Prescribing in Mental Health Crises

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This section provides an overview of emergency and crisis care for individuals with Intellectual and Developmental Disability (IDD) and Autism Spectrum Disorders (ASD). Acute crises are likely to occur when the intensity of stressors overwhelms the individual’s limited social, cognitive, emotional regulation and adaptive skills. For individuals with co-occurring behavioral health disorders, an adverse life event can trigger relapse, exacerbation of baseline challenges, or contribute to persistent vulnerability. The prescriber must focus on the relationship between preventative and resilience factors and the adverse events.

What is a Crisis and Who is Vulnerable?

Crises can be singular or recurring events that lead to difficulties for the individual in adapting or resolving the situation, significant changes in emotional states (internalizing), expressed behaviors (externalizing) or relapses in pre-existing mental disorders. Individuals with IDD, ASD and ASD + IDD constitute a heterogeneous population that vary relative to the severity, etio-pathogenesis, genetic/metabolic/medical and behavioral comorbidities, temperamental traits, and patterns of attachment. Events become crises in the context of the transactions among a multitude of ecological and biopsychosocial forces. In vulnerable individuals, crises can trigger the relapse of pre-existing conditions, or the onset of new disorders. Left unresolved, some crises can lead to life-threatening circumstance or worsening in baseline levels from a wide range of physical or mental health conditions.

How and for Whom Do We Evaluate?

It is important first to rapidly triage based on a quick assessment of nature, severity, and ecological context of the presenting symptom. Depending on the severity, medical evaluations help with the triage by ruling out potentially life-threatening illness or injury. The next step is to provide a protective environment to minimize any further physical or emotional trauma as the team provides a more focused assessment, gathers collateral information, completes a more detailed history, and performs medical/mental status examinations. The medical decision-making moves quickly towards rapid treatment at the expense of more detailed behavioral health decision-making.

Where Is the Best Place to Evaluate?

Unfortunately, for many behavioral health crises, there is pressure to jump to a rapid screening and referral to behavioral health specialists. The first step in the triage process is to decide whether to refer the individual to the ED or for community-based assessment. Community providers need to understand the strengths and weaknesses of ED referrals and, when possible, reserve ED consultations for complex, severe crises that require a higher level of care. The nature and structure of most emergency departments (ED) can intensify challenging presentations for individuals with IDD.

Assessment

An assessment begins with obtaining enough history to determine deviations from previous functional baselines, a search for predisposing and precipitating factors. Three timelines are useful:

1. Track the description of the emotional states or evolving signs/symptoms- time of appearance, escalation, frequency, and level of intensity.
2. Develop biopsychosocial and ecological timelines and maps of current life stressors.
3. Develop a timeline of interventions during this crisis and previous episodes.1,2

This approach is also helpful when combined with the template outlined in the DM-ID-2- addressing predisposing, precipitating factors leading to persistence, and protective/resilience factors.3

Any template or timeline strategies remain incomplete without addressing both previous trauma history and the imbalance between protective/resilience and vulnerability factors. In short, the assessment is an ongoing process that may take time and flexibility. Table 1 outlines a useful mnemonic and key methodology in assessing individuals in crisis.
Table 1. Key Components in Assessing Individuals with IDD, ASD or IDD + ASD in Crisis

- Assess for medical/neurologic disorders (use the HEAD TO TOESS acronym as a guide) \textsuperscript{1,2,4}
  - Headache and other pain (ingrown toenails, calluses)
  - Epilepsy
  - Aspiration Pneumonia or dysphagia
  - Drugs: Assess for adverse medication effects or interactions; ask about complementary and alternative medications; understand recent changes
  - Teeth: Examine the individual’s teeth for dental pain, infection, abscesses, or impacted teeth
  - Ocular and Otolaryngology Issues: Earache, hearing issues, sinusitis, vision problems, and obstructive sleep apnea
  - Tummy: GERD, Constipation, Bowel obstruction and volvulus
    - Osteoporosis and atypical fractures, pressure sores, spasticity
    - Etiology/cause of IDD: Genetic syndromes can have acute presentations
      - Eg. Calcium Disturbance in William’s Syndrome
      - Serious or new onset illness can present atypically (hypothyroidism, DM I or II)
        - Look for subtle signs that the individual is very ill such as not drinking/eating
    - Screen for abuse \textsuperscript{1,4}
- Assess for psychosocial stressors including personal loss (e.g. caregiver, friend, staff, etc.), change in program, residence, etc.
- Assess for comorbid substance use/abuse/dependence
- Assess for comorbid psychiatric disorder
- Physical examination: Conduct a full and comprehensive physical examination
- Mental Status Examination: Assess suicidality and homicidality, psychotic symptoms, catatonic symptoms, and future orientation
- Labs to consider: thyroid stimulating hormone (TSH), complete blood count (CBC), vitamin D level, liver function tests (LFTs), renal function tests, urine drug screen, (any other pertinent labs based on exam and history).
- Consider imaging based on history and physical examination (eg. Abdominal imaging for constipation, etc.)

Psychotropic Drugs

The use of psychotropic drugs in crisis stabilization is a balancing act. In some contexts, the individual’s expressed emotional state and/or signs of stress requires a thorough assessment, but they cannot tolerate the ED. Unfortunately, an over sedated person can provide limited information but an agitated one may interfere with a comprehensive evaluation. Non-pharmacological strategies (Table 2) can be extremely helpful.

Table 2. Non-Pharmacologic Strategies to Utilize in Emergencies and Crisis

- Attempt to verbally de-escalate the individual
- Find out what thing are comforting, soothing or enjoyable to the individual- consider utilizing positive psychology interventions
- Quiet room, minimize non-essential monitoring equipment, dim fluorescent lighting
- Ensure safety, consult with or have available individuals familiar with the patient’s history
- Consistent staff, minimize intrusive or nonessential contacts
- Explain or demonstrate when possible what is about to be done
- Minimize physical restraints or prn injections if possible \textsuperscript{5,7}
- See chapter on Sensory Recommendations for Medication Prescribers in this guide for further recommendations.

When Do We Prescribe?

The decision to use psychotropic drugs in crisis intervention is a complex topic that cannot be reviewed in depth here. Many of the basic decision-making steps are outlined in this guide. Each section in this guide provides guidelines for medication selection for psychiatric disorders.
Who Should Get Psychotropic Drugs?

Externalizing behaviors like aggression, self-injury, agitation and loud vocalizations are heterogeneous and arise from many sources. There is no one-size-fits-all for behavioral or pharmacological treatment. Table 1 provides an outline of many medical factors that can contribute to crisis. The presence of a psychiatric disorder does not eliminate the possibility that one or more of these medical issues is the culprit. Frequently, treating the underlying psychiatric disorder or medical condition will mitigate the crisis. The same approach applies to many internalizing symptoms.

The evidence-based treatments available for irritability provide a problem. Irritability is a transdiagnostic pattern of behavior (occurs across many diagnostic categories) that may respond to a variety of medications. Evidenced-based choices frequently include broad-spectrum treatments such as risperidone and other second and third generation antipsychotics. Other options include anticonvulsant mood stabilizers, benzodiazepines, psychostimulant-type drugs for patients with comorbid emotional lability, SSRIs and SNRIs.

One major issue involved in pharmacological crisis intervention hinges on factors such as patterns of co-occurring symptoms, lack of specificity of a drug for a specific behavior, delivery systems (IM, PO etc.), and a prolonged latency of absorption and response. Each of these factors can also limit the efficacy of many drugs as PRNs. Equally problematic is the challenge of polypharmacy, multiple complex pattern of drug-drug interactions, and the increased likelihood of an adverse drug reaction mimicking psychiatric symptoms.

Unfortunately, there is a modicum of research on psychopharmacologic treatments for individuals with IDD, ASD and IDD + ASD in crisis. We have the usual guidelines of “start low and slowly titrate” based on response to treatment with consideration of comorbid medical issues and drug-to-drug interactions. The individual should be closely monitored for response or adverse reaction to treatment. Selection of the medication is based on: symptoms, comorbid diagnosis, safety, side effect profile, drug-to-drug interactions, and historical response to a medication/or class of medications 5. If the individual is in need of medications the goal should be to calm the patient and not completely sedate them 6. Oral medication administration is preferred over intramuscular or intravenous route 7. Problems with maintaining IVs and the risk of prolonged QTc intervals and other cardiac side effects restrict the use of IV antipsychotics. Some combinations of IM antipsychotic and benzodiazepine are a mainstay for treatment of acute agitation. In the emergency department setting these include haloperidol 5 mg with lorazepam 1-2 mg, or IM olanzapine or ziprasidone 10 mg 5.

Side effects to consider when selecting a medication include the following.

- Antipsychotics: may cause acute dystonic reactions, akathisia or QT prolongation
- Benzodiazepines: over sedation, respiratory depression, and some individuals with IDD or ASD may have a paradoxical reaction to benzodiazepines and become more agitated instead of more calm/sedated.

While medications may calm the individual, it is important to recognize that they are not diagnostic and the cause for the emergency/crisis should be pursued, fully evaluated, and treated appropriately.

References


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