Psychiatric Emergencies and Psychotropic Medication

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Estelle Restaurant Wed 5 March 2014

No respect: Jonah, the foul-mouthed Islander in Chris Lilley's Summer Heights High, has become a cult figure in schools across the country.

Case 1 George

- 15 years old
- Autistic non-verbal moderate ID
- Escalating agitated anxious and aggressive behaviour school and home over last 6 months. 180cm, 85kg
- Two admissions to Austin CAMHS
- In home BIST support, respite care, medication treatment
- Risperidone 2mg BD, Epilim 300mg BD, Seroquel 100mg PRN
- Previous trials on Lovan 20mg and Valium 10mg PRN
- Jumped out of moving car in agitated state.
- Passing ambulance subdued him and brought him to ED
- Screaming, frightened and aggressive in ED

Case 2 Ben

- 15 years old
- Severe disruptive behaviour disorder. ADHD, ODD, SLD
- FH Bipolar Disorder (M), Serious criminal behaviour (F). Parents separated. No contact with F in NZ. Explosive rages and violence with M and younger brother at home
- Into DHS care then with maternal aunt and uncle
- On Concerta and Clonidine some years

Case 2 Ben

- Acute onset change in mental state over days. Agitated, anxious, sleeping poorly, vague, disconnected. Difficulty with listening comprehension and speech. Incoherent, mumbling at times. Described flashing lights, smelling things, hearing noises (not voices), feeling nauseous
- Exam normal except BP 140/95, P 110 Dilated pupils
- Acute psychosis. ?Substance abuse ?Overdose ?Other organic psychosis
- Sent to ED Friday night

Case 3 Britney

- Age 14
- Oppositional, defiant, explosive, aggressive since preschool years. Youngest of 3 children, 9 years younger than next youngest. Parents separated from age 3, indulgent parenting with poor limit setting
- Disruptive behaviour in primary school. Tantrums, wants her own way, academically capable. Asked to leave mainstream school. Transferred to Larmenier
- Graded back to mainstream and into secondary school. Settling

Case 3 Britney

- Rapid escalation in behaviour end 2013. "Sick of being leashed". Missing from home for 1 week. Brought to ED by police after being found wandering on train tracks and threatening self harm. Alleged panadol overdose and possible marijuana intake. Involvement with delinquent friendship group. Risk taking including sexualised behaviour. Making allegations to DHS about abuse from parents and older brother.
- Diary entry indicated parents deserve pay back and she has been told how to do it..
- Angry and aggressive in ED, abusive towards staff, threatening to leave

Practical guide to emergencies

- **When child is a danger to themselves or others**
  - The suicidal child
  - The out-of-control or dangerous child
- **Adverse drug reactions**
  - Respiratory depression and excessive sedation
  - Acute dystonic reactions
  - Other adverse drug reactions
- **Initial management of major psychiatric disorder**
  - Severe depression
  - Psychosis
  - Mania and hypomania

Psychiatric emergencies

Priority is obviously medical stabilisation and investigation to rule out organic pathology

The suicidal child

- Second commonest cause of death in <18
- Suicide extremely rare in <10

1. Current suicidal ideation
2. Plans
3. Stressors
4. Risk factors
    1. Previous attempts
    2. Mental illness
5. Protective factors

Characteristics of psych disorders likely to lead to suicide

- Agitation
- “Nowhere to go”
- “No way out”
- “No relief in sight”

The out of control child

- Think: substance abuse, medical illness, head injury, psychosis, social chaos
- Medical investigation as priority

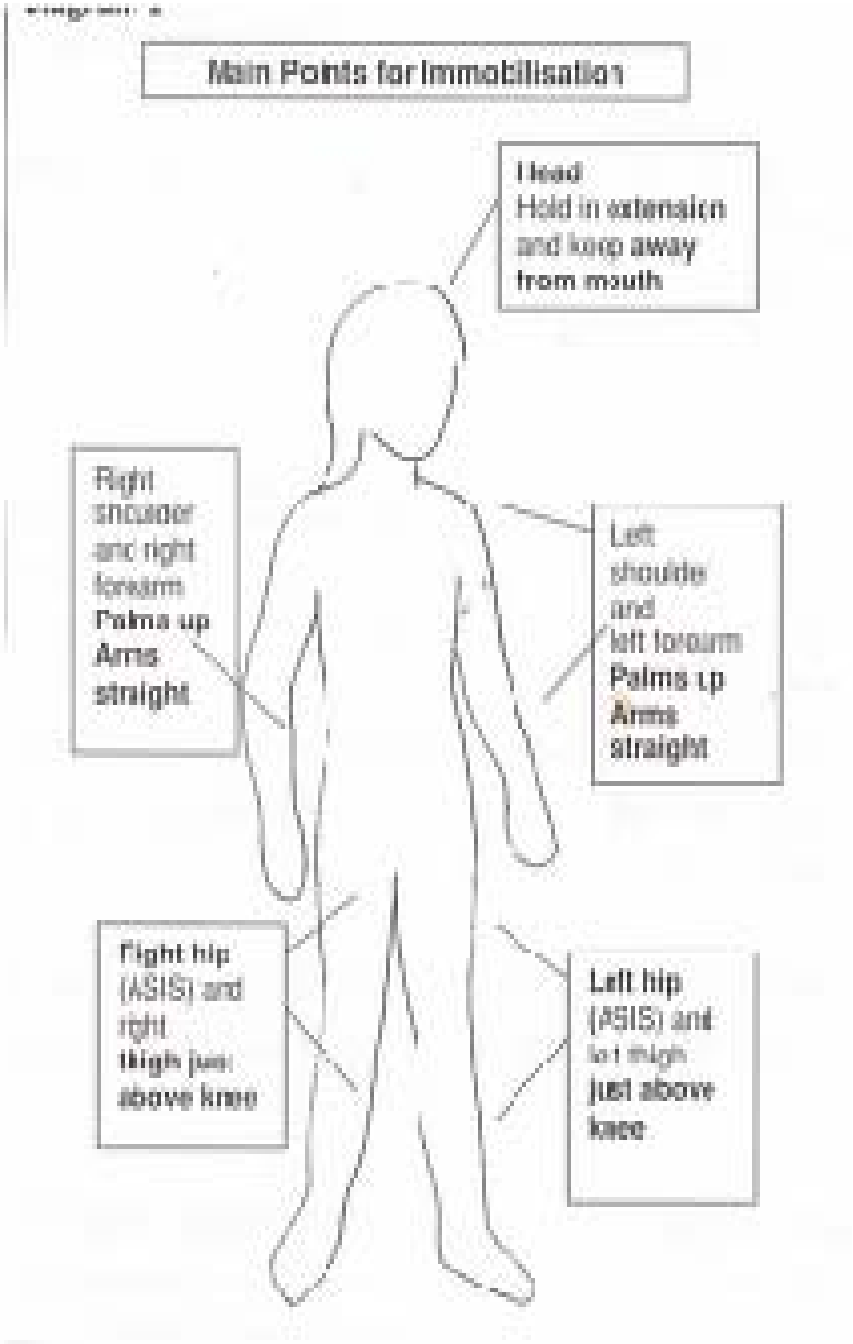
- Non-pharmacological
  - Talking (one voice), reassuring, safe containing environment
- Pharmacological
  - Oral: Diazepam, Lorazepam, Risperidone, Olanzapine
  - Parenteral: IM/IV Midazolam, IM Olanzapine, IM/IV Haloperidol, Benzo/Antipsychotic alternating
  - BEWARE RESPIRATORY DEPRESSION, HYPOTENSION, DYSTONIA

The out of control child

- Code grey procedure, clear roles
- Safe area
- Prevent escalation through talking listening, one person only
- Offer meds
- If restraint is necessary act decisively and speedily
- Sedation should usually accompany physical restraint

When restraining a child

- One staff member in charge for managing restraint and talking to child (others remain silent)
- Remove any jewellery or loose clothing
- Hold the head in slight extension with the staff members thenar eminences over the childs masseter muscles
- Stay away from mouth
- Hold the childs arms straight with palms upwards to immobilise the elbow joint
- Hold the child's legs at the ASIS and just above the knee (don't worry about their feet)


Main Points for Immobilisation
Head
Hold in extension
and keep away
from mouth
Right
shoulder
and right
forearm
Palms up
Arms
straight
Left
shoulde
and
left forearm
Palms up
Arms
straight
Right hip
(ASIS) and
right
thigh just
above knee
Left hip
(ASIS) and
left thigh
just above
knee

Tranquil sedation

- The deepest level of sedation appropriate for an out of control child outside and anaesthetic or intensive care setting
  - Allows protective reflexes to be maintained
  - Retains ability to maintain a patent airway independently
  - Permits appropriate response to non-painful physical stimulation or verbal command such as “open your eyes”

- A child no longer waking to voice or non-painful stimuli suggests the sedation has become too deep and there is a significant risk of respiratory depression or even respiratory arrest

- Cardiac ,O2 sat monitoring

Chemical restraint - oral

- If possible, oral
- Benzodiazepines first
  - Diazepam (0.2-0.4mg/kg, max 10mg initially)
  - Lorazepam (0.5-1mg <40kg, 1-2.5mg>40kg)
  - Midazolam buccal (0.2-0.4mg/kg)
- Then antipsychotic
  - Olanzapine wafer (2.5-5mg <40kg, 5-10mg>40kg)
  - Risperidone quicklet or tab (0.5mg <40kg, 1mg>40kg and up to 2mg)
  - Quietapine tab(25mg<40kg, 50-100mg>40kg)
- If known psych patient, consider extra doses of usual meds

Chemical restraint - parenteral

- Midazolam IM/IV 0.1-0.2mg/kg (max 10mg)
- Diazepam IV (never IM) 0.05-0.2mg/kg (max 20mg)

- Olanzapine IM 5mg (<40mg) 10mg (>40mg)
- Haloperidol IM/IV 2.5mg(<40mg) 5mg (>40mg)

- Midazolam /Haloperidol combination or alternating

Adverse effects of chemical restraint

- Respiratory depression (Benzos mainly) Rx Flumazenil 100-200mcg IV
- Extrapyramidal reactions (Rx benztropine 0.5-2mg IM/IV)
  - Acute dystonia
  - Oculogyric crises
  - Akathisia
- Neuroleptic malignant syndrome (Antipsychotics).
  - Hyperthermia, muscle rigidity, autonomic dysfunction. Elevated CK
- Paradoxical reactions (Benzos)

Releasing restraint

- One person talking. We think youre back in control now. We need to be sure so we are going to see if your right foot is in control (release grip on foot slowly). If OK repeat for each limb

Discharge

- A patient who is "acting out" and who does not need acute medical or psychiatric care should be discharged from the hopsital to a safe environment rather than be restrained
- Contact usual practitioner if possible for follow up