Mental health and alcohol withdrawal

Mental health

HMP Mental health emergency - adult/child
Acute severe behavioural disturbance (ASBD)

Recommend

- Key Qld resources required to support clinicians during a mental health emergency https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/policies-guidelines
- If outside of Qld, refer to local policies + procedures
- In Qld, a member of the public with concerns for the mental health of a person can contact the police, ambulance or the Mental Health Review Tribunal (MHRT) for further intervention https://www.mhrt.qld.gov.au/information-about/examination-authorities

1. May present with[1,2]

- Violent behaviour or extreme agitation
- Self-destructive, physically or verbally aggressive or threatening behaviour
- Possession of a weapon with intent to use
- Bizarre, disorientated behaviour:
  - unable to stand still
  - inappropriate anger or sadness
- Hallucinations:
  - ordering person to harm themselves
  - seeing, hearing or feeling things that are not there
  - talking to people who are not there
- Delusions:
  - suspicious of people or things in surroundings
  - grandiose thoughts
- Withdrawn eg refusing to talk or eat
- Current suicide attempt, or:
  - expresses intent to die
  - has a plan in mind
  - has access to lethal means
- Situational crisis
- Family member seeking help for any of the above

- In Qld, if a **police or ambulance officer** presents with an involuntary patient, they must:[3,6,7]
  - seek approval from the Director of Nursing/person in charge prior to bringing patient in
  - complete **Part A** of an *Emergency Examination Authority* (EEA) form, then give to doctor or clinician to complete **Part B**
- Patient can be detained for 6 hours after an EEA is completed to undertake examinations

2. Immediate management

- DRSABCD
- **If person has survived an attempted suicide or a self-harm event, manage accordingly:**
  - eg hanging see Traumatic injuries, p. 134, Spinal injuries, p. 147
- Consider injuries consistent with self-harm attempt

Stay safe[1,2]

- Never approach a patient who has a weapon
- If needed take protective measures eg lock yourself in the pharmacy, leave the facility
- Consider risks in the immediate environment eg access to knives, scissors, IV poles
- Note exits for escape
- Remove other people and bystanders
- Assess in an open space
- Minimise distractions + give full attention to the patient
- Use a calm, confident manner, avoid sudden or threatening gestures
- Avoid prolonged eye contact, and do not confront, corner or stand over the patient
- Be familiar with duress alarms

Then

- Phone police if concerned about safety
- Phone MO/NP urgently
- Ensure at least 2 staff are on hand at all times
- Always remain with patient unless your safety is at risk

If required attempt de-escalation[1,2]

- Listen. Allow patient to speak without interruption
- Be empathic, non-judgemental + respectful
- Monitor changes in mood or composure that may lead to aggression
- Continually show respect + empathy for patient
- Identify any patient needs that have not been met
- Use a slow, clear + steady voice + do not raise your voice
- If the patient raises their voice, pause + listen to the patient vent their frustrations
- For children, consider removing people who may be the source of violent or aggressive behaviour

Never undertake physical restraint

- Rural and remote facilities lack the resources to undertake this procedure safely
- As a matter of urgency staff are to:
  - call the police (000)
  - protect themselves + others - retreat from the situation

- If restraint is to be used, it should be undertaken in accordance with Qld state-wide policy[3] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/policies-guidelines

3. Clinical assessment

For non-consenting or uncooperative patient (Qld)[1,4,5]

- Forms are required by law before examination or treatment
- **If brought in by police or ambulance** under an *Emergency Examination Authority* (EEA):
  - examination of patient can be done for 6 hours
  - can be extended to 12 hours if needed
  - involuntary detention under the EEA expires after the 12 hours or examination is complete
  - if patient requires further examination then complete a *Recommendation for Assessment* (RA)
- **If patient presents otherwise (eg with family):**
  - a doctor or **authorised** mental health practitioner, who believes the patient may have a mental health condition, needs to complete a *Recommendation for Assessment* (RA) form (via Telehealth if required):[1,4,5]
    - patient can be detained for 1 hour before form completed
    - the RA authorises involuntary detention for 7 days
    - keep copy in records + send copy with patient (if evacuated)

If police assistance is required (Qld)

- If patient absconds under an *Emergency Examination Authority* (EEA) +
  - they are at risk of harm to themselves or others, call 000 for urgent police assistance + any health practitioner can complete a Public Health Act 2005 *Request for Police Assistance* form
  - they are not at risk of harm to themselves or others, clinician should attempt to contact and encourage them to return voluntarily
- If patient under a *Recommendation for Assessment* (RA) and police assistance needed eg to examine, treat, or transport:
  - a doctor or **authorised** mental health practitioner can complete a Mental Health Act 2016 *Request for Police Assistance* form

- Get history, including:
  - current mental health management plan and related presentations[1,2]
  - establishing patient's behaviour + personality prior to the current presentation. Via family + friends if needed[1,2]
- Do vital signs+
  - BGL + SpO_2 to exclude glycaemic + hypoxic causes of behaviour change[1,2]
- Do physical examination - consider injuries consistent with self-harm attempt
- Do a **Mental State Examination (MSE)**. See following box for observations + example questions
- **For children**, assess for sudden or significant, unexplained changes of behaviour or emotional state such as:[1,2]
  - unusual fearfulness or severe distress eg inconsolable crying
  - self-harm or social withdrawal
  - aggression or running away from home
  - indiscriminate attention seeking with adults
  - development of new behaviours eg soiling or wetting, thumb sucking
- Consider alternate cause where child presentation is inconsistent with history. See Child protection, p. 551

Mental State Examination (MSE) observations and example questions[6,7]	
Appearance	• Gender, ethnicity, apparent age, clothing, grooming, hygiene + cultural appropriateness
Behaviour	• Agitation, aggression, eye contact, cooperativeness, motor activity, retardation, inappropriate or unusual behaviour
Speech	• Rate, rhythm + volume of speech. Is it spontaneous
Mood	• Ask patient to describe their mood eg elevated, depressed, labile, angry, happy
Affect	• The outward appearance of the patient's emotional state eg blunted, flattened, euphoric, anxious
Perception	• Auditory or non-auditory hallucinations • Does the patient believe the hallucinations or voices are real • What are the voices saying. Commands to harm self or others. Has the patient responded to the voices
Thought form	• Are the patient's ideas or thoughts connected in a strange or illogical fashion. Record some quotes of the patient's speech • Is the patient incoherent, use words that rhyme or have secret meanings different to actual meaning
Thought content	• Explore anxieties, obsessions, preoccupations and delusions ie patient is certain their ideas are reasonable despite being grandiose, persecutory or bizarre eg television is talking to them • Does patient think their concerns are excessive • Are beliefs different to cultural and religious background
Judgement	• Assess patient's capacity for responsible decision making eg to care for children
Insight	• Does the patient acknowledge their symptoms, diagnosis or need for treatment
Cognition	• Orientation to time, person and place • Memory, attention and ability to concentrate ie need for redirection or repeating • Alert, drowsy, delirium, stupor • Impression of current abilities, awareness to confusion of self

4. Management

- Once imminent risk of harm to themselves or others has been addressed, refer to relevant presentation:
  - Suicidal behaviour, p. 344
  - Psychosis, p. 350
  - Mood disorders, p. 352
  - Panic attack, p. 354
  - Dementia, p. 348
  - Delirium, p. 131
- Manage in consultation with MO/NP + psychiatrist or Mental Health Team
- **Only consider sedation** (see flowchart on next page):[1,3,5]
  - if attempts at de-escalation have been exhausted
  - to control severe behaviour disturbance for patient's safety + safety of others
  - to allow diagnostic assessment + management
  - to relieve patient distress
  - **if child, adolescent or medically frail** patient - after consultation with MO/NP or psychiatrist
  - for **eligible adults only**, see Qld Health sedation policy https://www.health.qld.gov.au/__data/assets/pdf_file/0031/629491/qh-gdl-438.pdf

Sedation for Acute Severe Behavioural Disturbance (ASBD) in adults outside a mental health facility[1,4]

Have de-escalation techniques been attempted prior to sedation

YES
Notify MO/NP you are proceeding to sedation

NO
Continue to use de-escalation techniques

Assess need for sedation
Use scale below to assign a single score between +3 and −3 according to the patient's responsiveness and speech

Responsiveness	Speech	Score
Combative, violent, out of control	Continual loud outburst	+3
Very anxious and agitated	Loud outburst	+2
Anxious/restless	Normal/ talkative	+1
Awake and calm/ cooperative	Speaks normally	0
Asleep but rouses if name is called	Slurring or prominent slowing	−1
Responds to physical stimulation	Few recognisable words	−2
No response to stimulation	None	−3

Score +3 or +2:

Contact MO/NP who may order:

- IM droperidol or IM ketamine if droperidol fails

Repeat **sedation assessment** every 15 minutes. Aim for score of **0**

Continuous SpO_2 + vital signs for all patients receiving IM sedation

Score +1: Oral diazepam **OR** oral olanzapine

Score 0: No sedation required

Repeat **sedation assessment** every 30 minutes. Aim for score of **0**

Score −1, −2 or −3:

Notify MO/NP immediately if:

Adult - SpO_2 < 94%, RR < 10, HR < 50, GCS < 5

Child or adolescent - CEWT score ≥ 2 for any domain

For reversal of benzodiazepine induced respiratory depression give flumazenil

- For family members + relatives of patient, including children:
  - this may be a very frightening experience for them. Provide support
  - consider immediate safety needs of vulnerable people for whom the patient has care responsibilities ie children
  - provide a copy of any management plan

S4	Diazepam			Extended authority ATSIHP/IHW/IPAP/RIPRN
ATSIHP, IHW, IPAP and RN must consult MO/NP				
RIPRN may proceed				
Note: if a non-consenting patient, can only be given by an RN or RIPRN + after consultation with MO/NP				
Form	**Strength**	**Route**	**Dose**	**Duration**
Tablet	2 mg 5 mg	Oral	**Adult** 10 mg (max. 60 mg/24 hours)	stat Further doses on MO/NP order
			Medically frail adult 5–10 mg (max. 60 mg/24 hours)	
			Child > 5–adolescent 0.2 mg/kg (max. 10 mg x 2 doses only)	
Offer CMI: May cause drowsiness, oversedation, light-headedness, hypersalivation, ataxia, slurred speech or effects on vision				
Note: Monitor respiratory rate closely. Halve the usual adult dose if elderly ± debilitated. Diazepam tablets can be crushed and mixed into food eg yoghurt/fruit puree or dispersed in 10–20 mL of water				
Contraindication: Drug overdose, myasthenia gravis, severe hepatic impairment				
Management of associated emergency: If respiratory rate < 10 after sedation, reverse with flumazenil. Consult MO/NP. See Anaphylaxis, p. 82 [1,4,8]				

S4	Olanzapine			Extended authority ATSIHP/IHW/IPAP/RIPRN
ATSIHP, IHW, IPAP and RN must consult MO/NP				
RIPRN must consult MO/NP unless circumstances do not allow, in which case notify the MO/NP as soon as circumstances allow				
Form	**Strength**	**Route**	**Dose**	**Duration**
Tablet or Wafer	2.5 mg 5 mg 10 mg	Oral	**Adult only** 5–10 mg (max. 30 mg/24 hours)	stat Further doses on MO/NP order (after 60 minutes)
			Medically frail adult 2.5–5 mg (max. 15 mg/24 hours)	
Offer CMI: Caution if moving from lying to sitting or to standing position				
Contraindication: Known allergy; drug overdose				
Management of associated emergency: Give benzatropine as an antidote for extrapyramidal side effects eg acute dystonic reaction. Consult MO/NP. See Anaphylaxis, p. 82 [1,4,9]				

S4	Flumazenil			Extended authority ATSIHP/IHW/IPAP/RIPRN
ATSIHP, IHW, IPAP and RN must consult MO/NP				
RIPRN must consult MO/NP unless circumstances do not allow, in which case notify the MO/NP as soon as circumstances do allow				
Form	**Strength**	**Route**	**Dose**	**Duration**
Injection	500 microg/ 5 mL	IV	**Adult** **Initial dose** 200 microg **Further dose(s)** 100 microg (max. total dose 1 mg)	stat Inject over 15 seconds Repeat every 60 seconds if necessary to a total dose of 1 mg
Offer CMI: May cause nausea and vomiting				
Note: Use with caution in patients with epilepsy receiving long-term benzodiazepine treatment. Patients may become agitated, anxious or fearful on awakening. Use with caution in those who have mixed overdose of benzodiazepines and proconvulsant drugs - can result in death. **Half life** approx. 1 hour (much shorter than that of all benzodiazepines) - observe for at least 4 hours after dose				
Pregnancy: Do not use in benzodiazepine dependent women; risk of precipitating withdrawal in fetus				
Management of associated emergency: Consult MO/NP. See Anaphylaxis, p. 82 [1,4,10]				

S4	Droperidol			Prescribing guide
MID, RIPRN and RN only. Must be ordered by an MO/NP				
Form	**Strength**	**Route**	**Dose**	**Duration**
Injection	10 mg/2 mL	IM	**Adult** 2.5–10 mg (max. 30 mg/24 hours)	stat May be repeated after 20 minutes
Offer CMI: May cause hypotension, respiratory depression (especially if given with benzodiazepines) or extrapyramidal side effects (rare)				
Note: Monitor patient closely after administration. QT prolongation may occur (rarely clinically significant with doses used for ASBD)				
Management of associated emergency: Give benzatropine as an antidote for extrapyramidal side effects eg acute dystonic reaction. Consult MO/NP. See Anaphylaxis, p. 82 [1,4,11]				

S4	Benzatropine			Extended authority ATSIHP/IHW/RIPRN
ATSIHP, IHW and RN must consult MO/NP				
RIPRN may proceed				
Form	**Strength**	**Route**	**Dose**	**Duration**
Tablet	2 mg	Oral	**Adult only** 1–2 mg	stat Further doses on MO/NP order
Injection	2 mg/2 mL	IM		
Offer CMI: May cause drowsiness, dizziness or blurred vision. May increase effects of alcohol				
Contraindication: GIT or urinary obstruction, myasthenia gravis				
Management of associated emergency: Consult MO/NP. See Anaphylaxis, p. 82 [1,4,12]				

5. Follow up

- If referred to the Mental Health Team:
  - see **Mental Health Team response time** table below for expected response + action times

Mental Health Team response time[13,14]			
Urgency	**Typical presentation**	**Response time**	**Actions may include**
Emergency	• Actions endangering self or others • Overdose • Suicide attempt • Violent, aggression • Possession of a weapon	**Immediate**	• Face to face • Videoconference • Telehealth • Telephone support • Police involvement
Very high	• Suicidal ideation with risk of harm with clear plan • Thought disturbance • Delirium • Dementia • Impaired impulse control	**Within 4 hours**	• Face to face • Videoconference • Telehealth • Telephone support
High	• Suicidal ideation, no plan • Rapid increase in symptoms of psychosis or severe mood disorder • Overt unprovoked aggression • Wandering at night • Vulnerable isolation or abuse	**Within 24 hours**	• Same day contact • Videoconference • Telehealth • Telephone support
Moderate	• Significant patient/carer distress associated with severe mental illness • Not suicidal • Early symptoms of psychosis • Obstructing care • Wandering • Failing carer	**Within 72 hours**	• Videoconference • Telehealth • Telephone support
Low	• Stable and low risk of harm • Able to be managed in the community • Requires non-urgent review adjustment of treatment • Service review • Carer support	**Within 4 weeks**	• Videoconference • Telehealth • Telephone support

6. Referral/consultation

- Consult MO/NP as above
- Refer for further mental health assessment by psychiatrist or Mental Health Team
- Always consider referral to child protection agencies for:
  - a child presentation
  - a child in care of the patient
  - see Child protection, p. 551

Suicidal behaviour - adult/child

1. May present with[1,2]

- Verbalises suicidal ideas/suicidal intent
- Previous presentations for suicidal thoughts or deliberate self-harm
- A recent psychosocial stressor or loss eg grief, relationship breakdown, loss of job, pregnancy or new birth
- Feelings of helplessness or hopelessness

2. Immediate management[1]

- DRSABCD
- **Do not leave patient alone**
- **If person has survived an attempted suicide or a self-harm event, manage accordingly**
- Consider injuries consistent with self-harm attempt eg for hanging, see Traumatic injuries, p. 134, Spinal injuries, p. 147
- If the patient is highly agitated, expressing an intent to suicide, aggressive or violent. See Mental health emergency, p. 336

3. Clinical assessment[1]

- **Ensure patient has an opportunity to discuss their suicidality alone**
- **With consent** seek information from patient's family, friends, support person or others

Communication skills[1]

- Listen. Allow patient to speak without interruption
- Develop and maintain rapport with the patient
- Be mindful of your own values and beliefs in relation to suicide
- Convey a sense of warmth, non-judgemental acceptance, and an interest in understanding the patient and the cause of their emotional distress
- Be respectful and empathic
- Avoid minimising the seriousness of the risk of suicide

- Ask **Questions about suicidal thoughts**:[2,4]
  - it is important to ask the person directly about feelings or thoughts of suicide
  - asking about self-harm does not provoke acts of self-harm[4]
  - discuss the balance of confidentiality versus notifying others to ensure safety

Questions about suicidal thoughts[1-4]
Suicide risk
• When people feel like you are/have been feeling, they sometimes think that life is not worth living. Have you been thinking like that or have you ever thought like that • Have you been thinking of harming yourself • Are you thinking of suicide • If yes, how often are you having these thoughts: – have you thought about how you would act on these. Is there a plan. Does this plan seem feasible. Are the methods available. Is it likely to be lethal – have you thought about when you might act on this plan – are there any things/reasons that stop you from acting on these thoughts • Have you tried to harm yourself in the past: – if yes, how many times – when was the most recent time • Do you know anyone who has recently tried to harm themselves • Do you feel safe at the moment
If a suicide attempt has been made
• What did you hope would happen as a result of your attempt. Did you want to die, or end your pain • Do you regret that you did not succeed • Do you still have access to the method used • Did you use alcohol or drugs before the attempt. What did you use • Do you have easy access to a weapon
Risk of harm to others
• Have you thought of hurting anyone else: – if yes, have you acted on these thoughts • Have you been involved in any fights recently: – if yes, were you using drugs or alcohol at the time

- Consider factors that may be contributing to current thoughts (if patient comfortable and clinician experienced to do so):[1,2]
  - current mental health management plan and related presentations
  - behaviour and personality prior to presentation
  - childhood abuse, neglect, exposure to traumatic events
  - recent self-harm episodes or suicides in the community (suicide clusters)
  - recent, ongoing or unresolved loss or grief
  - physical or sexual abuse
  - family conflict, domestic violence. See Domestic and family violence, p. 241
  - school difficulties
  - problems with peers
  - bullying
  - substance misuse
- Do a Mental State Examination, p. 339 +
  - vital signs and physical examination as required
  - risk assessment:
    - depressive symptoms. See Mood disorders, p. 352
    - neglect or victimisation by others
    - harm to others especially children in patient's care

- Determine suicidal intent (flowchart below)

Determining suicidal intent[1,2,4]

Patient strengths

- Therapeutic relationship between clinician and patient
- Family warmth, support and acceptance
- Willingness to access and engage with professional help
- Activities/hobbies that an individual finds meaningful
- Community support and cultural identity
- Having children and child rearing responsibilities
- Sense of belonging and connection
- Skills in coping and problem solving, conflict resolution and non-violent ways of handling disputes

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Risk factors

- Mental health issues eg depression
- Gender (male)
- Relationship or family problems, violence, abuse or custody issues, pregnancy
- Substance misuse
- Social or geographical isolation
- Aboriginal and Torres Strait Islander
- Financial stress, unemployment, impending court case
- Recent bereavement
- Prior suicide attempt
- Bullying, sexual assault, torture, or refugee status
- Losing a friend or family member to suicide

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Warning signs

- Hopelessness
- Feeling trapped
- Escalating substance misuse
- Giving away possessions
- Seeking ways to kill oneself ie searching online or buying a means
- Withdrawing from friends, family or society
- Voicing no reason for living, no sense of purpose in life, being a burden to others
- Uncharacteristic or impaired judgement or behaviour
- Verbalising or writing about wanting to die

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Tipping points

- Relationship separation
- Loss of status or respect
- Recent death or suicide of relative or friend
- Recent argument at home
- Current abuse or bullying
- Debilitating physical illness, accident or pain

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Imminent risk

- Expressed intent to die
- Has plan in mind
- Impulsive, aggressive or anti-social behaviour
- Has access to lethal means

4. Management

- Consult MO/NP who will plan:
  - immediate and ongoing management in the community, or
  - transfer/evacuation for comprehensive management
- If the patient is the primary carer for children or other vulnerable people, consider alternative arrangements for care. See Child protection, p. 551[1,4]
- Discuss the patient's behaviour to family or friends to reduce their anxiety or anger towards the patient
- In consultation with MO/NP **assess whether a patient is safe to be managed at home**:[4,5]
  - acute problems are identified and being actioned
  - patient knows where and how to seek help if suicidal thoughts recur
  - patient is not demented, intoxicated, sedated, delirious or psychotic
  - **'lethal means' counselling** has been undertaken ie working with the patient and their support persons to limit access to a means of suicide until they are no longer at elevated risk:
    - discuss who is responsible for managing lethal means (eg guns, knives, ropes, drugs, medications, poisons, high places) and removing, restricting or limiting access (may include supervision of the patient)
    - discuss if the patient's occupation gives access to lethal means eg council workers accessing pesticides, police officer accessing guns, clinicians accessing medicines
    - discuss who holds and dispenses all medicines in the home
    - consider reduction of prescription medicine quantities to nonlethal amounts
    - if patient has access to a firearm notify the police/Weapons Licensing Branch[6] at https://www.police.qld.gov.au/weapon-licensing/mental-and-physical-health
  - follow up arrangements have been documented with a copy given to the patient and carers
  - a treatment plan has been arranged for current mental health and medical problems
  - a written **Safety Plan** has been provided to both the patient and their support person
- Develop a written **Safety Plan** with the patient. It involves:[2,4]
  - recognising warning signs and triggers
  - making surroundings safe
  - reminders of reasons to live
  - things that can make them feel strong
  - people and places to connect with
  - family and friends they can talk or yarn with
  - professional support and access
  - safety planning information is available at https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning

5. Follow up

- For Mental Health Team follow up response time and action, see **Follow up** under Mental health emergency, p. 336
- Consult the Mental Health Team/psychiatrist who will plan ongoing management and coordination
- 24 hour access to clinical support should be available to all patients being managed in the community
- Advise the patient to enact their safety plan if the situation deteriorates

6. Referral/consultation

- Always consider referral to child protection agencies for:
  - a child presentation or a child in care of the patient. See Child protection, p. 551

HMP Dementia - adult
Severe behavioural and psychological symptoms

Recommend

- For ongoing management of dementia see the *Chronic conditions manual* https://www.health.qld.gov.au/rrcsu/clinical-manuals/chronic-conditions-manual-ccm

1. May present with

- A patient with known dementia +
- Psychosis, agitation or aggression

2. Immediate management

- **DRSABCD**
- If a person is a risk of harm to themselves, others or their behaviour is associated with perceptual or thought disturbance, delirium or impaired impulse control, see Mental health emergency, p. 336

3. Clinical assessment

- Assess + manage calmly in a quiet area, with a familiar person present
- Get history, including:
  - current mental health management plan + related presentations[2]
  - patient's behaviour + personality prior to the current presentation
  - alcohol + drug use
- Identify the trigger **(antecedent)**:[1]
  - side effects or toxicity from medicines
  - signs of infection or presence of wounds eg acute febrile illness + altered mental status
  - herpes simplex virus leading to encephalitis eg headache, seizures, focal neurological signs[1,2]
  - acute thiamine deficiency eg ocular abnormalities, gait ataxia, inability to concentrate, apathy, impaired awareness of the immediate situation, spatial disorientation, confusion, psychosis + coma[1,3]
  - environmental stimuli eg temperature extremes, noise
  - unmet needs eg hunger, thirst, warmth
  - patient-carer conflict
  - pain, constipation
  - vision or hearing difficulties
  - separation from family
- What **behaviour** occurred:
  - does behaviour cause significant distress to themselves or others eg verbal aggression, use of a weapon[4]
- What was the **consequences** of the behaviour eg injury, fall
- Consider elder abuse where presentation for non-accidental cause is inconsistent with history or is unexpected in older or vulnerable people
- Do physical examination[1] +
  - vital signs
  - BGL + SpO_2 to exclude glycaemic or hypoxic causes of behaviour change
  - bloods - FBC, TFT, PTH, UE, calcium, vitamin B12, folate, niacin, CHEM20, thiamine
  - urine for MCS + drug screen

- Use table below to distinguish current dementia presentation from an episode of delirium or depression

Distinguishing signs and symptoms of delirium, dementia and depression[8]			
	Dementia	**Delirium** Also see Delirium, p. 131	**Depression** Also see Mood disorders, p. 352
Onset	Chronic, progressive	Acute illness, medical emergency	Rapid over weeks to months, episodic
Course	Stable during day, progresses	Fluctuates hourly	Can be self-limiting, recurrent, or chronic. Worse in morning, improves during day
Duration	Progressive, irreversible	Hours to weeks, resolves with treatment	Months or years, resolves with treatment
Orientation	Impairment progressively worse, loss of ability to recognise function of everyday objects	Disoriented to time and place	Selective disorientation
Memory	Impaired short-term, unconcerned about memory loss	Impaired short-term	May be impaired, concerned about memory loss
Speech	Repetitive, trouble finding words, confabulates	Incoherent, loud, belligerent	Quiet and minimal, can be belligerent, aggressive. Language skills intact
Sleep	Disturbed, day/night reversal	Disturbed, changes hourly	Disturbed, early morning wakening, sleepy during day
Contributing factors	Advancing age, cardiovascular deficits, substance dependence or unknown cause	Infection, drug side-effect, renal failure, head trauma, substance use	Recent or cumulative loss, medicine toxicity

4. Management

- Address any identified triggers eg polypharmacy, pain, UTI
- Consult MO/NP or general physician/geriatrician/psychiatrist who may order:
  - sedation for violence, agitation or aggression.[4] See Mental health emergency, p. 336
  - thiamine for suspected thiamine deficiency[1,3]
- Offer analgesia if indicated. See Acute pain, p. 32
- Develop a **Behavioural management plan** with patient, carer and family, specifically:
  - access to dangerous items
  - access to exits if patient is wandering
  - over-stimulation eg too many people in house, excessive noise, clutter
  - under stimulation eg lack of activities or items of interest to patient
  - regular exercise
  - limiting access to alcohol or other drug use
- Consider transfer/evacuation for comprehensive management

5. Follow up[2]

- According to MO/NP. Regular review if commenced on pharmacological management

6. Referral/consultation[2]

- Geriatrician/psychiatrist/Older Persons Mental Health Team
- Consider the Aged Care Assessment Team (ACAT), via My Aged Care, for assessment of long-term care needs https://www.myagedcare.gov.au/

Psychosis - adult

Drug-induced psychosis, schizophrenia, postnatal psychosis, brief psychotic disorder, bipolar psychosis

Background[1]

- Psychosis is a general term used when a patient has lost some contact with reality and may have distorted thinking, perception and mood

1. May present with[2]

- Delusions:
  - firm fixed belief of things that are not true eg the person must harm someone, their baby is the devil
- Hallucinations:
  - seeing or hearing things that are not there eg voices giving commands
- Disturbed sleep, walking or pacing at night
- Very suspicious and paranoid of others
- Family or friends report strange, disruptive or frightening behaviour
- Women in the perinatal period
- Intoxicated
- Also consider Delirium, p. 131 if:
  - disoriented to time and place
  - incoherent, loud, belligerent

2. Immediate management[2]

- DRSABCD
- **Do not leave patient alone**
- **If person has survived an attempted suicide or a self-harm event, manage accordingly**
- Consider injuries consistent with self-harm attempt eg for hanging, see Traumatic injuries, p. 134, Spinal injuries, p. 147
- If the patient is highly agitated, expressing an intent to suicide, aggressive or violent. See Mental health emergency, p. 336

3. Clinical assessment

- Listen. Allow patient to speak without interruption
- Enquire about but do not challenge their thoughts or behaviours
- Develop and maintain rapport with the patient
- Convey a sense of warmth, non-judgemental acceptance, and an interest in understanding the patient's thoughts or behaviours
- Be respectful and empathic

- Avoid minimising their experiences
- Seek information from patient's family, friends, support person or others
- Get history, including:[2,3]
  - current mental health management plan and related presentations
  - behaviour and personality prior to the current presentation
  - adverse medication event
  - substance use including cigarette use
  - head injury, trauma or seizures
  - STIs
  - other psychiatric disorders
  - diet and exercise
  - if a woman in the perinatal period, assess for:
    - capacity to safely care for her infant (if delivered)
    - quality of mother-infant relationship eg cuddling, eye contact, responding to cues
- Do physical examination +
  - vital signs
  - BGL + SpO_2 to exclude glycaemic or hypoxic causes of behaviour change
  - bloods - FBC, TFT, PTH, UE, calcium, vitamin B12, folate, niacin, CHEM20
  - urine for MCS and drug screen
  - pregnancy test if female of reproductive age
  - STI/BBV tests, p. 448 - HIV and syphilis
- Do Mental State Examination, p. 339
- Do risk assessments:[3]
  - depressive symptoms. See Mood disorders, p. 352
  - suicidal intent. See Suicidal behaviour, p. 344
  - neglect or victimisation by others
  - harm to others especially children in patient's care

4. Management[2]

- Patients with psychosis are unlikely to be managed in the community. Consult MO/NP who will:
  - plan immediate management and coordination
  - arrange evacuation for comprehensive management
  - order antipsychotic and sedative medicine as required. See Mental health emergency, p. 336
  - if psychosis is due to an adverse effect to antipsychotic medication, may advise to cease medication
- Monitor closely if intoxicated
- For women in the perinatal period consult the MO/NP or midwife for further management options
- Provide family support and education

5. Follow up[2]

- Consult MO/NP, Mental Health Team/psychiatrist who will plan ongoing management and coordination
- For Mental Health Team follow up response time and action, see **Follow up** under Mental health emergency, p. 336

6. Referral/consultation

- MO/NP and psychiatrist
- Mental Health, Alcohol and Other Drugs (MHAODS) if problem alcohol or drug use
- Social worker if the patient requires counselling or support navigating services
- Refer women in the perinatal period to a midwife
- Consider child health services or Child and Youth Mental Health Services if concerned about welfare of children in care of patient. See Child protection, p. 551

Mood disorders - adult/child

Depression, bipolar disorders

Background

- For ongoing management of depression, see the *Chronic conditions manual* https://www.health.qld.gov.au/rrcsu/clinical-manuals/chronic-conditions-manual-ccm

1. May present with

- Existing history of depression, mood disorders or mania

Depression[1,2]

- Suicidal ideation/attempts. See Suicidal behaviour, p. 344
- Insomnia or sleep pattern changes
- Appetite changes
- Irritability, low mood, tiredness
- Difficulty concentrating
- Concerns about social problems such as finances or relationships
- Feelings of helplessness or hopelessness
- Use of alcohol or other substances
- Women in the perinatal period

Mania (bipolar)[1,2]

- Irritable mood or anger
- Elevated mood
- Inflated self-esteem
- Decreased or unable to sleep, active all night
- Pressured speech and racing thoughts
- Excessive goals, plans and activities
- Poor judgement, impulsive and taking risks eg excessive spending, promiscuous behaviour
- Symptoms of psychosis. See Psychosis, p. 350

2. Immediate management

- DRSABCD
- **Do not leave patient alone**
- **If person has survived an attempted suicide or a self-harm event, manage accordingly**
- Consider injuries consistent with self-harm attempt eg for hanging, see Traumatic injuries, p. 134, Spinal injuries, p. 147

- If a person is a risk of harm to themselves, others or their behaviour is associated with perceptual or thought disturbance, delirium, dementia or impaired impulse control. See Mental health emergency, p. 336

3. Clinical assessment

- Listen. Allow patient to speak without interruption
- Develop and maintain rapport with the patient
- Be mindful of your own values and beliefs in relation to mood disorders
- Convey a sense of warmth, non-judgemental acceptance, and an interest in understanding the patient and the cause of their pain or distress
- Be respectful and empathic
- Avoid minimising the seriousness of their presentation
- Get history, including:
  - current mental health management plan and related presentations[2]
  - establishing patient's behaviour and personality prior to the current presentation, by family and friends if needed[2]
  - treatment history and engagement with psychotherapy[3]
  - adherence to medication at the dosages prescribed[3]
  - recent loss or stressors
  - chronic illnesses
  - physical disorders
  - sleep history, patterns, insomnia
  - if a woman in the perinatal period, assess for:
    - capacity to safely care for her infant (if delivered)
    - quality of mother-infant relationship eg cuddling, eye contact, responding to cues
    - mood using a mood scale eg EPDS, DASS https://www.psychologytools.com/download-scales-and-measures/
- Do physical examination +
  - vital signs
  - BGL + SpO_2 to exclude glycaemic or hypoxic causes of behaviour change
  - bloods - TFT, CHEM20, lithium and sodium valproate levels
  - urine for MCS and drug screen
  - pregnancy test if female of reproductive age
- Do Mental State Examination, p. 339 +
  - risk assessment:[3]
    - suicidal intent. See Suicidal behaviour, p. 344
    - neglect or victimisation by others

4. Management

- Consult MO/NP and Mental Health Team or psychiatrist who will:
  - plan immediate management and coordination
  - consider evacuation for comprehensive management
- For mania related behaviours consider sedation. See Mental health emergency, p. 336
- For women in the perinatal period consult the MO/NP or midwife for further management options

5. Follow up

- According to MO/NP and psychiatrist or midwife

- For Mental Health Team follow up response time and action, see **Follow up** under Mental health emergency, p. 336

6. Referral/consultation

- MO/NP and psychiatrist
- Mental Health, Alcohol and Other Drugs (MHAODS) if problem alcohol or drug use
- Social worker if the patient requires counselling or support navigating services
- Refer women in the perinatal period to a midwife
- Consider child health services or Child and Youth Mental Health Services if concerned about welfare of children in care of patient. See Child protection, p. 551

Panic attack - adult/child

Panic disorder, anxiety

Background

- Unless complex or recurrent, most panic attacks will not require mental health intervention
- For ongoing management of anxiety, see the *Chronic conditions manual* https://www.health.qld.gov.au/rrcsu/clinical-manuals/chronic-conditions-manual-ccm

1. May present with[1,2]

- History of panic attacks
- Fear they may collapse or die
- Restlessness or feeling 'keyed up' or 'on edge'
- Trembling
- Difficulty concentrating or mind 'going blank'
- Irritability and racing heart beat
- Feeling like they can't catch their breath, hyperventilating
- Dizziness
- Sleep disturbance
- Preoccupation about attacks recurring

2. Immediate management

- If the person is too anxious to concentrate consider:
  - a slow breathing technique:[2]
    - the person breathes in for 4 seconds
    - holds their breath for 2 seconds
    - then breathes out slowly over 6 seconds
    - perform with the person
    - repeat for a minute

3. Clinical assessment

- Get history, including:[2]
  - personal and family history
  - perform mood scale eg DASS (access online)
  - alcohol and drug use
  - medication use

  - symptoms, fears or phobias
  - what may be making them anxious. Can occur for no reason
  - what does it stop them doing
  - what do they fear will happen
  - how long have they had the symptoms
  - what led them to come today
- Do physical examination +
  - vital signs
  - BGL + SpO_2 to exclude glycaemic or hypoxic causes of behaviour change
  - ECG
  - bloods - TFT, UE, FBC

4. Management

- Simply sitting in the waiting room can help reduce anxiety
- If overwhelming or unresolving panic attack, consult MO/NP who may recommend stat dose of a benzodiazepine
- Reassess medications and their effect on anxiety
- Patient education:[2]
  - teach and practice breathing exercises
  - reassure that their disorder has been recognised and that help is available
  - anxiety is a normal arousal response to enable a person to focus and act quickly to a threat
  - anxiety in the face of no rational threat can escalate to a pronounced disabling anxiety state; a panic attack
  - treatments take time and may include medications ie antidepressants
  - lifestyle modification:
    - diet and nutrition
    - good sleep patterns
    - regular exercise
    - avoid caffeine, tobacco, alcohol, illicit drug use and overworking
  - self-monitoring and recording of symptoms if they reoccur:
    - where and when do the symptoms happen
    - how do they respond eg escape, avoid, medications, substances
  - return if panic attacks persist
- For recurrent panic attacks refer to mental health services for psychological interventions eg cognitive behaviour therapy

5. Follow up

- Review the patient the next day
- According to MO/NP
- If referral has been made to Mental Health Team see response time and action under Mental health emergency, p. 336

6. Referral/consultation

- MO/NP or psychologist
- If complex or recurrent then psychiatrist and mental health services
- Mental Health, Alcohol and Other Drugs (MHAODS) for problem alcohol or drug use
- Social worker if the patient requires counselling or support navigating services

- Consider child health services or Child and Youth Mental Health Services if concerned about child in care of patient. See Child protection, p. 551

Alcohol withdrawal

HMP Alcohol withdrawal - adult

Delirium tremens, Wernicke encephalopathy

Recommend[1,2]

- Alcohol withdrawal delirium (delirium tremens) is a medical emergency
- Benzodiazepines are indicated for delirium tremens not antiepileptics

Background[1,2]

- Onset occurs 2–5 days after stopping last alcoholic drink
- Progression from mild to moderate to severe withdrawal can occur quickly without treatment
- For alcohol cessation resources, see the *Chronic conditions manual* https://www.health.qld.gov.au/rrcsu/clinical-manuals/chronic-conditions-manual-ccm

1. May present with

Mild to moderate withdrawal[1,3]

- Tremor
- ↑ HR and BP
- ↑ T
- Anxiety, agitation, restlessness
- Insomnia
- Nausea and vomiting
- Sweating
- Headache
- Palpitations

Severe withdrawal (progressing to delirium tremens)[1,2]

- Altered mental status eg confusion and disorientation or restlessness
- Heightened response to stimuli
- Severe hyperactivity, tremor and agitation
- Hallucinations, paranoid and delusional thoughts[3]
- Seizures
- Sympathetic overdrive eg fluctuation in BP or HR, disturbance of fluid balance and electrolytes, raised temperature
- Cardiovascular collapse

2. Immediate management

- Contact MO/NP for patients with signs of severe withdrawal (delirium tremens) for urgent evacuation/hospitalisation[4]
- Rapid assessment of past and recent alcohol intake, withdrawals, delirium, seizures and medical

conditions. Observe outstretched hands[1,2]

- If confused or withdrawn, strange, aggressive or acutely disturbed behaviour, see Mental health emergency, p. 336

3. Clinical assessment[1,2]

- If in a hyperstimulated state, assess in a quiet room with low light, in the company of a familiar person, friend or relative if possible
- If patient is frightened, reassure and avoid confrontation
- Get history:
  - from family members if patient unable to give a history
  - medications, including non-prescription and illicit drugs
  - alcohol intake:
    - amount, type and duration
    - other alcoholic compounds ie methanol, ethylene glycol, methylated spirits
- Do vital signs +
  - GCS, p. 562
  - BGL + SpO_2 to exclude glycaemia or hypoxia as cause of behaviour
- Assess for thiamine deficiency (Wernicke encephalopathy):
  - confusion and global memory impairment
  - slurred speech, stumbling, falling
  - involuntary eye movements
- **Wernicke encephalopathy is considered an emergency**
- Assess using the **Alcohol withdrawal scale (AWS)**

Alcohol withdrawal scale (AWS)[1]			
Perspiration	**0.** Nil **1.** Moist skin **2.** Beads on face and body **3.** Profuse, whole body wet	**Temperature**	**0.** < 37 **1.** 37.1–37.5 **2.** 37.6–38 **3.** 38.1–38.5 **4.** > 38.5
Tremor	**0.** No tremor **1.** Tremor can be felt in fingers **2.** Visible tremor but mild **3.** Moderate tremor, arms out **4.** Severe, arms not extended	**Hallucinations**	**0.** Lucid **1.** Infrequent, aware **2.** Brief, persuadable **3.** Frequent, distressed **4.** No meaningful reality
Anxiety	**0.** Calm **1.** Uneasy **2.** Apprehensive **3.** Fearful, slow to calm **4.** Unable to calm/panic	**Orientation**	**0.** Fully oriented **1.** Unsure of time **2.** Unsure time, place **3.** Unsure time, place, person **4.** Disorientated
Agitation	**0.** Able to rest **1.** Unsettled, fidgety **2.** Restless, tossing, turning **3.** Excitable, pacing **4.** Constant movement	**Scoring Key** < 5 = mild 5–14 = moderate > 14 = severe	

4. Management

- The immediate aim is to modify the withdrawal and increase the safety of the patient over the next 3–4 days
- Discuss inpatient, outpatient or evacuation options with MO/NP
- Initiate diazepam early in the course of alcohol withdrawal to prevent progression to more severe withdrawal without over-sedation[2]
- **Give all patients prophylactic thiamine** for Wernicke encephalopathy[1,2]

> **ALERT give thiamine before glucose in any form**
> Glucose may deplete thiamine stores causing Wernicke encephalopathy

- **Mild withdrawal AWS < 5:**[1]
  - supportive care
  - maintain hydration, antiemetics, paracetamol for headache, loperamide for diarrhoea
  - sedation with diazepam if necessary as per drug box
  - 4 hourly observations
- **Moderate withdrawal AWS 5–14:**[1]
  - maintain hydration
  - sedation with diazepam as per drug box
  - 1 hourly observations
  - continue to **monitor AWS** prior to administering diazepam
  - if not settling after 80 mg diazepam, MO/NP may consider olanzapine 5–10 mg
- **Severe withdrawal AWS > 14 or delirium tremens requires hospitalisation:**[1]
  - insert IVC and rehydrate with IV sodium chloride 0.9%
  - urgently contact MO/NP and arrange evacuation
  - diazepam every 2 hours as per drug box (specialist may order midazolam infusion)
  - if not settling after 80 mg diazepam, consult MO/NP
  - continue to **monitor AWS** prior to administering diazepam
- MO/NP will order ongoing diazepam and thiamine regimen for above[1]
- Offer antiemetic. See Nausea and vomiting, p. 40
- Attend to any underlying chronic conditions or infection
- **If being treated as an outpatient, the MO/NP may order**:[1,3]
  - supply of **daily diazepam regimen:**[1]
    - **day 1** diazepam 10 mg 6 hourly
    - **day 2–3** diazepam 5–10 mg 8 hourly
    - **day 4** diazepam 5 mg morning and night
- Other outpatient considerations:
  - a reliable adult to regularly monitor progress
  - a safe, alcohol-free environment
  - withholding medications if alcohol use is resumed
  - a clear plan in case of deterioration or emergency
  - child protection for children of parents or carers who are withdrawing. See Child protection, p. 551
  - domestic and family violence and safe transport needs

S4	Diazepam			**Extended authority** ATSIHP/IHW/IPAP/RIPRN
ATSIHP, IHW, IPAP and RN must consult MO/NP				
RIPRN may proceed to administer **1st dose only (max. 10 mg)**, then must consult MO/NP				
Form	**Strength**	**Route**	**Dose**	**Duration**
Tablet	2 mg 5 mg	Oral	**Adult** **Mild AWS < 5** 5–10 mg	stat Then every 6–8 hours for first 48 hours
			Adult **Moderate AWS 5–14** 10–20 mg	stat Then every 2 hours until good symptom control (max. 80 mg)
			Adult **Severe AWS > 14 or delirium tremens** 20 mg	stat Then 1 hourly for 4–6 hours (max. 80 mg)
Offer CMI: May cause drowsiness, oversedation, light-headedness, hypersalivation, ataxia, slurred speech or effects on vision				
Note: Monitor respiratory rate closely. Halve the usual adult dose in the elderly ± debilitated or discuss with MO/NP				
Contraindication: Myasthenia gravis, severe hepatic impairment				
Management of associated emergency: Consult MO/NP. See Anaphylaxis, p. 82 [1,4]				

Unscheduled	Thiamine			
ATSIHP, IHW, IPAP, RIPRN and RN may proceed				
Form	**Strength**	**Route**	**Dose**	**Duration**
Injection	300 mg/3 mL	**IV** Dilute in 10–20 mL of sodium chloride 0.9% or **IM** undiluted	**Adult** 300 mg	stat If IV inject slowly over 10 minutes
Offer CMI: Given to prevent Wernicke encephalopathy				
Note: Give IV/IM thiamine before or with glucose to patients at risk of alcohol-related thiamine deficiency; administration of glucose without thiamine may precipitate Wernicke encephalopathy				
Management of associated emergency: Contact MO/NP. See Anaphylaxis, p. 82 [1,2,5]				

5. Follow up

- On the first morning, assess the patient for:
  - early withdrawal symptoms. See **Alcohol withdrawal scale (AWS)**
  - intoxication or alcohol consumption in the past 8 hours. If any, cease treatment
- MO/NP/drug and alcohol RN should see the patient daily for the first 3–4 days. Then continue daily or second daily contact until withdrawal is completed

6. Referral/consultation[1]

- Mental Health, Alcohol and Other Drugs for ongoing follow up, counselling and case management
- Consider child health services or Child and Youth Mental Health Services if concerned about welfare of children in care of patient. See Child protection, p. 551

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