# Psychiatry Fellowship Teaching Notes

Mental Health= more medical illness and injury, shorter life span by 8-30 yrs

50-90% chronic medical problems

meningitis/sepsis/tox/NMS/hepaticencephalopathy/withdrawal/thyroid/trauma/metabolic derangement

First presentation mental health = diagnosis of exclusion to rule out organic illness first

No consensus on what constitutes *medical clearance or medically stable for psych admit*

Ensure no weapons

**Historical Features suggesting medical cause for Psych presentation**

* No previous psychiatric history
* Recently hospitalized or with symptoms suggestive of possible infections
* Recent medication changes
* Sudden changes in behavior
* Visual hallucinations
* Extremes of life; age >40 y or <12 y
* New-onset seizure
* Recent memory loss
* History of substance abuse

**Physical Examination Features Suggestive of Organic Causes of Psychiatric Complaints**

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| * Abnormal vital signs * Fluctuating level of consciousness/alertness (e.g., clouded sensorium) * Significantly decreased level of consciousness (Glasgow Coma Scale score <8) * Focal neurologic findings (e.g., new-onset seizures, inability to walk unassisted) * Ophthalmologic abnormalities (e.g., rotary nystagmus) * Evidence of trauma (e.g., raccoon eyes, Battle’s sign, septal hematoma, abrasions, lacerations) * Abnormal dermatologic manifestations (e.g., rashes, purpura, jaundice, uremic frost, cool, mottled extremities) * Abnormal mental examination or Quick Confusion Scale * Presence of visual hallucinations |

**Interview Techniques in the ED**

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| **Safety**   * Know where the exits are before you talk to the patient; stand close to exit * Leave enough distance to avoid being physically hurt * Wear a badge clip that cannot be used to choke you   **Cooperation/rapport**   * Always introduce yourself clearly * Establish eye contact; smile if possible * Reuse terms the patient uses to describe their condition before asking for clarification; this makes the patient feel heard * Start with open-ended questions because they are best to establish therapeutic rapport * Transition to close-ended questions if open-ended questions are not productive * Last resort: Yes or no and multiple-choice questions |

**Violent Patients**

* Verbal de-escalation
* Offer meds
* Explanation
* Listen
* Show of force
* 5 point restraint
  + Never prone
  + Ensure schedule completed
* Chemical sedation
  + Elevate head to stop aspiration
  + Monitoring
  + 1-1 nursing
  + Skin/toileting/fluids etc
  + Sedation scales

**Capacity**

A person has capacity to give informed consent to treatment or medical treatment if they:

* understand the information that is given to them about the treatment
* can remember the information relevant to the decision
* can use or weigh the information relevant to the decision
* can communicate the decision.

**Involuntary Admission**

* Has a mental illness
* No capacity
* Risk to self (physical/psychological/reputational
* Risk to others
* Cant be treated as an OP
* Least Restrictive means

**Capacity vs Competency**

**Capacity** - The ability to make a decision about a specific health matter at a discrete point in time. The concept includes the ability to understand risks and benefits of the suggested intervention, medication, or procedure; the repercussions of declining it; and alternative choices.

**Competency** - Legal term decided by court and extends to financial, health, and personal matters. It is not a dynamic concept like capacity. Absence of competence usually implies the presence of a legal guardian, either an individual or a court-appointed entity. The concept is not to be confused with power of attorney

# **Acute Agitation**

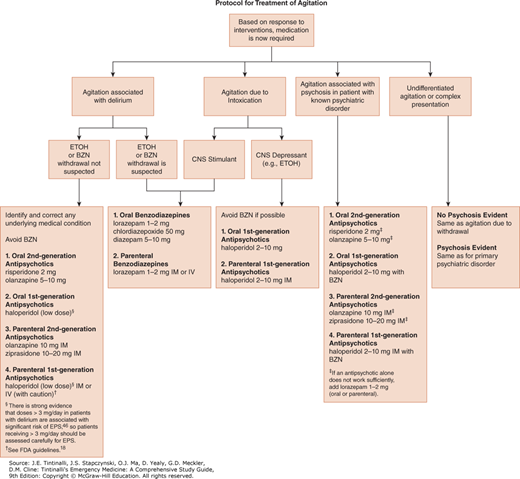
Safety – verbal deesc – show of concern – treat medical problems – restraints used sparingly – medication – 2nd gen antipsychotics

**Verbal Deescalation**

* Respect personal space
* Do not be provocative
* Establish verbal contact
* Be concise
* Identify wants and feelings
* Listen closely to what the patient is saying
* Agree or agree to disagree
* Lay down the law and set clear limits
* Offer choices and optimism
* Debrief the patient and staff

**Sedation assessment tool**

| **Score** | **Responsiveness** | **Speech** |
| --- | --- | --- |
| +3 | Combative, violent, out of control | Continual loud outbursts |
| +2 | Very anxious and agitated | Loud outbursts |
| +1 | Anxious/restless | Normal/talkative |
| 0 | Awake and calm/cooperative | Normal |
| –1 | Asleep but rouses if name called | Slurring or prominent slowing |
| –2 | Responds to physical stimulation | Few recognizable words |
| –3 | No response to stimulation | Nil |



Ketamine – hypersalivation, hypertension/tachycardia, frequent redosing, ??worse psychosis (unproven)

Haloperidol – QTc prolongation, motor side effects, don’t use

Olanzapine – 10mg IM is as sedating as 5mg midazolam, less somnolence, increased airway issues if given IV (don’t do)

# **Elderly Mental Health**

Dementia vs Delirium vs Depression

Depression = increased risk of dementia

**Features of Delirium, Dementia, and Psychiatric Disorder**

| **Characteristic** | **Delirium** | **Dementia** | **Psychiatric Disorder** |
| --- | --- | --- | --- |
| Onset | Over days | Insidious | Varies |
| Course over 24 h | Fluctuating | Stable | Varies |
| Consciousness | Reduced or hyperalert | Alert | Alert or distracted |
| Attention | Disordered | Normal | May be disordered |
| Cognition | Disordered | Impaired | Rarely impaired |
| Orientation | Impaired | Often impaired | May be impaired |
| Hallucinations | Visual and/or auditory | Often absent | May be present |
| Delusions | Transient, poorly organized | Usually absent | Sustained |
| Movements | Asterixis, tremor may be present | Often absent | Varies |

Medication side effects more frequent – EPSE/sedation/falls

Dose lower

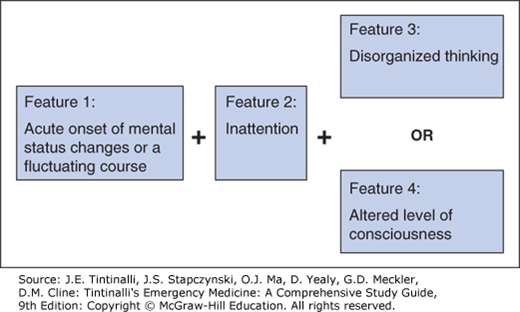
Check interactions/ECG for QTc

**Delirium**

Hypoactive/hyperactive/mixed

Predictor of 6 month mortality, increased LOS, hospital complications, need for NH on discharge, lasting cognitive deficits

Old people – lower baseline temp/altered pain responses/abdo exam/BB/wider pulse pressure/higher BP



**DELIRIUM: Mnemonic for Reversible Causes of Delirium**

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| --- | --- |
| **D**rugs | Any new additions, increased dosages, or interactions  Consider over-the-counter drugs and alcohol  Consider high-risk drugs\* |
| **E**lectrolyte disturbances | Dehydration, sodium imbalance, thyroid abnormalities |
| **L**ack of drugs | Withdrawals from chronically used sedatives, including alcohol and sleeping pills  Poorly controlled pain (lack of analgesia) |
| **I**nfection | Especially urinary and respiratory tract infections |
| **R**educed sensory input | Poor vision, poor hearing |
| **I**ntracranial | Infection, hemorrhage, stroke, tumor  Rare; consider only if new focal neurologic findings, suggestive history, or diagnostic evaluation otherwise negative |
| **U**rinary, fecal | Urinary retention: “cystocerebral syndrome”  Fecal impaction |
| **M**yocardial, pulmonary | Myocardial infarction, arrhythmia, exacerbation of heart failure, exacerbation of chronic obstructive pulmonary disease, hypoxia |

Prevention – low stimulus, glasses and hearing aids, reorientation, avoid anticholinergics sedatives and opiates, family support, bathroom access, sleep, hydration, avoid IDC, nutrition

**Mental Status Examination**

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| **Appearance, behavior, and attitude**  Is dress appropriate?  Is motor behavior at rest appropriate?  Is the speech pattern normal?  **Disorders of thought**  Are the thoughts logical and realistic?  Are false beliefs or delusions present?  Are suicidal or homicidal thoughts present?  **Disorders of perception**  Are hallucinations present?  **Mood and affect**  What is the prevailing mood?  Is the emotional content appropriate for the setting?  **Insight and judgment**  Does the patient understand the circumstances surrounding the visit?  **Sensorium and intelligence**  Is the level of consciousness normal?  Is cognition or intellectual functioning impaired? |

DSM diagnostic criteria

