Clinical update no. 507
7 February 2017

The Sydney Morning Herald

Suicide may have been prevented: coroner

Suicide may not have been prevented: psychiatrist

OK, the second part is made up, but probably more accurate.

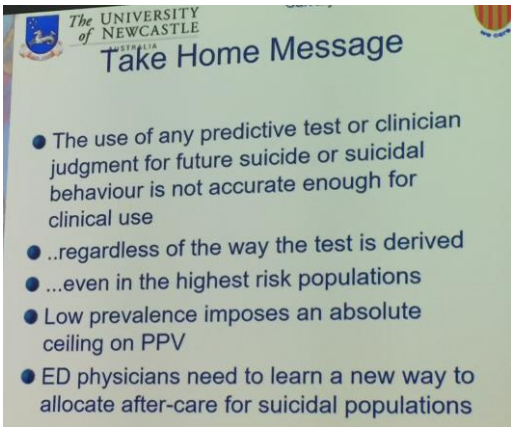
Charmaine Dragun's suicide could probably have been prevented if the talented TV newsreader had been diagnosed with a bipolar disorder, a coroner has found.

… the "emotionally troubled" perfectionist was beset by negative thinking and feelings of hopelessness - all signs of her being at an increased risk of suicide. "Hopefully the medical profession will read and take in the findings and we will see a difference in medical health care," her mother said. "My daughter, then, has not died in vain."

A tragic outcome, but how to prevent?

Predicting a successful suicide attempt is difficult, and there are no reliable risk stratification tools by which to do so.

ACEM ASM
SYDNEY 2017



Not great handouts but the message is fairly clear – trying to predict short term risk of suicide is not really possible. Even in high risk populations, there is an overall low prevalence making any risk assesment inherently unreliable. Among hospital treated deliberate self harm there is completed suicide in 1.6% at 12mth and 4% at 5 years It is important to refer and have care commenced. Addresing treatable psychiatric conditions and managing risk, such as access to lethal means and providing ongoing support is what helps; it's just predicting short term risk is difficult.

NSW HEALTH

Suicide Risk Assessment and Management

Emergency Department

http://www.health.nsw.gov.au/mentalhealth/programs/mh/Publications/emergency-dept.pdf

Determination of suicide risk level

There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide.[7, 8, 9] A thorough assessment of the individual remains the only valid method of determining risk.

The Policy then details a risk assessment guide; despite clear limitations, the important point is to refer for mental health assessment and provide access to follow up including a 24-hr contact telephone number.

UNCERTAINTIES

Can we usefully stratify patients according to suicide risk?

BMJ 2017;359:j4627 doi: 10.1136/bmj.j4627 (Published 2017 October 17)

The overwhelming majority of people who might be viewed as at high risk of suicide will not die by suicide, and about half of all suicides will occur among people who would be viewed as low risk.

LETTERS

Correspondence from Sydney: "*The authors dismiss the findings of a recent meta-analysis of controlled studies, which concluded that risk assessment provides "false reassurance and is, therefore, potentially dangerous,"*

There can be clear harms from admission. There are issues about involuntary care of patients who for the most part have competence and capacity to make decisions. Less restrictive alternatives are preferred.

Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department

480 Annals of Emergency Medicine Volume 69, no. 4 : April 2017

CRITICAL QUESTIONS

1. In the alert adult patient presenting to the ED with acute psychiatric symptoms, should routine laboratory tests be used to identify contributory medical conditions (nonpsychiatric disorders)?

Level C recommendations. Do not routinely order laboratory testing on patients with acute psychiatric symptoms. Use medical history, previous psychiatric diagnoses, and physician examination to guide testing.

Pretty clear – no routine lab testing.

2. In the adult patient with new-onset psychosis without focal neurologic deficit, should brain imaging be obtained acutely?

Level C recommendations. Use individual assessment of risk factors to guide brain imaging in the ED for patients with new-onset psychosis without focal neurologic deficit. (Consensus recommendation)

No routine brain imaging either for new onset psychosis without focal neurological deficits, though assumes a reliable exam is done.

3. In the adult patient presenting to the ED with suicidal ideation, can risk-assessment tools in the ED identify those who are safe for discharge?

Level C recommendations. In patients presenting to the ED with suicidal ideation, physicians should not use currently available risk-assessment tools in isolation to identify low-risk patients who are safe for discharge. The best approach to determine risk is an appropriate psychiatric assessment and good clinical judgment, taking patient, family, and community factors into account.

Don't use suicide risk assesment tools in isolation; asses the many variables involved.

4. In the adult patient presenting to the ED with acute agitation, can ketamine be used safely and effectively?

Level C recommendations. Ketamine is one option for immediate sedation of the severely agitated patient who may be violent or aggressive. (Consensus recommendation)

Outside of the FOAM world there is very little evidence regarding use of ketamine in the acutely agitated patient.

> Given the paucity of quality literature on this topic, future high-quality research is needed to establish the safety and efficacy of ketamine compared with other agents for control of the acutely agitated patient in the ED.

Maybe they haven't been to SMACC; then again maybe better they didn't. Some evidence would help to supplement the blogs.

Droperidol is safe and effective but is not used in the US because of its black box warning.

Ketamine has potentially serious adverse effects, notably tachycardia and hypertension in already agitated patients, as well as emergence phenomenon, laryngospasm, hypersalivation, and vomiting. It may worsen symptoms in psychotic patients. Studies report dosing up to 4 - 6 mg/kg, and its use in aeromedical retrieval. Most studies report additional sedating agents are required. Intubation can be required, more so with higher dosing ranges.

Medical assessment of mental health patients 21 Sep 2017

www.aci.health.nsw.gov.au/networks/eci/clinical/clinical-resources/clinical-tools/mental-health/mental-health-assessment : the ubiquitous request for "medical clearance" can be guided by confirming normal vital signs and BSL, and excluding a toxidrome, infective basis, or abnormal findings on a neurological exam. For psych if:

Physiological Observations

Heart rate	BP	Temp.	Resp. Rate	O2Sats	BSL

Meets low risk criteria (all required)

- ☐ Age 15-65 years
- ☐ No acute physical health problems (including trauma, ingestion or drug side-effects)
- ☐ No altered level of consciousness (GCS 15, no delirium)*
- ☐ No evidence of physical cause for the acute presentation
- ☐ Not the first or significantly different psychiatric presentation

- Investigations done based on clinical findings

Psych can ask for a medical evaluation, but they can't then dictate how to do it. For chronic psych problems the need is even less.

In the US they have other concerns:

The NEW ENGLAND JOURNAL of MEDICINE

President Trump's Mental Health — Is It Morally Permissible for Psychiatrists to Comment?

This article was published on December 27, 2017, at NEJM.org.

The Dangerous Case of Donald Trump challenges the APA position that a psychiatrist cannot know enough about a person she has not interviewed to formulate a diagnostic impression.

The background was speculation by psychiatrists about Barry Goldwater's mental stability based on his behaviour during the 1964 Presidential election, and particularly comments regarding use of nuclear weapons. It's arguably worse now.

inform him that I too have a Nuclear Button, but it is a much bigger & more powerful one

Available at http://www.heti.nsw.gov.au/programs/emergency-medicine-training/emergency-medicine-training-test/educational-resources/em-clinical-updates/