Acute, Emergency & Critical Care for the Advanced Practitioner

Chapter 14 **Mental Health Presentations**

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**Aim**

The aim of this chapter is to review the fundamental principles of working with clients with mental health issues; then more specifically to explore mental health presentations in acute, emergency and critical care and to elevate and advance skills particularly around assessment for these clients in line with Health Education England’s (HEE) Multi Professional Advanced Clinical Practice Framework. (HEE, 2017). This will further enable practitioners to work confidently and effectively with these clients.

**Learning Outcomes**

After reading this chapter the reader will:

1. Understand the importance of their own mental health.
2. Be aware of the parity of esteem agenda, including consideration of diagnostic overshadowing and therapeutic communication.
3. Understand how to undertake a mental state examination as part of a holistic, biopsychosocial assessment,
4. Though these outcomes can be applicable to all service areas:

Specifically for acute care, have an awareness of the psychological principles of illness perception and the link between chronic illness and depression.

Specifically for emergency care there is a focus on assessment of suicidality and psychosis.

Specifically for critical care to have an understanding of Post Traumatic Stress Syndrome (PTSD) and Post Intensive Care Syndrome (PICS) for patients and their families.

**Introduction**

This chapter can only introduce the salient points for these clients very briefly and it is hoped it will offer a foundation for further and continuing thinking about how they are worked with in your service(s). Before looking at specifics, it is important to understand some underlying principles when working with mental health.

Mental health issues occur on a spectrum, and they affect all of us. We all work in relation to other, regardless of the service you are based in. Understanding your own mental health and your attitudes and beliefs around mental illness/disorders is a vital component of working with those who are known to have or present with mental health issues. We all get anxious, stressed, sad or low at times. It is the degree of how much these issues impact on your life that determines whether professional or other support is needed.

In working with clients with mental health issues, it is important to have a high degree of self-awareness, particularly around the impact their mental health has on you and the interaction this has with your own mental health. It is not within the scope of this chapter to go into detail as to how you can do this, but simply connecting to how to are feeling day to day and being aware of changes to your mental health (often, but not always, in reaction to external events) and the use of supervision in the workplace around the impact of the work is a good place to start.

Work with this often disenfranchised and stigmatised group of clients’ needs to come from a place of respect for them and their experiences, which have often been traumatic, acknowledging the intrinsic value of their individual worth as people.

**Parity of Esteem**

Understanding the individual worth of each client, means it is also important to understand the parity of esteem agenda in relation to working with clients who present with mental health issues; either as a singular presentation, as psychological sequalae of physical health issues or as a co-morbidity. Parity of esteem in relation to mental health was enshrined in law in the Health and Social Care Act 2012. (Baker & Gheera, 2020). It describes the imperative to give equal value to both mental and physical health and originated from the mortality gap that had been identified, in which people with mental illnesses were dying 15-20 years before the general population. (Centre for Mental Health, 2013). There were and still are many reasons for this mortality gap, that include both discrimination and stigma, unconscious bias, and inadequate funding. (RCN, 2019). The improvement required to achieve parity of esteem is a big undertaking and there is much work going on to achieve this. Awareness and acknowledgement of these issues is fundamental and further reading is recommended.

### **Diagnostic overshadowing and unconscious bias**

*“The Interpretation of new information depends on what you believed beforehand”.* Sox et. al. (2013).

These are vital issues to be aware of in relation to working with patients who present with mental health issues. Diagnostic overshadowing is a term that originally came from the field of Learning Disabilities. Diagnostic overshadowing has been described as the tendency to attribute all behavioural, emotional, and social issues to a certain diagnosis and other issues are not considered. Diagnostic overshadowing also occurs when symptoms of physical illness are attributed to the service user’s mental illness. As a result, people get inadequate diagnosis or treatment of their overall condition (Jones et. al, 2008). This has been a significant contributor to the previously mentioned mortality gap.

As unconscious bias can contribute to diagnostic overshadowing, so it is definitely worth having some awareness of this. Lang (2019) describes two types of bias: conscious bias, or explicit bias, which is intentional — you are aware of your attitudes and the behaviours that result from them. You may wish to revisit these in yourself. Unconscious Bias, or implicit cognitive bias represents the set of biases that are unintentional, you are not aware of your attitudes and the behaviours that result from them (Lang, 2019). Unconscious bias functions below the level of consciousness and is evolutionary in nature when speed was more important than accuracy, leading to information processing shortcuts. They are associated with amongst other things stereotypes, social influence, and emotional and moral motivation. It requires work and self-awareness to identify them in yourself, and in others, as they can also be institutional and societal. There are numerous identified unconscious biases and I recommend you become more familiar with them, as this will allow you to identify the bias(es) that you or your colleagues/service may be most prone to. Examples of unconscious bias are ascertainment bias, whereby we see what we expect to see, like a self-fulfilling prophecy and confirmation bias, whereby we look for information that confirms what we suspect/think and disregard information that does not fit this picture. Both of these unconscious biases can be directly linked to diagnostic overshadowing.

**Therapeutic communication.**

Working with this client group requires an expert communicator, with high level interpersonal skills. We have already touched on self-awareness and will touch briefly here on therapeutic communication. It can be difficult to define therapeutic communication precisely; van Servellan (1997) defines therapeutic communication in this way: “interpersonal exchange, using verbal and non-verbal messages, that culminates in someone’s being helped to overcome stress, anxiety, fear, or other emotional experiences that cause distress” (van Servallen, 1997, p.30). This could describe any client in our service(s) therefore, therapeutic communication should underpin all our communication in healthcare settings.

Epstein et. al (2000) have suggested that all therapeutic communication is based on a therapeutic relationship with the client, which is determined by your therapeutic use of self. Therapeutic use of self is the ability to use your personality consciously and in full awareness to establish a relationship with your client. Therapeutic communication always has a context. Things to be aware of in yourself and if possible, your client, are your/their values, attitudes, and beliefs; culture and spirituality; gender, social status, age and developmental level. (Epstein et. al, 2000). These all determine how you both will interact and react to each other. Some techniques for therapeutic communication include providing rationale, open ended questioning, active listening techniques, non-verbal and verbal cues to continue the conversation, reflecting, exploring feeling tones, silence, clarification, non-verbal communication through expression, stance, and gestures and summarizing (Sharma and Gupta, 2022).

**Mental Health and Ethnicity**

MIND (2021) has identified several noteworthy facts in relation to mental health and ethnicity. Black men are more likely to have experienced a psychotic disorder in the last year than White men. Additionally, black people are four times more likely to be detained under the Mental Health Act than white people; older south Asian women are an at-risk group for suicide; refugees and asylum seekers are more likely to experience mental health problems than the general population, including higher rates of depression, anxiety, and PTSD. People of Indian, Pakistani, and African-Caribbean origin show higher levels of mental wellbeing than other ethnic groups. Suicidal thoughts and self-harm are less common in Asian people than Caucasian people. Mental ill-health is lower among Chinese people than in Caucasian people.

The caveat to this is there may be under-reportage from some communities, perhaps amongst other issues in relation to stigma and different cultural perceptions of mental illness.

**Mental Health Assessment**

**Mental Health Screening tools**

There are a multitude of screening tools that can be used in the assessment of mental health issues and as a pointer to further services including specialist services if required. The two most used screening tools, which you may be familiar with are the Generalised Anxiety Disorder 7 (GAD 7) and the Patient Health Questionnaire 9 (PHQ 9). The first screens for symptoms of anxiety and the second for depression. Depression is said to be the predominant mental health issue worldwide, followed by anxiety. (Vos et. al. 2013). If you or your service choose to use screening tools, you must ensure there is a clinical governance structure around them, including prescribed actions in relation to any score.

**Holistic Assessment in Mental Health**

Whilst we are focusing on holistic assessment in mental health, I would also like to suggest that all assessments should be/are holistic, as we work with an individual person and their systems, both internal and external, which impacts on their health presentation(s). Therefore, the use of a biopsychosocial framework in health as a basis for assessment is a good place to start. For the purposes of this chapter I am focusing on a biopsychosocial framework in the assessment of mental health.

The biopsychosocial framework offers a basis for understanding the impact of an illness presentation whether acute or chronic on a person’s life and how that may be expressed in the biological, psychological, and social domains. This allows for a more in depth understanding and synthesis of information gathered to inform the formulation of the person’s difficulties and leads directly to a more targeted specific management plan. This use of the biopsychosocial model in mental health has more recently been supported in the proposed Research Domain Criteria (RDoC) by the National Institute of Mental Health (NIMH) as part of a framework for research into mental health which brings both physical and mental health together, rather than looking at them separately which has been an issue in the past. (Bolton & Gillett, 2019). It may also still be an issue today and you are encouraged to think about how you/your service works holistically with both, regardless what the presentation is.

To undertake holistic assessments in mental health within a biopsychosocial framework it necessary to consider the following:

* Interpersonal skills and therapeutic communication, which we have looked at in more detail earlier in the chapter.
* The purpose of the assessment and any limitations to what you and your service can offer.

Before undertaking a mental health assessment some useful questions to think about are contained in this short precis from Garlick & Rhodes (2011) below:

**WHY**

This is usually based on information from the referrer and/or carers or other agencies Consider does the person knows they have been referred? why have they been referred now? Triggers? What is the level of risk? Do they have a communication issue?

**WHAT**

What is the aim of the assessment? Is it an emergency? Are you assessing whether the person can be treated at your service or for treatment elsewhere?

**WHERE?**

Where will the assessment take place? Your service, home, online? Risk in relation to environment should be considered here.

**WHO?**

Who should undertake the assessment? Should it be a joint assessment? Should parents/carers be there? Do you need an interpreter?

**WHEN?**

This is based on local definitions of timelines for emergencies: is this an emergency; is it urgent; is it routine?

(Garlick & Rhodes, 2011)

Other issues to consider in a mental health assessment include:

* Whether your service has a local protocol for conducting a mental health assessment.
* The reason for referral including the person being referred/referrer/carer’s perception of why they have been referred as appropriate, particularly in relation to how much you involve a carer.
* Individual information including personal history, spiritual beliefs and cultural practices
* Mental and Physical Health history past and current including medication
* Substance use
* Current Social Circumstances
* Synthesis and formulation

All mental health assessments must include a Mental State Examination (MSE). This is conducted as part of the overall assessment and has specific things to pay attention to.

**Ten Point Guide to Mental State Examination**

Examples of what to look for in each category from Hufton et. al. (2022):

**Appearance**: posture, gait, dress, self-care, physical health

**Behaviour**: Facial expression, eye contact

**Speech**: rate and flow, volume

**Mood:** how does the patient describe how they are feeling?

**Affect**: Patients' expression, what you observe

**Thoughts:** what does the patient talk about? Any abnormalities?

**Perception:** consider the presence of hallucinations

**Cognition:** an awareness of self and environment, do they know what day it is etc.

**Insight:** do they recognise and understand their experiences? what is their understanding of the problem?

**Clinical Judgement and risk assessment**: Summarise your findings including an assessment of risk.

(Hufton et. al., 2022)

**Risk assessment mental health**

Risk assessment is an essential and intrinsic component of any mental health assessment.

There are three primary risks to consider in a mental health assessment:

* Risk to self (Self harm, suicidality, neglect, substance use etc.)
* Risk to other (violence)
* Risk from other (safeguarding). This is the risk that gets overlooked the most in a mental health presentation. It needs to be remembered that these are vulnerable adults and safeguarding must always be considered.

**RED FLAGS**

Adapted from the UK Mental Health Triage Scale

**Emergency**

Current actions endangering self or others

Overdose / suicide attempt / violent aggression

Possession of a weapon

**Very High Risk**

Acute suicidal ideation or risk of harm to others with clear plan or means

Ongoing history of self-harm or aggression with intent

Very high-risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control

**High Risk**

Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent

Rapidly increasing symptoms of psychosis and/or severe mood disorder

High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control

Overt / unprovoked aggression in care home or hospital ward setting

Wandering at night (community)

Vulnerable isolation or abuse

**Moderate Risk**

Significant patient / carer distress associated with severe mental illness (but not suicidal)

Absent insight /early symptoms of psychosis

Resistive aggression / obstructed care delivery

Wandering (hospital) or during the day (community)

Isolation / failing carer or known situation requiring priority intervention or assessment.

(Sands et. al., 2016)

**Brief Tips for assessing Children and Young People (CYP) presenting with mental health issues.**

It is not within the scope of this chapter to go into detail here, but you should always assess a young person in the context of their wider systems (family, school etc.) and genograms are a very useful way to obtain a history and identify patterns. A genogram is a diagram outlining the history of the behavior patterns (e.g., divorce or suicide) of a family over several generations. (Merriam Webster, 2022). They are a useful tool to engage the family with their story and to highlight both mental and physical health issues generationally.

**Pharmacological principles in Mental Health**

The same universal principles that apply for all patients should also be followed in relation to pharmacology and prescribing for patient’s presenting with mental health issues. You should also check with national, regional and local guidelines in relation to first line prescribing of medication for psychiatric disorders.

Most psychiatric disorders use both psychosocial and pharmacological interventions. In relation specifically to mental health patients who use medication to help manage their illness, concordance may be an issue, especially for those whose symptoms are severe. Not taking a prescribed medication can lead to a worsening of the illness, further interventions, and admission to hospital. The input and expertise of a pharmacist is said to be good practice when prescribing and monitoring a medication for severe mental health conditions (RPS, 2022).

There are four primary types of medication for mental health problems (MIND, 2022)

* Hypnotics and anxiolytics– These medications can be prescribed for severe anxiety or insomnia (difficulty getting to sleep or staying asleep).
* Antidepressants – usually for moderate to severe depression. Some are also licensed to treat anxiety, phobias, bulimia, and some physical conditions including managing severe pain.
* Anti-psychotics – to reduce the symptoms of schizophrenia, schizoaffective disorder, psychosis, and sometimes severe anxiety or bipolar disorder, as well as the psychotic symptoms of a personality disorder. Some are also licensed to treat physical problems, such as persistent hiccups, problems with balance and nausea, agitation and psychotic experiences in dementia. This is only recommended if there is a risk to self or others, or in severe distress.
* Lithium and other mood stabilisers - They are licensed to be used as part of the treatment for: bipolar disorder, mania and hypomania, recurrent, severe depression, and schizoaffective disorder. Lithium, anticonvulsants, and antipsychotics are the three main types of medication which are used as mood stabilisers.

A note on Lithium Toxicity.

Lithium has a very narrow therapeutic index and can be highly toxic when levels in the body fall outside that index. Therefore, lithium levels are usually measured one week after starting treatment, one week after every dose change and weekly until levels are stable when they then should be measured every 3 months. (Taylor et. al. 2012; NICE, 2018). If you know a patient is on lithium, the first thing to check is when they last had their lithium levels measured.

Lithium toxicity can present with a variety of symptoms including diarrhoea, vomiting, anorexia, muscle weakness, lethargy, dizziness, ataxia, lack of coordination, tinnitus, blurred vision, coarse tremor of the extremities and lower jaw, muscle hyper-irritability, choreoathetoid movements, dysarthria, and drowsiness. Patients with severe lithium toxicity can also present with hyper-reflexia and hyperextension of limbs, syncope, toxic psychosis, seizures, polyuria, renal failure, electrolyte imbalance, dehydration, circulatory failure, coma, and occasionally death. (NICE, 2022a).

Lithium toxicity needs rapid assessment and the risk for toxicity is higher for patients who have a pre-existing diagnosis of hypertension, diabetes, congestive heart failure, chronic renal disease, schizophrenia, or Addison's disease. If you suspect lithium toxicity, an urgent lithium level should be carried out immediately and specialist advice sought. Lithium toxicity has no specific antidote, in secondary care the treatment is supportive and lithium levels are normally rechecked every 6–12 hours. On occasion osmotic or forced alkaline diuresis may be required. (Taylor et. al., 2012; Joint Formulary Committee, 2019).

**Thinking about Acute Care**

**Perception of illness**

Disease itself is pathological and the way an individual perceives physical or emotional discomfort is not easily measured. The perception of illness might be influenced by cultural beliefs, psychological needs, or something else that may have little to do with the identified illness. An understanding of a person’s illness perception is necessary both in diagnosis and in treatment.

Perception is subjective, so having a structure and language to describe their perception can be helpful to the patient. A way of doing this is described by Gregory (2022) using four areas of focus:

Identity: What does the patient believe is true about the disease, what do they think the symptoms are?

Cause: What does the patient believe started it?

Timeline: The initial illness appearance. What is the trajectory? How long will it take? What will be the conclusion, is it acute or chronic?

Consequences: What does having this illness mean? Will it have a negative effect on their life? (Gregory, 2022)

Threats to health and how an individual responds to them are fundamental processes for survival and maintenance of everyday functioning. The Common Sense Model of Illness Regulation also provides a framework to understand how threats to health are detected, processed and managed (Hagger & Orbell, 2022) and could provide a more detailed way of exploring these issues.

**Chronic illness and depression**

People can experience symptoms of depression after being diagnosed with a medical illness. These symptoms may or may not decrease as the condition is treated or they adjust to the impact the condition has on their life. Certain medications used to treat various illness can also trigger depression, so it is worth being mindful of this when treating your patients and/or prescribing.

Some of the risk factors for depression include a personal or family history of depression and/or a family member(s) who have died by suicide. For the purposes of this chapter the risk factors for depression to be particularly mindful of are directly related to having another illness. For example, conditions such as Parkinson’s disease and stroke cause changes in the brain. In some cases, these changes may have a direct role in depression. Illness-related anxiety and stress also can trigger symptoms of depression.

As well as the above, the same factors that increase the risk of depression in otherwise healthy people will also raise the risk in people with physical health issues/illnesses, particularly if those illnesses are chronic. Depression is common among people who have chronic illnesses such as: Alzheimer’s disease, Autoimmune diseases, including systemic lupus erythematosus, rheumatoid arthritis, and psoriasis; Cancer, Coronary heart disease, Diabetes, Epilepsy, HIV/AIDS, Hypothyroidism, Multiple sclerosis, Parkinson’s disease, Stroke. (National Institute of Mental Health (NIMH, 2021)

Research suggests that people who have depression and another medical illness tend to have more severe symptoms of both illnesses. (NIMH, 2021). A collaborative, holistic, individualised approach to care that includes both mental and physical health care can improve a person’s heath overall. Treating both conditions together can help people better manage both their depression and their chronic disease.

***Case Scenario:***

Harry is a 54 year old White Irish Male.

He lives with his wife and 2 sons (23 and 25) and is a lorry driver, so spends long periods of time away from home and on the road.

There is a history of Type 1 diabetes in his family (father). His mother has suffered from depression and anxiety.

Harry was diagnosed with Type 1 Diabetes 6 months ago and is on a multiple daily injection basal-bolus insulin regimen.

Harry presents to you with the following symptoms:

Not wanting to do anything, he is beginning to miss work.

Feeling tired and sleeping a lot

Overeating

Irritable with his family.

***What are the differential diagnoses?***

***What are the risks?***

***What would your management plan be?***

**Thinking about Emergency care**

The Royal College of Emergency Medicine (RCEM) (2021) has produced a toolkit to improve care for those who present with mental health issues to the emergency department (ED). It is hoped and strongly recommended that this is available for all EDs and is used as a reference point for caring for these patients. Below is a list of auditable standards for individual patients from this toolkit.

1. Patients should have mental health triage by ED nurses on arrival to briefly gauge their risk of self-harm, suicide, and risk of leaving the department before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.

2. Patients at medium or high risk of self-harm or suicide should be searched for objects or medication that may be used to self-harm.

3. Patients at medium or high risk of suicide or of leaving before assessment and treatment are complete should be observed closely whilst in the ED. There should be documented evidence of either continuous observation or intermittent checks (recommended every 15 minutes), whichever is most appropriate.

4. If a patient states that they want to leave or decline treatment, then there should be documentation of the assessment of that patient’s capacity to make that particular decision at that time, based on a face-to-face conversation and not rely on records from previous attendances.

5. When an ED doctor reviews a patient presenting with self-harm or a primary mental health problem, they should conduct a brief risk assessment of suicide and further self-harm.

6. Previous psychiatric history should be documented in the patient’s ED clinical record. This should include previous self-harm or suicide attempts, previous admissions and current treatment.

7. A Mental State Examination (MSE) should be recorded in the patient’s ED clinical record.

8. From the time of referral, a member of the mental health team should see the patient face-to-face and offer appropriate assistance to both patient and referrer within one hour. Full assessment may be delayed if the patient is not yet fit for assessment.

9. People who have attended the ED for help with self-harm should receive a comprehensive biopsychosocial assessment with appropriate safety or care planning at every attendance, unless a joint ED/Psychiatric written management plan states that this is not necessary or unhelpful.

10. Details of any referral or follow-up arrangements should be documented in the patient’s ED notes.

(RCEM, 2021).

***Patients presenting with psychotic symptoms in the ED.***

A person presenting with psychotic symptoms will each have their own unique set of symptoms and experiences. However, there are three main symptoms associated with a psychotic episode: confused and disturbed thoughts, hallucinations, and delusions.

There are many conditions known to trigger psychosis, the most well-known being schizophrenia and bipolar disorder, as well as alcohol or substance use. However, it is important to remember in differential diagnoses that stress, anxiety, depression and sleeplessness can also cause psychosis, as well as several physical health conditions, such as HIV and AIDS, Malaria, Syphilis, Alzheimer’s Disease, Parkinson’s Disease, Hypoglycaemia, Systemic Lupus Erythematosus and Brain Tumour. (NHS, 2019).

***Case Scenario***

Josie is an 17 year-old Black British female. She presents to the ED with acute pain and tenderness in her right shoulder, arm and wrist. There is no apparent injury.

She lives at home with his mother, father and younger sister (12).

She has no past medical history.

She does not drink alcohol, but does some “weed”, two to three “spliffs” daily and often uses it to manage her pain.

Her hobbies are skateboarding and weight training.

She has presented before with similar complaints and injuries. These have been treated and she has been discharged with no follow up.

When you ask about the pain this time, she says it is because the government have planted an electronic device in her shoulder, so they can monitor and control her. It hurts particularly when they are activating it and that’s when she comes to the ED. Lately, the implanted device has been sending her messages telling her to find people who don’t have an implant and make them ready to receive one.

1. What are your differentials?
2. What clinical investigations will you do?
3. What will you ask next?
4. What are the risks?
5. How will you manage them? Now? In the longer term?
6. Will you notify her parents?
7. What are the specific issues you might need to be aware of?

**Patients presenting with self harm and suicidality in EDs.**

For the purposes of this chapter, I will use the National Institute of Clinical Excellence (NICE) (2022b) definition of self-harm and the National Institute of Mental Health (NIMH) (2022) definitions for suicide related behaviour and thinking.

NICE (2022b) defines self-harm as intentional self-poisoning or injury, irrespective of the apparent purpose. While many people who engage in self-harming behaviour do not wish to die, it is a risk factor for suicide as there is an increased risk of attempting or completing suicide, either deliberately or accidentally..

The National Institute of Mental Health (2022) defines suicide as death caused by self-directed injurious behavior with intent to die as a result of the behavior. A suicide attempt is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury. Suicidal ideationrefers to thinking about, considering, or planning suicide. (National Institute for Mental Health, 2022).

The NICE guideline (NG225, 2022) makes many recommendations for good practice in working with people of all ages who self-harm and it is recommended this is referred to in service(s) when planning care pathways/protocols etc. for working with this client group.

In relation to risk assessment, it very clearly states that risk assessment tools should **NOT** be used to predict future self-harm or suicide attempts, they should **NOT** be used to decide who should or should not be offered treatment or discharged. This also precludes the use of any global risk stratification, such as low, medium or high for the same purposes.

It is well known that the same people can present to EDs on multiple occasions following an episode of self-harm. It is important to remember to treat the person with dignity and compassion and to treat each individual episode as a singular presentation, within the context of their overall presentation, dependant on the previous history if known; to remember diagnostic overshadowing and potential cognitive bias(es) and be mindful of the use of any punitive measures.

NICE (2022b) suggests that following a patient presenting with an episode of self-harm, the triage or initial assessor needs to assess the severity of the injury and how urgently physical treatment is needed; the person's emotional and mental state, and level of distress; whether there is immediate concern about the person's safety; whether there are any safeguarding concerns; the person's willingness to accept medical treatment and mental healthcare; the appropriate nursing observation level; if they are a repeat attendee, whether the person has a care plan; offer referral to age-appropriate liaison psychiatry services, or for children and young people, crisis response service (or an equivalent specialist mental health service or a suitably skilled mental health professional) as soon as possible after arrival, for a psychosocial assessment and support and assistance alongside physical healthcare. (NICE, 2022).

***Red flags for suicide:***

a sense of hopelessness, a feeling of entrapment, well-formed plans, perception of no social support, distressing psychotic phenomena, significant pain/physical chronic illness.

***Learning Event***

***Lucy’s story***

*“I have had severe mental illness for over 20 years, involving a nine-year inpatient stay and several shorter inpatient stays since then. I have often gone to emergency departments when I’m in crisis and have required surgery for my self-harm injuries. My experiences in emergency departments have often made my physical and mental health worse. Being acutely psychotic and in pain is hard enough, but the environment of ‘safe rooms’ in emergency departments often makes this harder. I’m left to sleep on the floor – sometimes for days on end – while waiting for a mental health bed. Often, I don’t have access to proper food, aside from sandwiches (which I can’t eat as I need a gluten-free diet). My antidepressant medication is stopped suddenly; it’s taken away from me when I arrive, and the emergency department don’t stock it. This leads to horrendous withdrawal symptoms including nausea, vomiting, tremors, anxiety – and a worsening of my psychotic state.”* (CQC, 2020).

Could this happen in your department? How do we learn from patient experiences?

**Thinking about Critical Care**

A stay in the Intensive Care Unit (ICU) can be traumatic. It forces patients to confront their own mortality. They are hooked up to things, drift in and out of sleep are sometimes delirious and communication is difficult to say the least, especially when intubated.

The main mental health presentations you are likely to encounter in critical care are depression, Post Traumatic Stress Disorder (PTSD) and Post Intensive Care Syndrome (PICS). As we have previously discussed depression, we will focus on PTSD and then more specifically PICS here.

**Post Traumatic Stress Syndrome**

“Endless days and nights filled with strange broken sleep. A sea of fragmented menacing faces and shadows swimming through erratic beeps and bells.” (Wake & Kitchiner, 2013, p.1). This is from a patient describing their experience of being in the Intensive Care Unit (ICU). These disturbing memories affected her psychological recovery and led to the development of PTSD.

There appears to be a paucity of data around the occurrence of this phenomenon and there are varying statistics about how many patients develop PTSD following a stay in ICU from 1 in 10, to 1 in 5 or around 25%. (Wake & Kitchiner, 2013; PTSD UK, 2022; Burki, 2019).

The strongest risk factor for developing PTSD after being in ICU appears to be a pre-existing diagnosis of anxiety and not necessarily the condition that necessitated the stay in ICU (Burki, 2019). According to Calsavara et. al (2021), there is however, also a strong correlation between sepsis and psychiatric sequalae, including PTSD.

Whilst you will not see the symptoms of PTSD necessarily manifest in ICU, what is helpful during the ICU stay is to be mindful that any patient can develop PTSD, to be aware of the risk factors above in particular and consider the psychological support that is offered both during admission and especially after discharge.

**Post Intensive Care Syndrome**

Surviving the illness/incident that brought a patient to ICU is not always the end of the story. Some of those survivors will go to develop cognitive, psychological/psychiatric and/or physical disabilities, which have been grouped together into a syndrome, PICS. We will focus primarily on the cognitive and mental health presentation of this syndrome for the purposes of this chapter.

The definition of PICS in this context is new and worsening symptoms in cognitive and mental health that arise in the critical care setting and persist after discharge. (Rawal et. al., 2017)

ICU is also known to have a psychological impact on families and carers of the patient, and this is described separately in Post Intensive Care Syndrome-Family (PICS-F). Rawal et. al, 2017 describe it as the acute and chronic effects on the family psychologically during admission, discharge and sometimes death of their loved one.

Again, as with PTSD, it is useful to think about/assess patients on admission for any predisposing factors such as their ability to adapt to stress in the past, medication history, current mental and clinical status, and environmental and family factors. (Rawal et. al. 2017).

The management of PICS starts on admission requiring a multi-disciplinary approach for best outcomes. The ABCDE bundle has been used with good preventive rates for PICS. (Kress, 2013; Morandi, Brummel & Ely, 2011; Pandharipande et. al, 2010). This consists of:

**A**wakening (using light or minimal sedation)

**B**reathing (spontaneous breathing trials)

**C**oordination of care and communication among various disciplines

**D**elirium monitoring, assessment, and management

**E**arly ambulation in the ICU.

Amongst other additional measures, there are two others mentioned in Rawal et.al. (2017), I would like to note. The first is diary keeping either by the family, the health care professional or both. This can be used to support both the patient and family and there is evidence that it can decrease symptoms of PTSD. (Garrouste-Orgeas et. al., 2014; Jones et. al., 2010). The second is further supported by evidence and is the creation or continuation of post ICU clinics that provide support and follow up counselling to the patient and their family. (Mehlorn et. al., 2014).

***Case Scenario***

Nawar, an 80 year old Asian male has been admitted to your ICU with severe symptoms of Covid 19 leading to pneumonia and acute respiratory distress syndrome requiring ventilation.

He is a widower with 5 children. He lives with his eldest daughter Sabira (58).

Nawar had been suffering from anxiety prior to his admission and been prescribed Citalopram.

1. What steps will you take to prevent PTSD and PICS for Nawar?
2. What steps will you take to prevent PICS-F for Sabira?
3. How will you know if either condition manifests in Nawar post discharge?
4. How will you know if PICS-F manifests in Sabira post discharge?
5. What is your duty of care post discharge in respect to these conditions?
6. What is the discharge management plan?

**Learning Event**

To take part in World Mental Health Day.

World Mental Health Day is run by the World Federation for Mental Health. It occurs with a different theme each October. This year’s theme (2022) is: ‘Make mental health and wellbeing for all a global priority’.

Mental Health UK are partnering with ITN Productions Industry News to produce Play Your Part, a digital news-style programme highlighting how everyone has a role to play when it comes to the future of mental health.

Mental Health UK states:

“The programme will raise awareness around the cost-of-living crisis and the affect this has on mental health, highlight the positive stories surrounding the recovery phase of the pandemic and showcase the changing conversations around mental health in the workplace. Showing how prevention is key, the programme will also explore the importance of educating the digital first generation at an early age, provide information to empower individuals to understand and manage their own mental health and will highlight the role of the NHS and local community initiatives.”

Please watch this programme:

[World Mental Health Day 2022 - Mental Health UK (mentalhealth-uk.org)](https://mentalhealth-uk.org/get-involved/mental-health-awareness-days/world-mental-health-day-2022/)

Please consider how you and/or service can take part in this and future World Mental Health Days/Weeks.

**Conclusion**

Working with people who are mentally unwell requires a high degree of self-awareness, enhanced and advanced communication skills, as well as an understanding of the conditions, risks and how they present. This of course is not mutually exclusive to this client group and it is hoped that the assessment of a person’s mental health is included in all assessments. This chapter cannot possibly cover the depth or breadth of information that is really required to fully appreciate the needs and complexities of this population. However, I hope that by highlighting the principles that underpin the work such as parity of esteem, diagnostic overshadowing, including unconscious bias, some of the risks, red flags and specific issues in acute, emergency and critical care the chapter will encourage clinicians to consider the needs of these groups and be able to focus attention on their needs.

There are of course experts in the fields of mental health who can and should be consulted, and often a multi-disciplinary approach is called for when working with individuals who are mentally unwell. Good quality care for this group hinges upon a commitment to therapeutic communication, holism, person-centred care, as well as an appreciation of the value of all individuals. Then and only then can we begin to address the huge health inequalities that still exist for these individuals and achieve true parity of esteem.

**References**

Baker, C; Gheera, M. (2020) Mental Health: Achieving ‘parity of esteem’. House of Commons Library. UK Parliament. Online. Mental health: Achieving 'parity of esteem' (parliament.uk); accessed 9/6/2022.

Bolton D, Gillett G. (2019) The Biopsychosocial Model of Health and Disease: New Philosophical and Scientific Developments [Internet]. Cham (CH): Palgrave Pivot; 2019. Chapter 4, Biopsychosocial Conditions of Health and Disease. 2019 Mar 29. Available from: https://www.ncbi.nlm.nih.gov/books/NBK552028/ doi: 10.1007/978-3-030-11899-0\_4

Burki, T. K. (2019) Post-traumatic stress in the intensive care unit. Spotlight. Volume 7, Issue 10, p843-844. DOI:https://doi.org/10.1016/S2213-2600(19)30203-6.

Calsavara AJ, Costa PA, Nobre V, Teixeira AL. (2021) Prevalence and risk factors for post-traumatic stress, anxiety, and depression in sepsis survivors after ICU discharge. Braz J Psychiatry. May-Jun;43(3):269-276. doi: 10.1590/1516-4446-2020-0986. PMID: 33053073; PMCID: PMC8136386.

Care Quality Commission. (2020) Assessment of mental health services in acute trusts programme. How are people’s mental health needs met in acute hospitals, and how can this be improved? [Microsoft Word - 20201014\_AMSAT\_FINAL FOR WEB (cqc.org.uk)](https://www.cqc.org.uk/sites/default/files/20201016b_AMSAT_report.pdf).

Centre for Mental Health. (2013) Briefing note: Parity of esteem. Parity of esteem: a briefing note | Centre for Mental Health. Accessed 17/8/2022.

Epstein RM, Borrell F, Caterina M . (2000) Communication and mental health in primary care. In New Oxford Textbook of Psychiatry (Edrs. Gelder MG, López-Ibor JJ, Andreasen NC), Oxford University Press, 2000.

Garlick & Rhodes. (2011). Holistic Adult Mental health Assessment Tool. Pavillion.

Garrouste-Orgeas M, Périer A, Mouricou P, Grégoire C, Bruel C, Brochon S. et al. Harris F. (2014) Writing In and Reading ICU Diaries: Qualitative Study of Families’ Experience in the ICU. 2014;9:e110146. ed. PLoS ONE. [PMC free article] [PubMed] [Google Scholar]

Gregory, C. (2022) [What Is Illness Perception? (with pictures) (wise-geek.com)](https://www.wise-geek.com/what-is-illness-perception.htm). Accessed 8/9/2022

Health Education England (2017) Multi-professional framework for advanced clinical  
practice in England: [https://www.hee.nhs.uk/sites/default/files/docuemtns/HEE%20ACP%Framework.pdf](https://www.hee.nhs.uk/sites/default/files/docuemtns/HEE%20ACP%25Framework.pdf)

Hufton, F., Petch, J., Rege, S. (2022) Ten Point Guide to Mental State Examination (MSE) in Psychiatry (psychscenehub.com). Accessed 13/7/2022

Joint Formulary Committee (2019) British National Formulary (online). BMJ Group and Pharmaceutical Press. <https://bnf.nice.org.uk>. Accessed 27/9/2022

Jones C, Bäckman C, Capuzzo M, Egerod I, Flaatten H, Granja C. et al. (2010) . Intensive care diaries reduce new onset posttraumatic stress disorder following critical illness: a randomised, controlled trial. Crit Care. 2010;14:R168. [PMC free article] [PubMed] [Google Scholar]

Jones, S.; Howard, L. & Thornicroft G. (2008). Diagnostic overshadowing: Worse physical health care for people with mental illness. Acta Psychiatric Scandinavica, 118: 169-171.

Kress JP. (2013) Sedation and mobility: changing the paradigm. Crit Care Clin. 2013;29:67–75.

Lang, R. (2019). What is the difference between conscious and unconscious bias?: Faqs. https://engageinlearning.com/faq/compliance/unconscious-bias/what-is-the-difference-between-conscious-and-unconscious-bias/. Accessed 1/8/2022

Martin S. Hagger & Sheina Orbell (2022) The common sense model of illness self-regulation: a conceptual review and proposed extended model, Health Psychology Review, 16:3, 347-377, DOI: 10.1080/17437199.2021.1878050.

Mehlhorn J, Freytag A, Schmidt K, Brunkhorst FM, Graf J, Troitzsch U. et al. (2014) Rehabilitation interventions for post-intensive care syndrome: a systematic review. Crit Care Med. 2014;42:1263–71.

Merriam Webster (2022) “Genogram.” Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/genogram. Accessed 25 Aug. 2022.

MIND, (2022) A to Z of psychiatric drugs - Mind. Accessed 31/8/2022.

MIND, (2021) <https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/black-asian-and-minority-ethnic-bame-communities>. Accessed 31/8/2022

Morandi A, Brummel NE, Ely EW. (2011) Sedation, delirium and mechanical ventilation: the ‘ABCDE’ approach. Curr Opin Crit Care. 2011;17:43–9.

National Health Service (2019) <https://www.nhs.uk/mental-health/conditions/psychosis/causes/>. Accessed 13/9/2022

National Institute of Mental Health (2021) Chronic Illness and Mental Health: Recognizing and Treating Depression.

National Institute of Mental Health. (2022) [NIMH » Suicide (nih.gov)](https://www.nimh.nih.gov/health/statistics/suicide). Accessed 15/9/2022.

NICE (2022a) Bipolar disorder: Lithium. <https://cks.nice.org.uk/topics/bipolar-disorder/prescribing-information/lithium/>. Accessed 27/9/2022.

NICE (2022b) Self-harm: assessment, management and preventing recurrence.

NICE guideline [NG225] [Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE](https://www.nice.org.uk/guidance/ng225). Accessed 15/9/2022.

NICE (2018) Bipolar disorder: assessment and management (NICE guideline). National Institute for Health and Care Excellence.

Pandharipande P, Banerjee A, McGrane S, Ely EW. (2010) Liberation and animation for ventilated ICU patients: the ABCDE bundle for the back-end of critical care. Crit Care. 2010;14:157.

PTSD UK (2022) PTSD from being in an Intensive Care Unit. [PTSD from being in an Intensive Care Unit – PTSD UK](https://www.ptsduk.org/ptsd-from-being-in-an-intensive-care-unit/). Accessed 21/9/2022.

Rawal G, Yadav S, Kumar R. Post-intensive care syndrome: An overview. J Transl Intern Med 2017; 5: 90-92

Royal College of Nursing. (2019) Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs. Royal College of Nursing.

Royal Pharmaceutical Society. (2022) The role of pharmacy in mental health and wellbeing | RPS (rpharms.com). Accessed 30/8/2022.

Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale. International Journal of Mental Health Nursing.

Sharma N, Gupta V. Therapeutic Communication. (2022). In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK567775/. Accessed 11/8/2022.

Sox, H.C., Higgins, M.C., Owens, D.K. (2013) Medical Decision Making. 2nd edn. Oxford:Wiley-Blackwell.

Swires-Hennesey, K., Hayhurst, C. (2021) Mental Health in Emergency Departments. Royal College of Emergency Medicine.

Taylor, D., Paton, C. and Kapure, S. (2012) The Maudsley prescribing guidelines. 11th edn. London: Informa Healthcare.

van Servellen, G. (1997) Communication skills for the health care professional: concepts and techniques. Aspen, Gaithersburg, MD

Vos, T., Barber, RM., Bell, B., Bertozzi-Villa, A., Biruyukov, S., Bollinger, I., ...Murray, CJ.. (2013). Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990-2013: A systematic analysis for the Global Burden of Disease study. The Lancet, 386(9995), 743-800.

Wake, S. Kitchiner, D. (2013) Post-traumatic stress disorder after intensive care. BMJ 2013;346:f3232 doi: 10.1136/bmj.f3232