

Victorian Emergency Department Mental Health Triage Project 2005–06

Training manual



Victorian Emergency Department
Mental Health Triage Project

Training manual
May 2006



A Victorian
Government
initiative



Acknowledgements

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Foreword

In 2005, the Department of Human Services commissioned the National Institute of Clinical Studies (NICS) to develop a mental health triage tool providing specific mental health descriptors for the Australian Triage Scale (ATS).

The Emergency Department Mental Health Triage Tool is designed to guide nurses in the triaging of mental health presentations to the emergency department by providing descriptors of observed and reported behaviour to assist in allocating an appropriate triage scale. It is designed to be used in conjunction with the Australasian Triage Scale.

This training package was developed to assist in the implementation of the Triage Tool. This tool is based on previous work and implementation by Barwon Health Service (Victoria) and South East Sydney Area Health Service (New South Wales).

This training package has been designed to:

- assist the implementation of the Victorian Emergency Department Mental Health Triage Tool
- standardise nursing skills in assessing patients with mental health problems
- strengthen the confidence of nursing staff in dealing with patients with mental health problems
- provide an educational tool and resource to optimise the level of triage nursing care provided in the emergency department for people with mental health problems.

Each organisation will need to develop or consider their own individual protocols and processes to ensure the needs of mental health patients presenting to the emergency department are met appropriately, according to their level of acuity and the local mental health service framework.

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1. Introduction

The purpose of this training package is to provide basic information related to the recognition of behaviours associated with mental health presentations to the emergency department and to assist in the implementation of the Victorian Emergency Department Mental Health Triage Tool.

The core components of the training package include:

- information to assist the triage process for mental health presentations to the emergency department including:
 - the Emergency Department Mental Health Triage Tool (page 6)
 - a worksheet describing general management principles in response to typical presentations to identify the corresponding response or protocols to each triage category (pages 7-11)
- an overview of:
 - the mental status examination
 - medical clearance for mental health presentations
- information to assist in the care and management of patients with self-harm, psychotic disorders, organic disorders, anxiety disorders and depressive disorders
- relevant sections of the *Mental Health Act 1986*
- case scenarios for training.

2. Triageing patients with mental health problems in emergency departments

The emergency department is a common site for presentation of patients experiencing acute behavioural change or situational crisis. In addition, patients with mental health problems frequently use emergency departments as a source for mental health care. Many patients with physical illness have co-morbid psychological problems complicating their condition. In some cases it may be the development of concurrent psychological symptoms that precipitates the patient's presentation or that prompts family members or carers to bring the patient to the emergency department for assessment. The emergency department is an important entry point for people with mental health problems to access care.

2.1 Common mental health presentations

Common mental health presentations to hospital emergency departments include:

- patients with depression, psychosis, anxiety disorders, organic brain disorders, psychiatric complications of substance misuse and unexplained somatic complaints
- patients who have attempted self-harm or who are at risk of self-harm
- patients may present with physical symptoms that can mask underlying psychiatric symptoms.

2.2 Triage processes

Triageing patient with mental health patients involves a range of processes to:

- assess the patient's risk of self-harm and the risk of harm to others
- assess the severity of the patient's illness and therefore the treatment acuity
- identify co-morbid physical and psychological symptoms contributing to the patient's presentation
- create an appropriate environment for patients and their families or carers to facilitate the disclosure of information about mental health problems
- respond in an empathic manner to patients and their families or carers distress.

Establishing rapport: first contact

The triage nurse provides the first point of contact in the emergency department. The nature of this first contact is critical for many patients with mental health problems who may be distressed, angry or ambivalent about seeking treatment. During initial contact, the patient should be encouraged to disclose information that may indicate key signs and symptoms of a mental health disorder, including risk of self-harm. The patient should also be encouraged to co-operate throughout the triage process and wait for assessment.

Steps to assist the triage assessment

When conducting a triage assessment of a patient who has, or who may have, mental health problems it is important to:

- approach the patient in a calm, controlled manner
- introduce yourself to the patient, family or carers and explain the triage process and the purpose of the initial assessment
- avoid sudden gestures or movements when patients are distressed or disturbed
- ensure the interview or triage environment is quiet, non-threatening and as private as possible
- maintain an even tone of voice, even if the patient is angry or agitated
- maintain an empathic manner. Use eye contact and empathic phrases such as
 - ‘That must be very distressing’
 - ‘I can see that you are angry but we are here to help you’
 - ‘I can see that you are very frightened, but you will be safe here’
- be sensitive and consider whether to interview or triage the patient alone or with family members/carers present. For example, adolescents may not disclose information about drug and alcohol abuse or suicidal thoughts if a family member is present. Alternatively, a delirious, frightened, elderly person may feel reassured by the presence of a familiar person
- watch for signs of increasing behaviour disturbance or aggression and maintain your safety and the safety of others.

Key factors to consider in the triage process

- Is the patient at risk?
- Is the patient in distress?
- Is the patient able to co-operate with the triage process?
- Is the patient’s behaviour likely to be unpredictable?
- Is the patient likely to deteriorate?
- Is the patient physically unwell?
- Is the patient likely to wait to see a medical, mental health or allied health professional?
- If the patient does not wait – what is the likelihood that they will be a risk to themselves or others?
- Does the patient have a supportive person with them who will co-operate with the triage process?
- What level of supervision will the patient require to prevent any adverse outcomes occurring, such as absconding, self-harm, harm to others or damage to property?

2.3 Maintaining safety

The role of the triage nurse includes taking steps to minimise risks to the patient and others in the ED.

Risk of harm to others

Early identification and assessment of aggressive patients is important to prevent harm to staff or others. Aggressive behaviour is a common occurrence in the emergency department and may be caused by:

- acute confusional states, such as delirium
- organic brain conditions, such as post-head injury or post-seizure
- drug and alcohol withdrawal or intoxication
- acute situational stress, such as a recent job loss or the death of family member
- maladaptive personality type, (such as anti-social, borderline personality traits), poor impulse control or poor verbal or problem solving skills.

Signs of impending aggression

Each person displays increasing aggression in a different way. However, there are some common signs of impending aggression including:

- tense and agitated appearance
- an increase in voice pitch and volume
- dilated pupils
- change in usual skin colour
- angry, withdrawn or brooding behaviour
- abrupt responses accompanied with gestures
- increased physical movement, pacing or banging of objects
- acting out behaviour aimed at staff or others
- expressed fear of losing control and potentially harming others.

Factors to consider when assessing mental health patients

- Maintain your safety and the safety of others. Remove dangerous objects or potential weapons from vicinity and consider alternative areas for triage.
- Try to maintain a quiet, non-stimulating environment for the patient. Excessive noise or people may contribute to aggression.
- The presence of a familiar person may help to calm and reassure the patient.
- A patient's previous experience in the emergency department, or experience of being coerced into presenting for treatment, may contribute to aggressive behaviour.
- If the patient's behaviour escalates, withdraw and seek assistance immediately.
- Remember, not all aggressive behaviour is associated with mental illness.

2.4 Interview and communication skills

When performing the initial triage assessment, consider the following:

- Adopt an attentive, unhurried appearance and attitude
- Observe the patient for non-verbal cues, such as poor eye contact
- Ask open-ended questions such as:
 - ‘Can you tell me what has been happening?’
 - ‘Can you tell me more about that?’
 - ‘How have you been feeling recently?’
- Listen for verbal cues such as:
 - ‘I don’t care what happens’
 - ‘I’ve given up’
 - ‘I can’t cope’
- Ask clarifying questions such as:
 - ‘What do you mean when you say you feel strange, weird or out of it?’

Useful questions to consider when interviewing

- Have these symptoms started recently or are they part of a chronic illness?
- Does the patient have a history of psychiatric illness and treatment?
- Are the current symptoms consistent with the patient’s past illness?
- Has the patient attempted self-harm in the past?
- Does the patient have a past history of violence or aggressive behaviour?
- What is the patient’s current medication and could it be contributing to the patient’s problems, such as toxicity, abrupt withdrawal of benzodiazepines or a drug interaction?
- Does the patient have a current physical illness such as hypothyroidism that may be contributing to their presentation?
- Has the patient suffered recent trauma or head injury that may have contributed to the onset of symptoms?
- What are the patient’s current living circumstances?
- What type of support does the patient have in the home or community?

Section 3 (pages 6–11) contains the triage tool and worksheet developed for use by participants of the Victorian Emergency Department Triage Tool project. The triage tool and worksheet have been designed to assist in the development of hospital protocols or assessment of current protocols.

3. Emergency department mental health triage tool and worksheet

3.1 The mental health triage tool

Victorian emergency department

Mental health triage tool

Triage code	Description	Treatment acuity	Typical presentation	General management principles*
1	<p>Definite danger to life (self or others)</p> <p>Australasian Triage Scale¹ states:</p> <ul style="list-style-type: none"> Severe behavioural disorder with immediate threat of dangerous violence 	Immediate	<p>Observed</p> <ul style="list-style-type: none"> Violent behaviour Possession of weapon Self-destruction in ED Displays extreme agitation or restlessness Bizarre/disoriented behaviour <p>Reported</p> <ul style="list-style-type: none"> Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations) Recent violent behaviour 	<p>Supervision</p> <p>Continuous visual surveillance 1:1 ratio (see definition below)</p> <p>Action</p> <ul style="list-style-type: none"> Alert ED medical staff immediately Alert mental health triage or equivalent Provide safe environment for patient and others Ensure adequate personnel to provide restraint/detention based on industry standards <p>Consider</p> <ul style="list-style-type: none"> Calling security +/- police if staff or patient safety compromised. May require several staff to contain patient 1:1 observation Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management.
2	<p>Probable risk of danger to self or others</p> <p><i>AND/OR</i></p> <p>Client is physically restrained in emergency department</p> <p><i>AND/OR</i></p> <p>Severe behavioural disturbance</p> <p>Australasian Triage Scale¹ states:</p> <ul style="list-style-type: none"> Violent or aggressive (if): Immediate threat to self or others Requires or has required restraint Severe agitation or aggression 	Emergency Within 10 minutes	<p>Observed</p> <ul style="list-style-type: none"> Extreme agitation/restlessness Physically/verbally aggressive Confused/unable to cooperate Hallucinations/delusions/paranoia Requires restraint/containment High risk of absconding and not waiting for treatment <p>Reported</p> <ul style="list-style-type: none"> Attempt at self-harm/threat of self-harm Threat of harm to others Unable to wait safely 	<p>Supervision</p> <p>Continuous visual supervision (see definition below)</p> <p>Action</p> <ul style="list-style-type: none"> Alert ED medical staff immediately Alert mental health triage Provide safe environment for patient and others Use defusing techniques (oral medication, time in quieter area) Ensure adequate personnel to provide restraint/detention Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of Mental Health Act. <p>Consider</p> <ul style="list-style-type: none"> If defusing techniques ineffective, re-triage to category 1 (see above) Security in attendance until patient sedated if necessary Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
3	<p>Possible danger to self or others</p> <ul style="list-style-type: none"> Moderate behaviour disturbance Severe distress <p>Australasian Triage Scale¹ states:</p> <ul style="list-style-type: none"> Very distressed, risk of self-harm Acutely psychotic or thought-disordered Situational crisis, deliberate self-harm Agitated/withdrawn 	Urgent Within 30 minutes	<p>Observed</p> <ul style="list-style-type: none"> Agitated/restless Intrusive behaviour Confused Ambivalence about treatment Not likely to wait for treatment <p>Reported</p> <ul style="list-style-type: none"> Suicidal ideation Situational crisis <p>Presence of psychotic symptoms</p> <ul style="list-style-type: none"> Hallucinations Delusions Paranoid ideas Thought disordered Bizarre/agitated behaviour <p>Presence of mood disturbance</p> <ul style="list-style-type: none"> Severe symptoms of depression Withdrawn/uncommunicative And/or anxiety Elevated or irritable mood 	<p>Supervision</p> <p>Close observation (see definition below)</p> <p>Do not leave patient in waiting room without support person</p> <p>Action</p> <ul style="list-style-type: none"> Alert mental health triage Ensure safe environment for patient and others <p>Consider</p> <ul style="list-style-type: none"> Re-triage if evidence of increasing behavioural disturbance ie. <ul style="list-style-type: none"> Restlessness Intrusiveness Agitation Aggressiveness Increasing distress Inform security that patient is in department Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
4	<p>Moderate distress</p> <p>Australasian Triage Scale¹ states:</p> <ul style="list-style-type: none"> Semi-urgent mental health problem Under observation and/or no immediate risk to self or others 	Semi-urgent Within 60 minutes	<p>Observed</p> <ul style="list-style-type: none"> No agitation/restlessness Irritable without aggression Cooperative Gives coherent history <p>Reported</p> <ul style="list-style-type: none"> Pre-existing mental health disorder Symptoms of anxiety or depression without suicidal ideation Willing to wait 	<p>Supervision</p> <p>Intermittent observation (see definition below)</p> <p>Action</p> <ul style="list-style-type: none"> Discuss with mental health triage <p>Consider</p> <ul style="list-style-type: none"> Re-triage if evidence of increasing behavioural disturbance ie. <ul style="list-style-type: none"> Restlessness Intrusiveness Agitation Aggressiveness Increasing distress Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management
5	<p>No danger to self or others</p> <ul style="list-style-type: none"> No acute distress No behavioural disturbance <p>Australasian Triage Scale¹ states:</p> <ul style="list-style-type: none"> Known patient with chronic symptoms Social crisis, clinically well patient 	Non-urgent Within 120 minutes	<p>Observed</p> <ul style="list-style-type: none"> Cooperative Communicative and able to engage in developing management plan Able to discuss concerns Compliant with instructions <p>Reported</p> <ul style="list-style-type: none"> Known patient with chronic psychotic symptoms Pre-existing non-acute mental health disorder Known patient with chronic unexplained somatic symptoms Request for medication Minor adverse effect of medication Financial, social, accommodation, or relationship problems 	<p>Supervision</p> <p>General observation (see definition below)</p> <p>Action</p> <ul style="list-style-type: none"> Discuss with mental health triage Refer to treating team if case-managed

Management definitions²

Continuous visual surveillance = person is under direct visual observation at all times

Close observation = regular observation at a maximum of 10 minute intervals

Intermittent observation = regular observation at a maximum of 30 minute intervals

General observation = routine waiting room check at a maximum of 1 hour intervals

* Management principles may differ according to individual health service protocols and facilities.

1 Australasian College of Emergency Medicine (2000). Guidelines for the implementation of the Australasian Triage Scale (ATS) in Emergency Departments.

2 South Eastern Sydney Area Health Service Mental Health Triage guidelines for Emergency Departments

Acknowledgements NICS acknowledges existing triage tools provided by Barwon Health and the work of the Mental Health Emergency Interface Project Teams 2005.

This document can be downloaded at: www.health.vic.gov.au/emergency/mental

3.2 Victorian emergency department mental health triage tool worksheet

Triage code	Description	Treatment acuity	Typical presentation	General principles of management	Individual hospital procedure/ protocols for consideration
1	<p>Definite danger to life (self or others)</p> <p>ATS' states:</p> <ul style="list-style-type: none"> Severe behavioural disorder with immediate threat of dangerous violence 	Immediate	<p>Observed</p> <ul style="list-style-type: none"> Violent behaviour Possession of weapon Self-destruction in ED Displays extreme agitation or restlessness Bizarre or disorientated behaviour <p>Reported</p> <p>Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations)</p>	<p>Supervision</p> <p>Continuous visual surveillance 1:1 ratio</p> <p>Action</p> <ul style="list-style-type: none"> Alert ED medical staff immediately Alert mental health triage or equivalent Provide safe environment for patient and others Ensure adequate personnel to provide restraint or detention based on industry standards <p>Consider</p> <ul style="list-style-type: none"> Calling security +/- police if staff or patient safety compromised. May require several staff to contain patient 1:1 observation Intoxication of drugs and alcohol may cause an escalation in behaviour that requires management 	<p>Examples:</p> <p><i>Discussion with on-call mental health consultant to determine if appropriate for admission to acute service</i></p> <p><i>Obtain current treatment details and relevant history from mental health treating team if available</i></p> <p><i>Refer to protocols for appropriate restraint and containment</i></p>

Triage code	Description	Treatment acuity	Typical presentation	General principles of management	Individual hospital procedure/ protocols for consideration
2	<p>Possible danger to self or others and/or client is physically restrained in the emergency department and/or severe behavioural disturbance</p> <ul style="list-style-type: none"> • Semi-urgent mental health problem • Moderate behaviour disturbance <p>ATS' states: Violent or aggressive (if)</p> <ul style="list-style-type: none"> • immediate threat to self or others • requires or has required restraint • severe agitation or aggression 	Emergency Within 30 minutes	<p>Observed</p> <ul style="list-style-type: none"> • Extreme agitation or restlessness • Physically or verbally aggressive • Confused or unable to cooperate • Hallucinations, delusions or paranoia • Requires restraint or containment • High risk of absconding and not waiting for treatment <p>Reported</p> <ul style="list-style-type: none"> • Attempt at self-harm or threat of self-harm • Threat of harm to others • Unable to wait safely 	<p>Supervision</p> <ul style="list-style-type: none"> • Continuous visual supervision <p>Action</p> <ul style="list-style-type: none"> • Alert ED medical staff immediately • Alert mental health triage • Provide safe environment for patient and others • Use of defusing techniques (oral medication, time in quieter area) • Ensure adequate personnel to provide restraint or detention • Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of the Mental Health Act <p>Consider</p> <ul style="list-style-type: none"> • If defusing techniques ineffective, revise category to category 1 as above. • Security in attendance until patient sedated if necessary • Intoxication with drugs and alcohol may cause an escalation in behaviour that requires management 	<p>Examples:</p> <p><i>Consider discussion with on-call mental health consultant to determine if appropriate for admission to acute service</i></p> <p><i>Obtain current treatment details and relevant history from mental health treating team if available</i></p> <p><i>Refer to protocols for appropriate restraint and containment</i></p>

Triage code	Description	Treatment acuity	Typical presentation	General principles of management	Individual hospital procedure/ protocols for consideration
3	<p>Possible danger to self or others</p> <ul style="list-style-type: none"> • Semi-urgent mental health problem • Moderate behaviour disturbance <p>ATS' states:</p> <ul style="list-style-type: none"> • Very distressed, risk of self-harm • Acutely psychotic or thought disordered • Situational crisis, deliberate self-harm • Agitated or withdrawn 	Semi-urgent Within 30 minutes	<p>Observed</p> <ul style="list-style-type: none"> • Agitated or restless • Intrusive behaviour • Confused • Ambivalence about treatment • Not likely not to wait for treatment <p>Reported</p> <ul style="list-style-type: none"> • Suicidal ideation <p>Presence of psychotic symptoms</p> <ul style="list-style-type: none"> • Hallucinations • Delusions • Paranoid ideas • Thought disorder • Bizarre or agitated behaviour <p>Presence of mood disturbance</p> <ul style="list-style-type: none"> • Severe symptoms of depression • Withdrawn or uncommunicative • And/or anxiety • Elevated or irritable mood 	<p>Supervision</p> <ul style="list-style-type: none"> • Close observation • Do not leave patient in waiting room with no support person <p>Action</p> <ul style="list-style-type: none"> • Alert mental health triage • Ensure safe environment for patient and others <p>Consider</p> <ul style="list-style-type: none"> • Re-triage if evidence of increasing behavioural disturbance such as <ul style="list-style-type: none"> - restlessness - intrusiveness - agitation - aggressiveness - increasing distress • Inform security that patient is in department • Intoxication with drugs and alcohol may cause an escalation in behaviour that requires management 	<p>Examples:</p> <p><i>Patient to be reviewed by ED doctor within specified time as per protocol</i></p> <p><i>Obtain current treatment details and relevant history from mental health treating team if available</i></p>

Triage code	Description	Treatment acuity	Typical presentation	General principles of management	Individual hospital procedure/ protocols for consideration
4	<p>Moderate distress</p> <p>ATS' states:</p> <ul style="list-style-type: none"> • Semi-urgent mental health problem • Under observation and/or no immediate risk to self or others 	<p>Semi-urgent</p> <p>Within 60 minutes</p>	<p>Observed</p> <ul style="list-style-type: none"> • No agitation or restlessness • Irritable without aggression • Cooperative • Gives coherent history <p>Reported</p> <ul style="list-style-type: none"> • Pre-existing mental health disorder • Symptoms of anxiety or depression without suicidal ideation 	<p>Supervision</p> <ul style="list-style-type: none"> • Intermittent observation <p>Action</p> <ul style="list-style-type: none"> • Inform mental health triage <p>Consider</p> <ul style="list-style-type: none"> • Re-triage if evidence of increasing behavioural disturbance such as <ul style="list-style-type: none"> - restlessness - intrusiveness - agitation - aggressiveness - increasing distress - intoxication with drugs and alcohol may cause an escalation in behaviour that requires management 	<p>Examples:</p> <p><i>Clinical mental health assessment to be commenced within 60 minutes (one hour) if indicated or</i></p> <p><i>Patient to be reviewed by ED doctor within specified time as per protocol</i></p> <p><i>Referral to: appropriate services such as CMHT, GP or a social worker</i></p>

Triage code	Description	Treatment acuity	Typical presentation	General principles of management	Individual hospital procedure/ protocols for consideration
5	<p>No danger to self or others</p> <ul style="list-style-type: none"> No acute distress No behavioural disturbance <p>ATS' states:</p> <ul style="list-style-type: none"> Known patient with chronic symptoms Social crisis, clinically well patient 	<p>Non-urgent</p> <p>Within 120 minutes</p>	<p>Observed</p> <ul style="list-style-type: none"> Cooperative Communicative and able to engage in developing management plan Able to discuss concerns Compliant with instructions <p>Reported</p> <ul style="list-style-type: none"> Known patient with chronic psychotic symptoms Pre-existing non-acute mental health disorder Known patient with chronic unexplained somatic symptoms Request for medication Minor adverse effect of medication Financial, social, accommodation or relationship problems 	<p>Supervision</p> <ul style="list-style-type: none"> General observation <p>Action</p> <ul style="list-style-type: none"> Alert mental health triage Referral to treating team if case managed 	<p>Examples:</p> <p><i>Clinical assessment to be commenced by mental health clinician within 120 minutes (two hours) if indicated or</i></p> <p><i>Patient to be reviewed by emergency department doctor within specified time as per protocol</i></p>

Management definitions:	
Continuous visual surveillance	Person is under direct visual observation at all times
Close observation	Regular observation at a maximum of 10-minute intervals
Intermittent observation	Regular observation at a maximum of 30-minute intervals
General observation	Routine waiting room check at a maximum of one-hour intervals

1 Australasian College of Emergency Medicine (2000). *Guidelines for the implementation of the Australasian Triage Scale (ATS) in emergency departments*
 2 South Eastern Sydney Area Health Service (1998). *Mental health triage guidelines for emergency departments*

4. General information to assist in managing patients with mental health problems within the emergency department

4.1 Mental status examination

The mental status examination (MSE) is a structured tool that is used for more formalised assessments of mental health patients.

At triage, it is not practical to use such a comprehensive examination due to time constraints. However, to assist emergency department staff in the assessment of the patient's mental state, key points from the MSE are listed below.

**A mnemonic to assist in the assessment of patients:
ABC STAMP**

A = Appearance

B = Behaviour

C = Cognition

S = Speech

T = Thought

A = Affect

M = Mood

P = Perceptions

Appearance

How does the patient look?

- Posture – slumped, tense, bizarre
- Grooming – dishevelled, make-up inappropriately applied, poor personal hygiene
- Clothing – bizarre, inappropriate, dirty
- Nutritional status – thin, cachectic
- Signs of drug or alcohol use – flushed, dilated or pinpoint pupils, track marks

Behaviour

How is the patient behaving?

- Motor activity – immobile, pacing, restless, hyperventilating
- Abnormal movements – tremor, dyskinetic movements, abnormal gait, ataxic
- Bizarre, odd or unpredictable actions
- Patient response to the current situation
 - Angry or hostile towards interviewer or others
 - Uncooperative
 - Over familiar, inappropriate or seductive
 - Fearful, guarded, hyper-vigilant, agitated

Cognition

- Is the patient orientated?
- Is the patient attentive during the interview?
- Are they able to recall recent events?
- Are they able to make judgements about their situation; for example, a young drug affected man wanting to drive his girlfriend home?

Speech

How is the patient talking?

- Rate – rapid, uninterruptible, slow
- Tone – loud, angry, quiet, whispering
- Quality – clear, slurred, mute

Thought

How does the patient express themselves? What is the pattern of thought?

- Illogical, incoherent, disjointed, nonsensical
- Rapid thoughts or few thoughts

What is the patient thinking about?

- Bizarre or delusional thoughts
- Paranoid thoughts
- Depressive thoughts
- Anxious thoughts
- Suicidal thoughts
- Homicidal thoughts

Affect

What do you observe about the person's emotional state?

- Depressed – flat, restricted, tearful, downcast
- Anxious – agitated, distressed, fearful
- Labile – rapidly changing
- Inappropriate – inconsistent with content; for example, laughs when talking about mother's death or setting fire to the house
- High or elevated – excessively happy or animated

Mood

How does the patient describe their emotional state?

- Down or depressed
- Angry or irritable
- Anxious or fearful
- High or elevated

Perceptions

Is the patient experiencing any misinterpretations of sensory stimuli?

Reported by patient

- Auditory, visual, olfactory or somatic hallucinations
- Illusions

Observed

- Appears to be responding to unheard sounds, voices, unseen people or objects

4.2 Medical clearance

Some patients may require medical clearance and or assessment to exclude organic causes of their presentation.

Factors to consider in deciding whether the patient requires medical clearance and/or assessment include:

- first presentation of psychiatric and physical signs and symptoms
- abnormal vital signs or suggestions of infection
- overdose or substance abuse
- new acute medical complaint
- elderly patients > 65 years
- physical injuries that may, or may not, be related to their mental health presentation.

Massachusetts medical clearance protocol

This is a consensus-based protocol developed by the Massachusetts College of Emergency Physicians together with the Massachusetts Psychiatric Society.

Available at: www.macep.org/practice_information/medical_clearance.htm

4.3 The *Mental Health Act 1986*

A basic understanding of the *Mental Health Act* (1986) is necessary for health professionals working in emergency departments. The Mental Health Act is a law that governs the care and treatment of people in Victoria who experience a mental health illness or disorder.

The Mental Health Act states that those people who have a mental health problem are to receive the best possible care and treatment. This is to be attempted in the least restrictive environment so that any restriction on their liberty or interference with their rights, dignity and self-respect is kept to a minimum, and that care is at least equal to that provided to patients who are suffering from physical illness.

The Mental Health Act describes ways in which a person can be transported to a hospital for psychiatric assessment, where that person is not capable of giving consent.

Relevant sections of the Act are described below. Please see also Department of Human Services flowchart on page 18 for definitions of terms used in the *Mental Health Act 1986*.

Criteria for involuntary treatment

Section 8(1)

Mental Health Act 1986

(see also Department of Human Services flowchart, page 18)

The criteria for the involuntary treatment of a person under the Act are that:

- (a) the person appears to be mentally ill (a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory)
- (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order
- (c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

Admission and detention of involuntary patients

Section 9

Mental Health Act 1986

Section 9 of the Mental Health Act provides for the admission and detention of involuntary patients. The usual or standard admission procedure for involuntary patients requires that a request for admission (Schedule 1) and a recommendation for admission (Schedule 2) be completed.

Apprehension of mentally ill persons in certain circumstances

Section 10

Mental Health Act 1986

Section 10 of the Mental Health Act provides for apprehension of mentally ill persons in certain circumstances. A member of the police must form a belief that the person appears to be mentally ill and have reasonable grounds for believing that the person has harmed him/herself or others, or that there is a serious risk that the person is likely to do so in the future. They must arrange an examination/assessment of those persons whom they have apprehended.

A protocol developed between the Victoria Police and the Department of Human Services, Mental Health Branch (2004) states:

'In all situations where police have initiated a referral for prompt or urgent assessment, they will remain present at the location (including within an accident and emergency department or mental health service) until an initial assessment is conducted and preliminary decisions are made by CAT/triage service staff regarding the management of the situation'³

Involuntary treatment orders

Section 12AA

Mental Health Act 1986

1. This section applies if –
 - (a) a request and recommendation have been made for a person; and
 - (b) the person has been taken to an approved mental health service.
2. A registered medical practitioner employed by the approved mental health service to which the person has been taken must make an involuntary treatment order for the person.
3. An involuntary treatment order under this section must be in the prescribed form and contain the prescribed particulars.
4. An involuntary treatment order made for the person in accordance with this section is sufficient authority for the detention of the person in an approved mental health service.
5. If the registered medical practitioner who makes an involuntary treatment order for a person under sub-section (2) does not consider that –
 - (a) the criteria in section B(1) apply to the person; or
 - (b) an involuntary treatment order should be made for the person –the practitioner must notify the authorised psychiatrist as soon as practicable.

Community treatment orders

Section 14(1) and 14(2)

Community treatment orders enable involuntary clients to receive treatment in the community. This is used either as an alternative to admission to a psychiatric inpatient service, or where the person's condition is such that a psychiatric inpatient service is no longer the least restrictive environment in which the person can receive treatment.

1. At any time, an authorised psychiatrist may make a community treatment order for a person who is subject to an involuntary treatment order if the authorised psychiatrist is satisfied that –
 - (a) the criteria in section 8(1) (criteria for involuntary treatment) apply to the person; and
 - (b) the treatment required for the person can be obtained through the making of a community treatment order.
2. A community treatment order is an order requiring the person to obtain treatment for their mental illness while not detained in an approved mental health service.

Revocation of community treatment orders

Section 14D

1. The authorised psychiatrist may revoke a community treatment order if satisfied on reasonable grounds that –
 - (a) the criteria in section 8(1) still apply to the person subject to the order; and
 - (b) the treatment required for the person cannot be obtained under the order.
2. The authorised psychiatrist may also revoke a community treatment order if –
 - (a) the authorised psychiatrist is satisfied on reasonable grounds that the person subject to the order has not complied with the order or the person's treatment plan; and
 - (b) reasonable steps have been taken, without success, to obtain compliance with the order or plan; and
 - (c) the authorised psychiatrist is satisfied on reasonable grounds that there is a significant risk of deterioration in the person's mental or physical condition because of the non-compliance.
3. If the authorised psychiatrist revokes a community treatment order –
 - (a) the authorised psychiatrist must make reasonable efforts to inform the person that the order has been revoked and that the person must go to an approved mental health service; and
 - (b) the person remains an involuntary patient under the person's involuntary treatment order and is taken to be absent without leave from an approved mental health service.

4.4 Department of Human Services Flowchart for seeking involuntary treatment

Procedure for making a request and recommendation for involuntary treatment as an inpatient or in the community under the *Mental Health Act 1986*

CRITERIA FOR INVOLUNTARY TREATMENT

Section 8(1) Mental Health Act 1986:

(a) the person appears to be mentally ill (a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory); and

(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and

(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and

(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

PRESCRIBED PERSON

A 'prescribed person' is a member of the police force, an ambulance officer or a:

- Registered medical practitioner
- Registered nurse
- Registered psychologist
- Social worker

•Occupational therapist—

—employed to provide care and treatment to persons with a mental disorder in an approved mental health service, a State child and adolescent psychiatry service, any premises licensed under section 75 of the Act, a hospital admitting or caring for persons with a mental disorder, a mental health service of a community health centre, a psychiatric outpatient clinic or a community mental health service.

APPROVED MENTAL HEALTH SERVICE

An approved mental health service (AMHS) is any service or premises that has been proclaimed by the Governor in Council under section 94 of the **Mental Health Act 1986** as a place at which treatment can be provided to patients under the Act. Typically, public hospitals that have an acute psychiatric in-patient unit are proclaimed as approved mental health services.

MENTAL HEALTH PRACTITIONER (MHP)

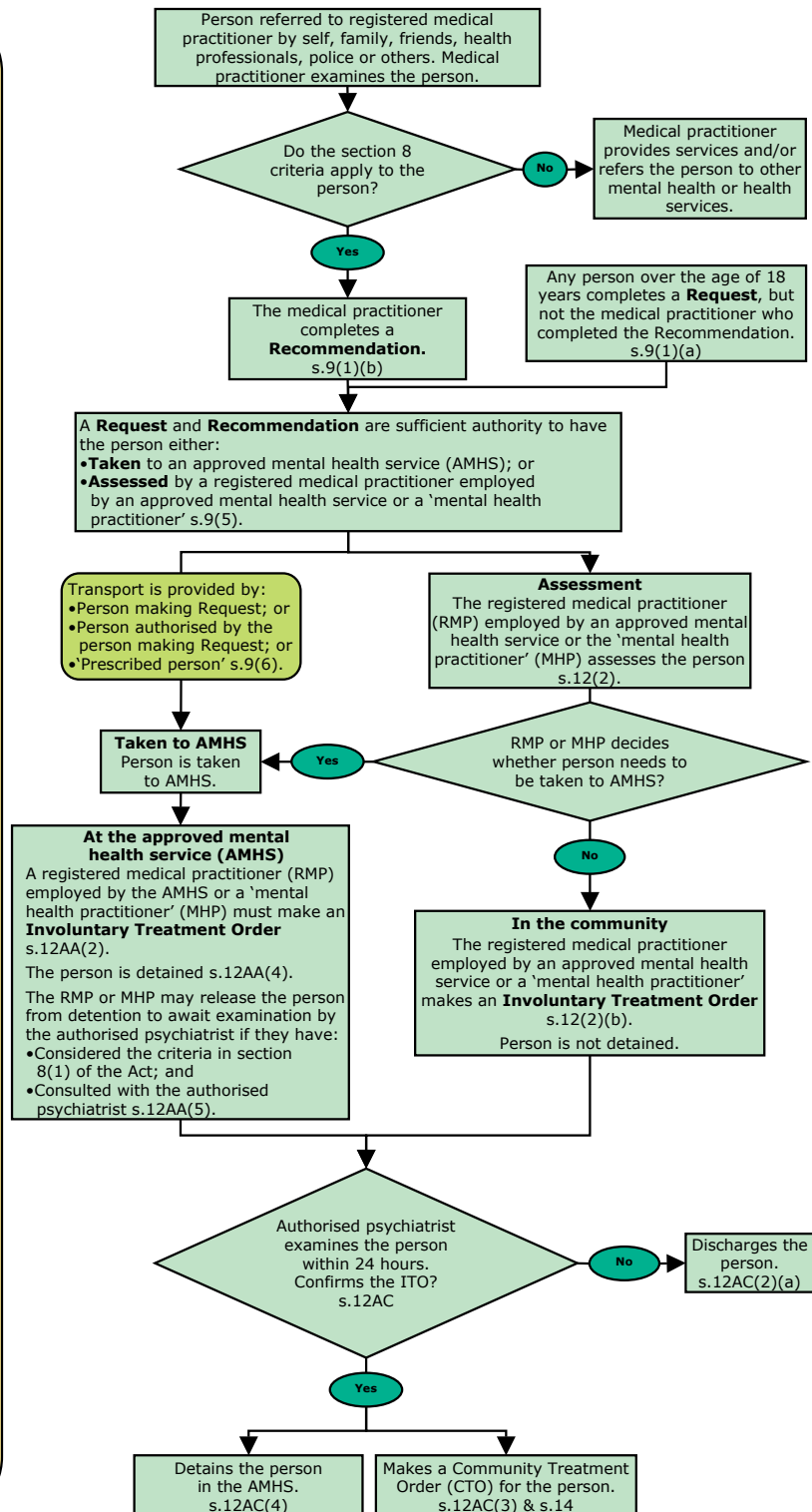
'Mental health practitioners' are—

- (a) - Registered nurses
- Registered psychologists
- Social workers
- Occupational therapists; and

(b) employed by a public sector mental health service (within the meaning of section 120A of the Mental Health Act) that is an approved mental health service or a community mental health service; and

(c) engaged in the provision of acute psychiatric assessment and treatment functions in the community.

Typically mental health practitioners are members of community based mental health teams, such as Crisis Assessment & Treatment Services (CATS) or integrated teams with a crisis, assessment and treatment function.



October 2005

5. Psychiatric emergencies

A psychiatric emergency is defined as an acute disturbance of thought, mood, behaviour or social relationship that requires an immediate intervention as defined by the patient, family or the community.⁴ Prompt treatment of a psychiatric emergency is important to prevent serious adverse outcomes for the patient and to minimise risk of harm to the patient, staff or others.

5.1 Psychiatric emergency triggers

Common triggers for psychiatric emergencies include:

- an acute stress response – this is often triggered by a sudden event, but may also be the ‘last straw’ in a chronic stress situation such as sudden defection of a spouse after drawn-out marital difficulties.
- specific psychological symptoms characterising a form of psychiatric illness such as depression with suicidal ideation or severe agitation associated with a psychotic illness.
- psychological changes induced by drugs or medications, presenting as confusion, disorientation, memory impairment, abnormal emotional reactions, behaviour disturbance such as amphetamine psychosis or acute alcohol withdrawal syndrome.
- psychological and behavioural changes induced by other organic conditions such as hypothyroidism or urinary tract infections in the elderly.

Note: Not all behavioural disturbances are associated with mental illness.

5.2 Principles of managing a psychiatric emergency

The priority for triage is the assessment of the patient’s potential to harm themselves or others. As a triage nurse you should:

- ensure the safety of the patient, staff and others. Remove dangerous objects or potential weapons from vicinity and consider alternative area of triage
- engage sufficient numbers of staff to provide restraint if required
- never turn your back on the individual
- ensure a safe escape route for staff

Note: Chemical sedation may mask organic illness.

When restraint is required the patient should be placed under the Mental Health Act wherever possible.

5.3 Common presentations

Common presentations of psychiatric emergencies include:

- attempted self-harm, such as overdose, attempted hanging or self mutilation
- unexplained injury or physical signs of self-harm
- suicidal ideas or suicidal intent
- significant depressive illness
- significant anxiety symptoms
- psychotic illness, especially patients who are agitated, distressed or experiencing command auditory hallucinations
- an organic brain syndrome or acute confusional state
- chronic medical illness, especially when associated with severe pain
- distress associated with a recent psychosocial stressor or loss such as bereavement, marital separation, relationship breakdown or loss of job.

Give particular consideration to patients in high-risk groups

- Young males <25 years
- Older males >65 years
- Those who have been widowed or recently separated

5.4 Assessing risk of self harm

The emergency department is a common site of presentation for patients who have attempted, or are at risk of attempting, self-harm.

Factors to consider when assessing the patient who may be at risk of self-harm

- Do not be afraid of asking about suicidal ideation where risk of self-harm is suspected
- Ensure patient has no immediate means of self-harm. Remove weapons and potentially dangerous objects
- Consider sections of the Mental Health Act if the patient is uncooperative and is at risk of self-harm due to mental illness

What do you look for?

Appearance

- Distress, tearfulness, agitation
- Poor self-care, poor physical health
- Evidence of past or recent self-harm, such as cuts on wrists or arms
- Depressed, withdrawn, uncommunicative

Behaviour

- Restlessness
- Slowed movements
- Behaviour disturbance indicative of psychosis (see psychiatric emergency triggers, page 19)

Verbal cues

- Unresponsive to questioning
- Expressed hopelessness
- Inability to cope or threatening to self-harm

What do you ask?

Intention

- How do you feel at the moment?
- What is your mood like?
- Do you feel that life is worth living?
- Have you felt that you would be better off dead?
- How often are you having these thoughts?

Plan

- Have you thought of harming yourself?
- What have you thought of doing?
- Have you come close to acting on this?
- Have you made any plan to carry this out?
- What has stopped you up until now?

Suicidal means

- Have you thought about how you would go about harming yourself?
- Have you got the pills? Do you own a gun?
- Could you get access to a gun or tablets?

Other questions in assessing suicide risk

- Is there any history of self-harm or a suicide attempt?
- Is there any history of mental health problems?
- Is there a current mental illness, especially psychotic illness, depression, anxiety?
- Is there a history of drug and alcohol problems?
- What is the patient's current drug and alcohol use?
- Does the patient have a current medical illness?
- What are the patient's current social circumstances, including recent changes or losses?
- What kind of social support network does the patient have?

A mnemonic for assessment of suicide risk: SADPERSONS⁵

S = Sex

A = Age (aged >55 or youth)

D = Depression
(pharmacotherapy)

P = Previous attempts

E = Ethanol

R = Rationality

S = Spouse (presence or absence)

O = Organised plan

N = No supports

S = Sickness (organic)

Factors to consider when assigning a triage code for a patient at risk of self-harm

- What is the immediate risk of self-harm?
- Is there a supportive accompanying person present?
- Is the person presenting likely to abscond, deteriorate or become a threat to themselves or others if they were left to wait for 10/30/60/120 minutes?
- If the person presenting does not wait for treatment, what is the risk of a serious adverse outcome occurring, such as an attempt to suicide or completed suicide or serious deterioration in medical condition?
- History of psychotic illness, for example, schizophrenia, bipolar disorder or drug induced psychosis.

5.5 Assessing patients with psychotic disorders

The term psychosis is used to describe conditions where there has been some loss of contact with reality. Psychosis can happen to anyone but is most likely to first occur in young adults. Psychosis has many causes and can be associated with a number of conditions including schizophrenia, bipolar affective disorder, delirium, drug intoxication or drug withdrawal, major depression or post trauma/ head injury. Many people make a full recovery from the experience.

Common presentations

Patients with psychotic symptoms may present to the emergency department for a variety of reasons, including:

- acute onset of psychotic symptoms
- exacerbation of an existing psychotic illness, such as schizophrenia
- behavioural disturbance, such as aggressive or violent behaviour towards family members
- depressed mood on a background of a chronic psychotic illness (suicide is common in patients with schizophrenia, psychotic depression or bipolar disorder)
- problems due to side-effects of medication, such as dystonic reactions
- problems associated with co-morbid physical illness often poorly recognised or treated in patients with schizophrenia
- problems due to co-morbid drug and alcohol misuse
- requests for medication, accommodation or financial assistance.

Symptoms of psychosis

The most characteristic symptoms of psychosis include:

- disorganised thinking – inability to concentrate, to remember, to follow a conversation. Sentences are unclear or make little sense. Thoughts are blocked, too fast, too slow or are not linked together appropriately
- delusions – fixed, false beliefs out of keeping with the patient's cultural background or education that cannot be challenged by logical argument or reasoning
- hallucinations – false perceptions occurring in the absence of external stimuli that can involve all senses, most often auditory
- changed feelings – including changes in mood, dampened, extreme or inappropriate emotions
- changed behaviour – inappropriate, bizarre, and disorganised.

What do you look for?

Appearance

- Looks perplexed, angry, dishevelled, unkempt, poor personal hygiene, bizarre or inappropriately dressed

Behaviour

- Agitated, restless, inappropriate or strange, return of gaze to a spot, sudden head turning or gesturing, staring at one place in a room, eyes following something not present, mumbling or conversing with an unseen person

Verbal cues

- Difficulty following and responding to questions, answers make no sense, gives too much information that is irrelevant or gives no or minimal information

What do you ask?

- Are your thoughts mixed up at the moment?
- Are you having difficulty concentrating?
- Are you having difficulty understanding my questions?

About delusions

- You seem very frightened. Can you tell me what you're frightened of?
- Do you think that anyone is watching or following you?
- Do you think that anyone is trying to harm you?
- Do you get messages from TV or radio that are meant especially for you?
- Do you feel that you are a special person, have special powers or have a special relationship with God?
- Do you feel that your thoughts or actions are being controlled by someone?

About hallucinations

- Have you been having any unusual experiences?
- Can you hear voices that no one else can hear?
- Do these voices tell you to harm yourself or harm other people (command hallucinations)?
- Can you see things that no one else can see?
- Have you had any other unusual sensations (odd smells, unusual tastes, bizarre physical sensations)?
- Is there a past history of psychotic illness?
- Is the patient currently taking anti-psychotic medication?
- Is there a past history of aggression or violence?
- Is there a past history of self-harm?
- Does the patient have any current medical problems?

Factors to consider when assigning a triage code for a person presenting with a psychotic disorder

- Is this person at risk of self-harm?
(see page 20)
- Is this person at risk of harming others?
(see page 4)
- Is this person's behaviour likely to be unpredictable?
- Is there a supportive accompanying person present?
- Is this person's behaviour likely to deteriorate in the next 10/30/60/120 minutes?
- Is this person likely to abscond if they have to wait 10/30/60/120 minutes for treatment?
- If the person presenting does not wait for treatment, what is the risk of a serious adverse outcome occurring such as an attempt to suicide or completed suicide, serious deterioration in medical condition or harm to others in the near future.

5.6 Assessing patients with delirium

Delirium is a syndrome indicative of acute brain syndrome, not a disease. It has many causes, all of which result in a similar pattern of symptoms characterised by alteration in the patient's level of consciousness and cognitive impairment.

Most of the causes of delirium lie outside the central nervous system. Delirium usually has a sudden onset with a brief and fluctuating course and improves rapidly when the causative factor is identified and eliminated. It is common in the elderly and in people with dementia.

Diagnostic features of delirium

- Global disturbance of cognition, including impaired consciousness, attention and recent memory disturbance
- Delusions (often paranoid)
- Perceptual distortions, hallucinations
- Psychomotor disturbances with increased or decreased activity
- Disturbance of sleep
- Nocturnal worsening of symptoms, often leading to unpredictable and gross disturbance of behaviour
- Emotional disturbances, including anxiety, fear, irritability, depression.

Common presentations

- Acute onset of behaviour change in older people with no history of mental illness
- Exacerbation of cognitive impairment or worsening behaviour in a patient with dementia
- Accidental injury such as falls
- Symptoms of physical illness and confusion, disorientation and or behaviour disturbance.

What do you look for?

Appearance

- Looks perplexed
- Apprehensive or fearful
- Dishevelled, unkempt
- Inappropriately dressed
- Signs of physical illness such as a rash or pallor

Behaviour

- Agitated restless
- Stuporous or inactive
- Repetitive purposeless movements
- Gait disturbance
- Appears to respond to auditory hallucinations or to be observing unseen objects or people, or picking at unseen things on clothes or skin

Verbal cues

- Difficulty speaking or following questions
- Answers do not make sense or responds in a repetitive manner

What do you ask?

- How are you feeling at the moment?
- What are the times that you feel worse?
- Are your thoughts mixed up?
- How long have you felt like this?
- Do you know where you are at the moment?
- Can you tell me what day/date/month/year it is?
- Have you been feeling fearful about things?
- Have you felt that people were against you or trying to harm you?
- Have you had any strange experiences?
- Have you seen, heard, smelled or felt things that no one else can experience?
- Have you had any problems with your physical health?

Factors to consider when assigning a triage code for patients displaying delirium

- Is the patient at risk of self-harm? (see page 20)
- Is this person at risk of harming others? (see page 4)
- Is the person able to cooperate throughout the triage process?
- Is there a supportive accompanying person present?
- Is the patient's behaviour likely to deteriorate?
- Is the patient's behaviour or physical condition likely to deteriorate over the next 10/30/60/120 minutes?
- Is the patient likely to abscond if they have to wait 10/30/60/120 minutes for treatment?
- If this person does not wait for treatment, what is the risk of a serious adverse outcome occurring such as harm to others in the near future?

5.7 Assessing patients with anxiety disorders

Anxiety is an uncomfortable feeling of apprehension and is a normal part of daily life. When it effects every day functioning then an anxiety disorder has developed.

Symptoms of anxiety

- Restlessness, agitation
- Muscle tension, aches and pains
- Palpitations, chest tightness
- Sweating and dry mouth
- Dizziness, headache
- Gastrointestinal disturbance
- Irritability
- Sleep disturbance
- Difficulty concentrating
- Feelings of fearfulness
- Inability to cope

Common presentations

Patients with anxiety experience both physical and psychological symptoms. Organic conditions and drug and alcohol misuse may also be associated with symptoms of anxiety.

An anxious patient may present with:

- panic symptoms characterised by:
 - shortness of breath, hyperventilation, palpitations, chest tightness, light headedness, tremors, sweating, nausea, tingling in peripheries, together with fearfulness or fear of having a heart attack
- somatic symptoms such as headache, gastrointestinal disturbance, dizziness or fatigue
- acute distress associated with a psychosocial stressor such as assault, burglary or threat of harm
- agitation, fearfulness, restlessness associated with an underlying mental disorder such as schizophrenia or with an organic brain syndrome, hypothyroidism or post-head injury
- symptoms of both depression and anxiety
- suicidal ideation or attempted self-harm.

Note: Fearfulness, restlessness, sleep disturbance and agitation may be associated with drug intoxication or withdrawal.

What do you look for?

Appearance

- Agitated, distressed, tearful
- Flushed, sweating
- Hyperventilating

Behaviour

- Restlessness
- Pacing
- Tremulous

Verbal cues

- Difficulty concentrating
- Distracted
- Stammering or difficulty speaking

What do you ask?

- Do you feel tense, wound up, under stress?
- Have you been finding it hard to cope recently?
- How are you sleeping?
- Are you worrying a lot about things?
- Have you felt suddenly panicky or had difficulty breathing?
- What is your physical health like?
- What medication are you taking at the moment?
- Is there a past history of mental health problems?

Factors to consider when assigning a triage code for patients with anxiety disorders

- What is the patient's level of distress?
- What is the patient's risk of self-harm? (see page 20)
- Is there any evidence of physical illness?
- Is there any evidence of psychosis?
- Is the patient able to cooperate?
- Is a supportive accompanying person present?
- Is the patient's condition likely to deteriorate if they have to wait longer than 10/30/60/120 minutes?
- If the patient does not wait for treatment what is the likelihood of a serious adverse event occurring in the near future?

5.8 Assessing patients with depressive disorders

Depression is a common illness and is frequently seen in patients with physical illness, chronic pain or disability.

Patients may not complain of feeling depressed at the point of triage. Depressive illness should be suspected and sought for in instances where:

- the patient is overtly distressed, tearful or agitated
- the patient is withdrawn or is unable to communicate well
- there is suspected self-harm
- there are repeated presentations with unexplained physical symptoms
- there is a history of drug or alcohol misuse
- there is a history of recent loss, such as bereavement or unemployment
- there is a past history of depression or self-harm.

Symptoms of depression

- Low mood
- Appetite disturbance, change in weight
- Loss of energy or tiredness
- Loss of pleasure in things
- Loss of motivation
- Social withdrawal
- Poor concentration or recent memory loss
- Physical aches and pains
- Sleep disturbance
- Agitation or psychomotor retardation
- Feelings of guilt, hopelessness or worthlessness
- Suicidal ideation

Common presentations

- Clear depressive symptoms
- Somatic symptoms such as fatigue and or sleep disturbance, headaches, gastrointestinal disturbance or aches and pains
- Suicidal ideation or attempt at self-harm
- Loss of appetite and weight loss without evidence of organic pathology
- Problems associated with drug or alcohol use
- Concurrent physical illness due to inability to cope at home
- Behavioural disturbance or conduct problems in a young person

What do you look for?

Appearance

- Tearful, distressed, agitated
- Withdrawn
- Slumped posture
- Poor self-care
- Dishevelled
- Evidence of weight loss

Behaviour

- Restlessness
- Pacing
- Wringing of hands
- Slowed movements

Verbal cues

- Difficulty concentrating
- Minimal response to questions or unresponsive

What do you ask?

- How do you feel at the moment?
- What is your mood like?
- Do you feel sad or down a lot of the time?
- What is your sleep like?
- What is your appetite like?
- Have you lost any weight?
- What is your energy level like?
- Are you able to enjoy things as much as usual?
- Do you feel hopeless about things?
- What is your physical health like?
- Have you ever been depressed before and if so, what treatment did you have?
- Are you taking any medication now?
- Questions to determine risk of self-harm? (see page 20)
- Is there any history of suicide attempts or self-harm?

Factors to consider when assigning a triage code for patients with depressive disorders

- Is the patient at risk of self-harm? (see page 20)
- Is the patient distressed?
- Is the patient likely to wait 10/30/60/120 minutes for assessment, especially a young person?
- If the patient does not wait for treatment, what is the likelihood of a serious adverse event occurring in the near future?

6. Case scenarios

The following scenarios have been included for teaching purposes to provide a basis for discussion about triage allocation.

Suggested triage categories are listed on page 36.

Case scenario 1 – 1200 hours

You receive a call from an ambulance officer advising of a patient for whom the road crew has requested security back-up on arrival.

The patient is a 32-year-old male who you are told is extremely agitated and currently being restrained by police.

The patient arrives 10 minutes later with two police officers present. He is hand-cuffed, face down on an ambulance trolley. The patient appears agitated requesting removal of the cuffs and to use the toilet.

The handover from the paramedics is as follows:

‘32 year old male named Jack, with no significant past history. He had an argument with his parents over money, and became very agitated and abusive to his family. He has all but destroyed the family home and threatened to kill his parents then jump in front of moving train. Neighbours called police. When police arrived Jack’s agitation increased and he resisted any attempts to help him. He was arrested and transported to hospital under Section 10 of the Mental Health Act.’

Observation

Jack is red in the face and sweaty but remains still on the ambulance trolley. He refuses to answer any questions and is speaking incoherently. Every now and then he attempts to break free from his cuffs.

What triage category would you allocate this patient?

Case scenario 2 – 0900 hours

Jane is an 18-year-old female who presents to triage accompanied by two girlfriends. Jane states she has been feeling depressed and is now unable to work. She is afraid to go out of the house alone. As yet she does not appear to have a plan for self-destruction. Jane has a past history of depression but with no suicide attempts.

Observation

Jane is dishevelled and pale with dry mucous membranes. She denies drug or alcohol intake and has no pain. All vital signs are within normal limits.

What triage category would you allocate this patient?

Case scenario 3 – 1000 hours

A couple in their mid 20s arrive at triage clutching a baby.

John, the baby's father, states the baby is three-weeks old and has not slept since arriving home from the hospital. His wife, Mary, is constantly sleeping and seems to resent the baby for waking her on occasions. She refuses to care for the baby and no longer breastfeeds. John has had to care for the baby and is missing work. Mary has not showered for seven days and no longer prepares meals or looks after the house.

She is refusing to see her family and friends and constantly blames John and the baby for this.

Observation

Mary is quiet, standing behind her husband. Mary will not make eye contact. She denies any abnormal behaviour and cannot understand why her husband has brought her to the emergency department. She wants to go home and sleep. Her vital signs are all normal. Her husband states he will stay with her until she is seen by a doctor.

What triage category would you allocate this patient?

Case scenario 4 – 1800 hours

Annie is a 40-year-old female who has been brought into the emergency department by the crisis assessment team (CAT). CAT state Annie is a client who is 'on their books under a community treatment order'. It seems Annie has not been taking her medication and has become very thought-disordered and paranoid toward family members. The community treatment order has been revoked.

Unfortunately there is no bed in the inpatient psych unit so she will need to stay in emergency for the time being. Paper work accompanies Annie. CAT requests a medical assessment while Annie is in the department.

Observation

Annie is in pyjamas despite it being 1800 hours. She is speaking in isolated words only. She is not orientated to date and time but thinks she is in a hospital in London. Annie refuses attempts at vital signs.

What triage category would you allocate this patient?

Case scenario 5 – 2000 hours

You are sitting at triage and a well-dressed male is helping an old lady through the front doors. As they approach the desk the male starts yelling that Lilly, his mother, is 'still confused' and he has had enough. After calming down he says he and his family have had discussions with the aged care assessment team and they were waiting for a place for his mother.

It appears Lilly no longer sleeps, is very aggressive to her family, refuses to eat and is no longer looking after her own needs for hygiene and toileting. While her son is speaking to you, Lilly is hitting him with her walking stick and yelling for a drink.

Observation

Lilly is disorientated to place, time and date. She presents with dry mucous membranes and vital signs within normal limits.

Her son then states he must go home to his wife and children and refuses to wait with his mother. He leaves you with his mother.

What triage category would you allocate this patient?

Case scenario 6 – 2100 hours

Jim is a 50-year-old male who presents to triage requesting a prescription. He states he has run out of his Largactil and he is feeling a little anxious. Jim has a private psychiatrist he sees regularly but is unable to tell you the nature of his psychiatric problem. He has a medical history of hypertension for which he is on regular medication.

Observation

Jim presents as a calm, well-dressed man.
BP 150/70, HR 80, afebrile.

What triage category would you allocate this patient?

Suggested triage categories for case scenarios

- Scenario 1** = triage category 1
- Scenario 2** = triage category 4
- Scenario 3** = triage category 4
- Scenario 4** = triage category 3
- Scenario 5** = triage category 4
- Scenario 6** = triage category 5

7. Readings and references

- 1 De Guio A, Bolton C, Fry M et al (1998). *Training manual for non-mental health trained staff to work with mental health patients. Area Mental Health Program; South Eastern Sydney Area Health Service*
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Footnotes to Victorian emergency department mental health triage tool and worksheet

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