CASE FOUR

Short case number: 3_5_4
Category: Mental health and human behaviour
Discipline: Psychiatry
Setting: Emergency Department
Topic: Mood disorders – Bipolar disorder

Case
Mae House, aged 21 years, presents in police custody to the emergency department. She is agitated and screaming and tells everyone that the police are harassing her. The police advise that she was causing a disturbance in a shoe shop as she was trying to buy all the shoes in the shop. Mae states that she likes shoes and wants to buy them all. She tries to tell you that she must have shoes because they are needed so she can 'dance all the way to heaven'. The police officer states that they know Mae's family and think the 'family has a history of mental illness'.

1. What further history, examination and investigations would you undertake in your assessment of Mae? What are the symptoms of elated mood you would need to check for?
2. During your assessment of Mae, what are the differential diagnoses of elated mood you will be considering? Remember to consider organic causes.

During your assessment Mae tries to dance about whilst being restrained by the police officer. She constantly moves and jiggles and sings whilst you are talking. Her words and ideas seem to make little sense, but she appears to sing and laugh inappropriately. She wants the police to let her go so she can get ready for a party.

3. What is your immediate management plan in Mae's case? Make a flow chart that addresses your strategy of management for an acutely disturbed patient?
4. Would you use the mental health act in this case? Please explain your reasoning.

You make a diagnosis of bipolar disorder with a first episode of mania. When you speak to Mae's GP to collect collateral information you find out she has had 2 prior episodes of depression, the first when she was 17 and the second age 19. She was treated with sertraline successfully for each episode but stopped this medication 6 months ago because she was doing very well.

5. What management is available in the longer term for Mae? Consider non-pharmacological and pharmacological therapies.

Suggested reading:

- What is bipolar disorder? Clinical resources https://www.blackdoginstitute.org.au/clinical-resources/bipolar-disorder/what-is-bipolar-disorder

- Malhi et al (2015), Mood disorders: Clinical practice guidelines and associated resources, available at
- https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/mood-disorders-cpg-and-associated-resources
- Colledge NR, Walker BR, Ralston SH, Penman ID, editors. Davidson's Principles and Practice of Medicine. 22nd edition. Edinburgh: Churchill Livingstone; 2014. Chapter 10.

Answers

1. What further history, examination and investigations would you undertake in your assessment of Mae? What are the symptoms of elated mood you would need to check for?

Mae House's presentation is highly suggestive of an elated mood typical of a manic episode. However, it needs to be clarified whether she is intoxicated or has another mental or physical disorder. This may require clarifying some of these aspects with Mae herself, or with friends or family members if she does not provide that information (manic patients are often uncooperative, irritable or too disorganised to give a coherent account of themselves).

Therefore, it needs to be confirmed the presence of a 'distinct' period in which there is an abnormally and persistently elevated, expansive or irritable mood, as well as other symptoms such as grandiosity, decreased need for sleep, pressure of speech, flight of ideas, lack of judgement, often with involvement in pleasurable activities with high potential for negative consequences. Isolated episodes of mania/hypomania do occur but they are typically followed by an episode of depression.

Psychosis may occur in both the depressive and the manic phases, with delusions and hallucinations that are usually in keeping with the mood disturbance. This is described as an affective psychosis. Patients who present with symptoms of both bipolar disorder and schizophrenia may be given a diagnosis of schizoaffective disorder.

2. During your assessment of Mae, what are the differential diagnoses of elated mood you will be considering? Remember to consider organic causes.

Manic episode due to Bipolar disorder is the likely diagnosis - is an episodic mood disturbance with periods of both depressed and elevated mood, known as mania or hypomania, when not severe.

There are a variety of medical conditions that can present with symptoms similar to mania or hypomania, for example multiple sclerosis, brain tumours, and Cushing's syndrome. Elated mood can also be substance-induced by both medications (e.g., corticosteroids) and drugs of abuse (e.g., cocaine).

All antidepressant drugs can cause manic symptoms in some patients ('manic switch'). This can be the manifestation of an underlying bipolar disorder in some but not in other patients.
When irritability is a prominent symptom of mania, distinguishing this from irritable depression can be difficult.

Schizophrenia needs to be excluded in cases with delusions. The typical age of onset, as well as the lifetime risk of 1%, is similar in schizophrenia and bipolar disorder.

In young people, hypomania or mania can be mistaken for attention deficit hyperactivity disorder and vice versa.

3. What is your immediate management plan in Mae's case? Make a flow chart that addresses your strategy of management for an acutely disturbed patient?

Immediate management plan will include ensuring Mae's safety, deciding if sedation is needed (see below), clarifying the diagnosis, deciding on the appropriate setting of care and deciding on the use of the mental health act.

- Ensure medical investigations, urine drug screen etc. completed to look for medical cause of symptoms.

- Collect collateral information about Mae: Little may be learned from an attempted interview with an uncooperative patient. Other sources of information about the patient are therefore crucial and include medical and psychiatric records, and discussion with nursing staff, family members and other informants, including the patient's general practitioner.

- Key information is psychiatric, medical (especially neurological) or criminal history; current psychiatric and medical treatment; current or previous alcohol and drug misuse; recent stressors; and the time course and accompaniments of the current episode in terms of mood, belief and behaviour.

- Simple observation of patients' behaviour may yield useful clues. Do they appear to be responding to hallucinations? Are they alert, drowsy and/or confused? Are there physical features suggesting drug or alcohol misuse or withdrawal? Are there new injuries or old scars, especially on the head? Do they smell of alcohol or solvents? Do they bear marks of drug injection? Are they malodorous and unkempt, suggesting a gradual development of their condition?

If a medical cause is found thought likely or found for Mae's presentation then, psychiatric transfer is inappropriate and the patient should be managed in a medical setting, with whatever nursing and security support is required. If no medical cause is found the Mae will need admission to a psychiatric facility with a diagnosis of bipolar mania, and likely under the mental health act (see below).

Flow chart that addresses management for an acutely disturbed patient:
Disturbed behaviour, mostly aggressive, is common in hospitals, especially in emergency departments. Most behavioural disturbance arises not from medical or psychiatric illness, but from alcohol or drug intoxication or withdrawal and dysfunctional personality.

The flow chart should include the following:
Ensure safety
1. The patient's safety: consider confidentiality but must be balanced with their safety.
2. One's own safety: do not turn your back to the patient; let the patient talk; ensure a safe escape route; do not try to handle a violent individual on your own (don't be a 'hero'); never try to disarm a person who has a weapon; adopt a non-confrontational, calming attitude (minimal eye contact, allow the patient plenty of personal space and distance, be respectful, remain calm, don't appear impatient or hurried, listen and show empathy, don't promise things that you can't deliver).
3. Other's safety: ensure that other people not necessary to manage the situation leave the area, remove items that can be dangerous or used as weapons.

Establishing control requires the presence of an adequate number of trained staff, an appropriate physical environment and, in some cases, sedation. Hospital security staff and the police may need to be involved.

Verbal de-escalation - In all cases staff responses to the patient are important. Early signs can be detected and diffused or ignored, leading to an escalation of the problem. A calm, respectful, non-threatening approach by a doctor or nurse who can understand and address the patient's fears may suffice (keeping in mind the safety issues).

Sedation - In some cases, acute sedation is necessary (hospitals usually have specific protocols for acute sedation and you need to become aware of and follow them). Oral sedation is the preference where possible, but at times intramuscular sedation or intravenous sedation is needed, and restraint may needed at this time.

The most widely used sedating agents are antipsychotic drugs such as haloperidol and/or benzodiazepines such as diazepam. The choice of drug, dose, route and rate of administration will depend on the patient's age, sex and physical health, as well as the likely cause of the disturbed behaviour. The benefits of sedation must be balanced against the risks, of which sudden death, though rare, is the most concerning. Haloperidol can cause acute dystonias and oculogyric crises, while the benzodiazepines can precipitate respiratory depression in patients with lung disease, and encephalopathy in those with liver disease. Thus appropriate sedation for a frail elderly woman with emphysema and delirium may be a low dose (0.5 mg) of oral haloperidol, while a threatening young man having an acute psychotic episode may need at least 10 mg of intravenous diazepam and a similar dose of haloperidol. A parenterally administered anticholinergic agent should be available to treat extrapyramidal effects arising from haloperidol. When benzodiazepines are used, flumazenil should be on hand to reverse respiratory depression. When benzodiazepines are used in large doses, oxygen and ventilation should be available.

Measures such as restraint, sedation, the investigation and treatment of medical problems, and psychiatric transfer all raise legal as well as medical issues. In most countries the law confers upon doctors the right and indeed the duty to intervene against a patient's wishes in cases of acute behavioural disturbance if this is urgently necessary to protect the patient or other people. Nevertheless, dealing with these situations is traumatic for the doctor and the patient. It is important that doctors understand that feeling worried, angry, guilty, afraid or anxious is a normal reaction to these events and, if so, is important to talk about it with trusted supervisors or more experiences colleagues to prevent further problems (e.g., alcohol abuse, post-traumatic stress) or burnout.

4. Would you use the mental health act in this case? Please explain your reasoning.

The laws covering involuntary hospitalisation vary from state to state, but generally, people can only be hospitalised involuntarily if they meet all of the following criteria:

- They have a mental illness
- They need treatment
- They can't make a decision about their own care

And one or both of these criteria:

- They are considered to be a danger to their own safety
- They are considered to be a danger to someone else's safety.

Below is an excerpt from for the principals of the mental health act in NSW and Vic from:
RANZCP Mental health legislation – comparison tables as at 30 June 2017
www.ranzcp.org/legislation

The mental act would likely be appropriate to use in Mae's case given she meets the criteria for a mental illness (a severe mood disorder and a severe disorder of thought form, with possible delusions) and poses a risk to herself via risk to her reputation, via misadventure and there is a risk to her finances.

	NSW: **Mental Health Act 2007** ss12, 14, 68	VIC: **Mental Health Act 2014** s5
Mental Illness	The person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment and control of the person is necessary:	The person has a mental illness and because the person has mental illness the person needs immediate treatment to prevent:
Harm	for the person's own protection from serious harm or the protection of others from serious harm and	serious harm to the person or to another person or
Need for care	N/A	serious deterioration in the person's mental or physical health and
Psychiatric treatment	N/A	the immediate treatment will be provided to the person if the person is subject to a temporary treatment order or a treatment order and
No less restrictive alternative	no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.	there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.
Additional criteria	In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effect of any such deterioration, are to be taken into account.	N/A

5. What management is available in the longer term for Mae? Consider non-pharmacological and pharmacological therapies.

The student should focus on the care for Mae once her acute episode of mania is controlled. The principals of longer term management for Mae would be using a biopsychosocial approach which aims to prevent or to quickly recognise and treat any mood episodes and to optimise function.

In most cases bipolar disorder is a serious, chronic, recurrent illness with a high mortality rate (suicide and collapse from exhaustion and dehydration) and significant impairment. It can also lead to patients putting themselves in situations which are later highly embarrassing and may be costly in financial terms.

Its treatment is complex and often requires input, at least initially, from a specialist. Therefore, referral to a specialist psychiatrist is recommended in most cases to confirm diagnosis and establish the most appropriate treatment. The engagement of the community mental health MDT team might also be necessary. However, primary care physicians are well placed to provide ongoing treatment in most cases.

Management of bipolar disorder varies according to phase (manic, depressed), severity, and whether one is treating an acute episode or trying to prevent recurrences (prophylaxis).

The diagrams below are from Royal Australian New Zealand College of Psychiatrists, Mood disorders: Clinical practice guidelines and reflect evidence based care.
https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/mood-disorders-cpg-and-associated-resources

Figure 11. Management of Mania.

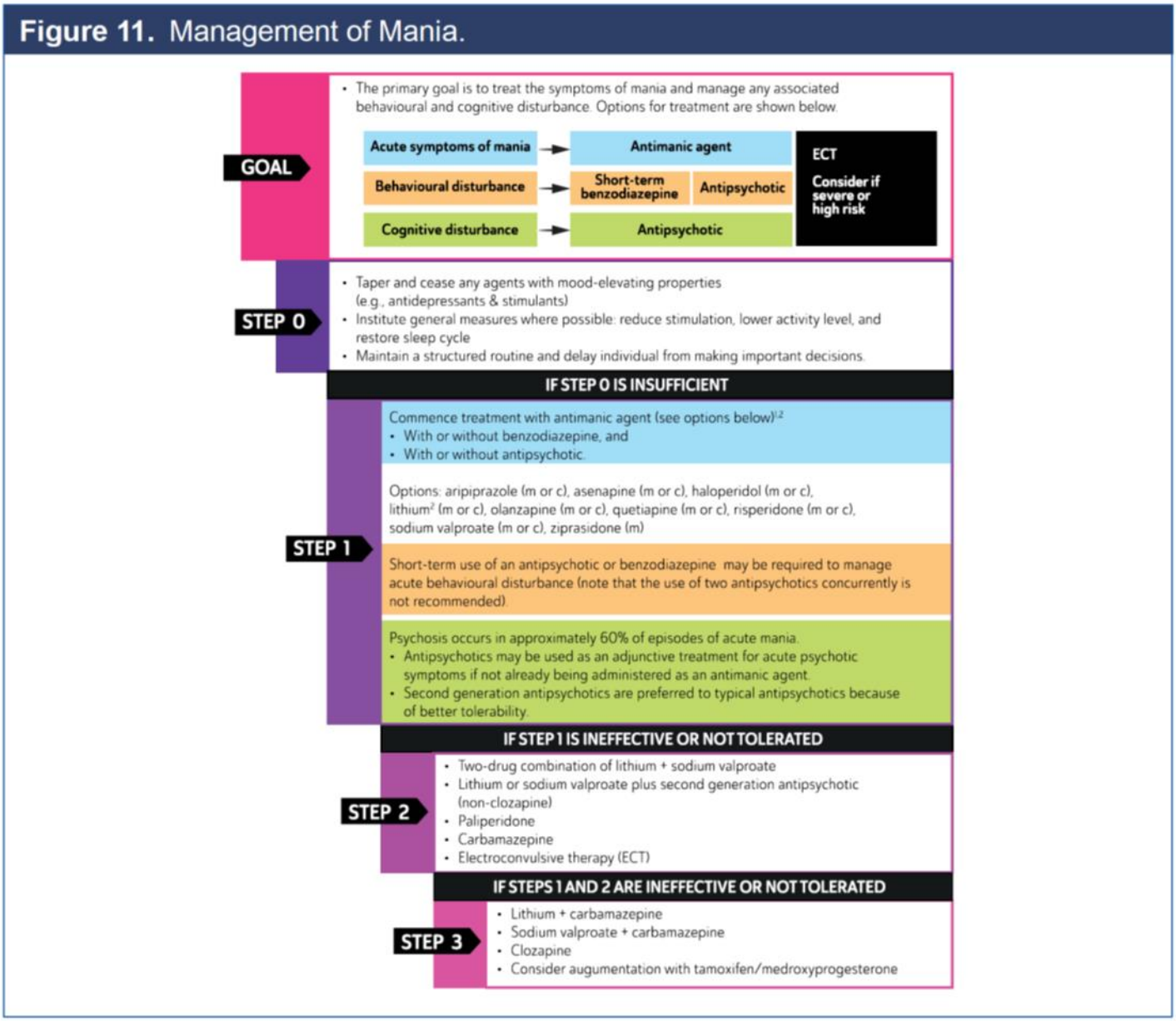
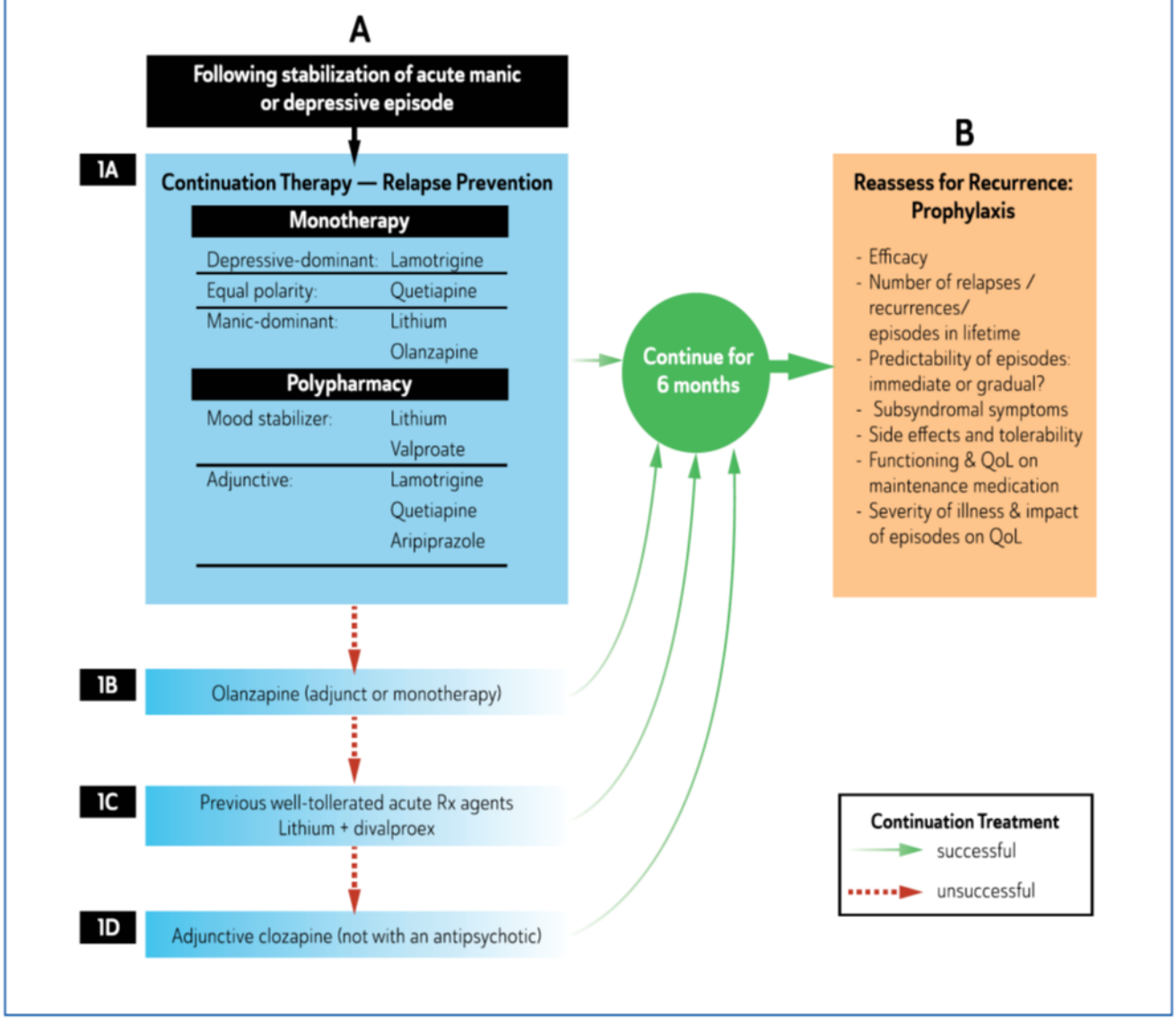


Figure 15. Continuation Therapy of Bipolar Disorder.



Decision making diagram for continuation therapy of Bipolar Disorder. Rx = treatment. QoL = Quality of life.

Table 23. Specific psychological interventions for bipolar disorder.

Four specific psychological interventions can be considered evidence-based (i.e., have at least one positive RCT), and have associated published manuals to guide treatment.

Psychological Intervention	Description
Cognitive-Behavioural Therapy (CBT) (Lam et al., 2010).	Focuses on the reciprocal relationships between thinking, behaviour and emotions to decrease symptoms and relapse risk.
Psychoeducation (Colom and Vieta, 2006)	Aims to assist people to become experts on managing their bipolar disorder, emphasising adherence to medication and stabilising moods. Psychoeducation is a descriptive term referring to providing information about the condition, but has been developed into manualised high intensity treatments by two groups of researchers (Bauer et al., 1998; Colom et al., 2003) and these formal interventions are the focus of the majority of the evidence base.
Family-Focused Therapy (FFT) (Miklowitz, 2008)	Based on evidence that family stress and interactions moderate relapse, FFT aims to improve communication and problem-solving skills in the family. Although only one family member may have a diagnosis of bipolar disorder, the entire family is considered 'the client'.
Interpersonal and Social Rhythm Therapy (IPSRT) (Frank, 2005)	An amalgamation of interpersonal therapy addressing losses, role conflicts and other interpersonal problems with behaviours aimed at stabilising circadian rhythms via stabilising social rhythms (e.g., fixing wake time across 7 days of the week).