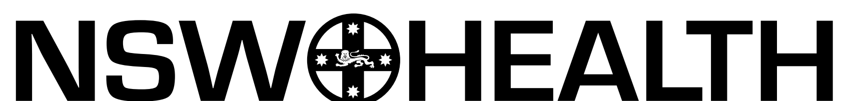
Mental Health for Emergency Departments

A REFERENCE GUIDE

2009



This Reference Guide is intended to assist emergency department staff and other clinicians in their care for people experiencing emergency mental health problems.

It is intended to support the wealth of experience and evolved practice that exists in emergency departments, and not to supplant nor replace local protocols and practice. It is meant to encourage, not replace consultation with senior colleagues who remain the best source of information and advice. Further, it is not a substitute for sound clinical judgement.

This Reference Guide builds upon the earlier versions of the reference guide (2001; 2002). It has been prepared though an extensive review process involving nursing, medical, and allied health clinicians from both the emergency medicine and mental health fields.

As a result, this Reference Guide represents the views of clinicians with extensive experience in the field. It is based on the best clinical advice currently available, however it will require updating in the light of evidence and changes to clinical best practice. This is particularly the case with the more technical aspects such as medication regimes.

To keep the Reference Guide up-to-date with contemporary best practice, it is intended that it be reviewed and updated at least every three years.

If you believe information contained in this publication is incorrect, or open to misinterpretation, or if you have any general comments please contact the Mental Health and Drug an Alcohol Office at the NSW Department of Health, 73 Miller Street, North Sydney (telephone 02 9391 9000).

NSW HEALTH DEPARTMENT

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A full copy of this Reference Guide can be downloaded from the NSW Health Intranet site:
http://internal.health.nsw.gov.au

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EATING DISORDERS

REMEMBER SACCIT

Eating disorders are moderate to severe illnesses characterised by disturbances in thinking and behaviour around food, eating and body weight or shape. Eating disorders can be associated with significant lifetime risk of physical morbidity and mortality.

People with an eating disorder may feel uncomfortable disclosing information about their behaviours, making detecting disordered eating symptomatology difficult at times.

The peak incidence of Eating Disorders is at age 14 but can affect people of all ages. The ratio in females to males is at least 10:1, but is lower in younger presentations.

Key symptoms of eating disorders may include

- Low body weight or failure to achieve expected weight gains
- Fear of weight gain
- Body image disturbances
- Severe body dissatisfaction and drive for thinness
- Preoccupation with food, weight and shape
- Restricted dietary intake
- Self-induced vomiting
- Misuse of laxatives, diuretics or appetite suppressants
- Excessive exercise
- Amenorrhoea or failure to reach menarche in women, loss of sexual interest in men
- Binge eating episodes, involving loss of control over eating and eating unusually large amounts of food

Anorexia Nervosa patients are at 85% or less of their expected body weight for age (body mass index 17.5 in adults).

Bulimia Nervosa patients tend to be normal weight or slightly overweight and are characterised by cycles of uncontrolled binging followed by a compensatory behaviour such as purging, extreme dieting or exercise.

Other symptoms include

- Acute medical presentations include:
  - Dehydration
  - Electrolyte imbalance
  - Hypothermia
  - Syncope
  - Cardiac arrhythmias (Bradycardia)
  - Suicide attempts
  - Overwhelming infection, renal failure
  - Bone marrow suppression, GIT dysfunction
  - Acute massive gastric dilatation from bingeing.
- Comorbid psychiatric illnesses are seen in up to 80% of patients with an eating disorder including:
  - Major Depressive Disorder
  - Anxiety Disorders
  - Obsessive Compulsive Disorder
  - Substance abuse / dependence
  - Self-harm and suicidal ideation

What is the context?

- Why has the patient come?
- Has there been some precipitating event?
- Has their physical or mental status changed?
- Is the patient presenting of their own accord, or on family or health professional advice?
- Is there a treating clinician involved in caring for the patient?

Suggested questions

The SCOFF Questionnaire:

1. Do you ever make yourself sick because you feel uncomfortably full?
2. Do you worry you have lost control over how much you eat?
3. Have you recently lost more than 6kg in a three month period?
4. Do you believe yourself to be fat when others say you are too thin?
5. Would you say that food dominates your life?

(From: Morgan JF, Reid, F, Lacey JH. (1999), The SCOFF Questionnaire: assessment of a new screening tool for eating disorders) *British Medical Journal,* 319, 1467-1468)

One or two positive answers should raise your index of suspicion and indicate that consultation with mental health is needed.

Some patients will deny these symptoms so it is important to also keep weight and physical markers under review if an eating disorder is suspected.

To help ascertain an accurate clinical picture, interview parents in the case of children and adolescents. Also consider interviewing family members of adults, with prior consent from the patient.

What is the physical state of the patient?

A thorough physical examination is mandatory. Consider also an ECG, Urinalysis to assess hydration and look for ketones, and a complete blood picture including electrolytes and renal function, liver function, full blood count, thyroid function (T3, T4, TSH), calcium, magnesium, phosphate, amylase, ESR, Luteinising Hormone, Follicle Stimulating Hormone and Oestradiol.

If patients exhibit any one of the following, physician consultation and possible admission to hospital is indicated:

- Temperature <35.5°C
- Blood pressure <90/60mmHg in adults or <80/40mmHg in adolescents
- Postural drop ≥20mmHg
- Tachycardia
- Bradycardia (heart rate <40 in adults and <50 in adolescents)
- BMI <14kg/m2 or <15kg/m2 with co-existing medical conditions (e.g. diabetes or pregnancy)
- Rapid weight loss (≥1kg per week over five or more weeks)
- Dehydration
- Urinary Ketones
- Significant electrolyte disturbance such as low serum phosphate or low serum potassium
- Cardiac arrhythmia including prolonged QT interval on ECG

What is the mental state of the patient?

Screen for significant eating disorder symptomatology.

Assess motivational status including acceptance of condition, willingness to comply with physical and mental health investigations.

Is there evidence of depression, anxiety, obsessionality, substance abuse, or other psychiatric condition?

Has the patient any suicidal thoughts or impulses?

Are there active self-harm behaviours?

Key risks

- Suicide or self-harm
- Treatment resistance or sabotage
- Missed physical illness
- Refeeding syndrome (a rare potentially fatal complication of refeeding of severely malnourished patients. Refeeding should be managed under close medical supervision)

What to do?

Patients should be assessed for medical complications of starvation or purging behaviours and referred for appropriate medical review.

If patient is displaying significant eating disordered symptoms or medical complications of their illness, contact the appropriate medical, mental health or paediatric staff to facilitate admission for weight restoration and management, treatment of comorbid mental illness or referral to appropriate community-based eating disorders services where available, a mental health professional, General Practitioner and Dietitian.

For consultation, contact the NSW Health Centre for Eating & Dieting Disorders (02 9515 5843) or www.cedd.org.au

Key points

Patients may present to EDs with medical complications of their starvation, self-harm or suicidal ideation, comorbid depression or anxiety that requires attention in addition to their eating disorder symptoms.