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Commentary

Surveillance of Mental Health Patients in the Emergency Department

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Introduction

This is known that the entry point for all cases into the hospitals is via the emergency department with limitations of space, surge capacity issues have led to patients being backlogged in the emergencies waiting for admission beds to be allocated.

Thus, this is very challenging to identify a patient or child /adolescent if they need mental healthcare or not. Patients who have other medical conditions also have a challenge with missed recognition and treatments (Singh & Arithra, 2020).

The first step to recognizing the issue is the first look, first ask, first feel method that should be applied at the triage. First look at the appearance of the patient, first ask for identification, and first feel to look for organic causes.

Surveillance triage is one of the medical assistances to keep an eagle eye looking out for potential mental health candidates in a crowded ED.

An initial emergency can be measured with surveillance scores. This is not the most efficient but the most efficacious way to detect the mental condition. The process is easy to apply and f aster. It can detect alcoholism, CAGE, depression, SADPERSON, etc.

A patient with MH should not be left alone in a clinical treatment area without surveillance in surge areas, rather patient should be kept in a visible space with the presence of emergency staff.

A healthy environment in a chaotic emergency department might be the key to recognition.

The approach of treatment to a mental health patient in the emergency department has always been superficial. A proper flow of interventions similar to other life support interv entions basic advanced trauma or neurological life support also deserves a place with mental health similar to other approaches and steps in improving care in the emergency department (Singh, 2022).

A mental health flow chart in the emergency dealing with patients with mental health can include verbal interventions, physical interventions and pharmacological interventions.

Verbal interventions are also known as psychoeducation. Speaking to parents, the children and adolescents affected, and exploring further will help in debriefing strategies.

Physical interventions include resuscitation, and life support ruling out organic causes by blood investigations or radiological investigations.

Psychopharmacological methods include medications and this does not mean sedating the patients with midazolam or valium, but rather exploring more pharma co-interventions such as risperidone and its disability to be prescribed within the emergency medicine setting.

Evidence-based medicine, especially the PICO method, must be incorporated into the existing treatments of mental health patients in the ED. DSR classification which is underutilized must also find a role into the emergency diagnostic pathways.

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Cultural aspects in Mental Health

Now it is a easily accessible world for all. Many of the patients come from the culture that continues to be prevalent in that area. However, All medical must be aware of the other cultures in the region and well as less common cultures to create holistic care for all patients while they came to take the emergency services. Healthcare professionals in a particular community must investigate this iceberg phenomenon, which describes the shallow, medium, and deep cultures, rather than just dismissing it since it might not be a serious issue.

When it comes to language, how a patient describes their illness, how they approach first aid treatments performed at home, whether they seek care right away or wait, whether they prefer invasive or conservative treatment methods, and other factors, cultural variation can speak volumes in the emergency room.

The CFI (cultural formulation) definitely would help in identifying and treating our patients with different cultures better and make the disease treatment more accurate and cultural sensitive to our patients in which majority of the tertiary centers are now practicing patient-focused or patient-centered care (Jarvis *et al.*, 2020).

Mental healthcare can involve a pattern like: Tired, hungry, in attention—---ADHD—---Adjustment disorder—---Defiant behaviors Conduct disorder.

Knowing where the world is and intervening with either a change in lifestyle or the addition of pharmacotherapy can help us identify and treat each one.

It is required a clear, quick, and simple pathway for identification, emergency treatme nt prescription, discharge, or referral, whether it be for inpatient or outpatient care, to help the busy emergency physician. First would be a Cognitive behavioral therapy or parenteral guide.

If the patient is causing harm to himself, others, or the environment that he or she is in, then the addition of medications may be necessary. In older adults or adolescents, a combination of often required and using risk stratification tools to decide on inpatient or outpatient medications can be helpful.

Depression/ Anxiety

Depression is an underdiagnosed condition in patients presenting to the emergency departments. Patients may present with physical symptoms such as nausea, vomiting, irritability, abdominal pains, or headaches rather than mental symptoms and this is particularly important for the emergency physician to pick them up early. Early suspicion and recognition can lead to a more accurate diagnosis and identification of major depressive symptoms in the emergency department. One simple way is to use thescreening tools such as the SADPERSON score as well as the PHQ-9 questionnaire (Manea, Gilbody & McMillan, 2015). Once screening is done a REACH approach should be used. An abbreviation of SBIRT can also be used in the early treatment and recognition of anxiety disorders by emergency physicians in the emergency department.

R RECOGNISES WARNING
SIGNS E EMPATHY
A ASK ABOUT SUICIDE
C COMMUNICATE
HOPE
H HELP SUICIDAL VICTIMS ASSESS CARE

SBIRT
S SCREENING
B BRIEF
INTERVENTION R
REFERRAL
TREATMENT

Somatoform disorders

Somatoform disorders with functional disorders presenting as bodily symptoms can be common in emergency departments. However, it is the job of the emergency physician to rule out organic causes first. Once organic causes have been ruled out functional causes rather than structural causes should be considered with consideration of functional neurological symptoms. Conversion disorders which present as somatic bodily symptoms may also be present at the doors of emergency departments. Hypochondriasis should be thought of as well in patients with mental health disorders presenting to the ED with complaints that yield a normal investigation result. A rehabilitative mindset with appropriate referrals should be the mainstay of therapy in the emergency setting

Eating Disorders

Patients presenting to the ED with eating disorders are not uncommon (Chandra, Abbas & Palmer, 2012). Persistent vomiting with lethargy and electrolyte imbalances are telltale. From the ED perspective, organic causes must be ruled out but we know that eating disorders have the highest mortality among them in mental health disorders. Thus refeeding syndrome can occur after aggressive treatment in ED which can lead to morbidity as well. A careful history eliciting eating disorders such as anorexia nervosa and bulimia, leading to malnutrition, and other organ impairments such as liverderange, patients electrolyte imbalances, cardiac malfunctioning, and sexual dysfunction are all spectrums of the same disease and must persuade the emergency physician to think of eating disorders as the underlying cause. Cognitive behavioral therapy can then be planned with meal planning which can treat the patient on a long-term basis

Conduct disorders

It has been seen that many conduct disorders in the emergency departments daily. Interagency alliances and collaborations have made conduct disorders a one-stop crisis center or blood investigation and urgent medical checkups at hospitals a common understanding and routine. However, how we approach these patients matters and a proposed quick screening and modality of treatment tool is introduced here to help facilitate busy emergency medicine physicians to not only do routine calls for conduct disorders but rather approach them with a conducive and helpful approach.

B Behaviour exhibition
O Onset
L Location
D Duration
E ExacerbatesR Relief

PRESTO PLAN
P Partner with the family
R Risk assessment
E EducateS Support
T Track signs and symptoms O
Objectives and action plans

Substance use disorders

substance abuse in the emergency setting is encountered often and is one of the main reasons for ED visits. The approach of the emergency physician has always been to rule out other organic causes, recognize the substance, provide the antidote, and plan a disposition for the patient based on toxicology and toxicology screens. However, a mental health perspective must be taken by the emergency physician and included it in the management of substance abuse patients.

Habits
benefits
Dependence

is a known cycle and we must identify which stage the patient is in the stages of acts and their recovery plan would bePre-contemplation(engagement) contemplation(awareness) prepare(change strategies)action(treatment) maintenance(relapse prevention).

Conclusion

As a conclusion, mental health screening is an important parameter to measure and treat in the emergency department. Though it may not be as acute or life and limb threatening as other illn esses, it may pose danger to the patient if risk assessment is not done adequately that can lead to mortality and morbidity. Recognition of common mental health disorders in the emergency department is important and early, quick screening methods must be applied to assess the severity and improve recognition. A quick treatment method must also be applied and proper disposition and referral system must be applied for the patient to get adequate help they need.

Conflict of Interest

The author(s) declare that they have no competing interests.

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