CEN Mental Health: Crisis, Suicide Risk, Eating Disorders and Abuse

The suicide screen and one-to-one observation, eating disorders and their medical dangers, panic look-alikes, crisis and acute stress, staff after a child's death, and abuse the ED must not miss

ICU Basics
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WHO GOES FIRST

PICTURE	THINK	FIRST MOVE
Anorexia, drowsy, glucose 38, better after dextrose	Empty glycogen stores: it will recur	Dextrose infusion, frequent glucose, admit; glucagon may fail
Teen, energy drinks, HR 148, tremor, "just stressed"	Caffeine toxicity	Monitor, 12-lead ECG, potassium
Fast breathing, tingling, wants a paper bag	Panic only after medical causes are out	No bag; coach slow breathing
Suicidal patient on one-to-one asks for bathroom privacy	Bathroom is the highest-risk room	Observer stays, same gender, door ajar, explain why
Prepubertal child with gonorrhea	Sexual abuse	Report; child-abuse team

SUICIDE RISK SCREEN (C-SSRS)

- The Columbia screen asks about ideation in the past month, rising from a wish to be dead to intent with a plan, and about suicidal behavior in the past 3 months.
- Behavior includes preparing (collecting pills, getting a weapon) and attempts that were interrupted or aborted.
- High risk: some intent to act, or a plan with intent, in the past month, or any behavior in the past 3 months, even if today's thoughts are only passive. Thinking about a method: moderate. A wish to be dead or nonspecific thoughts: low.
- High risk: continuous observation, remove means, prompt provider and behavioral health evaluation (usual practice). The screen starts the assessment; it never dismisses a patient.

ONE-TO-ONE OBSERVATION

- Continuous means continuous: toileting and bathing included (PSNet).
- Same-gender observer for toileting and bathing; door ajar, patient in view; a gown or towel for modesty.
- Talking through a closed door and pausing for the bathroom are not observation.
- Search belongings, supervise visitors, post that the patient is never left alone (PSNet).

EATING DISORDERS

DISORDER	CLUE	DANGER
Anorexia nervosa	Restriction, low weight, fears fatness	Bradycardia, hypotension, hypoglycemia, low K, long QT, sudden death
Atypical anorexia	Same, at normal weight after rapid loss	Same instability; BMI does not rule it out
Bulimia nervosa	Bingeing then vomiting, laxatives; normal weight	Low K, alkalosis; painless parotid swelling, eroded front teeth, scarred knuckles
ARFID	Avoids food for texture, low interest or fear of choking or vomiting; no body-image concern	Weight loss, growth delay, nutritional deficiency; complications can be as severe as anorexia

- Screen privately: SCOFF (5 yes-or-no questions; 2 or more yes is a likely case) plus orthostatic vital signs.
- Admission supported by any of (SAHM 2022): HR under 50 awake or 45 asleep; BP under 90/45; T under 35.6 °C (96 °F); 75% of median BMI or less; orthostatic pulse rise over 40 (under 19 y) or over 30, or BP fall over 20 systolic or 10 diastolic; low K, Na or phosphate; long QTc; syncope; acute food refusal; suicidal thoughts.

HYPOGLYCEMIA AND REFEEDING IN STARVATION

- Symptomatic hypoglycemia in anorexia mostly comes with BMI under 15; it means glycogen and gluconeogenic substrate are gone, warning symptoms can be blunted, and it marks a poor prognosis.
- Glucagon needs liver glycogen: in starvation, treat with glucose. After the bolus, a dextrose infusion, glucose checks overnight, admission.
- Refeeding hypophosphatemia tracks how malnourished the patient is: check phosphate and other electrolytes as feeding starts.

PANIC OR SOMETHING ELSE?

- Panic is diagnosed only after medical causes are excluded (for example ACS, hyperthyroidism, substances).
- No paper bag: rebreathing lowers oxygen and was linked to deaths in patients who were really hypoxemic or ischemic. Coach slow, steady breathing; tingling fades as CO_2 returns. Tingling is from respiratory alkalosis, so calcium is not the fix.
- Caffeine: a can holds about 80 to 160 mg (up to 357 mg); about 1 g gives toxic symptoms. Tachycardia, tremor, vomiting, then VF and seizures; low K, high glucose, acidosis. Monitor, 12-lead ECG, K; benzodiazepine for agitation and seizures; poison center. Rate drugs are for the provider after the rhythm is known.

CRISIS, ACUTE STRESS AND THE TEAM

SITUATION	GOAL OR PLAN
Situational crisis (house fire)	Short-term, present-focused: restore pre-crisis function; first concrete steps, supports, referral (SAFER-R)
Acute stress disorder: 3 days to 1 month after trauma	Trauma-focused CBT lowers the risk of PTSD; over 1 month, think PTSD
Single-session detailed debriefing	Not effective, may worsen symptoms
Team after a child's death	Brief shared pause at the bedside; later support offered, not forced (usual practice)

ABUSE THE ED MUST NOT MISS

FINDING	ACTION
Partner hides pills, refuses condoms, pushes pregnancy	Reproductive coercion goes with partner violence: screen further, safety plan, long-acting contraception he is less likely to detect
IPV disclosed, children at home with the abuser	Next: are the children hurt or threatened, who is with them; then state-required report and safety plan
Recurrent unexplained illness, normal tests, caregiver pushes procedures	Caregiver-fabricated illness: chart witnessed vs reported events, raise it with the team; confront only after a protection plan
Gonorrhea, syphilis, chlamydia or trichomonas not acquired at birth	Sexual abuse: report on reasonable suspicion; culture or FDA-cleared NAAT, never Gram stain

Sources (25) are listed with links at icubasics.com/sheets/cen-mental-health-crisis.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. ICU Basics is an independent study aid not affiliated with any certifying body.