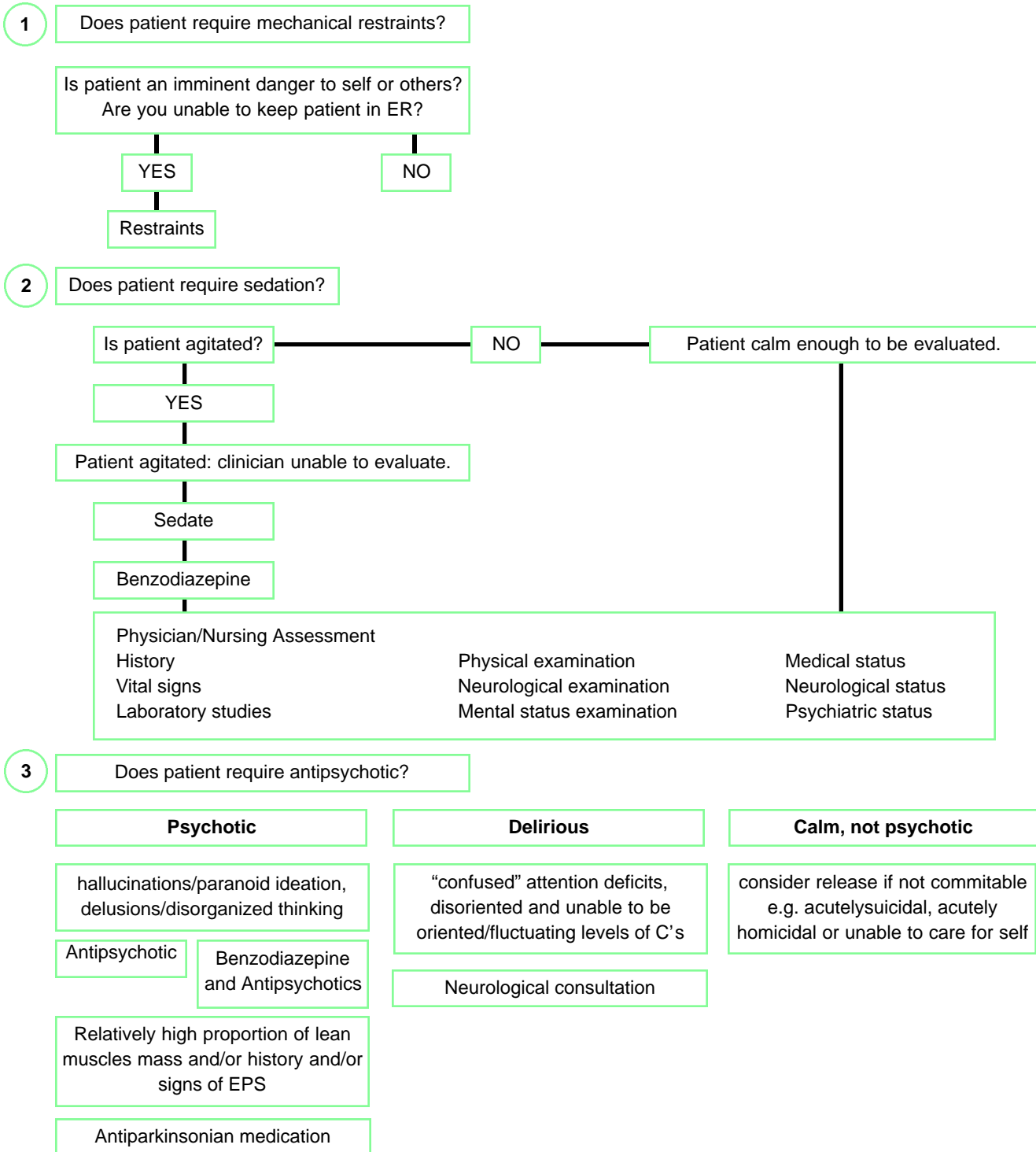
Control behaviour

Assess quickly

Treat specifically

## A management approach to behavioural emergencies

Patient presents at emergency room or clinic  
Initial assessment



**Debriefing:** ("after")

After a violent incident:

"Walk it out...talk it out...let it go."

Immediate debriefing of all staff involved:

What went well?

What didn't go so well?

What can we improve on?

Critical incident stress refers to normal reactions to an abnormal event. Consider the need for Critical Incident Stress Management (CISM). Provides confidential emotional support facilitated by a trained peer and/or CISM trained counsellor. A few models available of which the best known is perhaps that of Dr. Jeffrey Mitchell (15)

It is proposed that dealing with critical incident stress (16) (i.e. normal reactions of normal people to an abnormal event) allows incidents to be processed cognitively and emotionally. Although this may not limit the incidence of Post Traumatic Stress Disorder (PTSD), it helps identify those most at risk for PTSD and certainly can help morale.

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## **6** The Suicidal Patient



## The Suicidal Patient

The phrase: "I want to kill myself..." is a very powerful catalyst for a repertoire of responses on the part of the health care provider. There is probably nothing more anxiety provoking than the encounter with the client who presents with suicidal ideation and/or intent. There is no absolute method to predict if a client will or won't suicide. The reality is that while suicide risk is possible to estimate, suicide as an outcome, is not predictable. Nevertheless you need to thoroughly assess the client's level of suicide risk to meet currently acceptable standards of care. Health care providers can assess and manage the suicidal client with a level of comfort derived from clinical experience, confidence, and self awareness, thus engendering a greater level of comfort when dealing with these challenging clients.

The suicide statistics reveal more prevalence in males than females. Across age groups, the ratio is approximately three male suicides to one female. Rates of suicide among adolescents increased significantly between the period 1960 to 1980, with a plateau starting to emerge in the 1990's. Elderly rates of suicide have been consistently high for decades. In Canada, one in 25 persons attempt suicide in a lifetime. Females attempt suicide more often than males. Between 1979 and 1993, there have been 52,825 documented deaths from suicide. In British Columbia there are over 500 deaths due to suicide each year. Individuals who live alone, who have experienced a recent loss, who are in poor health, and who live in deprived socioeconomic circumstances share some of the common characteristics of those who commit suicide. The presence of a psychiatric diagnosis such as Schizophrenia, mood disorder or personality disorder, the concurrent use of alcohol and/or a substance, as well as past attempts increase the risk of suicide. The rate of suicide in patients with a mood disorder is 700 per 100,000. For patients with a diagnosis of Schizophrenia, the rate is 450 per 100,000. One other consideration to remember: not all patients who kill themselves will explicitly express their suicidal intent.

### At risk populations

- Male
- Adolescent/Elderly
- Living alone/Few social supports
- Significant losses
- Psychiatric disorder
- Extensive alcohol/Substance use
- Medical illness
- History of suicide attempts
- Family history of suicide
- Lowered socioeconomic circumstances
- Outlook: No future orientation

The goal of the interview with the client who presents as suicidal is to ascertain whether the situation is an emergency that warrants an admission or is a "crisis" requiring stabilization with resources external to the hospital system. The challenge of interviewing a client who presents as suicidal requires attention to client safety and privacy. The provider must determine whether there is an existing mental illness, a mental status exam should be conducted, and the presence of significant character traits must be noted. Every attempt should be made to collect information from relevant sources other than the client; this collateral information provides context and chronology.

### Psychiatric emergencies

There are some circumstances that constitute a psychiatric emergency and absolutely warrant an admission to hospital:

- **Psychosis**  
the client is experiencing command hallucinations to self harm /annihilate or has delusions that will endanger him/herself.
- **Mood disorder**  
the client is experiencing suicidal intent attributable to the mood disorder, has access to lethal means, and has no social supports.
- **Alcohol/Substance intoxication**  
the client is intoxicated, judgement is severely impaired, impulsivity is high, there has been a recent loss, and there is a specific plan.
- **Personality disorder**  
the client is in crisis, is suffering from a micro-psychotic episode, has heightened impulsivity, and a history of attempts.



Documentation of suicidal risk is an important part of the assessment process. The health care provider documents specific information related to suicidal risk, at the following times:

- Upon admission or upon the first psychiatric assessment
- With the occurrence of any suicidal behaviour or ideation
- Whenever there is any significant clinical change
- Whenever suicidality is an issue for an inpatient
- Before increasing privileges or giving passes
- Before discharge

Jacobs, D. G., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment. In D. G. Jacobs (Ed.), *The Harvard Medical School Guide to Suicide Assessment and Intervention* (p. 34). San Francisco, CA: Jossey-Bass.

#### What are the levels of suicidal risk?

Lowest Risk:	No thoughts of death
Low Risk:	Nonsuicidal thoughts of death
Elevated Risk:	Suicidal thoughts without specific method
Highest Risk:	Suicidal thoughts with specific method

Jacobs, D.G., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment. In D.G. Jacobs (Ed.), *The Harvard Medical School Guide to Suicide Assessment and Intervention* ( p. 21). San Francisco, CA: Jossey-Bass.

Given the above discussion about at risk populations, documentation, and levels of risk, here is an example of high risk: A fifty-two year old married, white male is admitted to the hospital after being found in his house, threatening to shoot himself with a rifle.

#### Step 1: Identify predisposing factors

He is diagnosed as having a major depressive episode with vegetative symptoms, severe, but without psychotic features, first episode, and presents with significant psychic anxiety. He has recently started drinking alcohol excessively.

#### Step 2: Elicit potentiating factors

Axis II diagnosis is deferred, but personality issues do not seem prominent. He has recently been laid off from his job and is worried

about his financial situation. His father committed suicide. There is a family history of alcoholism. His wife seems supportive but passive and lacking insight about mental illness. He has two adult children. His is a hunter with an extensive collection of firearms.

### **Step 3: Conduct a specific suicide inquiry**

He admits to wanting to kill himself. He says he is sorry he did not shoot himself before his son pulled the gun out of his hands. He feels his family would be better off without him because he has an insurance policy. He says he just cannot bear this agony anymore and would like to "finish the job."

### **Step 4: Determine the level of intervention**

- Estimate the acuteness or chronicity of the client's suicidality. He is in the midst of a major depressive episode and has received no treatment for it. The client is unable to assume any control at this time. The intervention is to hospitalize and conduct appropriate searches and institute one-to-one observation.
- Evaluate competence, impulsivity, and acting out. The client is not obviously psychotic, although there is an exaggerated quality to his financial worries, and his judgement is severely impaired. His suicide attempt was impulsive according to his family.
- Assess the therapeutic alliance. This is a new client, unknown to the staff or physician. Although he seemed somewhat relieved to talk about his problems, his risk is increased because he is not known and has no firm alliance.
- Plan the nature and frequency of reassessments. This client will be assessed every shift by the nursing staff and reassessed by a physician daily until his depressive episode begins to respond to treatment. At that point, the frequency of reassessments can be reevaluated. The client has been started on antidepressant and anti-anxiety medications.
- Document the assessments. An assessment of suicide risk should appear in each shift's nursing note. An example might read: "John Doe continues to feel suicidal although he says he is not thinking about it constantly since he slept better last night and feels somewhat calmer after taking \_\_\_\_\_ (medication). One-to-one observation maintained throughout the shift."

Jacobs, D.G., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment. In D.G. Jacobs (ed.), *The Harvard Medical School Guide to Suicide Assessment and Intervention* (pp. 35 – 36). San Francisco, CA: Jossey-Bass.

Here is another example of high risk:

A twenty-one year old single, white, female university student is

admitted to the psychiatric unit of the hospital after cutting her arms and abdomen.

### **Step 1: Identify predisposing factors**

This is the third admission at this hospital for this young woman, who was previously diagnosed as having dysthymia, a history of polysubstance abuse, and Borderline Personality Disorder. Her comorbid diagnoses increase the risk.

### **Step 2: Elicit potentiating factors**

An Axis II diagnosis of Borderline Personality Disorder is prominent. She has been under more stress at school and is required to complete several papers before receiving credit for last semester's work. She has also been fighting with her boyfriend. Her parents are divorced and live out of town but have been in touch with the social worker and are familiar with this unit of the hospital. Her mother expressed some frustration at this most recent hospitalization. The young woman's therapist of several years is on vacation.

### **Step 3: Conduct a specific suicide inquiry**

She says she wanted to die when she cut herself recently, but also says it relieved the tension she was experiencing and made her "feel real." She says she does not feel like dying at the moment but that she is frequently overwhelmed by suicidal thoughts.

### **Step 4: Determine the level of intervention**

- Estimate the acuteness or chronicity of the client's suicidality.  
Twice in the past she has made near lethal suicide attempts by overdoses on multiple drugs, both prescribed and illicit. Her cutting behaviour is usually associated with tension release rather than suicidal intent. She has the capacity to take some control.
- Evaluate competence, impulsivity, and acting out  
She is not psychotic. Her cutting was precipitated by the combination of her academic advisor's issuing a warning about her work and her fights with her boyfriend. Her long term therapist is on vacation. She can be quite impulsive when she is feeling stressed and has acted out angry feelings, usually by cutting.
- Assess the therapeutic alliance  
This patient has been admitted to this unit twice before and is well known to most staff members. She has a good alliance with her therapist, who will return in two days.
- Plan the nature and frequency of reassessments  
This patient will be assessed every shift by the nursing staff and assessed by her therapist upon his return from vacation. Nursing staff will also ask her about her suicidal feelings any time she isolates herself.

### **Step 5: Document the assessments**

An assessment of her suicide risk should appear in each shift's nursing note. An example might read: "Jane Doe reports having fleeting suicidal thoughts three times today. Two of the three times, she has been able to identify feelings of anger related to thinking about her most recent argument with her boyfriend. She has been able to follow through with seeking out this writer on one occasion and in listening to a progressive relaxation tape on another occasion."

Jacobs, D.G., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment. In D. G. Jacobs (Ed.), *The Harvard Medical School Guide to Suicide Assessment and Intervention* (pp. 36 – 37). San Francisco, CA: Jossey-Bass

To assess suicide risk it is essential to specifically ask questions related to suicidal ideation. During the assessment interview a first question might be: "Sometimes people have thoughts about ending their life. Have you had these thoughts?" or "Tell me if you have had thoughts of harming yourself or of ending your life?" Depending on the client's answer, together with other relevant assessment information, you will then determine whether to ask for other information specifically related to suicidal ideation/intent.

### **If you have a client with suicidal ideation, here is information that is essential and should be documented:**

*Has the client expressed suicidal ideation?*

- What is the frequency: occasional, frequent, or constant
- What is the intensity: easy to put out of mind or impossible
- Degree of control: patient has a sense of being in control vs. ideation is in control
- How recent is ideation: only today vs. existing over days, weeks, months, years

*Is there a plan the client intends to carry out?*

- How specific and detailed is the plan (e.g.: how, when, and where)
- Does the client have the expectation and ability to carry out the plan
- Does the client have access to the specific means of suicide (e.g.: firearm, medication)
- How readily can the client carry out the plan

*Why does the client want to commit suicide?*

- Intensity of desire to die
- Intensity of desire to express anger or distress to the living
- Presence of voices or other factors telling the patient to die

*Are there factors that would prevent the patient from making an attempt, such as the presence of supportive factors?*

*Is the client less anxious and thinking less about suicide at the end of your interview than at the beginning?*

*Is there a clear future orientation?*

Hillard, J. R. (1990). Suicide. In J. R. Hillard (Ed.), *Manual of Clinical Emergency Psychiatry* (p. 112). Washington, D.C.: American Psychiatric Press, Inc.

**If you have a client who has made a suicide attempt, these are questions to ask. This information needs to be documented:**

*How medically serious was the attempt?*

*What was the overt purpose of the attempt?*

- An attempt to die
- An attempt to escape or to end emotional distress
- An attempt to express the intensity of emotional distress to others
- An attempt to relieve tension by getting high, trying to calm down, or falling asleep
- One or more of the above

*What are the client's beliefs of this attempt?*

- A belief that death would not happen
- A belief that death, although possible, was not probable
- A belief that death was inevitable

*What was the covert purpose of the attempt?*

- Did the client make a will, give personal items away, put finances in order, etc.
- Did the client leave a note, other clues, etc.
- Did the client save medications or collect other potentially lethal items
- Did the client take steps to be found or to not be found
- Was the attempt impulsive
- What is the extent of the client's impulse control
- Did the client consume alcohol/substances at the time
- Is alcohol/substances an ongoing risk

*What is the client's response to the attempt? In retrospect, does the client feel embarrassed? Is there regret in making the attempt?*

*Does the client feel it was a mistake?*

- Does the client feel that significant people in his/her life have responded appropriately to the attempt

- Is there remorse on the client's part for the attempt or does the client express remorse for surviving

*What is the client's mind set at the time of the interview?*

- Is the client confused or disoriented because of intoxication or emotional chaos
- How able is the client to establish a relationship with you or is the client angry and unwilling to share information

*Future planning:*

- Does the client feel s/he can restrain suicidal impulses in the near future
- Does the client express some degree of hopefulness about the future
- Does the client demonstrate some ability to cooperate with future treatment planning

Hillard, J.R. (1990). Suicide. In J.R. Hillard (Ed.), *Manual of Clinical Emergency Psychiatry* (p. 115). Washington, D.C.: American Psychiatric Press, Inc.

Here is an example of elevated risk:

A twenty-seven year old married, white female presents to the emergency room with anxiety and a depressed mood. She expresses suicidal thoughts without a clear method; only that she would do it when her husband was away at work. She only feels suicidal when she is alone during some evenings

### **Step 1: Identify predisposing factors**

She is diagnosed as having a major depressive episode, mild. There are few vegetative symptoms and no psychotic features. There is no alcohol or substance use.

### **Step 2: Determine potentiating factors**

She was diagnosed with a similar episode at age twenty-five when her husband accepted a promotion at the mill as supervisor of the afternoon shift. Because of this promotion, he no longer worked days. At the time, she had also expressed suicidal ideation without a specific method. She is a file clerk in a small office and obtained this job after her husband received his promotion three years ago. She has fairly strong dependency traits and any hobbies or activities are done together with either her mother or her husband. This most recent episode seems to be precipitated by the news that her husband has to work alternate weekends. In context to this change in his work schedule, he has suggested to her that she expand her social network.

**Step 3: Conduct a specific suicide inquiry**

She admits to wanting to kill herself when her husband is at work. She has not identified the method she would choose. She doesn't know why she would want to kill herself, except perhaps, then her husband might feel guilty and wished he had spent more time with her.

**Step 4: Determine the level of intervention**

- Estimate the acuteness or chronicity of the client's suicidality  
Her past pattern indicates a chronic course that is exacerbated by changes in her husband's work schedule and responsibilities. Her depressive episode is mild, there is no clear method of suicide at this point, and there is a question of further regression if hospitalized. The plan is to send her home after negotiating with her specific problem solving related to her time at home alone.
- Evaluate competence, impulsivity, and acting out  
The client has few vegetative symptoms, is not psychotic, and there is no influence of alcohol or substance use. Her judgement is not impaired and she has not demonstrated any impulsivity or acting out. Her husband and mother confirm the patient is cautious by nature and has never demonstrated behaviour out of the ordinary for her.
- Assess the therapeutic alliance  
This client has not been seen here previously; her first episode was treated by her family physician who indicates a prescription of an antidepressant. The client did not report any significant changes, stopped taking the medication when she ran out upon discussion with her family physician. Her husband and mother report the patient tends to follow through with suggestions; her family physician confirmed this. The client was cooperative during the assessment and expressed a willingness to do some structured problem solving. She agreed with followup recommendations.

**The six step method of structured problem solving**

1. Identify the problem  
Defining problems or goals helps to focus on thinking of the issue at hand. Tackle only one problem or goal at one time.
2. Generate solutions through brainstorming  
The more solutions, the better.
3. Evaluate the solutions  
List the pros and cons of each.
4. Choose the optimal solution  
The solution chosen may be a beginning step toward other solutions but at least it will change the situation for this individual.

5. Plan

What must be put in place for the solution to work?

6. Review

Problem solving is a process. Perhaps some plans are not feasible to obtain the desired solution. Perhaps the solution is not working out.

**Example of application of six step method with above case**

1. Goal: To feel secure when home alone and husband is at work
2. Solutions: Get mother to stay  
Get others to keep me company  
Join a club or take up new hobbies  
Get husband to give up supervisor job
3. Evaluation: Mother may get on nerves  
Don't know anyone that well to ask  
Has always liked to sing  
Marital relationship might be strained
4. Choices: Will explore joining a singing group, club, choir
5. Plans: Will talk with husband  
Will ask at the local church  
Will pick up the community centre recreation calendar  
Will ask someone at work
6. Review: I will attend one choir practice one night a week  
This might be a way to meet other people and socialize outside of choir practice

World Health Organization. (1999). *Acute Inpatient Psychiatric Care* (pp. 133 – 134). New South Wales, Australia: Author.

- Plan the nature and frequency of reassessments  
The client is referred to an outpatient clinic and given an appointment for that week. Her family physician will contact her at least one time prior to that appointment. The client agrees to contact the family physician if she feels overwhelmed with suicidal thoughts at any time prior to that appointment.
- Document the assessments  
Part of the assessment might read: "Janet Doe states she feels better after talking with the writer. Her suicidal thoughts have decreased and she agrees to follow through with the problem solving plan as well as her appointment at the outpatient clinic on \_\_\_\_\_ (date)."



### Treatment planning

1. Assessment is completed; all relevant data is collected; the decision to admit has been made.
2. The treatment plan is individualized to meet the needs of the client.
3. Involve the client, family, significant others (as appropriate) in the treatment process.
4. Include existing resources the client has engaged. Is there an involved family physician, a psychiatrist, a therapist, etc.? Are there support groups or other networks the client is involved with?
5. Contracts are only as good as the client's ability to participate, if they are part of a cohesive treatment plan, and if staff continue with ongoing suicide assessments.
6. Determine the appropriate levels of observation, supervision, and privileges. The levels range from most restrictive to least restrictive:
  - Seclusion
  - Restraints
  - One-to-one
  - Q 15 minutes
  - Q 30 minutes
  - In pajamas
  - Staff supervision in use of sharps, lighters, other implements
  - Staff supervision in bathroom, kitchen, off ward activities
  - No off ward
  - Accompanied off ward by staff
  - Accompanied off ward by family, friends (as deemed appropriate)
  - Unaccompanied off ward (limited time, unlimited time)
7. Document the treatment plan, rationale, patient response. While all documentation relevant to suicidality is important, here are some particularly important times to document:
  - Admission
  - First off ward unaccompanied
  - Subsequent off ward passes
  - Discharge

Risk Management Foundation of the Harvard Medical Institutions. (1999). Guidelines for identification, assessment, and treatment planning for suicidality. In D.G. Jacobs (Ed.), *The Harvard Medical School Guide to Suicide Assessment and Intervention* (pp. 582 – 584). San Francisco, CA: Jossey-Bass

1. If the client is not admitted, then there must be appropriate resources in the community to support the client.
2. There must be an individualized discharge plan.
3. Can the client return to the home environment and be safe?
4. Can the client be alone or do there need to be responsible supports at home for the client? (e.g.: client to be accompanied at night by mother)
5. Are there concrete back up plans for when the client is alone? (e.g.: crisis line)
6. Are there appropriate followup appointments? (e.g.: family physician, therapist, appointment for outpatient counselling)

As you can see, the assessment and management of the suicidal client must be individualized. Risks must be taken into consideration and appropriate treatment planning, including problem solving/crisis intervention with the client, must be done if the client has the capacity to do so. Accurate and adequate documentation of suicidal risk should be reflective of the quality of care.

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# 7 Emergency Management of Substance Related Disorders



## Emergency Management of Substance Related Disorders

Substance use disorders are recognized as significant causes of morbidity and mortality. Epidemiology studies consistently find the life time prevalence of substance use disorders between 10-20%. Health care providers have an opportunity to intervene at all stages during the course of addictive illness. Management of alcohol and drug disorders includes assessment, psychological and pharmacological intervention, participation in specific addiction treatment strategies, and monitoring of recovery. A caring and empathic stance opens the door to treatment of medical conditions and substance disorders. Health care providers need to be aware of their own personal attitudes of low expectations given the high rate of relapse. Encouragingly, research suggests warnings from providers of the danger of substance use are associated with significant decrease in substance use and improved physical health. The complexity of medical and psychological problems of the substance user should alert providers to evaluate carefully vital status, physical exams, complementary laboratory investigations, and mental status.

### Assessment of substance related disorders

Addiction assessment is an ongoing process to determine personal and illness characteristics that influence the treatment and understanding of patients' illness. The well know CAGE questionnaire for alcohol use is a useful screen.

#### CAGE Questionnaire

1. Have you felt that you ought to Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you felt Guilty about your drinking?
4. Have you ever had a drink upon waking up as an Eye-opener or to steady your nerves?

A single positive answer warrants further clarification of alcohol history. Two positive answers indicate alcohol abuse and scores of three or higher are indicative of alcohol dependence. It is highly specific although there may be some false negatives. Other simple screening tests use to assess the adverse consequence of alcohol include the Michigan Alcohol Screening Test and the Drug Abuse Screening Test. Patients generally respond to a non judgmental and compassionate approach. Helpful questions may include: "Have you ever experimented with any drug of any kind?" or "Sometimes when people are stressed out, alcohol seems to settle their nerves, do you find yourself doing that some times?" Formal diagnosis of substance abuse or dependence is based on the DSM IV criteria. (1)

**Substance dependence** is described by both *physical* and *psychological* components: (any 3 of)

- tolerance
- withdrawal
- greater than intended use, and longer than intended use
- persistent and unsuccessful effort to cut back or to control
- great deal of time is spent in activities necessary to obtain substance or recover from its effect
- important social, occupational, or recreational activities given up or reduced
- continued use despite knowledge of persistent or recurrent physical or psychological problems

**Substance abuse** is defined in *social* terms: (any of)

- recurrent use resulting in failure to fulfill major role obligation
- recurrent use in physically hazardous situation
- recurrent legal problems
- use despite recurrent or persistent social or interpersonal problem exacerbated by substance

Frequently a review of systems will reveal long neglected medical conditions. It is important not to collude with patients on the denial of their physical and addiction problems. HIV and hepatitis screen is recommended for all intravenous substance users. Patients with alcoholic hepatitis often exhibit an AST: ALT ratio  $>1$ , an elevated GGT with a GGT: ALP ratio  $>2.5$ . Drinking is also associated with elevations in MCV, triglycerides, and uric acid. MCV tends not to return to normal until at least one to two months of abstinence due to RBC life span of 120 days.



For alcohol and barbiturates blood levels can provide some clinical indication of level of intoxication. Cocaine, opiates, and hallucinogens generally have very short blood half lives so blood concentration is often too low for detection and urine screen is the test of choice. Most short acting drugs last in urine up to 4 days post ingestion. The exceptions are PCP up to 7 days and cannabis, which may last up to 30 days in chronic users. Highly fat soluble benzodiazepines and barbiturates rarely may last up to 30 days.

### **Stages of change**

Clinicians have long recognized that some patients are more willing to enter treatment than others. What constitutes this difference? One explanation is the concept of the stages of change that grew out of the work by Prochaska and DiClemente. They defined recovery as a process. Success is greatly enhanced by matching treatment to each patient's stage of recovery.

### **The stages of recovery are:**

- **Precontemplation:** the patient does not recognize that he has a problem. The task of the clinician is to raise doubt – increase the patient's perception of risks and problems with current substance use.
- **Contemplation:** the patient experiences ambivalence of both reasons to change and status quo. Here the task is to gently tip the balance of ambivalence to evoke reasons to change, and evaluate the risks of not changing and to strengthen the patients sense of self efficacy for change.
- **Preparation:** the patient is motivated to consider strategies to change but has ambivalence toward specific strategies. The clinician helps the patient to identify the resources that best meet the patient's needs and offers choices.
- **Action:** the patient invests energy and time in a specific set of actions and may be easily frustrated. Patients will need support along the way toward change. Here advice and support are welcomed.
- **Maintenance:** the patient is committed to a set of values to counterbalance the real possibility of relapse. The primary task is to help the patient to identify the risk factors and strategies to prevent relapse.
- **Relapse:** although this stage was not initially included in the stages of change, risk of relapse is universal. The patient at this stage is to re-start the process of recovery rather than being stuck. Patients need support and encouragement to renew the process of contemplation and preparation.

## Treatments of Alcohol, Benzodiazepine and Sedative use Disorders

The principle of treatment for alcohol intoxication and withdrawal can be applied to all other sedatives. During acute alcohol intoxication patients may be disinhibited and aggressive, along with very little insight and a high level of impulsivity. Alcohol blood concentration is often greater than 0.8 mg/ml - the legal limit for impaired driving. Although physical restraints are generally used and patients can sleep through the intoxication, for violent patients lorazepam (2- 4 mg orally or intramuscularly) may be helpful.

In the absence of serious medical complications, withdrawal from benzodiazepine, alcohol and other related sedatives is usually transitory and self limiting. Pharmacologic therapies are indicated to prevent life threatening withdrawal complications such as seizures and delirium tremens, and to increase compliance with psychosocial forms of addiction treatment. Untreated delirium tremens has a mortality rate of 10-15%. Symptoms of withdrawal can start as early as 5-10 hours in fragile alcoholics and usually peak at about 48-72 hours. Most severe withdrawal tends to have symptoms by day one. The old belief that withdrawal usually takes place at day 3-5 misses the early warning symptoms of tremor, mild to moderate agitation. Studies support that early intervention reduces the risk of DT and withdrawal seizure.

Alcohol withdrawal may be treated with pharmacologic agents that exhibit cross tolerance with alcohol. Cross tolerance is the phenomenon that different drugs acting on same set(s) of neurotransmitters will produce a tolerance amongst each other. All sedatives are cross tolerant at least partially. The commonly recommended agents for withdrawal treatment are diazepam (Valium), lorazepam (Ativan), chlordiazepoxide (Librium), and phenobarbital. A patient who has developed alcohol tolerance will also develop a benzodiazepine tolerance. Understanding this phenomenon will reduce the common error of serious underdosing of benzodiazepines because clinicians are uncomfortable using large doses of benzodiazepines generally required for effective treatment. Don't forget some alcoholics drink in excess of a half gallon of vodka per day! It is safer to slightly overdose than to underdose.

Dosages used are titrated according to elevations of blood pressure, pulse rate, degree of agitation and presence of delirium. The Clinical Institute for Withdrawal Assessment (CIWA) Scale (Appendix 1) is used to assess baseline vital signs and to follow the progression of withdrawal. For scores < 8, there is no need for medication; for scores of 8-14, medication use is optional. Between 15-20, the

danger of a complicated withdrawal is high and medication is mandatory. For scores greater than 20, DT is impending and rapid sedation is required. The CIWA scale is both subjective and objective to prevent exaggeration of symptoms by the patient, which may lead to overmedication.

In general long acting benzodiazepines (diazepam or chlordiazepoxide) are the drugs of choice for most uncomplicated mild to moderate detoxifications. They provide a smoother detoxification and require less complicated nursing monitoring. A short acting benzodiazepine (lorazepam) is better for patients with moderate to severe liver disease, taking H2 antagonists, the elderly, or those with severe medical illness (especially respiratory compromise). A short acting drug gives better control but needs good nursing monitoring and appropriate use of CIWA. If understaffed, judicious use of a long acting drug is better.

Three different dosing schedules are commonly used for alcohol withdrawal within the hospital setting. Each has slightly different advantages and disadvantages.

### Fixed schedule dosing

Fixed schedule is easy and can be used in outpatient detox. For outpatient detox, the presence of a family member is mandatory and the patient should be advised not to drive and to hold dose if sedated. To avoid problems of underdosing, as needed (prn) benzodiazepine should be made available. CIWA scale may be used as a guideline for prn dosing. If more than three prn doses are required over twenty-four hours, then fixed dose can be revised upward.

**Table 1.**

#### Fix schedule dosing of long and short acting Benzodiazepines

	Diazepam	Lorazepam
Day 1	15 to 20 mg p.o. qid	2 to 4 mg p.o. qid
Day 2	10 to 20 mg p.o. qid	2 to 4 mg p.o. qid
Day 3	5 to 15 mg p.o. qid	1 to 2 mg p.o. qid
Day 4	5 to 10 mg p.o. qid	1 to 2 mg p.o. qid
Day 5	5 mg p.o. qid	1 mg p.o. bid

### Symptom triggered dosing

Symptom triggered dosing is most commonly used and is the best option when there is good nursing support. Often, however, there is severe underdosing for fear of excessive benzodiazepine use. To reduce clinical uncertainties, CIWA scale should be used to ensure adequate treatment. Diazepam 5 to 10 mg orally as needed for day 1

and 2, or lorazepam 1 to 2 mg orally every 4 to 6 hours as needed for 1 to 3 days. Dosing is triggered by CIWA >10-15.

### **Front loading dosing**

Front loading is best used in inpatient type settings for uncomplicated detox. Using long acting benzodiazepine will provide a slow gradual detox and will self taper if initial doses are high enough. Furthermore if a patient leaves hospital against medical advice before detox is completed, front loading method provides continued coverage even after discharge. On day one, use diazepam 20 mg orally every two hours up to 80 mg or till the patient is comfortably sedated. No taper is needed.

For severe withdrawal delirium (DT) with autonomic instability, aggressive dosing is essential for rapid control of delirium and to prevent seizures. When immediate control is desired, (i.e. acute withdrawal delirium in a severely medically compromised patient) use diazepam 10 mg intravenously as loading dose, followed by 5 mg intravenously every five minutes until the patient is calm, but awake. Because diazepam crosses the blood-brain barrier rapidly there may be transitory apnea. There is also rapid redistribution, therefore even if respiratory arrest has occurred, manual bag and mask is usually sufficient and intubation is not needed. Be prepared! Intravenous lorazepam may be better if there are concerns for excessive prolonged sedation (i.e. a patient with head injuries or respiratory insufficiency). Use lorazepam 2 to 4 mg intravenously every hour till sedation. Patients will require a gradual tapering of the total first 24 hour dose over the next five to seven days by 15-20% a day.

Some providers still use phenobarbital for detoxification. This is not recommended. Benzodiazepines are better because phenobarbital requires close monitoring due to its low therapeutic index. Benzodiazepines are far superior in safety profile and are better tolerated. For markedly agitated patients, a low dose of haloperidol is safe. A one time dose of 5 mg intramuscularly is usually sufficient. Magnesium is generally not needed unless there is a low Mg level, cardiac arrhythmia or neurological complications. Give 5/grams of magnesium with intravenous fluid three times a day over 2-3 days.

Wernicke's Syndrome is an encephalopathy characterized by confusion and drowsiness, ataxia, ocular disturbance and nystagmus. Wernicke's Syndrome can progress to Korsakoff's psychosis manifested as severe short term memory loss, confabulation and dementia. These sets of conditions are brought on by thiamine (vitamin B1) deficiency of chronic alcoholism due to poor nutrition and gastrointestinal absorption insufficiency. If treated early, thiamine supplement can reverse this process. Therefore it is advisable to include thiamine in withdrawal states. For severe withdrawals give thiamine 100 mg

intramuscularly, followed by a daily oral dose of 100 mg. It is also recommended to include multivitamin and folic acid 100/mg daily. Withdrawal treatment may also include supportive measures such as fluid replacement, and electrolyte balance.

Medications to avoid include chlorpromazine which can lower seizure threshold. Beta-blockers (propranolol) and alpha-adrenergic agonists (clonidine) can mask autonomic instability and warning signs of impending seizures. Clonidine may be used in combination with a benzodiazepine.

### **The basic rules of withdrawal**

- Prevention is good. If you suspect there is withdrawal, treat the patient as if there is a withdrawal.
- Those with previous withdrawal/DT will have future withdrawal/DT.
- Never underdose, comfortable sedation is the guideline to needed dose, not how much you gave.
- Do not mix benzodiazepines. If possible, start with one and end with the same one.

## **Management of Benzodiazepine withdrawal**

Management of aggression secondary to benzodiazepine intoxication is identical to that of alcohol intoxication. Withdrawal from benzodiazepines is not usually marked by significant elevations in blood pressure and pulse compared to alcohol detox. However, acute benzodiazepine withdrawal can lead to severe seizures, even status epilepticus. Almost all benzodiazepines are cross tolerant with each other, and equivalence doses can be calculated, (see Appendix 2 for benzodiazepine equivalent table). Alprazolam (Xanax) is unique and does not completely cross tolerate with other benzodiazepines. It has a separate receptor site shared only by clonazepam. Clonazepam substitution is the best option for alprazolam withdrawal and detoxification, although there may be occasions when alprazolam self taper is needed. Avoid prescribing alprazolam whenever possible.

Long acting benzodiazepines are more effective than short-acting preparations in suppressing withdrawal symptoms and in producing a gradual and smooth transition to the abstinent state. A taper over six to 18 weeks may be indicated for patients who have been taking benzodiazepines for years. The rate of taper can be adjusted according to patient tolerance. The following taper schedule is an example of a patient taking 12 mg of lorazepam per day. First the short acting drug is converted to an equivalent dose of long acting drug (diazepam 60 mg in this case). The initial 50% reduction can be

accomplished right from the start. The remaining 50% reduction will need a more gradual reduction. The rate of taper is a reduction in dosage of approximately 25 percent per quarter of the withdrawal period. During taper prn dosing should be avoided.

**Table 2.**  
**Tapering schedule for equivalent dose of 12 mg of Lorazepam per day**

Day	Dosage per day (mg)
1	10 mg three times daily = 30 mg
2	10 mg three times daily = 30 mg
3	10 mg three times daily = 30 mg
4	5 mg four times daily = 20 mg
5	5 mg four times daily = 20 mg
6	5 mg four times daily = 20 mg
7	5 mg three times daily = 15 mg
8	5 mg three times daily = 15 mg
9	5 mg three times daily = 15 mg
10	5 mg twice daily = 10 mg
11	5 mg twice daily = 10 mg
12	5 mg twice daily = 10 mg
13	5 mg every day = 5 mg
14	5 mg every day = 5 mg
15	5 mg every day = 5 mg

For a small percentage of patients who used benzodiazepines for more than a year, there is a risk of benzodiazepine discontinuation syndrome. It is a prolonged set of symptoms lasting for months which includes irritability, insomnia, fatigue and muscular discomfort. Use of SSRI and buspirone may alleviate some of these symptoms. Generally these patients can tolerate only reductions to 10% of peak dose. If a patient is determined to discontinue benzodiazepines, the best option is a very gradual taper of 12-18 months using the patients subjective symptoms as a guideline.

## Treatment of stimulants and Cocaine use Disorders

Clinical presentations are similar for cocaine and amphetamine ("speed"), methyl-phenidate, methamphetamine ("crystal meth") and others stimulants. They differ in half-life, onset of action and length of withdrawal. Used in low dose, patients experience heightened alertness, euphoria, energy, mental acuity, and somatic sensation. There is a reduction in anxiety, social inhibition, and need for sleep or food. After repeated exposure, vulnerable patients will develop a repetitive compulsive binge pattern. Stimulant induced euphoria is intense and powerful, often described as "full body orgasms."

Stimulant intoxication initially produces euphoria, improved self image, feelings of power, and energy. This is followed by a phase of lability, anhedonia and irritability. In severe cases there are ideas of reference, frank paranoia, hallucinations, thought disorders and gross disorganization, commonly accompanied by aggressiveness and sympathetic autonomic discharge. Patients can be extremely violent and aggressive at this time. Homicidality is a real danger due to a combination of lability, aggression, impulsivity, and poor insight. The desire to get more cocaine at this stage is a major cause of violent robberies and assaults. In severe intoxication, life support may be needed. Calcium channel blocker is effective for cocaine induced arrhythmia. Acute anxiety and panic will respond to benzodiazepine (diazepam 5-10 mg orally or intramuscularly). Haloperidol (5-10 mg orally or intramuscularly) is very effective against cocaine or stimulant induced psychosis.  $\beta$ -blockers may help with severe  $\beta$ -adrenergic state.

The withdrawal, "crash", phase of stimulant use is marked dysphoria, fatigue, restlessness, hypersomnolence, and intense craving. Withdrawal onsets within 24 hours of last use and peaks in 2 to 4 days and may last up to 10 days. During the "crash" depression and suicidal ideation is prominent. No specific medical treatment is routinely recommended for stimulant withdrawal. Supportive treatment is the best option. Numerous medications have been studied to treat cocaine intoxication, craving and withdrawal but results are modest.

A major cause of cocaine relapse is the experience of craving. Craving is an intense, irresistible, and compelling urge to use cocaine that intrudes into a user's thoughts and often affects concentration, mood and behavior. All chemical and behavioral addicts universally understand the term "craving." Risk of relapse is highest during an episode of craving, which may last for years. So far craving is understood in terms of behavioral conditioning. Often cocaine users will describe how seeing cues such as white powder, rolled up dollar bills and mirrors will lead to intense craving. There are also internal cues such as anger or loneliness that trigger craving.

Patients describe intense emotional feelings during craving. Awareness of craving helps users to resist the compulsion to relapse and to manage the associated negative affects. Psychoeducation include teaching patients that craving is universal and is not a sign of weakness, and that craving will pass and diminish with time.

The aim of long term addiction treatment is to disrupt the binge-craving cycle. This includes frequent supportive contact (2-7 times per week during the initial 2-4 weeks), peer support groups (Narcotics Anonymous or Alcoholics Anonymous), education of cocaine and the pharmacology of craving, and involvement of family and friends as exogenous monitors. Behavioral techniques are effective such as urine testing and contingencies, restriction of money, access and social activities, and frequent immediate contacts with support network during craving. To break the intrusive hold of craving, availability of instant support is essential, sometime intervention can be as simple as checking-in over the phone. Collaboration with family, friends, and allied workers form a treatment team to provide "around the clock" coverage. Availability is the key to success.

### Treatment of Marijuana and other Hallucinogens

Hallucinogens are a divergent group of compounds. Lysergic acid diethylamide (LSD, "acid") is the prototypical hallucinogen; others include MDMA ("Ecstasy"), MDA ("Eve"), DOM ("Serenity"), mescaline (from peyote), and psilocybin (from magic mushrooms). They share the ability to alter perceptions and bodily sensations, and rarely cause frank hallucinations. Hallucinogens cause perceptual disturbance without delirium, sedation, excessive stimulation, or intellectual and memory impairment. During use, patients have mood changes from euphoria to indifference, and indulge in mundane thoughts with a sense of novelty. Duration of action for LSD is 8-12 hours and 3-4 hours for mescaline and psilocybin. There is no clinical or laboratory evidence of acute withdrawal effects.

The first few hours of hallucinogen use is called the "trip" with dramatic effect which can be divided into somatic (dizziness, weakness, tremor), perceptual (i.e. synesthesia -hearing color or seeing music), and psychic (depersonalization, altered time sense). There is some cognitive impairment. Hallucinogens also produce profound autonomic activities such as pupil dilation, increased temperature, blood pressure and heart rate, tremor, hyperreflexia, and piloerection. These are generally transient. Acute anxiety during intoxication is called a "bad trip" and may be associated with ideas of reference and paranoia. This is akin to a psychotic state and treatment with antipsychotics is indicated for agitated patients, however supportive reassurance and a quiet environment can help to bring a patient "back from a bad trip." Often injury results from perceptual distortion



and lost of insight.

Marijuana is the world's most commonly used illicit drug. Life time prevalence of use is about 40-50%. The incidence of abuse or dependence is likely quite low in comparison. The active ingredient is  $\Delta$ -9-tetrahydrocannabinol (THC). Cannabis intoxication is similar to hallucinogens but not as severe. Heightening of normal sensation is the typical effect. It has a well documented deleterious effect on cognition. Short term memory, attention, concentration, recall, learning and skill acquisition are impaired. There is also suppression of REM sleep. Because cannabis is highly fat soluble and accumulated in the body, withdrawal generally does not require medical intervention. Symptoms include irritability, anxiety, sleep disturbance, and other bodily symptoms.

Longer term effects of cannabis use are still elusive. Cannabis induced psychotic and anxiety disorders are described. Both illnesses improve with abstinence. There is no clear evidence that cannabis precipitates psychotic illness in those without pre-morbid vulnerability. Amotivational syndrome is not scientifically verified. The apathy associated with chronic use may be a complex interaction of social, psychological and interpersonal disruption from chronic use. However, animal studies have demonstrated brain cell degeneration.

Phencyclidine, PCP (Angel Dust), and its cousin ketamine (Special K) were initially marketed as dissociative anesthetics and are now restricted to veterinary use. PCP intoxication is very similar to acute psychosis. Mixed nystagmus, labile body temperature, seizure, rhabdomyolysis, posturing, pupillary constriction or dilation and hypertension are seen. Agitation is best treated with haloperidol (5-10 mg intramuscularly or orally) and not by "talking down." Low potency antipsychotics may have additive anticholinergic effects and should be avoided. Benzodiazepines can be used as sedatives. It is unclear whether PCP induces psychotic disorders.

## Emergency Management of Substance Abuse Related Disorders

### Appendix 1. Addiction Research Foundation Clinical Institute for Withdrawal Assessment - Alcohol (CIWA-Ar)

Addiction Research Foundation Clinical Institute Withdrawal Assessment-Alcohol (CIWA-Ar)

This scale is not copyrighted and may be used freely.

Patient: \_\_\_\_\_ Date: /\_\_\_/\_\_\_/\_\_\_ Time: \_\_\_ : \_\_\_\_\_

(24 hour clock, midnight = 00:00)

**NAUSEA AND VOMITING**—Ask "Do you feel sick to your stomach? Have you vomited? "

Observation. 0 no nausea and no vomiting

1 mild nausea with no vomiting

2

3

4 intermittent nausea with dry heaves

5

6

7 constant nausea, frequent dry heaves and vomiting

**TREMOR**—Arms extended and fingers spread apart.

Observation.

0 no tremor

1 not visible, but can be felt fingertip to fingertip

2

3

4 moderate, with patient's arms extended

5

6

7 severe, even with arms not extended

**PAROXYSMAL SWEATS**—Observation.

0 no sweat visible

1 barely perceptible sweating, palms moist

2

3

4 beads of sweat obvious on forehead

5

6

7 drenching sweats

**ANXIETY**—Ask "Do you feel nervous?"

Observation.

0 no anxiety, at ease

1 mildly anxious

2

3

4 moderately anxious, or guarded, so anxiety is inferred

5

6

7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.

**AGITATION**—Observation.

0 normal activity

1 somewhat more than normal activity

2

3

4 moderately fidgety and restless

5

6

7 paces back and forth during most of the interview, or constantly thrashes about

**TACTILE DISTURBANCES**—Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?"

Observation.

0 none

1 mild itching, pins and needles, burning or numbness

2 mild itching, pins and needles, burning or numbness

3 moderate itching, pins and needles, burning or numbness

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

**AUDITORY DISTURBANCES**—Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"

Observation.

0 not present

1 very mild harshness or ability to frighten

2 mild harshness or ability to frighten

3 moderate harshness or ability to frighten

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations.

**VISUAL DISTURBANCES**—Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"

Observation.

0 not present

1 very mild sensitivity

2 mild sensitivity

3 moderate sensitivity

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

**HEADACHE, FULLNESS IN HEAD**—Ask "Does your head feel different? Does it feel like there is a band around your head? "

Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 not present

1 very mild

2 mild

3 moderate

4 moderately severe

5 severe

6 very severe

7 extremely severe

**ORIENTATION AND CLOUDING OF SENSORIUM**—Ask "What day is this?"

Where are you? Who am I?"

0 oriented and can do serial additions

1 cannot do serial additions or is uncertain about date

2 disoriented for date by no more than 2 calendar days

3 disoriented for date by more than 2 calendar days

4 disoriented for place and/or person

Total CIWA-A Score \_\_\_\_\_

Rater's Initials \_\_\_\_\_

Maximum Possible Score 67

**Appendix 2. Benzodiazepine dose equivalents**

Generic name	Trade name	Therapeutic Dose Range (Mg/Day)
Alprazolam	Xanax	0.75-6
Chlordiazepoxide	Librium	15-100
Clonazepam	Rivotril	0.5-4
Clorazepate	Tranxene	15-60
Diazepam	Valium	4-40
Estazolam	ProSom	1-2
Flumazenil	Mazicon	**/**
Flurazepam	Dalmane	15-30*
Halazepam	Paxipam	60-160
Lorazepam	Ativan	1-16
Midazolam	Versed	***
Oxazepam	Serax	10-120
Prazepam	Centrax	20-60
Quazepam	Doral	15*
Temazepam	Restoril	15-30*
Triazolam	Halcion	0.125-0.50*
* Usual hypnotic dose	** antagonist	***iv formulary only

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## 8 Assessing the Confused Older Adult in the Emergency Department





# Assessing the Confused Older Adult in the Emergency Department

Older adults frequently present to the emergency department [ED] with confusion. The emergency department team is faced with sorting out whether the confusion is acute (delirium), chronic (dementia), or acute on chronic (delirium in someone who has an underlying dementia or a chronic psychotic illness).

## Delirium

Delirium has been known by many aliases throughout the years, including:

Acute Confusional State  
Acute Brain Syndrome  
Toxic Psychosis  
Post-op confusion

Delirium is a syndrome with many etiologies. It is characterized by:  
an acute onset of confusion  
fluctuating symptoms  
various behavioral symptoms

It is vital that the emergency physician [EP] recognizes Delirium for the following reasons:

- Delirium is common - particularly in the older population. Estimates suggest that 10-15% individuals admitted to acute care

hospitals are delirious. Looking at admitted patients, the incidence of delirium on acute geriatric services may be 35-80%. Delirium often indicates serious occult medical illness. The classic symptoms of illness in older patients are less intense and can be overlooked. Elderly patients with pneumonia are renowned for having less fever, cough, and pleuritic chest pain. Frequently, the first sign of the infection is the development of confusion and an increase in respiratory rate. The importance of identifying occult medical conditions in the older patient presenting with an altered level of confusion cannot be overstated.

- The underlying cause of Delirium is often treatable, and with prompt diagnosis and treatment, the person is likely to return to his premorbid level of function. However, if the diagnosis of delirium and its underlying cause are missed, the person may never recover to the best possible level of function.
- Delirious patients have longer hospital stays, higher mortality rates, and higher rates of institutional care after hospitalization. Rapid recognition of the syndrome and treatment of its underlying cause can improve the prognosis for the individual and decrease costs for the medical system.

### What does Delirium look like?

A 78 year old male presents in the ED 5 days after discharge from hospital following a lobectomy for bronchogenic carcinoma. His family describes mild forgetfulness preoperatively. Since discharge he has severe confusion and insomnia, with alternating drowsiness and agitation. He sleeps only 20-30 minutes at a time at night, and is often found trying to get out of bed. At these times he doesn't recognize his family and accuses them of trying to poison him. He reports seeing snakes in his bed. He is somewhat more settled and lucid during the day, often taking catnaps.

**The DSM IV criteria for Delirium are as follows:**

- a. Disturbance of consciousness (ie. reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.
- b. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by pre-existing or evolving dementia.
- c. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

In practical terms, the emergency team should look for the following behavioral changes.

**1. A relatively acute onset of confusion**

The onset of acute confusion in someone who is usually cognitively intact or the rapid worsening of confusion in an individual who already has a dementia are the classic features of delirium. History of onset of confusion is key to clarify the diagnosis.

**2. Fluctuating levels of consciousness**

There is frequently disturbance of the reticular activating system in the individual with delirium - reflected by a pattern which can fluctuate between somnolence to the point of stupor and severe agitation within minutes to hours.

**3. Deficits in attention**

Accompanying the fluctuation in consciousness, the person will often demonstrate a difficulty focusing, sustaining, or shifting attention. The interviewer may find herself repeating questions because the individual's attention has wandered, or may find the individual perseverating on an answer to a previous question. They are often easily distracted by irrelevant stimuli.

**4. Transient cognitive impairment**

The individual may experience deficits in short term memory, disorientation - especially to time and place or difficulties with language in the form of dysnomia or dysgraphia. These deficits fluctuate throughout the day. Speech can be rambling and incoherent, with rapid shifts of topic. Knowing the person's baseline level of functioning is key in determining which deficits are new and which are chronic.

### **5. Sleep wake disturbance**

New initial insomnia is often a tip off that an older person is becoming delirious. This usually develops into nocturnal agitation and daytime sleepiness. Occasionally there can be a complete day night reversal. Correcting the sleep disturbance is key to the resolution of the delirium.

### **6. Psychotic symptoms**

Visual misperceptions are common in delirium. They can occur as illusions or hallucinations. Illusions are the misperception of a true stimulus, ie misinterpreting the belt on a house coat lying on the bed as a snake. Hallucinations are the experience of a sensation in the absence of a real stimulus ie. seeing people on the ceiling. Auditory hallucinations occur rarely. Delusional ideation is usually transitory and often persecutory. The fear that someone is trying to poison the person is common, and may fluctuates over minutes to hours.

It is important to remember that the new onset of hallucinations, especially visual ones, suggests delirium in an older person. Elderly people with Schizophrenia may develop delirium, and these two conditions must be distinguished. Many older people with agitation and hallucinations/delusions as part of their delirium are mistriaged to psychiatric units, and their underlying physical disturbances are missed.

## **Differential diagnosis**

The most common differential diagnostic issue is the distinction between delirium and dementia. Older people with dementia tend to demonstrate memory impairment which is stable over the day. They do not have the fluctuations in level of consciousness typical of a classic delirium. Nor do they tend to have vivid visual hallucinations. They may experience delusions, but these tend to be more systematized and persistent than with delirium. The most difficult situation is the diagnosis of delirium in the person who already has a diagnosis of dementia. Collateral information from family members and other care takers is key to determining whether the person is now experiencing a delirium in addition to their dementia. In these situations, the classic delirium picture is often somewhat muted, and the presenting symptoms are restricted to increased confusion and sleep disturbance.

### Comparing Delirium and Dementia

Symptom	Delirium	Dementia
Onset	Usually rapid	Usually slow, insidious
Course of symptoms	Fluctuates during day	Relatively stable
Duration	Days, weeks	Months, years
Memory	Impaired recall of recent events	Recall of recent events, and new learning are impaired (permanent)
Hallucinations	Visual/Auditory - transient	Less common
Sleep/Wake cycle	Agitated at night, drowsy by day	Intermittent wakening without significant agitation
Orientation	Disorientation fluctuates	Disorientation stable
Level of consciousness	Fluctuates	Alert, stable
Thought content	Incoherent, confused	Disorganized - incoherent late in disease
Insight	May be present during lucid intervals	Most often absent

One form of dementia which is prone to delirium-like symptoms without an underlying medical illness is Lewy Body Dementia (a variant of Alzheimer Disease). Lewy Body Dementia is pathologically characterized by the presence of Lewy Bodies throughout the brain-stem and cortex. Its clinical presentation is defined by:

- a. Fluctuating cognition with pronounced variation in attention/alertness
- b. Recurrent visual hallucinations
- c. Spontaneous motor features of Parkinson's - esp. after neuroleptic exposure

They often have histories of repeated falls, syncope, and transient losses of consciousness. This group requires careful screening for delirium prior to making the diagnosis of Lewy Body Dementia.

Delirium must also be distinguished from Psychotic disorders in the ED. Older people may experience psychotic illnesses later in life, but a first episode of Schizophrenia is very rare. Older people may be psychotic as part of a severe depressive illness. When they develop psychotic illnesses, their thought form is often preserved and they do not show the loosening of associations or disorganized thought of a young person with Schizophrenia. They may have well systematized delusions with associated auditory hallucinations. Visual hallucinations in an older person are caused by delirium until otherwise proven. Older people who have aged with Schizophrenia often have more negative symptom presentations, or if their positive psychotic symptoms have become worse, it can often mean underlying medical illness. An elderly Schizophrenic who presents with a worsening of their psychosis requires a delirium work up.

Older people with delirium often present with variable intense affective states. Frequently, they will be in tears and say they want to die. While depressive illnesses are common in older people, it is important to rule out a delirium first, especially when associated with any new confusion.

### Causes of Delirium

There are many causes of delirium. It may be helpful to remember the mnemonic "I watch death" outlined in the accompanying table. However, for practical purposes, one should focus attention on the common causes of delirium in the elderly. These are outlined below.

1. **Drugs** including commonly prescribed medications such as Cimetidine, Ranitidine, Narcotics including Codeine, Warfarin, Isosorbide, Theophylline, Calcium Channel Blockers, and Digoxin, Diuretics, and Antibiotics. Chronic salicylate and lithium toxicity may cause delirium with levels in the upper therapeutic range.
2. **Infections** especially urinary tract infection and pneumonia.
3. **Cardiovascular events** such as myocardial ischemia or infarction, congestive heart failure, stroke, or ischemic bowel.
4. **Metabolic derangements** such as hypovolemia, hyponatremia, malnutrition, liver or renal failure.
5. **Alcohol and sedative withdrawal.**

<b>I</b> nfectious	Sepsis, encephalitis, meningitis, syphilis, CNS abscess
<b>W</b> ithdrawal	Alcohol, barbiturates, sedatives
<b>A</b> cute metabolic	Acidosis, electrolyte disturbance, hepatic and renal failure, glucose, magnesium, calcium
<b>T</b> rauma	Head trauma, Burns
<b>C</b> NS disease	Hemorrhage, ischemic stroke, vasculitis seizures, tumor
<b>H</b> ypoxia	Acute hypoxia, chronic lung disease, hypotension
<b>D</b> eficiencies	B12, niacin, thiamine
<b>E</b> nvironmental /endocrine	Hypothermia, hyperthermia, diabetes, adrenal, thyroid
<b>A</b> cute vascular	Hypertensive crisis, subarachnoid hemorrhage, pulmonary embolus
<b>T</b> oxins/drugs	Medications, street drugs, alcohol, carbon monoxide, cyanide, solvents
<b>H</b> eavy metals	Lead, Mercury

The emergency department evaluation of the confused elderly patient should include a focused history and physical examination aimed at detecting the conditions described in the previous case. It is essential to gain collateral information from caregivers, family and friends. Medications should be closely scrutinized. Nursing notes from the past 72 hours, if available can help make the diagnosis.

These investigations should be supplemented with a brief mental status examination. Few clinicians in a busy emergency department will take the time to perform a formal Folstein Mini-Mental Status Examination.

However, it is possible to quickly assess orientation, memory [object recall], attention, concentration, and arithmetic ability [serial sevens] constructional and spatial discrimination [drawing a clock face], and writing [write a sentence] in a very brief time.

**Diagnostic tests should include the following:**

CBC

Electrolytes, urea and creatinine

Glucose

Calcium, Magnesium

Liver Function

Pulse Oximetry or Blood Gases

Anion Gap

ASA Level if patient takes aspirin for any reason

B12, Folate Levels

TSH, VDRL

Urinalysis, Urine for C&S (catheter spec for females, supervised midstream for males)

ECG

Chest X-ray

Head CT if available

Lumbar Puncture

It should be emphasized that many patients with delirium will have no clear etiology after physical examination and initial laboratory investigations. Negative findings should therefore not be interpreted as evidence against the diagnosis of delirium.

Elderly patients may present without the usual signs of infection. There should be a low threshold for obtaining investigations such as chest x-ray, catheter urine specimens, and lumbar puncture.

## Treating Delirium

There are two parts to the treatment of Delirium:

1. Diagnosis and treatment of the underlying cause of the Delirium.
2. Management of behavioral symptoms of the Delirium.

The topic of defining the underlying causes of Delirium has been covered previously. It is important that diagnosis be made rapidly and precisely, as this can reduce the long term morbidity for the patient. It should be noted that if a delirious state has been left undiagnosed for more than a week or two, it can be very difficult to identify the initial cause. In this situation, treating the behavioral symptoms promptly and carefully is essential.



## Treating behavioral symptoms

The key to righting the behavioral symptoms of delirium lies in reversing the sleep wake disturbance. If the sleep wake disturbance has continued for more than a week, the resulting sleep deprivation can independently perpetuate the delirium.

Often, delirious patients will be uncooperative with their own care, pulling out their I.V.'s, refusing medication, or interfering with the care of other patients. Controlling the person's day time agitation may therefore be a prerequisite to treating the underlying medical condition.

Wherever possible, use the same medication to right the sleep-wake cycle and the day time agitation. Much of the literature makes mention of the use of Haloperidol for delirium. Haloperidol has the advantage of few anticholinergic side effects (which in themselves can often worsen the delirium) and minimal postural hypotension. However, in geriatric patients, doses required to achieve adequate sedation are highly associated with extrapyramidal side effects. Remember, we need sedation to get the person to sleep at night.

Dr. Rob Hewko, the consultation liaison psychiatrist at VGH has treated over 1000 cases of delirium over the past 15 years. His recommendation for the treatment of behavioral symptoms is Loxapine. Loxapine causes less extrapyramidal side effects, and sufficient sedation to right the sleep wake cycle. It does have slightly more anticholinergic potential than Haloperidol, and has more potential for postural hypotension.

### Side effect profiles of Neuroleptics

Symptom	Haloperidol	Loxapine	Chlorpromazine
Hypotension	low	moderate	high
Anticholinergic	low	low	high
EPS	high	moderate	low
Sedation	low	moderate	high

The atypical neuroleptics such as Risperidone and Olanzapine are used less in the acute management of delirium, and more often in the treatment of chronic psychosis and aggressiveness occurring as part of a dementing illness.

The key in the management of Delirium is to give the neuroleptic as a regular dose, usually in the late afternoon, and always at bedtime. Appropriate prn doses at an interval of every hour of either an oral or

parenteral preparation are indicated as well. Delirium requires close monitoring. The physician needs to review the nurses' notes daily, particularly from the night before. The staff should be encouraged to keep a 24 hour sleep/agitation log. The regular dosage should be increased based on the prn requirements and the pattern of sleep disturbance and agitation from the day before. The goal is to re-establish a normal sleep cycle and to control agitation over 2-3 days.

The VGH consultation liaison service recommendation is as follows:

1. Physically fragile patient: regular dose Loxapine 2.5 mg. at 1600 and 5.0 mg. at hs; prn dose, 2.5-5mg every hour p.o./I.M. for marked agitation to a maximum of 50 mg/24 hrs.
2. Physically stable older patient: regular dose 5.0 mg. at 1600 and 10 mg. at hs; prn dose 5.0-10 mg every hour p.o./I.M. for marked agitation to a maximum of 100 mg/24hr.

The nurses are encouraged to use prn doses during the night to try to get the patient to sleep during the night hours, while prns during the day are to be used only if the patient is markedly agitated.

It is acknowledged that there are no controlled studies on the efficacy of Loxapine in Delirium, and that the recommendations above are based on clinical experience alone.

Physical restraints are to be avoided. If absolutely necessary, they must be used in association with a chemical restraint. Use of physical restraints without appropriate sedation should be considered dangerous and unethical. Physical restraints have been associated with significant injury when used independent of chemical restraint.

Once the sleep wake cycle has been restored for 2-3 days, the neuroleptics should be tapered over another few days, leaving the hs neuroleptics until after the daytime dosages have been discontinued.

Routine use of Benztropine with a neuroleptic in Delirium is not recommended. While there is risk of an acute dystonic reaction, there is a higher risk of the anticholinergic medication worsening the delirium. A prn order may be helpful in case of a dystonic reaction.

Benzodiazepines are rarely helpful in Delirium unless one is treating an Alcohol or Benzodiazepine withdrawal Delirium. Benzodiazepines in other types of delirium tend to be helpful in terms of sedation, but can increase confusion and cause ataxia. They tend to be used as second line medications used when increasing doses of neuroleptics alone are not handling the agitation.

The supportive therapy for an older person with Delirium is key to their recovery. Appropriate levels of lighting need to be determined on an individual basis. Some people require less light to prevent sensory overstimulation, while others become more agitated in the dark. Subdued lighting levels are often the most helpful, providing they do not cause frightening shadows which can be misinterpreted by the patient. It is vital that the person with Delirium receive optimal fluids during their illness. Because of their agitation, they often are difficult to encourage to drink or eat. However, without adequate hydration, the delirious state can be perpetuated by dehydration.

The older person with Delirium needs to be ambulatory. Bedrest will weaken the individual's muscles and delay their recovery.

Reassurance is important to the older person with Delirium. They need to understand they are ill and that they are safe. Family members' presence can be very helpful in reorienting and reassuring the frightened individual with Delirium. Family members need to understand that this condition is transitory and that their relative will improve fastest with their presence.

## Summary

Delirium is a very common condition in the older person presenting to the ED. It is vital that the condition be recognized and the underlying cause diagnosed and treated as rapidly as possible to improve overall morbidity for the older person. Behavioral symptom management often requires pharmacological intervention - especially with reference to correcting the sleep wake cycle. Environmental interventions are also important to keep the older person with Delirium from experiencing more disability than is necessary and to improve the prognosis.

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## 9 Psychological Trauma



## Psychological Trauma

Trauma can be defined as experiencing and/or witnessing events that are beyond the expectations of ordinary experience. Psychological and physical resources may be overwhelmed, leaving the individual devastated, exhausted, and numb. Trauma may take the form of assault, rape, sexual abuse, or a horrific accident in which the individual's life is irreparably altered. Trauma may occur in civil war, famine, political persecution and/or torture.

The effects of trauma can be immediate or insidious. The emergency room is often one of the first places an individual will either come or be brought to, as the result of physical or psychological trauma. The long term effects of trauma can be subtle and require accurate diagnosis, especially if the presenting problem is attributable to or complicated by the effects of trauma. Some of the psychiatric problems associated with trauma are: Major Depressive Disorder, anxiety and phobias, alcohol and/or substance misuse, eating disorders, increased lifetime rates of attempted suicide, dissociative/post traumatic stress disorders, self harm and high risk behaviours, and altered sexual function.

Approximately 1% - 3% of the general population suffer from Post Traumatic Stress Disorder. Subclinical forms of posttraumatic stress are estimated to be as high as 5% - 15% in the general population. It has been estimated that one in three women have been sexually abused in childhood and that up to 21% of pregnant women are abused and are twice as likely to have miscarriages as those women who are not abused. That approximately 2% - 5% of domestic violence involve males being the victims of physical abuse, therefore it is important to keep in mind and in perspective that both genders are capable of inflicting trauma and of being traumatized.

There is evidence that trauma can cause changes in some of the neurobiological/biochemical tracts of the brain. These changes in neurobiology and biochemistry can explain why hyperarousal, intrusive thoughts, and emotional constriction are the hallmarks of Post Traumatic Stress Disorder. Memory is altered: there may be amnesia, flashbacks, dissociative episodes, or recurrent dreams. Changes to the biological stress response include: hypervigilance, and extreme startle reflexes. There are also changes in the secretion and regulation of stress hormones which may relate to numbness, avoidance of cues and context related to trauma reenactment. How and when does the health care provider begin to consider trauma as a significant contribution to the client's clinical picture? The provider can be guided by:

### **Life threatening injuries**

If the trauma is immediately life threatening, the provider will of course have to triage and attend to those injuries, as in the case of a serious motor vehicle accident. The client will still, at some level, be able to hear and therefore the provider needs to pay heed to what is said in the emergency room and what psychological comfort is being provided. Explanations to the client of what is happening are important. Care and consideration must be taken from the initial contact, throughout assessment, treatment, and discharge not to inadvertently retraumatize the client. For example, while it is essential to obtain accurate information, the provider can accomplish this by asking clear, open-ended questions which will essentially capture the clinical picture, without having to ask probing or interrogative questions. You can ask focussed questions that will assist in your assessment but specific, detailed questions related to the trauma should be delayed until the client has had an opportunity to recover from the initial shock.

An example might be: "You are in the hospital. Can you tell me what happened?" (See the discussion on collateral sources of information: this is where other team members who are not directly working with the client can facilitate information gathering.)

### **Presentation**

How does the client appear? Look for the obvious and the not so obvious. If there are bruises that are clearly visible or injuries that may or may not be the result of an accident, then the clinician must ask some very direct questions. In the course of your examination of the patient, is there evidence of old bruising or of old injuries? (e.g.: fractures, scars) Observe for subtle clues such as, does the client appear to be extremely vigilant of their environment? Does the client startle easily and out of context to the stimuli? Is the client nervous for



no apparent reason? Does the client present with vague somatic complaints like pain, headache, sleep disturbance? Does the client report dreams that are repetitive in nature? Is the client fearful of going to sleep?

An example might be: "Sometimes people are afraid of going to sleep after a bad experience or they have dreams about what happened. Has that happened to you?" Obtain information related to previous number of presentations to the emergency department and the reasons for those.

### **Psychiatric interview**

Aspects of the interview may give cause for the provider to require more information. Relevant personal history, family history, psychiatric history, hospitalizations, previous trauma, life stressors: these areas may contain very specific information, gaps, or very vague recollections. Mental status may reveal a range of emotional responses from very expressive to constrictive.

Trauma that has occurred recently can reactivate prior traumas, including episodes that may not be fully remembered. Do not attempt to recover these forgotten episodes at this time.

### **Collateral sources of information**

Key informants in the client's life are important. It is essential to note, that in cases of domestic trauma, the perpetrator may be the client's partner. Therefore, it would be important to interview each separately; note contradictions in histories, accounts of the events preceding the emergency presentation may differ; pay attention to the nonverbal behaviours/communications and especially to the interaction between client and partner. In the case of other types of key informants, their feedback may be that the client is noted to be "different" following a particular trauma or time in their life. Determine what these "differences" might be.

It is important to refrain from being overly curious about the client and risk the possibility of "opening up" the client too extensively. The cost will be at the client's expense. You do not want a client leaving the interview feeling overly vulnerable, exposed, and emotionally raw. During the treatment phase, as much as possible, involve the client as a partner in his/her treatment. Allow as much choice as feasible. In the case of clients who are certified under the B.C. Mental Health Act, "choice" is often limited to a few options. For example, the client requires psychotropic medication to control psychotic symptoms. The client does not voluntarily want to take the medication. The "choice" then offered to the client is to take the medication by oral route or by intramuscular route. How the choice is offered is very important. An example might be: "Here is some medication to help you gain control. Would you like to take it by mouth or would you like to take it by injection?"

The same principles apply in the use of restraints and seclusion. If you are working with a client who has a history of trauma, please keep in mind the risk of retraumatization. The effective use of behavioral controls to appropriately manage and minimize risk of escalation must be considered as an integral component of an ethical treatment plan. The judicious use of regular and prn medications, nicotine patches, healthy meals with decaffeinated beverages, adequate opportunity for exercise and movement, attention to the client's personal hygiene needs, as well as the ongoing therapeutic communication with the client are measures that may make the use of restraint or seclusion unnecessary or at least minimal.

If it does become necessary to use restraints and/or seclusion during the course of treatment, minimize the client's potential distress. You can do this in a number of ways:

- Always take the time to explain what you are doing and why.
- Follow through with your organization's policies and procedures relevant to the use of restraints and seclusion.
- Regular checks on the client are required.
- Adequate care and attention must be paid to the client's circulation, hydration, food intake, and hygiene needs.
- Sensory deprivation can be an effect of being in seclusion, therefore it is important to be mindful of "normalizing" the seclusion room environment as much as is safe and practical.
- Monitor and assist the client in maintaining a normal sleep-wake cycle, allow natural light into the room or adjust artificial lighting, offer the patient verbal cues as to where they are throughout the day, and try to provide as much natural stimuli as possible.
- Test out on a daily basis the client's ability to be let out of restraints or seclusion.

Once the client no longer requires restraint or seclusion, it is important that the client (and the staff) are offered a "debriefing" related to the restraint and/or seclusion experience. The client's family members and other visitors may be distressed to find the client in restraints and/or seclusion. Therefore, care and attention paid to them along with progress updates will go far to prevent or alleviate any feelings of anxiety, tension, or anger.

In working with clients who have trauma in their backgrounds, it may be helpful to use Herman's (1992) three stage framework. Remember that these stages are non linear and the client can move back and forth between them:

### **Safety**

The goal of this stage is for the client to establish control and power over his/her own body, emotions, cognitive processes, and the environment.

### **Remembrance and mourning**

The goal of this stage is for the client to tell the story of his/her traumatic experience. In order for the client to transform and integrate this experience into the past (as opposed to endlessly reliving/avoiding it), the telling of the story is reconstructed and reconstituted on cognitive, emotional, and interpersonal levels. This thorough and complete remembrance sets the stage for mourning. Mourning involves the grieving of the client's past which was prior to the traumatic experience as well as the client's experience of the trauma. During this stage, the client lets go of who s/he was and the context of that previous existence which may involve the client relinquishing certain relationships.

### **Reconnection**

The goal of this stage is for the client to build a present and a future. During this stage, the client has come to terms with the past and is ready to engage vociferously in determining the meaning of and the quality of life to be lived.

### **Strategies to create safety for the client**

In the hospital environment, especially in the emergency room, the provider will have the opportunity to cultivate a sense of safety for the client. Some of the ways this can be achieved are:

- Involve the client in their care planning as much as possible.
- Identify for the client, who will be the primary care providers during that particular shift or day.
- Establish a routine of giving care that is consistent and will have a likely chance of being followed through by other staff.
- Develop a written plan of care that is accessible to all and use it to facilitate verbal reports.
- Be aware of increased suicide risk, the potential for aggressive behaviour, or abuse of substances. (clients may attempt to attenuate their psychological distress by engaging in some of these behaviours)
- Teach the client how to "normalize" some of their symptoms. (poor quality of sleep, vivid dreams, flashbacks, startle response, mood/ability detachment, heightened anxiety, etc. are usually time limited)

- Teach the client strategies that facilitate a sense of regaining control. (establish routines of care, deep breathing and progressive relaxation exercises, basic hypnotherapy techniques)
- Offer psychoeducation about medications. (a SSRI may normalize the sleep-wake cycle while long acting benzodiazepines used over the short term may decrease feelings of anxiety)
- Contract in relation to specific behaviours as well as firm limit setting may be required.
- Allow the client to talk about what happened.
- Facilitate appropriate discharge planning.

### Health care provider responses

- Be aware of your responses to the client.
- Be firm and compassionate.
- Be aware of your need to rescue or to be punitive.
- Be clear of boundaries.
- Remember to take care of yourself.
- Issues related to consultation, debriefing, and support should be addressed within the interdisciplinary team.

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# 10 Management of Individuals with Personality Disorders



## Management of Individuals with Personality Disorders

What do the words "crisis" and "personality disorder" conjure up for the health care provider? Instability, disruption, loss of control may be some of the responses that come to mind. What is meant by the term "personality disorder"? According to the DSM IV, "a personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), (p. 629). Washington, D.C.: Author

With reference to "personality disorder", the provider needs to keep in mind that every one of us possesses certain character traits that are fairly consistent and influence how each one of us relates to the world and to others in it. For example, "Jane Doe is such a patient person" or "John Doe has a bad temper" are descriptions of specific characteristics or attributes an individual may possess. It is the degree to which the individual's attributes manifest as well as the consistency which will determine whether the individual has traits or disorder. Individuals with personality disorders have deeply ingrained maladaptive patterns of behaviour.

The DSM IV has categorized the ten personality disorders into three "clusters" or groupings: cluster A, cluster B, cluster C. These groupings capture the "core" or main characteristics an individual could manifest.

### **Cluster A: Paranoid, Schizoid, & Schizotypal Personality Disorders**

- These individuals can be described as "odd", "different", "unusual", "strange", or "weird"
- Their position in relation to the world is at arms length, distant, and tenuous
- For these individuals, there is a sense of discomfort, a sense of unfamiliarity in negotiating day to day routines (e.g.: work, civic duties, activities of daily living, etc.)
- Their relationships with others are limited, constrained, and awkward

**Cluster B:  
Antisocial, Borderline, Histrionic, &  
Narcissistic Personality Disorders**

- These individuals are the most "visible" of the personality disorders
- They demonstrate behaviours that can be described as "flamboyant", "attention-seeking", "egocentric", "impulsive", "difficult", "dangerous", "dramatic" or "wild"
- Their position in relation to the world is to challenge the status quo, to seek immediate gratification with little consideration for consequences, and to readily discharge feelings of inner tension
- Their relationships with others are unstable, they are extremely sensitive, and they have an enhanced ability to read nonverbal cues of others

**Cluster C:  
Avoidant, Dependent, &  
Obsessive-Compulsive Personality Disorders**

- These individuals are often described as "anxious", "fearful", "extremely self conscious" or "wary"
- Their position in relation to the world is tentative, submissive, or rigid
- In their relationships with others, these individuals try to avoid or minimize conflict by not expressing opinions or disagreement, they have difficulty with decision making, and can be constrained by their internal need to control

It would be appropriate to review some principles of human growth and development at this point because a key piece in understanding the individual with a personality disorder is to conceptualize how the individual's personality develops and evolves. Erik Erikson is a theorist who provides a clear framework, based on stages of human development. The eight stages he lays out revolve around a developmental goal or crisis to be mastered; if the individual does not meet the goal or resolve the crisis of that stage, h/she may always struggle with the goal of that particular developmental stage. The stages are permeable, non linear, and the individual may move in or out of them at various times in his/her life.



## Erikson's eight developmental stages

Stage	Age	Developmental goals
1. Trust vs. Mistrust	birth – 1 year	Basic physical needs are met consistently
2. Autonomy vs. Shame & Doubt	1 – 3 years	Independence of bodily functions
3. Initiative vs. Guilt	3 – 5 years	Goal oriented behaviours into social context within and beyond family
4. Industry vs. Inferiority	6 – 11 years	Beginning sense of mastery within an expanding social milieu
5. Identity vs. Role Diffusion	11 – 20 years	Forming ego identity and group identity
6. Intimacy vs. Isolation	21 – 40 years	Intimate attachments; finding productive roles in love and work
7. Generativity vs. Stagnation	40 – 65 years	Altruism, enriching society, facilitating success of new generation
8. Integrity vs. Despair	over 65 years	Achieving a sense of satisfaction in how one has lived

Kaplan, H. I., Sadock, B. J., & Grebb, J. A. (1994). *Synopsis of Psychiatry* (7th ed.), (p. 261). Baltimore, MD: Williams and Wilkins

Individuals with healthy personalities have generally negotiated their earlier developmental stages by working through the "crisis" of each stage. They also usually have some degree of insight or understanding into the reasons for particular patterns of behaviours and/or these behaviours generally do not contribute to an unhealthy manner of

relating. Individuals with personality disorders have had difficulties negotiating these developmental stages, their degree of insight is usually limited, and their particular patterns of behaviour generally have chaotic effects on interpersonal relationships.

How does the health care provider manage an individual with a personality disorder who presents in a crisis? The personality disorders that pose the most difficulty for providers are those who possess the "cluster B" criteria. In other words, the borderline, antisocial, narcissistic, and histrionic personality disordered individuals. The following discussion will focus on management strategies with the borderline and the antisocial personality disordered individuals. There are many principles of management and clinician response that can be utilized with all the cluster B group.

### Borderline Personality Disorder

#### Characteristics

- Emotional instability, anger predominant
- Self harm behaviours in context to perceived abandonment, rejection, loss
- Inability to tolerate being alone
- Will tend to idealize or devalue others
- Pattern of impulsive behaviour, unstable relationships, self destructive behaviours (mutilation, intoxication, risky sex)

#### Health care provider responses

- Rescue (save, protect)
- Rejection (won't have anything to do with)
- Anger (punitive, hostile)
- Acceptance (neutral, non judgmental, empathic)

#### Effects on an interdisciplinary team

- Splitting (divergent and oppositional ways to handle client)
- Projection (client discharges affect)
- Projective Identification (staff internalize client's discharge of affect, resulting in feelings of anger, betrayal, overprotectiveness, helplessness)

### Management strategies

- Do not hospitalize.
- If hospitalization is necessary, only do so if the individual is at high risk for suicide or homicide and if there are no other means to assist the individual in behavioral control.
- Hospitalize only for a short term period. (24 – 48 hours)
- Be clear about the goals for hospitalization: symptom reduction in relation to current crisis, goal – oriented behavioral treatment while in hospital, and setting of discharge date at the time of hospitalization.
- Clear limit setting: work with the client to develop a management plan that is detailed and clear, use behavioral goals that are manageable and achievable by client and staff, both staff and client agree to contractual obligations of management plan, state what behaviours will be tolerated, state specific consequences for behaviours that will not be tolerated.
- Problem clarification: simple, concrete steps toward solving one problem at a time.
- Utilize the assistance of the client's support network, as appropriate: make sure everyone knows who's who, distribute specific responsibilities to specific members. (e.g.: \_\_\_\_\_client will call "Jane, John, only" if feeling angry)
- Make sure there is cohesive, interdisciplinary team approach (hospital and community): there should be a specific plan to handle a specific situation (e.g.: if client is feeling suicidal, call \_\_\_\_\_), determine what situation constitutes a phone contact (and with whom), determine what situation constitutes a face to face contact (and with whom), determine when hospitalization should occur, ( and who will facilitate this), outline what constitutes a crisis, what constitutes an emergency, and what are the specific interventions for each.

### Health care provider responses

- Remind yourself to put one foot into the client's world and keep one foot firmly anchored in your own world.
- Do no harm: be aware of your countertransference feelings toward the client.
- If you are feeling angry toward the client, it may be best to ask another member of the team to deal with the client at that moment.
- Be firm, non judgmental, non reactive, and empathic in all contacts with the client.

- Reinforce the limits of the contract when necessary.
- Treat the client as a partner in their care.
- Always be open to the possibility of an exacerbation of an existing comorbid condition.
- Investigate any injury, overdose, or harm to the client.
- Utilize appropriate health teaching about the ways the client responds to crisis, ways to self monitor, keep track of solutions that have a healthy outcome.
- Be prepared to exercise control if the client truly demonstrates they are no longer in control or are at risk to self or others.(e.g.: judicious use of medications, time out, increased level of nursing, restraint, seclusion)
- Allow time for staff debriefing after a crisis with the client.
- Provide ongoing consultation in context to working with a client with a borderline personality organization.

### **Self harm, suicidal threats, suicidal behaviour**

- Do not take any of the above lightly and always remember to respond appropriately.
- Understand the motivation behind any of the above. Self harm is tension release, suicidal threats/behaviour involves a desire to die.
- Always rule out the possibility of any underlying illness. (physical or psychiatric)
- If you know the client, is this presentation "different?" Why?
- Is this crisis or situation something the client really cannot problem solve and therefore requires more active intervention on your part?
- Make any hospitalization short, goal oriented, and productive for the client. (and staff)
- Self harm is one way of problem solving for the patient. Understand this is only one choice and perhaps is the one the client has chosen for now. Help the client explore other choices.
- Monitor your own reaction to the self harming behaviour. Be matter of fact yet warm and compassionate.
- Partner with your client to problem solve the current crisis. Believe in and support the client to find their internal resources.
- What did the client hope to achieve with self harm behaviour? Are there other ways to defuse internal feelings of tension, anger, anxiety? Is the client aware of triggers that increase these feelings? Are treatment goals (in or outpatient) consistent with understanding and problem solving the dynamics associated with getting needs expressed and feelings met? Is the client at

risk for suicide?

World Health Organization. (1999). *Acute Inpatient Psychiatric Care*. (pp. 138 – 142). New South Wales, Australia: Author

## Antisocial Personality Disorder

### Characteristics

- Lack of conscience, little appreciation of or regard for consequences
- Charming, "smooth", manipulative
- Aggressive, deceitful, irresponsible
- Impulsive, immediate gratification of needs at expense of others

### Health care provider responses

- Manipulated (coerced unwittingly)
- Betrayed (feel used, lied to)
- Seduced (feel exposed, defenseless)
- Hostile (want revenge)

### Effects on interdisciplinary team

- Splitting (staff feel either charmed or manipulated)
- Fear (staff are afraid)

### Management strategies

- Set clear goals: limit manipulation, reduce conflict, and prevent aggressive/violent behaviours.
- Work as an interdisciplinary team both in hospital and in the community. Include necessary and relevant care providers. (legal involvement, forensic liaison, alcohol and substance counsellors, others)
- Limit setting: all staff members must be informed about the treatment goals. Members of the team who have authority (e.g.: physician in charge, nurse manager, charge nurse) need to present the plan of care to the client with the explanation that all staff members are involved.
- Consistency of care: at least two staff members should be present in any discussion related to care issues. (e.g.: physician and nurse, manager and nurse, physician and manager, etc.)

- Limit manipulation: be aware of boundaries. Be clear with yourself and with team members about the amount of personal information that is disclosed to the client. Do not disclose personal information. Name tags should have only first names. Any questions the client may ask about team members redirect the client to that team member.
- Reduce conflict: do not be overly curious about the client's history. Determine the type and amount of information that is required to provide appropriate care and do not ask for more. If the client tells "war stories" (graphic details about aspects of their history that may have a fear producing effect), redirect them and show a matter of fact response.
- Prevent aggressive/violent behaviour: provide opportunities for the client to exercise, attend to hygiene, and provide nicotine replacement. Allow for physical space in the room with the client. Attend to the client's non verbals. Always keep the door open. Do not put the client in an isolated space on the unit.

### Health care provider responses

- Be very aware of your responses to the client. Do not hate the client nor feel seduced by the client.
- Do not engage in power struggles with the client. You have the power by virtue of not being a client in hospital. Reinforce policies or protocols matter of factly; do not get into why they exist.
- Acknowledge appropriate behaviour. Provide positive reinforcement to the client for abiding by the contract.
- Be supportive, non judgmental, compassionate in your interactions with the client.
- Engage in ongoing consultation with other staff members when working with this type of client.
- If an incident has occurred, seek out debriefing.
- If you are concerned about another member of the team's involvement with this type of client, approach the staff member in a supportive manner.
- Be aware of basic safety issues such as verbal outbursts, physical acting out, or testing of limits and of your responses.

Working with individuals with personality disorders is difficult at the best of times. Clients usually come into hospital during times of crisis in their lives. Therefore, the tendency to regress by reverting to less developmentally appropriate and adaptive behaviour patterns is high. If health care providers are aware of the developmental issues, the intrapersonal dynamics of some of the personality types, and some of the common provider responses, and have self knowledge, then

there is a greater chance to mitigate some of the difficulties around care issues.

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# 11 Legal Guidelines



## Legal Guidelines

Emergency mental health providers require a working knowledge of legal guidelines covering "certification" (i.e. civil commitment), consent, competency and confidentiality, etc. Civil liberties remain an important consideration when a person comes, or is brought to hospital for treatment. Clinicians engage in a professional relationship with clients and therefore have a fiduciary responsibility to be informed of, and to inform clients as to the legal obligations, client/family rights, etc., associated with treatment. These same legal guidelines, if followed, also serve to protect the clinicians against potential liability in the course of carrying out professional responsibilities.

Only the two key areas of certification and confidentiality and "freedom of information" will be considered here. Please consult Guide to the Mental Health Act (effective November 15, 1999) which is freely available from the British Columbia Ministry of Health and Ministry Responsible for Seniors for more detailed information.

### Certification

Certification (civil commitment) is the process utilized to authorize involuntary detention and treatment in hospital of patients who meet commitment standards. Certification can be a useful therapeutic tool. The Mental Health Act of British Columbia employs wide criteria which allows broad interpretation. Employing a "least restrictive alternative" philosophy consistent with the patients needs, suggests that certification be viewed as a treatment of last resort, when all other less restrictive treatments either have failed, or are deemed inappropriate for the patient.

Certification law derives from twin powers of the state called "police powers" and "parens patriae". Historically "police powers" were invoked to protect the public from mentally ill persons who were considered dangerous. This is the origin of the so called "dangerousness" standard contained in mental health law.

"Parens patriae" derives from the days of the monarchy when the king (or queen) sought to protect the mentally ill from themselves. One can see how this translates in modern times to the "protection" component inherent in more liberal certification laws. A range of interpretation can apply to physicians' application of this "protection" standard. This results in various degrees of paternalism depending on one's definition of protection and on the patient involved. Mental Health Acts (MHA) leave a lot up to professional judgement and clinicians operate with different thresholds for commitment of patients to inpatient psychiatric facilities. Although many factors probably play a part, clinicians tend to advocate either a low or a high threshold for committal. This is one of the main areas in emergency mental health where there is legitimate diversity of professional opinion., There is therefore no correct answer, although emergency psychiatry experts in the U.S. advocate a moderately high threshold for involuntary hospitalization.

In British Columbia there are three methods of arranging an involuntary admission.

1. Through a physician's medical certificate. This is the preferred method.
  2. Through police intervention.
  3. Through an order by a judge.
- 
1. In order for a physician to fill out a medical certificate they must have examined the person and be of the opinion the patient meets all of the following four criteria:
    - a) is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
    - b) requires psychiatric treatment in or through a designated facility;

- c)** requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and
- d)** is not suitable as a voluntary patient.

The medical certificate provides authority for anyone to take the person to a designated facility where with the consent of the director or designate the person may be admitted for up to forty-eight (48) hours. A second medical certificate by a different physician is required for involuntary hospitalization beyond forty-eight (48) hours, and for up to one month from the day of initial admission.

- 2.** The police may take a person into custody under the Mental Health Act when satisfied that this person
  - a)** is acting in a manner likely to endanger their own safety or that of others; and
  - b)** is apparently suffering from a mental disorder.

The police must immediately take the person to a physician for examination.

- 3.** A judge, or if a judge is not available, a justice of the peace, can issue a warrant which provides the legal authority for police to take the person named to be examined by a physician. The judge must be satisfied that
  - a)** The person making the application has reasonable grounds to believe that the person to be examined:
    - i)** is a person with a mental disorder whose condition requires treatment in or through a designated facility, and
    - ii)** meets the criteria for involuntary admission in the Act.

Further the judge must be satisfied that it is not possible for the patient to be examined by a physician "without reasonable delay."

## Guidelines for completing medical certificates

A physician completing a medical certificate under the Mental Health Act is required to provide in summary form the reasons to support their opinion that the person meets the four criteria. Information may be obtained through interviews, observation and collateral sources.

The physician is providing reasons for their opinion that the person

- 1. Has a mental disorder.** Describe symptoms in layman's language which are most convincing of mental disorder, for example, "believes to be Jesus Christ." An appropriate sentence would be "hears voices, when no one is present, telling him to kill himself." A less appropriate statement would be "has auditory hallucinations."
- 2. Requires treatment in a facility.** Your opinion that the patient requires treatment could be supported by a statement that "the patient's symptoms remitted in the past with antipsychotic medication."
- 3. Requires care, supervision and control in a facility to prevent substantial mental or physical deterioration or for the protection of others.** Reasons should include evidence that the patient requires inpatient as opposed to outpatient treatment. It may include a statement of the patient's refusal of outpatient treatment during this episode of illness. Include a specific statement about why the patient requires protection, or why other persons need protection. This can include an account of any recent overt act, i.e. a suicide attempt, or significant history.

Protection need not be defined narrowly as protection from physical harm if the reason for certification relates to protection from serious deterioration (not eating, neglecting hygiene, etc.) or protection from financial ruin, or even serious psychological harm to others, which should be spelled out in detail, e.g., "social or family harm" (McCorkell)

"Likely to suffer substantial mental or physical deterioration" is an alternative to the need for "protection."

Although interpretation of the "protection" term of the criteria for certification is variable, clinically it may be broadly interpreted.

Protection of self is not limited to suicidal threats or gestures. A person with a mental disorder may neglect themselves which could lead to a medical or psychiatric illness. Neglect of basic needs for food, shelter, and appropriate clothing could lead to frostbite and nutritional deficiencies. Neglect of medical care, i.e., not taking medication for diabetes because of mental disorder could lead to vasculitis and blindness. Other jurisdictions refer to this as a "grave disability" standard. There is no need to link the neglect with actual proof of a resulting physical or mental illness.

Protection from victimization can be a factor here as can protection from being charged with a legal offence, i.e., the person with religious delusions which cause him to destroy property or the person with a mental disorder who insists that the roughest part of town is actually a holy place filled with good people. Similarly an individual who, during a manic episode, is giving his prize possessions away because his judgement is altered would meet the standard.

Regarding protection of others, it is not necessary to have a physical blow or an illegal act - in fact if there is a physical blow or other illegal act, legal charges would normally be expected to be laid and the person would obtain psychiatric care through the Criminal Justice or Forensic System. "Protection of others" includes any behaviours on the part of a patient which leads the clinician to think that others are in need of protection. This can be a prelude to aggression in a person who has previously been aggressive when mentally disordered, i.e., sleeplessness in a schizophrenic when previous episodes of sleeplessness led to physical aggression.

There does not have to be a history of violence associated with the current behaviour, i.e., an obviously psychotic man can knock on people's doors looking for a woman he saw in a dream. This could cause the inhabitants to feel threatened since he argues when told that she is not there.

A physical blow does not have to be present. A person can look angry, i.e., hands clenched, glaring eyes, swearing, etc., or can utter a threat.

There can be damage to property, i.e., the psychotic person who kicks at plate glass windows in a bank.

Protection of others can also be considered in the mentally disordered person who does not have any obvious behaviours but who has frequent thoughts "of wiping out a shopping mall." Another example is a man who is seen watching his ex-wife's home repeatedly in the evenings from across the street, when he has previously

assaulted her in a psychotic state.

Under the Mental Health Act, the judgement which needs to be made by a physician is a clinical one. There is no requirement for physicians to apply rules of evidence, i.e, assessing "hearsay" information, etc. It is sufficient for physicians to have a reasonable standard of care, and to make reasonable clinical judgements to certify.

If, however, the patient is certified, and subsequently the physician believes that the person is safe to discharge, the physician must decertify the patient. A decision should not simply be deferred to the Review Panel because a Review Panel is available. If the patient goes to the Review Panel, the documentation about the protection issue should be detailed. Doctors should not expect the Review Panel to draw conclusions which are obvious to clinicians, so spell it out!

The only exception to instituting involuntary treatment prior to certification would be an emergency order for some form of treatment or intervention which would be written up on an order sheet as an emergency order, and also discussed in the progress notes of the hospital chart, i.e., a dose of intramuscular Haloperidol to prevent a patient from injuring himself or another person in hospital, if the patient has no medical certificate.

Such an emergency order carries some legal risk and:

- a) should be documented in detail with a description of the behaviour justifying the intervention;
- b) medications should be written up as one dose only;
- c) should not be given as a telephone order or a verbal order, and should require that a physician be present and conduct an appropriate evaluation. A medical certification can often be completed before the order is written, even if the evaluation is very brief. The patient who will speak to a physician, can have his mental disorder observed objectively and documented by medical and nursing staff. If a second medical certificate is required to continue treatment beyond forty-eight (48) hours, a request should be made of any other physician on site. Documentation should be made if a physician is requested to evaluate a patient for certification, and declines. If a second physician examines the patient, understands the grounds for certification, and refuses to certify the patient, involuntary treatment cannot follow. Going through several physicians to find one who would so certify would not be acceptable.



If a physician evaluates a patient for certification under the Mental Health Act, that physician should make notes of the evaluation in the progress notes of the clinical record, as well as completing the medical certificate, and the two notes should be internally consistent, i.e., it is not acceptable to write a clinical note with very few symptoms, and in the same time frame write a medical certificate with symptoms which are not noted in the progress notes. A decision to certify should not be made only on information collected from one interview in a protected environment, i.e., a hospital. Information contributing to the decision to certify can be taken from any available source including family, police reports and other collateral, etc.

### **Timing of completion of certificate**

The patient cannot be admitted on a certificate showing the patient was examined more than fourteen (14) days before admission.

### **Consent to treatment - Involuntary patient**

This completed form is a statement that the patient is competent to consent to treatment, or not competent to consent to treatment. There is a presumption of competence under the law. "Deemed consent" can be applied to an incompetent or competent refuser of treatment.

This form presumes:

- a)** that the patient being evaluated for consent for treatment is an involuntary patient;
- b)** that some form of competency evaluation is being applied to the patient. No particular test of competency has been passed down to physicians for their use in this regard.

After the evaluation, if the opinion is that the patient is incapable of giving consent, date the form and sign it at the bottom right hand side of part B. Only after the director's or delegate's signature is applied to part B (and his/her name added to the first part of the form) can the patient be given the first dose of medication under the Act.

If the patient is considered incompetent to consent to treatment, on no account should the physician offer to have the patient complete the left side of the form, part A, since this implies that the patient was

actually determined, through competency testing to be capable of giving consent to treatment. Also, note that if the patient gives consent for treatment by signing part A, the patient can then revoke this consent at any time. You are then left with the problem of a competent refuser, i.e, the involuntary detained patient who refuses treatment. The patient may be mentally disordered, and certifiable, and still be a competent refuser. There would be an ethical decision to be made at that point about whether the patient should be discharged.

Under the B.C. Mental Health Act competent refusers can still be forced to accept treatment by "deemed consent." If a patient who has been considered competent withdraws his consent then the director would sign (because "if not signed by patient" applies). If the physician decides the person is competent, the director must still sign the consent form.

There should be a "consent for treatment" on all involuntary patients prior to the commencement of treatment under the Act.

The current Mental Health Act was proclaimed in 1964 and was most recently amended by the Mental Health Amendment Act, 1988/Bill 22, with changes that came into effect November 15, 1999.

All professionals acting under the Mental Health Act are not liable for damages providing they act "in good faith and with reasonable care".

It needs to be noted that civil commitment statutes only provide a framework for patient care. This point is in keeping with studies published in the United States which indicate that it is the level and quality of mental health resources (funding) not changes in law that determines what happens to patients.

## Releasing personal health information to third parties

The Freedom on Information and Protection of Privacy Act (FOIPPA) allows health care providers employed by a public body (e.g. hospitals and publicly funded clinics) to disclose the personal information of clients to third parties under certain circumstances. Public bodies may release personal information to third parties if the client consents to the release. Public bodies may release necessary personal information to third parties without the consent of the client where disclosure is required for continuity of care or for compelling reasons if someone's health or safety is at risk.

### Purpose of the Act

- To make public bodies more accountable to the public
- To protect personal privacy

Ministry of Health and Ministry Responsible for Seniors. (1999). *Overview of the Freedom of Information and the Protection of Privacy Act*. (p.1). Victoria, B.C.: Author

### How the Act Works

- Allows for the right of access to records
- Allows for the right to ask for correction of personal information
- Allows for regulation of collection, use, and disclosure of personal information
- Allows for independent review of decision by a commissioner

Ministry of Health and Ministry Responsible for Seniors. (1998). *Pocket guide to the Freedom of Information and Protection of Privacy Act*. Victoria, B.C.: Author

### Definitions

Personal information about an individual pertains to:

- The individual's demographic information (identifying information)
- File, case, record number that would identify the individual
- Physical characteristics that would identify the individual
- Information pertaining to the individual's health or mental health history
- Information disclosing financial status, employment, educational, or legal history
- Third party opinions or the individual's own opinions about self

Ministry of Health and Ministry Responsible for Seniors. (1999). *Overview of the Freedom of Information and the Protection of Privacy Act*. (p.2). Victoria, B.C.: Author

**The right of access to records:** a client can make a request to access records pertaining to his/her clinical assessment, treatment, and discharge. Each organization has its own set of policies and procedures related to this process. The internal process usually involves a review of the clinical records by an individual in that designated role in the organization, to determine whether any exceptions for the release of personal information applies. According to the FOIPPA, the exceptions are:

Section 15: Disclosure could be harmful to law enforcement (an investigation, identity of a confidential source, security system)

Section 19: Disclosure could be harmful to the mental or physical health or safety of a third party, or the applicant

Section 22: Disclosure would unreasonably invade a third party's personal privacy

Ministry of Health and Ministry Responsible for Seniors. (1999). *Clinical Records and Disclosure of Personal Information*. (pp.7-8). Victoria, B.C.: Author

**The right to ask for correction of personal information:** a client has the right to ask for correction of his/her personal information contained in the record and if that information has been disclosed during the previous year, the organization must then notify the relevant parties to whom that information was disclosed of the correction.

**The regulation of collection, use and disclosure of personal information without consent:**

- If under the authority of an "Act" (the hospital act or the provincial mental health act).
- Is for the purposes of continuity of care in the assessment, treatment, and discharge of a client and is pertinent to the physical and mental health of the client.
- Is for the purposes of law enforcement or for an aspect of the operation of an organization. Some discretion must be taken here. For example, if an officer of the law identifies him/herself as such, calls into a hospital unit or a community mental health clinic to request if "John Doe is there," the specific reason for calling must be determined. The release of this information should only occur if the reason for calling is very clearly

articulated and made very explicit that "John Doe" is involved. Be specific about what information you release. You have the right to withhold information: use your clinical judgement.

- If under a court order or next of kin contact for reasons of illness/death.
- In the interests of protection of public safety (for example, if there is a communicable disease). In this circumstance, the client must be notified of this release of information.

**Some examples are:**

1. A client has been hospitalized and the hospital nurse calls to find out what medication the client is taking. The client cannot remember or refuses to consent to the release of the information or is incapable of consenting. The information the hospital needs, including the type of medication the client is taking, is releasable in verbal or written form.
2. An interdisciplinary team share the planning assessment of a client who has Alzheimer's disease but who has not yet been declared incompetent, with family members in order to get the family's necessary input on the plan.
3. A therapist discloses to the parent or spouse of a client that the client is seriously suicidal.

Ministry of Health and Ministry Responsible for Seniors. (1999). *Client Records and Disclosure of Personal Information*. (p.3). Victoria, B.C.: Author

**Documentation on the chart**

- Write legibly in dark ink (do not change colours of ink or write with a different pen) or type notes
- Chart in an objective manner; document information relevant only to professional opinions about patient care
- Identify when third party information is disclosed to members of the interdisciplinary team by the patient
- Identify when third party information is disclosed to members of the interdisciplinary team *in confidence*
- Do not identify third parties by name unless necessary
- Maintain separate charts about each patient



## **12** Clinician: Know Thyself





## Clinician: Know Thyself

Mental health clients who present in the emergency room or hospital setting can be a challenge for even the most seasoned health care provider. For the provider who is knowledgeable and skilled in emergency room care or medical-surgical care, the transition to mental health care can seem rather daunting. However, it becomes less daunting if the provider can remember that s/he already possesses assessment skills, diagnostic skills, and management and treatment skills, and the ability to use oneself therapeutically.

For example, in the emergency room, the knowledge and skills necessary to work in this context are: clinically sound triage and assessment skills, knowledge of medications, physical treatments, and other interventions, ability to prioritize and make judicious use of resources, and the capacity to be a calm, confident, and reassuring human being amidst pain and suffering. Similar knowledge and skills are required of the medical-surgical context.

The provider of mental health care possesses a repertoire of knowledge and skills that are similar. Ability to triage and assess are fundamental in knowing what kind of mental health presentation you are dealing with. Knowledge of psychotropic medications, medical/nursing interventions, knowledge of appropriate and available resources, and the capacity to be a calm, confident, and reassuring human being to a client/family member who may be psychotic, suicidal, or who loses physical control and becomes aggressive are also essential. Basically, while the medications, physical tools, treatments, and interventions may be different in the different clinical contexts, the principles in working with your client/family member remain the same. The range of emotions and responses to different types of clients/family members, remains constant across clinical areas.

The health care provider must have a clear moral position from which ethical practice is derived. It is not necessary to like every colleague, client, or family member with whom one works or treats. It *is* necessary to regard every colleague, client, or family member with respect, dignity, and compassion. The client who presents with mental health issues in the emergency room setting or in a medical-surgical setting can and does create anxiety, tension, and fear in the provider who is not accustomed to dealing with this type of client. Many myths about clients with mental illness still exist.

Psychiatric disorders are not contagious nor are they untreatable. To reframe the context of a major mental illness, it may help the provider to think of chronic physical illness as a parallel to the mental illness process. For example, the cause of Type I Diabetes Mellitus is insufficient production of insulin by the pancreas, an endocrinological disorder. It is a lifelong medical disorder that is not curable, but it is treatable. The treatment regime involves lifestyle management, medications, attention paid to nutrition, regular followup with health-care providers, education for the client and family, and considerations for emotional/psychological support; all these elements are essential to facilitate a positive quality of life.

A similar treatment and management regime can be applied to an individual who has a major mental disorder. Schizophrenia, for example, is a disorder that is associated with dysregulation of neurotransmitters (Dopamine, primarily). Schizophrenia is a chronic mental disorder that is not curable, but it is treatable. The treatment regime involves lifestyle management, medications, attention paid to nutrition, regular followup with healthcare providers, education for the client and family, and considerations for emotional/psychological support; all these elements are essential to facilitate a positive quality of life.

Communication that is therapeutic is the underlying principle in working with any client or family member. With good communication skills, the health care provider may be able to prevent many of the worst case type scenarios that can develop and become out of control in the emergency room or medical – surgical setting. Speaking impatiently to a client or family member who is already feeling anxious, tense, or angry in having to wait may further escalate the situation. Telling a client in a peremptory manner that s/he cannot smoke, not taking the time to explain simple instructions, or refusing a drink of water to a client who requests one, are often the beginnings of acts of escalation to determine whether the provider or client will have the ultimate power and control over the given situation. Who usually "wins?" Certainly not the client who has been forcibly restrained due to "acting out" behaviour or the client who has been sedated, for inappropriate reasons, because of increased agitation in response to being treated with disrespect.

The provider may be offended by the appearance of a malodorous, dishevelled client who has neglected self care over a period of time due to psychiatric decompensation. The provider may have angry feelings toward the perpetrator of a sexual assault, or experience extreme hostility toward an intoxicated individual responsible for a serious motor vehicle accident that results in fatalities. Whatever the provider may be feeling, it is essential to be aware of and not allow those feelings to negatively influence any interactions with the client

or family members.

Countertransference and clear boundaries are the issue here. What is meant by the term countertransference? The term applies to feelings and emotional responses of one individual toward another. The context is usually within the provider and client relationship and applies to the responses of the provider toward the client. A provider may have a very strong emotional reaction toward a particular client. The basis of this reaction could be related to previous experiences in the provider's life, which the client has somehow triggered. For example, let's say a provider has a consistently negative response to individuals who present with alcohol/substance intoxication. What the provider may not be consciously aware of is that the negative response is related to having being brought up by a parent who had an alcohol/substance use problem. Certain types of clients may trigger very unpleasant emotional reactions or memories for the provider. The provider does not deliberately choose to respond in a consistently negative manner, it just happens. Unless the provider has done some self examination, or unless the consistency of their negative response is pointed out, they will remain unaware (e.g.: out of conscious awareness) of and will continue to have negative responses and interactions with this type of client.

Boundaries can be defined simply as where the health care provider begins and ends and where the client begins and ends. Let's use the example of personal space. For most individuals in North America, there is a certain amount of space between two individuals that is considered "public." It becomes almost immediately apparent once that public space becomes personal space. As an onlooker, one will observe that one of the two individuals will start to physically shift and perhaps even take a step or two back or away from the other in an attempt to regain space and move the interaction back into public space. In the context of interpersonal relationships between the provider and the client, the emotional boundaries are not always as clear as the physical ones. For example, take the case of a client with a mental disorder who has been brought into the hospital for a suicide attempt in response to command hallucinations. The provider caring for this client may have an adult son who is similar in age to the client. The provider becomes very involved in the care of this client and even comes in on days off just to "make sure that everything is alright." The provider's personal boundaries have become an aspect of their professional ones.

Working in a hospital environment, whether it is in the emergency department, on a medical surgical unit, or caring for clients with mental health issues, the provider is all too aware of the microcosm of the world reflected in the hospital environment. While out in the larger world, the provider is protected from the intensity of trauma,

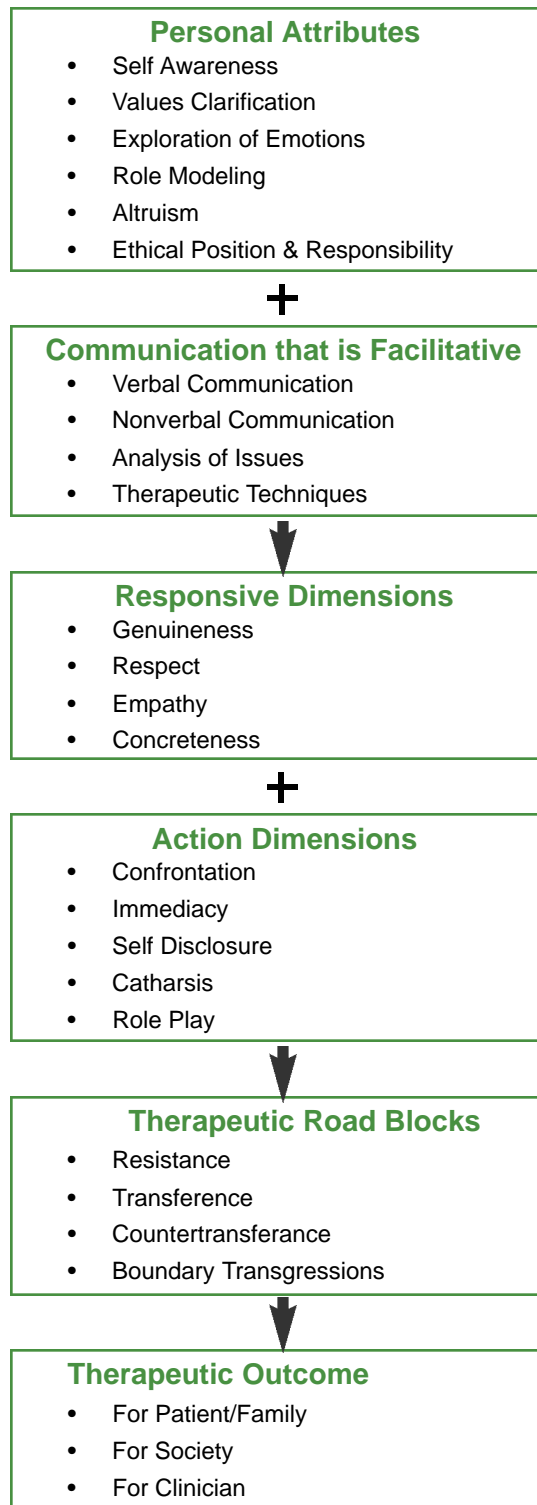
pain, and human suffering because those experiences are diluted and impersonal. While the provider can choose to be vicariously exposed to them, there are these other factors to balance the effects. At work, choice of what to be exposed to is not always available to the provider. There is no dilution if the provider is the first contact for the client, and there are few other factors to balance. Emotionally charged issues rarely escape the provider who has to deal with the range of life and death issues in the hospital environment. Suicide, homicide, the spectrum of assault, end of life issues, accidents, and trauma are all scenarios that unfold in the life of a hospital and involve the provider in every aspect.

Vicarious traumatization or traumatic countertransference is usually defined as bearing witness to horrific events that happen to others. The health care provider is at risk to absorb the effects of the client's trauma and, in turn, become vicariously traumatized. In being exposed to the client's experience of trauma, the provider may revisit his/her own personal traumatic experiences. The provider may begin to have symptoms of post traumatic stress such as nightmares, recurring dreams, hyperarousal, or emotional numbing: "Arthur told his therapist that he still feared his father, even though he had been dead for ten years. He felt his father was watching him and could control him from beyond the grave. He believed that the only way to overcome his father's demonic power was to unearth his body and drive a stake through his heart. The therapist began to have vivid nightmares of Arthur's father entering her room in the form of a rotting, disinterred body." (Herman, J.L., 1992, pp.140-141). Other vicarious emotional responses may range from fear, terror, rage, helplessness, the desire to be punitive, or the desire to be overprotective. This is where your awareness of self becomes critical. Unless you seek out supervision, you will be unable to engage therapeutically with your client.

How you effectively deal with the more difficult aspects of your work begins with honest self reflection and seeking out of constructive feedback from colleagues, supervisors, friends, and family.

Try out the following exercise. Examine each one of these elements:

**Elements affecting the clinician's ability to be professional and therapeutic**



Stuart, G. W., & Laraia, M. T. (1998). *Principles and Practice of Psychiatric Nursing* (6th ed.), (p. 19). St. Louis, MO: Mosby.

**Now ask yourself:**

- "What are my personal attributes?"
- "How do I communicate?"
- "Do I exercise responsive and action dimensions?"
- "Am I aware of my therapeutic impasses?"
- "What are the therapeutic outcomes of my practice?"

Another self awareness exercise is the Johari Window. The purpose of the Johari Window exercise is to gain self awareness by increasing the size of window 1 and by decreasing the sizes of windows 2-4. The Johari Window describes aspects of the self such as thoughts, behaviors, and feelings. A change in one window has impact on all the others. Begin the exercise with window 1 and ask yourself: "What do I know about myself?" "What are my thoughts, feelings, motivations, beliefs, impulses, etc. in relation to my physical self and my emotional self?"

The next step involves a little more courage because you have to approach others. To learn about yourself from others, you have to ask: "How do I relate to others?" You have to be open to honest feedback, to hear it, and to derive something from it.

The last step in this exercise involves the sharing of aspects of yourself. This is probably the most courageous step of all to take. Ask yourself: "What do I need or want to self disclose in order to grow in self awareness?"

**Johari Window Exercise:**

<b>1</b> <b>Known to self and others</b>	<b>2</b> <b>Known only to others</b>
<b>3</b> <b>Known only to self</b>	<b>4</b> <b>Known neither to self nor to others</b>

Stuart, G. W., & Laraia, M. T. (1998). *Principles of Psychiatric Nursing* (6th ed.), (p. 19). St. Louis, MO: Mosby.

How then does a health care provider stay sane, committed, and compassionate about the work and the clients? All providers need to address their self care. Ask these questions of yourself:

- What do I think of and how do I feel about the work I do?
- What do I like about my work? What don't I like about my work?
- Am I able to separate my professional work life from my personal home life?
- Do I take the time I need in keeping current, interested, and challenged about my work?
- Do I take the time I need to spend with myself, my family, my friends, and my community?
- Is my life in balance with respect to work and play? Do I get enough hours sleep a night? Do I exercise regularly? Do I eat healthily? Do I drink alcohol/smoke in moderation?

Self care also extends to the dialogues and relationships professionals cultivate with each other in the work place. Communication that is therapeutic for providers is a good starting place. Having permission to talk candidly with each other about clinical and personal issues that relate to clinical work, being involved in ongoing consultation or supervision, having the support from peers as well as administration are good examples. Critical incident stress management provides the opportunity to defuse and/or debrief events beyond the scope of normal and alleviates some of the stresses of work life. Employee assistance and family counselling programs that offer free, confidential, short term sessions to work through personal issues that impact on the provider's life is another way to self care.

Having said all of the above about self awareness and self care, how then does the provider put all of this together? How does any of it relate to working with clients? The term therapeutic alliance is frequently referred to when working with a client. What is meant by this term? To ally with someone is to be on their side, in other words, you are appropriately supportive of them. To be therapeutic, you must offer aspects of yourself that are conducive to the client's recovery.

A therapeutic alliance is the quality of relationship you form with the client and it will either hinder or facilitate their progress in treatment. This is where your self awareness and self care is reflected, in the quality of the therapeutic alliance forged with the client. Remember, it is not only what you communicate but *how* you communicate both nonverbally and verbally that determines how well you work with the client.

There are specific phases in working with a client and the therapeutic alliance begins well before even meeting the client. Just as there are ebbs and flows within the phases, the strength of the therapeutic alliance will also ebb and flow depending on the intensity of the work of each phase.

**The phases in working with a client are identified as:**

- pre-interaction
- orientation
- working
- termination

The pre-interaction phase occurs before meeting the client. This is where it is essential that you, the provider have done some critical and honest self examination. It is during this phase that you will be most actively experiencing fears, feelings, and fantasies about the client. This is especially true for staff who are not accustomed to working with a client who has primary mental health issues. This pertains to the discussion at the beginning of this topic about how psychiatric clients presenting in the emergency room can be a clinical challenge for even the most seasoned provider. If you have never worked with a client who has been diagnosed with Schizophrenia and you know your next admission is for someone with this diagnosis, what are your immediate reactions to this news? Do the images of some popular movies about mental hospitals come to mind? Or do you fantasize about the headline in the newspaper that reads: "Paranoid Schizophrenic mental patient stabs innocent bystander." Even if you are experienced in working with the psychiatric population and you hear that you will be getting a "borderline in crisis" as your next admission, what is the usual response amongst staff? Your other tasks during this phase include gathering facts about the client (old records, collateral from who is bringing the client in, etc.) and planning for the initial meeting with the client.

The orientation phase occurs when meeting the client for the first time. Going back to the discussion related to the mental health assessment, this is where you inquire about the reason for referral: "Why now?" Ask the client to describe in their own words as much as possible, the current circumstances of this presentation to hospital. Whether the client can tell you why and whether they have come voluntarily will give the provider a starting point. It is during the orientation phase, that you will outline the terms of the contract with the client. The client should be treated as an equal partner in formulating the contract as much as possible and this will depend on the type of presentation. You will also have to provide the framework, including who, how, when, where.



The contract should outline:

- Who:** names, roles of the interdisciplinary team members responsible for the client
- What:** responsibilities of each team member, of the client, expectations of each
- Where:** locations of the various aspects of treatment (on unit, in room, in gym, in occupational therapy)
- When:** specific scheduling of activities
- Why:** purpose of treatment, confidentiality, documentation, discharge planning

Now the working phase can begin. This is where the quality and strength of the therapeutic alliance will be tested the most. However, the nature and quality of the interactions during the orientation phase are a large determinant as to how the working phase develops. The active components of treatment involve working on the identified problems by talking about them, trying different ways of problem solving, learning new skills, encountering and working through resistance, etc.

The termination phase is the last phase of the working relationship. Again, the therapeutic alliance will be tested. The client may regress, symptoms may reoccur. There is a review of the progress of treatment to date. This is a time of mutual sharing between the client and you. It is as important for the client to reveal the lessons learned from the treatment process as it is for you to share with your client.

## Summary

Your personal and professional attributes have as much influence on the quality of the therapeutic relationship as the client's attributes. When clients come to the hospital or to the community health/mental health clinic, it is usually a time of difficulty and distress. When you are giving them the care and consideration they need and deserve, they will remember. And so will you.

## References:

1. Herman, J.L. (1992). *Trauma and Recovery*. USA: Basic Books
2. Peplau, H. (1952). *Interpersonal Relations in Nursing*. New York, N.Y.: Putnam.
3. Stuart, G. W., & Laraia, M. T. (1998). *Principles and Practice of Psychiatric Nursing* (6th ed.). St. Louis, MO: Mosby

