Common Psychiatric Presentations (https://galwayem.ie/index.php/guidelines/mental-health/common-psychiatric-presentations)

Category
Mental Health (https://galwayem.ie/index.php/guidelines/mental-health)

Deliberate Self Harm (D.S.H.)

In practice you will not have to deal with the psychiatric problem if the self-damage is sufficiently great to warrant admission for medical or surgical treatment. It is the minor overdose, the superficially cut wrist, or the patient who says he feels suicidal that will pose the immediate psychiatric management problem. Such patients may be no less potentially suicidal than the one who has severed his radial artery.

Remember that some patients may use more than one method of self-harm. For example, the girl who has a minor cut to her wrist may also have taken a large dose of paracetamol. Remember also that patients who have taken an overdose may well lie about the number of tablets taken. A decision will need to be reached as to whether the patient requires:
(a) medical admission
(b) psychiatric assessment
If suicidal ideas are associated with symptoms of severe depression such as ideas of hopelessness, guilt, slowing up, early waking and weight loss or with symptoms of schizophrenia, admission is required. Occasionally it may be necessary, to admit someone who is considered at severe risk under a Section of the Mental Health Act.

The majority of minor acts of self-damage will be in response to a social crisis, usually in a vulnerable personality. The act of taking the overdose (or other act) may have had a cathartic effect and may even have achieved its objective. However, whatever may appear to be the reason for the suicidal attempt or idea the circumstances of any attempt must be explored to determine the seriousness of intent. A risk assessment using the SAD persons score or similar tool must be undertaken in all these patients.

SAD PERSONS Score
Sex male
Age <19/>45
Depression
Previous self harm
Excessive alcohol/drugs
iRrational

Separated
Organised attempt
No social support
Says will repeat

Low risk <3
Intermediate risk 3 - 6
High risk >6

Low risk patients who have good social support (e.g. living with parents / partner who are supportive) and who already have psychosocial follow up in the community through GP may be allowed home with instructions to seek further support next day. You must inform the GP.

All other patients should be referred to the duty psychiatrist for a formal psychosocial assessment.

Refusing treatment
Not infrequently patients who have taken an overdose will refuse treatment. Obviously one must try to persuade the patient to stay but as long as the patient is competent to make the decision to refuse treatment one cannot treat patients against their will. Tests for competence include:
1. Is the patient able to comprehend and retain the information you give them?
2. Are they able to weigh up the information?
3. Are they able to believe the information?
Any assessment of competence should be documented on the ED notes. All patients should be reviewed by the duty psychiatrist and senior Emergency doctor. The duty Consultant must be informed in all cases.

Deliberate Self Harm in Children and Adolescents.
The same general principles apply as in adults. All children under 14 who present following DSH should be admitted under the care of paediatrics.

The violent patient
Violent or aggressive behaviour, with potential assault on staff, is no more common in the mentally ill than in the general population and is not necessarily a psychiatric problem. Most violence encountered in ED is the result of alcohol intoxication. A conscious effort must be made to avoid provocation by a rebuke or rough handling. Any physical handling must be gentle and unhurried.

Aggression
Aggression is an act or gesture, verbal or physical, which suggests that an act of violence may occur. The signs and symptoms are many and varied but include the following:
- tension and agitation; abrupt replies to questions with gesticulations and an increase in the pitch and volume of the voice; signs of tension in the face and limbs with clenching of the fist or striking of the hand.
- the pupils may be dilated.
- the patient may sit in a crouched posture in silence resenting communication and refusing to answer questions until a chance remark may trigger off sudden and dangerous violence.

Prevention is the first priority and should concentrate on gaining the patient's trust and confidence. Frustration may result from anger, fear, despair, confusion or a perceived threat.
Management
Suppress your personal feelings. Stay calm, confident, objective, non-critical and nondomineering. Personal safety is paramount. Get help from the security staff and the Gardai at the first signs of

violent behaviour, but be warned that the sight of the Gardai can sometimes inflame the situation. Physical confrontation should only take place as a last resort.
Try listening or talking to the patient, choosing the team member that has the best relationship, and do not argue. Relatives may assist.
Do not approach a violent patient on your own and ensure that sufficient staff are available to control the patient if necessary.
Do not position yourself in a way that allows an easy physical attack.
Do not allow the patient to stand between you and your exit route from the interview room.
Damaged property is relatively unimportant but damage to the individual is.
Keep away from anyone who is violently damaging the Emergency Department.
- The degree of force used should be the minimum required and used to calm rather than provoke further aggression.
- If possible, move and segregate the patient in a quieter environment. The interview room is designed for this purpose. There should be no furnishings in it. If there are remove them to prevent the patient sustaining harm. Placing the patient on the floor puts him at a disadvantage.
- Patients should not be reproached for previous actions.

The demented patient
Patients suffering from chronic brain syndromes may be brought to hospital either because of increasing confusion, inability to cope, or for assessment of intercurrent physical illness. A history should be obtained as quickly as possible from those who have brought the patient - they may disappear once the patient has reached the hospital. Common causes of increased confusion are:
- prescribed drugs or alcohol
- malnutrition
- vitamin deficiencies
- cardiac failure
- hypothyroidism
- TIAs
- hypothermia
- hypoxia
- infections, especially of chest and urinary tract
- head injury
Increased confusion may also occur when an old person is transferred from one environment to another, e.g. from home to a Nursing Home. Admission to appropriate medical care may be indicated if a disorder is found, but more often the cause of the crisis is a social one and neighbours or relatives have reached the limit of tolerance. Medical admission is often the only solution in these cases.

The Confused Patient
"Confusion' is often misapplied to mean bewilderment, poor concentration, or incoherence. It should only be used when a degree of clouding of consciousness or disturbed awareness (which may be fluctuating) is present. Although confusion may occur in patients suffering from manic excitement - and it may also resemble schizophrenia - it should be assumed that such a clinical presentation is due to organic disease or trauma.

The clinical picture will vary but may include:
Clouding of consciousness: Difficulty in maintaining attention, distractibility, illusions (e.g. seeing faces on the wall), irritability, noise intolerance, emotional lability, suspiciousness and fleeting paranoid ideas.
Delirium: Disorientation in time and place, dream-like hallucinations (often visual), poor comprehension, impaired memory, restlessness, plucking movements and fearfulness. Incoherent conversation.

The cause may be cerebral or extra-cerebral, including all of the following
- post epileptic
- trauma (subdural haematoma)
- encephalitis
- TIAs
- drugs including: anti-Parkinsonian drugs, anti-convulsants, analgesics, psychotropic medication metabolic o hypoxia o hypoglycaemia o hypothyroidism o vitamin deficiencies (especially thiamine and B12) o electrolyte disturbances, dehydration, hepatic failure and uraemia
- infections: chest, urinary tract
- drug and alcohol withdrawal
- constipation and urinary retention

The majority of patients suffering from confusional states will require urgent admission to a medical ward.

The panic stricken patient
Acute anxiety, associated with a fear of imminent loss of control, dissolution, serious disease or death, may have a variety of causes. Consider:
- Organic disease: Serious disease of sudden onset such as myocardial infarction, paroxysmal SVT, spontaneous pneumothorax and asthma may cause anxiety and fear of death
- Temporal lobe epilepsy
- Drug intoxication including amphetamines, hallucinogens
- Drug withdrawal including alcohol, benzodiazepines
- Psychiatric illness including: schizophrenia, agitated depression, phobic anxiety with hyperventilation.

Management
- Maintain a calm approach and encourage and reassure those around the patient.
- Organic disorders and drug withdrawal syndromes must be excluded as rapidly as possible and dealt with on their merits.
- Diazepam 5-10mg by mouth may be necessary as an emergency measure.
- Patients with hyperventilation may have light-headedness, air hunger, palpitations and carpo-pedal spasm. Firm reassurance and explanation that they are breathing unnecessarily fast and deeply may be sufficient to relieve them. Re-breathing into an anaesthetic mask or a paper bag should relieve the symptoms. Drugs are rarely necessary and should be avoided if possible. However, if panic does not respond to a psychological approach coupled with re-breathing, an oral dose of Diazepam 5 - 10 mg can be given.

The psychiatrically disturbed child
Acutely psychiatrically disturbed children are a relative rarity in the Emergency Department. Behaviour leading to the child being brought to hospital will usually be:
- self-harm, e.g. overdose, self-mutilation, or drug experimentation.
- uncontrollable or violent behaviour.

Disturbed behaviour in young people is usually due to problems within the family or school. However, early onset affective disorders or schizophrenia can occur. Epilepsy, drug experimentation, head injury and other organic disorders can present as loss of control.

Management
- Establish who is responsible for the child - parents, guardian, local authority care, etc., and involve them in any decisions.

- Obtain as much history as possible from the child and those who have brought him/her to the hospital. Contact the GP and social services, if appropriate.
- Children who have taken overdoses or harmed themselves will require admission.
- Disturbed or unmanageable behaviour will often respond to a calm, neutral, reassuring approach but physical treatment, or drugs, may occasionally be necessary. If possible the permission of both parents should be obtained before this is resorted to. In a crisis the wishes of the parents or guardian must take precedence over the wishes of the child. All such emergencies should be referred to the psychiatric services.

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