

Chapter

1

Assessment and general approach

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Introduction

Clinicians in overburdened emergency departments (EDs) and other acute care environments provide a broad array of services. In addition to handling emergent medical or surgical conditions such as trauma, heart attack, or stroke, ED providers are often the front line of care for patients with psychiatric disorders. Demand for a full spectrum of care provided in EDs continues to grow. The Institute of Medicine report *Hospital-Based Emergency Care: At the Breaking Point*¹ describes the ways in which demand for care in EDs far outpaces supply in the United States. The volume of patients with psychiatric complaints in EDs has continued to grow as part of this trend.^{2–7} Increasingly, ED providers are called on to assess and manage patients in psychiatric crisis, often for days at a time.

A number of factors have contributed to this greater use of EDs by patients who are in need of psychiatric assessment and care. These factors include shortages of psychiatrists and other mental health professionals, limited and often fragmented systems of outpatient psychiatric care options, lack of other sources of support for persons with chronic mental illness, and steadily diminishing inpatient psychiatric beds, both acute and long-term. Not surprisingly, patients and families seeking help for psychiatric conditions for which the community provides no other services look to the ED as the provider of last resort. With fewer inpatient and outpatient resources available, patients wait longer in the emergency setting, contributing to crowding, and in some situations adversely affecting staff and patient safety.

Given these circumstances, virtually all ED clinicians will likely provide some psychiatric assessment and care, in spite of often limited psychiatric resources for referral or inpatient care. Regardless of staffing models or location of emergency facilities, there are fundamentals of emergent psychiatric assessment that need to be applied to patients with psychiatric disorders. The most important consideration is the safety of all. This will be a recurring theme throughout this and subsequent chapters. A systematic approach to safety, assessment, stabilization, and disposition is the most effective means to create a secure and effective treatment environment for acute psychiatric conditions.

Practical safety considerations

There are numerous safety, legal, and logistical issues that arise when caring for patients with emergent psychiatric complaints. Prior to a discussion of the fundamentals of patient

assessment and management, it is important to review some of the issues that form the backdrop against which emergency psychiatry occurs. Instituting a culture of safety and having practice expectations clearly defined in advance will cut down on confusion and enhance patient care and safety.

Triage. ED nurses and physicians routinely perform assessments of acuity of a patient’s condition based on a very brief examination. This can be a particularly challenging task in patients with psychiatric complaints. There should be institutional and ED-based policies and protocols addressing the process of ED triage and management of patients with psychiatric and other behavioral presentations. These may vary depending on the availability and organization of psychiatric services. Triage practices should incorporate assessments for severity, risk, and potential need for time-sensitive intervention, and issues pertinent to communication between emergency and psychiatric providers, especially if they are available for rapid consultation. Absence of a policy or established protocols invites a variable approach to patients which can be a serious risk in the ED environment.

Space. Most EDs do not have a space specifically designed to handle patients with psychiatric complaints. In many settings, a space has been carved out of the main ED to prevent “clogging” of medical/surgical beds by longer-stay and occasionally behaviorally disordered patients. Ideally, the area would have maximum visibility for staff and privacy for patients. A thoughtful design would also incorporate safety features including detachable sprinkler heads and lack of other obvious anchoring sites, grounded outlets, and safe restroom facilities for patient/self-care.*

Even in facilities where there is a designated area for patients with psychiatric complaints, crowding of patients can be severe. Without an effective means of communicating concerns between dedicated psychiatric providers and other emergency medicine providers, the risk of adverse events increases. Concerns about a patient’s safety and need for observation must also be conveyed directly and plainly to subsequent providers at hand-offs. Similarly, if acuity in the psychiatric designated area (where they exist) is high, or if crowding threatens to surpass what can safely be handled, providers in both areas must be able to convey concerns in order to avoid catastrophe.

Safety meetings. Routine, multidisciplinary meetings to discuss issues related to the care of patients with psychiatric emergencies in the ED can have tremendous impact on safety and the quality of care delivered. The Comprehensive Unit-based Safety Program (CUSP)** has proven to be a successful model in creating and implementing needed change in other medical settings.^{8–10} This approach can be adapted to emergency psychiatry. Members of such a group focused on psychiatric care provided in the ED would optimally include ED physicians and nurses, security personnel, legal or other executive leadership, clerical staff, social workers, and others whose work involves patient care.

* The National Association of Psychiatric Health Systems (NAPHS) has a list of guidelines for inpatient psychiatric units and many of these guidelines have applicability to designated space for psychiatry in an ED ([http://www.naphs.org/Design Guide 4_3 FINAL.pdf](http://www.naphs.org/Design_Guide_4_3_FINAL.pdf)). Further discussion of physical space and categorization of types of psychiatric emergency services can be found in the APA Task Force on Psychiatric Emergency Services’ *Report and Recommendations Regarding Psychiatric Emergency and Crisis Services: A Review and Model Program Descriptions*.

** The CUSP format is an approach to improving patient safety which involves examining systems of care, introducing evidence-based (when possible), high-impact interventions to improve care, measuring rates and outcomes, addressing cultural issues in the setting and learning from errors.¹⁰

Communication among providers. In psychiatric emergencies and in the ED generally, communication among providers is fundamental, but is often taken for granted, and when not done well can be a source of confusion and error. Hand-offs at change of shift or patient transfer are particularly fraught with risk and have been recommended as a target for improvement.¹¹ Clear documentation of medical reasoning and effective verbal communication at hand-offs can help avert disaster. This applies to transfers to inpatient wards, communication with outside facilities when arranging transfers, and interactions with paramedical professionals (e.g. emergency medical technicians (EMTs), clinical aides) involved in patient care. Communication of threats or acts of violence by patients (or even family or friends of patients) is also important and is discussed in the section ‘Behavioral alerts and aftercare plans’ (below), and in Chapter 10.

Given the number of elements involved in the care of patients with psychiatric symptoms, an operational checklist^{12,13} may be a way to keep track of the various forms, documentation, and other elements of communication that a presentation can generate. For example, a patient may present with a somatic chief complaint and later require a psychiatric assessment. In that instance, it is useful for mental health providers to know the status of the workup and plan for medical issues.

Emergency assessment and involuntary commitment. In some settings, police bring patients in their custody to designated facilities or select hospitals for psychiatric assessment. In other places, these patients are taken to the nearest ED. Laws vary by state regarding the process by which people with dangerous behaviors thought to be based on a psychiatric disorder are brought to emergency medical attention. Knowledge of applicable laws is essential. A hospital’s legal team is usually willing to provide periodic updates or refresher courses for ED staff on the legalities of a state’s emergency involuntary assessment and commitment laws. Reviewing the sometimes arcane details of these laws can help avoid bad outcomes and allow staff to have a greater sense that their decisions, which may run counter to the wishes of the patient, are clinically driven and legally valid. Attention to the details of forms and paperwork is critical. Patients in clear need of involuntary psychiatric care may sometimes be released at a commitment hearing, not because of doubts about clinical judgment, but because of incomplete or poorly completed paperwork.

Reluctant patients. As with all patients seen in an ED, the patient’s autonomy must be respected and care provided only to the extent accepted by the patient. For the patient brought by family or friends for psychiatric issues, or for the patient who comes in for a somatic complaint but who appears to require psychiatric assessment, concerns for the safety of the person and others may outweigh patient autonomy. Both situations require judgment on the part of the physician as well as nurses and support staff and may necessitate urgent psychiatric consultation, or even contact with available legal counsel. Here again, ongoing communication of the patient’s status between providers is critical (especially when different disciplines are involved). Uninformed staff may mistakenly release a dangerously impaired person in need of further care. Conversely, a lack of adequate communication could result in holding a person against his/her wishes, even through use of force, leading to potential harm to the person.

Patient searches. Formal search policies, reviewed by the hospital’s legal team, should be in place. Searches, and confiscation of belts, potential (or actual) weapons, and drugs of any kind, remain important interventions and these should be adequately

explained to all patients prior to conducting searches. While some patients may take offense, ED staff have a responsibility to provide (and patients have a right to be seen in) a safe environment in which care is delivered. Some hospitals, often in response to adverse events, insist that all patients who present with psychiatric complaints be stripped and put in a gown. While this may have a practical benefit in removing many (though not all) means of harming themselves or others, it presents a number of problems. The first is a misguided impression that these patients are unquestionably safer in a hospital gown. Standard hospital gowns can easily be anchored for hanging, used for strangulation of others, or even torn up and ingested. Many people find these garments humiliating as they are usually open in the back and offer scant bodily coverage. Forcing patients to wear gowns can often increase the distress of an already stressed patient, compounding the difficulty of discussing intimate issues. For patients with histories of sexual trauma, the violation of personal space and forced stripping can exacerbate mood and anxiety symptoms and even lead to violence. Whatever the policy, forced stripping should not be routine.

Firearms and patients in custody. Prisoners or persons otherwise in custody frequently end up in the ED. They may have an armed police officer or guard at the bedside and may be physically restrained. For hospitals providing care in these circumstances, there should be a policy about the presence of firearms during psychiatric assessment of such patients. The unpredictable behavior that may accompany many psychiatric conditions should be adequate reason to ensure that firearms are highly secure.

Privacy. The Health Insurance Portability and Accountability Act (HIPAA) had a number of aims, including greater security for patients' personal information, but the Act has also inadvertently led some providers to fear disclosing any health-related information, even in emergencies when the information can be critically important. Adding to that is the tradition of keeping psychiatric records sequestered due to the risk of disclosure of intimate, potentially embarrassing information, all compounded by the stigma of mental illness. These are sound reasons for discretion in releasing psychiatric records, but there are times when clinical considerations may be more compelling. Many patients in psychiatric crisis are willing to sign a release form to allow communication between providers and other contacts, though some are not. Determining when a psychiatric emergency is dire enough (and the information critical enough) to go against a patient's wishes for privacy requires experienced clinical judgment, often buttressed by counsel (legal and medical) from others. Exceptions to absolute confidentiality in the ED for patients with psychiatric issues include situations where there is a duty to protect the patient, a duty to warn a patient's intended victims, or a duty to inform legal guardians or surrogates.^{14,15}

Privacy is a prized commodity, especially in a busy ED.¹⁶ When possible, the physical space should allow the patient to discuss psychiatric complaints without fear of being overheard by other patients or non-treating staff. In some settings, creating such an environment is no small task, and may involve use of family meeting areas, sound masking devices, and creative use of existing space. The desire for privacy must be balanced with the need for patient safety and ready access to security and other staff if needed.

Collateral informants. In psychiatric emergencies, the people who know the patient best, including physicians, can provide critical information and perspective that a patient may be unable or unwilling to provide. Nevertheless, there may be times to be skeptical about the motives of informants. Providers should seek to verify information whenever

possible, and confirming informants' observations is an important strategy. Police and EMTs who bring in patients may also be useful informants, for example, by providing information on where the patient was found and what he or she was doing prior to arrival and during transport.

Fellows, residents, medical students, and visitors. Though common sense goes a long way, it is useful to establish ground rules and expectations prior to allowing a rotation for newcomers in the ED.¹⁷ The level of supervision for the trainee interacting with patients and families should be clear in advance. A primer on confidentiality and basic safety in the area should be provided and should be tailored to the setting. Trainees should not interview patients alone in seclusion rooms. Interviews with potentially agitated patients should be conducted close to security guards and only by experienced and trained team members. In some instances, a gender-appropriate chaperone should be present. Trainees should know how to seat themselves and the patient to allow for the quick egress of the patient and the trainee if needed. Trainees should be told to keep a low threshold for terminating an interview, if the patient appears to be getting agitated or the trainee is otherwise becoming uncomfortable. In many settings, an introductory class is conducted for trainees and new employees (and refresher courses for current employees), with hands-on training to demonstrate take-downs (this should be performed by trained staff only), use of seclusion and restraints, and escape from various holds as well as a detailed description or tour of the setting, including security features, routes of egress, and the operation of emergency alarms. This training should include an explanation of the roles of security personnel, physicians, nurses, and other staff, as well as the alerts used in the facility for agitated and/or violent patients.

Patient visitors in the ED can be a thorny issue. In some EDs, friends, family, or even patient advocates may be allowed to stay with patients undergoing assessment in the ED. Visitors may provide a calming influence for someone in psychiatric crisis. There are times, however, when visitors may actually be a more destabilizing presence for the patient or others in the ED or may simply contribute to crowding in an already congested area. In some settings, limitations on space and concerns about safety can make visitors a significant risk for all involved. A thoughtful policy that reflects the practice at the facility is important and this should be conveyed to inquiring potential visitors.

Assessment

Patients presenting with psychiatric issues may arrive at the front door of the ED self-referred, brought or accompanied by concerned family and friends, or in police custody. The complaints may be straightforward or subtle, and in many cases the complaints may obscure the underlying issue. Patients presenting with somatic complaints may have active psychiatric issues¹⁸ and may even be harboring suicidal thoughts.¹⁹ Many patients who go on to complete suicide have recently seen a physician, though often not for an ostensibly psychiatric chief complaint.²⁰

Medical screening. One of the most important tenets of emergency care is that all patients, regardless of presentation, are carefully screened to determine if a medical condition is contributing to their symptoms and behaviors. Only after the extent of medical illnesses are known should an urgent yet careful psychiatric assessment take place, if warranted. The need for obtaining vital signs at triage with patients presenting with psychiatric symptoms is frequently raised. There are a number of medical

conditions that can masquerade as psychiatric presentations (see Chapter 5) and vital signs may be the only early clue. A delirium due to some infectious process, for example, may present as agitation and combativeness. Sometimes patients are too agitated for vital signs to be safely read at triage. Once stabilized though, a comprehensive set of vital signs should be obtained.

Laboratory studies and imaging. Routine use of ancillary services, such as electrocardiograms (ECGs), chest x-rays, head CTs, and laboratory panels, including a toxicology screen, for all patients with psychiatric complaints is of questionable utility.^{21–29} There is no one-size-fits-all approach to ancillary testing and there are no established or reliable standards for every patient and setting. Not all patients need a full, detailed workup.

Appropriate ancillary investigations are determined by the patient's presentation, an understanding that psychiatric diagnoses in the emergency setting are diagnoses of exclusion, time and resource constraints, and the need to guide stabilization or reversal of acute medical conditions that cause or mimic psychiatric symptoms. Basic metabolic panels and complete blood counts are generally indicated and can be of great utility in ruling in or out organic diagnoses. However, head CTs are not routinely appropriate even in those with an abnormal mental status. CT imaging of the head should be considered in a patient with unexplained new mental status change.

Not all patients need urine drug screens and blood alcohol levels, though these studies may prove instructive. Urine drug screens can be useful in confirming details of patient drug use, prescription or illicit,^{17,30} but may not contribute enough to emergency decision-making to warrant routine screens for all patients.³¹ General emergency medicine practice is to determine patient sobriety based on physical examination and clinical judgment. With alcohol, there is great variability in effect and tolerance among individuals, thus, basing judgment on levels alone may not always be appropriate. Assessment can be further complicated by the use of benzodiazepines to treat withdrawal symptoms. A full psychiatric assessment of an acutely intoxicated patient, however, is of little utility. Some assessments, such as a focused assessment of safety, are nonetheless an element in the management of intoxicated patients in the ED, who may be (or may become) belligerent, suicidal, or otherwise disruptive to the ED milieu.

Some ancillary studies are impractical and are unnecessary in the emergency setting. At many facilities, thyroid studies, vitamin levels (e.g. B12, folate, thiamine), and therapeutic monitoring levels (e.g. quantitative tricyclic antidepressant levels) are not performed daily or are sent to outside facilities to be performed. In instances of suspected overdose on tricyclics, an ECG will provide more rapid and useful information than a quantitative tricyclic level which may take days to be processed.

ECGs can be useful in emergency psychiatry, as many psychotropic medications used are known to prolong the QTc interval, potentially leading to a fatal arrhythmia. Thus, a screening ECG may be useful if psychotropics are being used or are contemplated. Severely agitated patients may require neuroleptic or other medications emergently, in order to keep themselves and others safe, before a baseline ECG can be obtained. Once the patient is calmer, an ECG should be obtained. Whenever possible, knowledge of a patient's pre-existing risk should determine the aggressiveness with which the ECG is pursued and may lead a provider to choose a different class of medication as an alternative. In many cases pre-existing risk may be difficult to ascertain before medications are given.

Physical examinations. The patient's presentation, elements of the history, and medical conditions being considered will likely determine the focus(es) of the physical exam. Routine disrobing in the ED of every patient with a psychiatric complaint for the duration of their ED visit should be avoided when possible.³² Patients who are presenting for primarily psychiatric reasons may not be expecting a physical examination. Patients should be told in advance that a physical exam or other contact is forthcoming. The gender identification, trauma history, and/or sexual orientation of the patient might also need to be considered and chaperoning with gender-appropriate staff (and documentation of same) provided for the patient's comfort and dignity.

Psychiatric assessment. Essentially, psychiatric assessment begins at triage with the chief complaint and includes the mode and details of presentation. The following questions are helpful to quickly understand the immediate needs of the patient.

- How did the patient present to the acute care setting? Who else was with the patient at the time of presentation? Was the patient found alone, or brought in by friends or family? Was the patient brought in by emergency medical services? Is the patient in police custody?
- What concerning statements did the patient make? What did others report about the patient?
- How did the patient appear? Was the patient discovered or found somewhere other than where he/she was expected?
- Is he/she here voluntarily? Is he/she in legal custody? Is he/she competent and does he/she have impaired capacity to make some/all decisions?
- Is he/she cooperative?
- What is the reliability of any information obtained?

There are a number of excellent resources that may be consulted regarding the assessment of patients with psychiatric complaints or signs.^{33–37} Time constraints in the ED do not usually allow for in-depth assessment of all psychiatric conditions that a patient may have ever experienced, but a focused examination may provide an accurate assessment of a patient's acuity along with important cues for determining the best treatment setting for continued care.

A psychiatric history and mental status exam follow the triage assessment/chief complaint described above. The Johns Hopkins Phipps Clinic psychiatry service has used a standardized approach (see Appendix) for history-taking which covers many psychiatric conditions. The general template can be adapted to the ED setting. The order in which the entire history is obtained is usually not crucial and may be determined to some degree by the chief complaint. The important issue is that fundamentals are covered. Basic history can be supplemented with more detailed history and an examination tailored to the presentation (for example, if an eating disorder or sexual disorder is present). There may not be adequate time to collect in-depth responses to all of these areas of inquiry, but even a skeletal outline with these components may be useful in formulating the likely causes for the patient's presentation and suggest the most appropriate treatment interventions. Listed below are the general topics and a set of questions frequently asked under each topic. In most ED encounters, it is unlikely that all these questions can be asked, but it is useful to have an understanding of what information is needed in a comprehensive psychiatric assessment, in order to apply important elements to a particular patient in the ED.

Family history

In the Phipps history, family history comes soon after chief complaint, though it can certainly be obtained later in the interview.[†] Patients may be unwilling or unable to provide much information and outside informants may be helpful. In the emergency setting, the family history should include a focused history of psychiatric disorders (including substance abuse) in the family, suicides, and any salient family medical issues, including neurologic (e.g. Parkinson's, Alzheimer's, Huntington's) or other somatic disorders that may have psychiatric manifestations. More extensive family history, such as family members' response (or lack of response) to certain psychotropics or more qualitative or quantitative description of family members' psychiatric syndromes might be more usefully explored in a non-emergent setting.

Personal history

Personal history usually includes details of development (including gestation, if appropriate), childhood health and behavior (including abnormalities such as discipline problems, animal cruelty, expulsions, violence, fire-setting, etc.), educational attainment and/or difficulties including any learning disorders or special education (including reasons for leaving school early), work history (profession(s), longest held job, reasons for terminations), military service, relationship history[‡], current social relationships, living arrangements, sexual history, history of abuse, neglect or trauma, legal history, religious or other social history. Further details on any overlap with past psychiatric history or the patient's current presentation may be expanded upon in "past psychiatric history" or "history of present illness."

Substance use history

This should include at a minimum the factors that might lead to adverse outcomes, especially alcohol and benzodiazepine use/dependence. Details here should include any history of delirium tremens, ICU or medical floor admissions for complicated withdrawal, history of hallucinations, seizures, tremors or other signs of physical dependence, and some estimate of amounts and rates of consumption, including last use. For illicit substances and misused prescription medications, route(s) of consumption, along with details of amounts (including monetary cost), rates, and how the drugs are obtained, can be useful information, as can information on repercussions (physical, legal, interpersonal, financial) of drug use. Outside informants may be helpful. Experience with abstinence, inpatient or outpatient detoxification, longest period of sobriety, past rehabilitation programs, and any involvement

[†] The Phipps history is based in part on Adolph Meyer's approach to assessment, which entailed a systematic and comprehensive assessment of the patient^{33,59} and considered a patient's presentation a culmination of all the biological and environmental influences that have acted upon the patient, not merely their current complaints. The history is described chronologically, beginning with family or genetic factors, then moves on to birth, development, childhood behaviors, and so on, finally reaching the assessment of the patient's current mental state. In most settings, the details of the patient's presentation and recent history are recorded just after the patient ID and chief complaint, the other elements of the history and exam then follow. Again, the order is less important than confirming that the critical elements of the history and examination (as can reasonably be obtained given the circumstances) are acquired and recorded, allowing for an appropriate formulation, risk assessment and plan.

[‡] A description of relationships can be instructive. For example, patients with certain personality disorders may describe a pattern of intense, unstable relationships with family, friends, and romantic partners.

with 12-step programs such as Alcoholics Anonymous or Narcotics Anonymous (if yes, does the patient have a sponsor?) may provide useful information on past successes or pitfalls that will guide treatment decisions. Use or misuse of other substances, such as LSD, MDMA, synthetic marijuana, “bath salts,” inhalants, tobacco, caffeine or others would also be listed here.

Past medical and surgical history

This should include a list of currently active diagnoses, past diagnoses and procedures (and dates), allergies, current care providers, and current medications. Any contact information for current providers may also be useful.

Review of systems

This should include a review of all physical systems, as with medical emergency evaluations. The degree of detail in any or all areas may be determined by the patient’s past medical history, level of physical or emotional distress, results of lab studies and physical examination, and ability or willingness to answer questions. Knowledge of somatic confounders for psychiatric diagnoses is important.³⁸ Review of current psychiatric complaints will be addressed primarily in mental status examination and history of present illness.

Pre-morbid personality

This is a description of the person’s personality traits, as described by the patient and by outside informants. A description by the patient alone may be of limited utility. Descriptors of stable or unstable temperament, impulsivity, degree of concern for the welfare of others, and how the person handles stress can be important insights that may affect management and care decisions in the ED.

Past psychiatric history

This should include: first psychiatric contact, if any; previous hospitalizations or crises, including ED visits for psychiatric complaints; past trials of psychiatric medications and other treatment modalities (e.g. electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), psychotherapy); current psychiatric provider and/or other mental health providers, such as therapists, and duration(s) of care; and any past history of self-injurious behavior, including self-mutilation and suicide attempts. Descriptions of any past prolonged depressive, manic, or hypomanic episodes and any periods of psychosis or other psychiatric syndromes and their treatments, if any, should be included here.

History of present illness

This should include all of the salient factors leading to the patient’s current presentation, including descriptors of timing, intensity, duration, psychosocial factors (e.g. job loss, romantic or other relationship issues, financial stressors, non-adherence to treatment), vegetative symptoms (e.g. sleep, appetite, energy), mood or anxiety symptoms (including irritability, panic episodes, anhedonia, diminished self-attitude or vital sense, passive death wish, suicidal or homicidal thoughts and/or plans, observed psychomotor retardation or agitation, pathologic guilt, racing thoughts), or cognitive symptoms (memory problems, problems with concentration or attention). Ongoing areas of concern such as eating disorder behaviors, obsessive-compulsive thoughts and behaviors, psychosis, bereavement,

or other psychosocial issues influencing the presentation, substance use, problematic sexual behaviors or others should be described here in sufficient detail. Some assessment of the level of impairment in overall function (such as failures to maintain their role at work, with family, or even care for themselves) including timing, duration, and intensity is important in gauging the severity of a patient’s complaints. Outside informants are useful here.

The mental status exam

This should include what the clinician observes and how the patient describes his/her inner state and experience currently. This part of the exam should begin with basic observation of alertness: awake, somnolent, significantly changed or depressed level of consciousness, or completely non-responsive? For patients who are awake, level of alertness should be noted: alert, distractible, fully inattentive. How cooperative is the patient: guarded, defensive, uncooperative? What is the patient’s appearance: well-groomed, disheveled, etc. Are there other factors in the patient’s physical appearance such as deformities or other abnormalities? Are there any abnormalities in movement, such as tremor or other seemingly involuntary movements?

What is the quality of their speech? Assessment of speech includes a description of rate, rhythm, volume, and tone. Is the speech hard to follow? An example of speech content can be very useful. Psychiatrists will often describe the quality of associations in a patient’s speech (how well does an expressed thought link to the preceding one?) and the presence or absence of evidence of disordered thought (for example, formal thought disorder, defined as the patient’s subjective complaint of how distorted his/her thinking is from baseline, or some description of speech that suggests underlying disordered thinking, as may be seen in patients with schizophrenia).³⁵

How does the patient describe their mood? Mood is the patient’s subjective description of his/her inner, emotional experience (“I feel happy/sad/neutral”). How would the clinician describe the patient’s affect, and does it match the patient’s description of their mood? Affect is the observer’s description of the patient’s outward appearance (“The patient’s affect is euthymic/downcast/euphoric”). Clinicians may also comment on the range of observed emotion a patient demonstrates or appears capable of demonstrating (“The patient’s range of affect is normal/labile/constricted”). An important component is to note if the affect is congruent with the stated mood.

Does the patient express any suicidal thoughts? If so, is there a plan? What are the details of that plan? What is the patient’s intent to carry out the plan? What are the odds of rescue if the person were to pursue the plan? Does the patient have access to the means to commit suicide (such as access to a firearm)? Are there thoughts or plans to hurt others? If so, what are the details? (Also see Chapter 3.) Does the patient report hallucinations? Are these hallucinations auditory, visual, olfactory, gustatory, tactile? Does the patient describe or appear to be hallucinating currently? Are any delusions (i.e., fixed, false, idiosyncratic beliefs) present? Does the patient describe obsessions, compulsions, phobias, anxieties, or panic symptoms? How impairing are they?

Finally, an assessment of cognition should be performed, including an assessment of insight and judgment. The Mini-Mental State Examination³⁹ or another screening tool of cognition can provide a useful and quick assessment of global cognitive capacity (though it may not allow a fine-tuned diagnosis of specific deficits).

Formulation. *The Perspectives of Psychiatry*³³ provides a useful framework in the emergency setting for formulating the salient features of patient presentations. The patient’s