



# **PSYCHIATRY SURVIVAL MANUAL**

**2<sup>ND</sup> EDITION - 2012**

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**Chapter 1**  
**INTRODUCTION**

### **A. Training Ethos for Residents:**

Never prescribe or order any medication without reading the basic material on pharmacodynamics, pharmacokinetics and clinical considerations.

1. All psychiatric diagnosis ask one to exclude medical and neurological illnesses. Please consider this possibility especially when the patient has a history of cancer, MS, autoimmune diseases such as lupus, malabsorption syndromes and seizure disorders.
2. Please remember that comorbidity is often the rule and not the exception in psychiatry, especially when it comes to substance abuse/dependence. However, the treatment of the substance disorder must often take place before appropriate treatment of the comorbid condition as substances tend to exacerbate and interfere with treatment of other axis I conditions.
3. Also please remember that just because a patient comes in with a certain diagnosis already assigned to him/her, it does not necessarily mean that it is the correct diagnosis. Furthermore, ask the patient why they have a diagnosis assigned to them and to explain their symptoms to you. For example, often times the patient will complain of anxiety to his/her GP, will get a Generalized Anxiety Disorder diagnosis, but really complain of paranoia. Therefore, investigate all previously assigned diagnosis.
4. Never write a psychiatric diagnosis without examining the patient yourself first, then reviewing the basic definition (DSM IV-TR) and a basic discussion of epidemiology, etiology, diagnosis, differential diagnosis, clinical course, comorbidity and treatment as provided in a full psychiatry text, not a synopsis. This is especially important in regards to conversion disorder. In this institution and the country in general, conversion disorder is often over diagnosed by other services, despite the increased possibility of finding a physiologic illness later in the course of this person's lifetime. Thus, a thorough history and physical exam, as well as literature review on your part is the best way to decrease the possibility of this happening with your patient.
5. Always ask supervising faculty for feedback and suggestions at some point during a collaboration.
6. Always provide feedback and evaluation of experiences in the program through suitable channels.
7. When a faculty psychiatrist recommends a course of action which you do not completely understand, always request an explanation.
8. When there is uncertainty or doubt, always seek assistance and advice from a faculty member, or senior resident.
9. When something is said by a patient that is not clearly understood, always ask for a clarification. This is something that needs careful attention, especially when it comes to whether what the patient is telling you is logical or not. Having an illogical thought process occurs in many disorders ranging from a psychosis to a pervasive developmental disorder, thus if something does not make sense to you, ask the person to explain. This is often the only way of discerning illogicality in a thought process.
10. In general, remember that you are in training, and it is always safer to take time for collaboration and consultation.

### **B. Disclaimers:**

Some of the views expressed in this manual are open to debate and do not necessarily reflect the official departmental position. Please let your best medical judgment serve as your guide.

**C. Suggestions for this Book, Residency and Beyond:**

1. Read this book before you are confronted with the situations outlined in this book.
2. Be a part of whatever team you are working with: ER staff, evening and night nursing staff.
3. A smile and a helpful attitude will get you farther than you may think.
4. Be flexible and improvise: ask, even when in doubt.
5. Document, document, document. Especially that your faculty agrees with the plan.
6. Use your resident backup for advice, not just another body when swamped in the ER.
7. Internship is for getting lots of different experience. You will definitely get this in the ER and on weekends.
8. If the ER staff trust and know you, they will sometimes get a curbside consult instead of a full one which will save you time.

**Chapter 2**

## ON CALL

### **A. Information Needed for Call:**

You always have a senior resident as backup. They must come to the PCU when you request it. Faculty must always be available for consultation.

Primary call responsibilities include:

- 1) Care of psychiatric inpatients' psychiatric and medical problems.
- 2) Consultative services to other inpatient departments.
- 3) Consultative services for LSUHSC ER physicians.

### **CHECK LIST**

- 1) Make sure your beeper is on, you have the PCU key, and that the switchboard is aware of any changes that have occurred.
- 2) Access the PCU census on EPIC
- 3) Find out if there are any open beds available.
- 4) Find out from the person on day call if there are any patients waiting in the ER or any patients waiting to come into the PCU. Day call resident must sign out ALL patients to you before they leave. It will be the job of the resident on-call to know everything about every patient in the PCU, and any patients on the floor and consult service patients needing follow-up.
- 5) Find out what needs to be done - who needs labs, who has labs pending, who needs orders, who needs a PEC, etc.
- 6) Use a log sheet for each call – document time call received and disposition. This can be as simple as a piece of paper, just write things down!

### **B. Equipment Needed for Call:**

1. This survival manual
2. Weekly on-call schedule, this is on [www.amion.com](http://www.amion.com) along with all contact information
3. Patient Transfer forms
4. All patient handouts are in EPIC under the smart phrase .pcu then the specific document that you are looking for
5. PEC forms and FV consent forms, see the chapter on Legal Documents for who is eligible for each form of admission

### **C. Call Responsibilities**

1. Primary On-Call Resident
  - Calls from psychiatry inpatient units
  - ER consults
  - Med/Surg psychiatry consults
  - Physical exams on ALL PATIENTS
  - Every patient needs a legal status, whether it be a FV or PEC/CEC

2. Back-Up Resident
  - Phone consultation from primary on-call resident
  - Help see patients in the hospital if primary resident feels overloaded with consults
  - Teaching
3. Students On-Call
  - The students can be helpful by data gathering and assisting with patient interviews.
  - Don't forget: a resident is needed on all documents. This means that the resident also sees the patient.
  - Review your expectations with all students.
  - Medical students are here to learn about psychiatry, not to do the work of the resident.
4. Faculty
  - Discussion of all patients seen before a disposition is made.
  - Never, discharge a patient without discussing it with faculty. If the faculty on call does not respond to paging and calling, you should call one that you know will answer the page. However, prior to deciding to discharge the patient, please consider all possibilities. If it is four o'clock in the morning, discharging the patient right then and there may be more harmful than waiting until faculty evaluation several hours later, even if you feel the patient is safe for discharge. Also prior to contacting faculty in the middle of the night about a possible discharge, make sure that you obtain good collateral information, do a suicide risk assessment, and take all necessary precautions for the safety the patient and others, especially children, as well as, appropriate follow up plans for that patient. Remember that despite what the patient states, it is rare for a person to end up in the PCU for no reason at all.
  - Once the decision to discharge is made, by faculty, complete the proper form in epic and print appropriate patient handouts.

**D. Weekend Call Guidelines:**

1. Weekend call starts at 8:00 a.m. Day call ends at 8 p.m. Night call starts at 8 p.m. Arrive prior to 8 o'clock in order to receive check-out so that your fellow resident may leave in a timely fashion.
2. The weekend team includes the on-call residents, medical students, and faculty.
3. Call your faculty member at the beginning of your shift to see when they want to round on the weekend as well as their expectations.
4. See weekend on-call policy to identify responsibilities of each team member.

**On-Call Responsibilities:**

- 1) On Saturday, Sunday and holidays the on-call person makes rounds of all patients and writes progress notes. A progress note is needed on all patients in the PCU who have already been seen by an attending.

- 2) Consult patient on a PEC/CEC/JC and other critical patients needing a follow up on the weekend will be posted on a list by the consult resident. This patient census can currently be found in EPIC, but the consult resident should also discuss the condition of each patient prior to leaving on Friday afternoon.
- 3) All evaluations should be discussed with faculty. It is to the discretion of the on-call faculty member and the RTD whether this happens on morning rounds or after each patient is seen. All problem patients should be checked out to faculty immediately after being seen.
- 4) All residents who were on call over the weekend will meet for PCU morning rounds on the Monday after call. These take place at 8 a.m. sharp. If the resident cannot make it to the PCU rounds, they can call the checkout room and discuss the patient over the phone. At the beginning of each year, the residents are given a card with everyone's telephone and pager number, thus you can even contact the faculty member (Usually Dr. Patterson) directly to check out.
- 5) When on call, the resident is also expected to handle any problems occurring with patients already hospitalized including seclusion, restraint, involuntary medication, medical problems, etc. He/she should follow policies and procedures for the above.
- 6) The on-call person is also responsible for any emergency consults for other services. The definition of an emergency consult is actually fairly loose, but please keep in mind the consequences of the condition they are consulting about so as to be able to triage patient care. An acute delirium or change in mental status of a hospitalized patient needs to be addressed prior to the anxious patient in the emergency room. Similarly capacity to leave AMA is usually prioritized over the patient wanting to be admitted for depression. On a side note, the OBGYN service often consults the PCU resident over the weekend. Please inquire whether the patient is going to be hospitalized as that service has an outpatient like facility on the 4<sup>th</sup> floor of the hospital so their consults maybe time sensitive despite not sounding like it on the phone.
- 7) These consults should follow the usual procedure: PGY-I's and II's discuss all situations with the faculty back-up. The PGY-III's and IV's have faculty back-up available for problem cases and patients sent home. If a patient needs to be transferred, the on-call M.D. needs to write admit orders and either complete a FV or PEC, and discuss the case with faculty.

**PCU Day Call:**

- 1) The resident will be assigned for at least two month long rotations during residency, and two night float rotations. There are two residents running the PCU Day service. One shift is 8 am – 5 pm, the second shift is 12 pm – 9 pm. Residents are asked to divide these shifts evenly amongst themselves. Again, arrive to your shifts on time.
- 2) Once in the PCU, the resident will interview the patient, obtain information from the old chart and collateral sources as necessary in order to complete an evaluation.



- 3) The resident will then complete a write up. The template is in EPIC, ensure that all blanks are filled. If information was unable to be obtained, write unable to be obtained due to... Do a physical exam.
- 4) The resident will discuss the case after his evaluation with his attending.
- 5) The resident is asked to see the patient within approximately two hours.
- 6) The PCU residents also serve as the outpatient consultation and liaison service to all outpatient clinics, including the Labor & Delivery clinic on the 4<sup>th</sup> floor of the hospital, as well as the Feist-Weiller Cancer Center . We routinely handle consults from Pediatric clinic, Internal Medicine clinic, and Family Medicine clinic. There are some situations where a consult from these clinics requires the resident to go there and evaluate the patient, and others where it seems obvious that the patient needs to be emergently committed to the PCU via the ED. Clinical judgment and discussion with the attending physician is advised.
- 7) Lectures come first. They take place on Tuesdays starting at noon. This time is protected, turn in your pagers.

### **PCU admit criteria**

There is a checklist in the PCU regarding admission of patients to PCU. Certain vital sign parameters, age restrictions, medical complications prevent patients from admission to PCU. In this situation, the patient should either stay in the ER, be admitted to inpatient medicine or pediatrics, or transferred to outside hospital.

### **Medically Unstable Patients**

- Sometimes, patients in the PCU develop serious medical problems – i.e. seizures, chest pain, hematemesis, etc.
- You have two options:
  - Call the ER and have the patient transferred back down (quicker)
  - Call internal medicine (or surgery, etc.) to admit the patient to their service
  - In the meantime, do all necessary labs, EKG, etc.
  - Discuss with your attending if you are unsure what to do
  - Keep track of where the patient is and where they are being admitted, and let the consult service know that they will need to follow this patient

### **E. Night float**

- The night float resident has in-house call Sunday through Thursday (8pm-8am) for one month.
- Typically two months of this service are required, but they cannot be sequential.
- Night float rotation is done during the PGY-II year.
- The night float resident is excused from all daytime responsibilities.
- Psychiatry faculty covering the ER will provide brief lectures and feedback sessions during rounds in the morning.
- The night float resident covers consult calls from the ER and medical floors, as well as tending to any needs of the 10<sup>th</sup> floor psychiatry inpatient unit.

- The night float resident will meet with the outgoing resident when they begin their service for patient hand-off during check-out rounds, and will also meet with the oncoming resident at the end of their service for same.
- Check-out rounds in the morning are staffed by the attending physician for education, patient care, and resident supervision, and the full treatment team is present during weekdays.
- Any night float resident may contact the upper level resident who is on back-up call with any questions or concerns. The night float resident will also contact on-call faculty for any case discussion, possible discharges, or questions/concerns.
- Please note any labs/radiology that you ordered while on night float. They will need to be followed up, but can be easily missed if there is no communication.
- Please remember all precautions, especially detox and suicide precautions. There is an increased rate of suicide attempts on admission and discharge from a psychiatric facility.

## **F. Check-out**

1. The resident who is leaving:
  - a. Goes over the PCU census, giving a brief history on all patients in the PCU highlighting problem patients and things that need to be done. The disposition plan on all patients needs to be reviewed, as well as who has been staffed and who needs a daily progress note, and who needs lab follow up.
  - b. Check out all patients who have not yet been seen, or who are waiting in the ER.
  - c. Go over the consult list, report any problem patients, anyone who needs to be staffed by an attending, and all PEC/CEC patients and patients needing daily notes. Also report consults who have not yet been seen along with the time that the consult was received.
  - d. Check-out any problem patients on the floor.
2. The resident who is coming on:
  - a. If you have a question, ask. It is your responsibility to know about the patients who are currently in your care.
  - b. Make a list of the things that need to be done, and complete them.
  - c. Inform the attending who is on call that you are coming on, and ask if they have any specific requests for how to check-out patients.

### Chapter 3 CONSULTS ON CALL

Always call your back-up resident when you need help.

All consult patients must be seen within 24 hours of the initial consult request.

#### **A. ER Consults**

- a) When you are called to see a patient:
- inquire whether labs have been drawn
  - Read the ER note if one is written
  - whether staff has evaluated the patient's general medical conditions.
  - The resident will evaluate the patients after a medical clearance by the ER. It is up to the resident accepting the patient to the PCU to make sure that this patient will be safe in that environment. Often times, psychiatry patients will be examined by one of the allied health professionals (triage, PA, PA student, nurse, a medical student, OMFS interns, or a rotating resident in the emergency room from another service) and the evaluation provided to the psychiatry resident is not always complete. It is your responsibility to obtain a thorough history about what has been done to medically clear a patient, as well as, to go through the electronic medical record prior to accepting a patient. In general, if you do not feel comfortable taking a patient to the PCU, you can always see them in the ER, discuss with the ER attending, and make a plan.

Commonly needed labs include:

- 1) URINE DRUG SCREEN!!!!
- 2) Blood Alcohol level
- 3) CBC
- 4) CMP
- 5) Urine/serum pregnancy test
- 6) Medication blood levels if applicable:
  - anticonvulsants
  - lithium
  - tricyclics
  - digoxin
  - theophylline
  - Aspirin, Tylenol
- 7) Thyroid studies (TSH, T3, T4)
- 8) Hepatitis Panel, HIV, and Syphilis IgG
- 9) B12/Folate

Sometimes you will be called to see an ER patient, when results of initial lab work are not available yet, not yet medically cleared and old records are not available. DO NOT REFUSE CONSULT, just ask the ER faculty to do all of the above and go down to see a patient. Many times the ER will only draw UDS and EtOH. If there is no indication to the ER that the patient requires a CBC, CMP or other labs, they will not draw it, and you

cannot force them to do so, unless their medical history necessitates that these labs are checked for medical clearance.

After evaluating the patient, review the old chart and any labs, call faculty to review the case and make a disposition. NEVER make a disposition without discussing the case with faculty/backup.

- If patient is not being admitted to psychiatry, complete the assessment with your recommendations
- If patient is admitted to psychiatry, complete the H & P. Complete the admit orders in EPIC, and make sure that patient has a legal status.
- Always remember to document that faculty approval was obtained.

### **B. Physician Emergency Certificate (PEC) (Involuntary Admission):**

The examining physician must document:

- 1) The patient is mentally ill
- 2) As a result of mental illness, the patient evidences substantial risk of serious harm to self or others, which risk shall be specified and described on the PEC, or the patient is gravely disabled. Patient must also be either unwilling or unable to seek treatment on his own.
- 3) The risk of harm is imminent unless the patient is immediately hospitalized.
- 4) Emergency detention in a hospital is the least restrictive alternative by which restraint can be affected.
- 5) See the section on the Legal Documents for specific legal definitions regarding dangerous to self, dangerous to others and gravely disabled. Know these definitions BEFORE you check the box
- 6) Duration of PEC is 72 hours.

\*The PEC must be filled out completely. If something is unknown, write unknown.

### **C. Prisoners in the ER**

- 1) Unless extremely gravely disabled, patients go back to jail with treatment prescribed.
- 2) Ensure jail has proper facilities. (document!)
- 3) Send written documentation with patient's guard telling them what to do, especially in regards to a suicide possibility.
- 4) Typical discharge instructions for a suicidal patient: Discharge to jail on suicide precautions. Ensure that the medications you are ordering are available at the facility

### **D. Child and Adolescent Consults in the ER**

- Anyone under 18 is not eligible for admit to PCU, and, therefore, must be seen in the main ER.
- Never see the child without parent or guardian permission unless it is an absolute emergency.
- Get collateral from the parent, but also evaluate the child alone so that safety data can be collected. Specific disorders often common to children and adolescents are:

- ADHD and other learning disorders
- Drugs
- Depression
- Bullying including through the internet
- Anxiety
- OCD
- Eating Disorders
- Abuse
- Pervasive Developmental Disorders
- After seeing the patient and documenting exam, contact faculty.
- If patient needs to be admitted, they must be transferred to Brentwood or admitted to pediatrics if no beds are available. First call Brentwood at 678-7500 to find out if beds are available. Brentwood is strictly a psychiatric facility and does not have medical physicians at their facility at all times. Thus, to transfer a patient there, one must fax the following documents to 678-7555:
  - Face sheet of the patient.
  - Certificate of need that is signed by you and another profession of at least an RN status or above. LPN does not count.
  - Medical evaluation
  - Labs
  - Psychiatric evaluation
  - Completed PEC: All children must be PEC'd as legally they are unable to sign formal voluntary due to their minor status.
- Then the accepting facility's psychiatrist will examine the paperwork, and accept the patient. Brentwood will call you back with the accepting physician at which point an interhospital transfer form must be filled out. Then, the patient will be transferred and the parent or guardian has to meet the patient there.
- Keep ER nurses informed as to the status of the transfer.
- Brentwood does not take PDD patients that have no ability to communicate.

#### **E. Floor Consults:**

- Generally consults are handled by the consult team during the day. However, at night the PCU resident may be asked for a consult. Please triage the patients you have and attend to the most unstable first. Therefore, an unstable, psychotic, agitated PCU patient needs to be seen prior to the suicidal patient on the inpatient unit that can be PEC'd by the consulting physician and assigned a sitter.
- If a consulting colleague states the discharge orders from their service are written, but the patient is suicidal, so "would you kindly come and take this patient?" then it is appropriate to remind them that you are glad to offer your service by "evaluating" this patient.
- The following are several helpful ways of wording your communication with consulting colleagues:

- a) Inform them in a matter-of-fact manner that an adequate evaluation takes some time and that you recommend they not discharge the patient until such an evaluation can take place.
- b) The consulting MD retains primary responsibility for the patient until you accept that primary responsibility.
- c) You understand that the consulting MD was concerned enough to involve psychiatry and hope that they will therefore be willing to retain the patient long enough for an adequate psychiatric evaluation. Should this not prove to be the case, you can only hope this MD feels confident in their decision to release the patient, and is comfortable with their decision. Make sure they understand that they are fully responsible.
- d) Often you can talk a medical or surgical team out of a transfer to psychiatry over a weekend, but sometimes transfer may be appropriate and should not be avoided. If there are patients awaiting admission in the ER, then transfer from a med/surg floor to psychiatry CANNOT take place on a weekend. Inform the primary team that the patient will be placed on the list for transfer to the 10<sup>th</sup> floor.

When you evaluate an inpatient, your write up should be concise, covering the following points:

- 1) The reason for the referral
  - 2) Referring service and attending
  - 3) Legal status
  - 4) The problem
  - 5) Past medical history
  - 6) Personal history
  - 7) Admitting PE and lab findings
  - 8) Your examination
  - 9) Formulation (brief but revealing)
  - 10) Clinical impression
  - 11) Recommendations
  - 12) "Thanks" and signature
  - 13) All floor consults should be discussed with faculty and documented.
  - 14) Tell the primary consult resident about the patient the next day, e-mail and written documentation is preferred
- In general, non-emergency consults can be seen the next morning by the consult team, but as a courtesy, the night resident sees them if he/she is not busy in the PCU. Please use your best judgment about seeing these patients. Although it is often appreciated by the day team if the patient is seen at night, the consult team is responsible for following these individuals, and more often than not, can do it more accurately if they are the ones that did the original consult.

## **F. Outside Phone Calls:**

- 1) Establish with whom you are speaking with.
- 2) Get the patient's name
- 3) Obtain the number from which the patient is calling.
- 4) Learn both the patient's home address and his current location.
- 5) Often, referral information is all the patient wants or needs:
  - give them the outpatient psychiatry phone number
  - do NOT prescribe benzodiazepines and pain meds
- 6) Encourage the patient to come to see you in person if the problem will require much investigation or intervention.
- 7) Call the police from another line if you feel the patient is in imminent harm.
- 8) If the patient has already taken action, call 911.
- 9) If you feel you have questions about the phone conversation, or you're unsure about the disposition or what recommendations to give to the patient, tell the patient you will call them back, call faculty or your backup for advice.
- 10) Log phone calls.

Occasionally, patients will call and threaten suicide but refuse to identify themselves. Express concern at your inability to help them. Press them for their information. Do not get drawn into extensive phone therapy.

## **G. Transfer Calls**

If you are called regarding a patient transfer from another hospital: if no beds available, then do not accept transfer.

## **H. Capacity Consults:**

Another consult is to "determine capacity"- usually to refuse treatment or to leave the hospital AMA. The consulting MD usually just wants your concurring opinion that the patient cannot be held against his will. Only in an emergency can anyone other than a judge order a patient to remain hospitalized. Capacity itself is task and situation dependent as far as the on call psychiatrist is concerned. When a person's capacity is questioned please ask the consulting physician why they do not think the person can make his/her own decisions. Then ask specifically for the risks and benefits of the proposed treatment or if the patient leaves the hospital. Ask about the alternative treatments, and finally ask whether the proposed treatment is an emergency. Make sure the consulting physician has explained the same information to this patient.

Then examine the patient using the regular psychiatric examination, with particular attention to the thought process in making the decision and the reasons for the patient's choice. Depending on the situation, the patient needs to be realistic, logical, and rational in his decision making process. Once that is finished, go through the chart to make sure the patient is not delirious when the decision is made. If you determine that the patient does not have capacity, make a recommendation about what needs to be done to regain capacity. Finally, non-emergency treatment cannot be forced onto a patient without a court order, even if the patient does not have capacity.

\* It is mandatory to address the patient's suicidal and homicidal potential when considering whether to allow patient to leave or refuse treatment.

### **I. Violent Patients:**

At times you will be faced with a possibly violent patient. You need to assess the situation in order to try and predict the patient's actions and measures you will need to take.

- 1) Make sure it is not a withdrawal: look at the patient's vitals
- 2) Make sure patient is not in pain.
- 3) Be careful with demented patients as well, always try behavioral modifications first.
- 4) Make sure patient is not delirious as these individuals often think they have been kidnapped.
- 5) Obtain past history from the chart or the deputy
- 6) Look at the patient's body language:
  - a) Psychomotor agitation
  - b) Tense posture
  - c) Pacing
  - d) Approach / avoidance of behavior
  - e) Loud or profane speech
- 7) Give yourself a clear path to the exit
- 8) You should show the patient respect
- 9) Call the patient by their last name putting "Mr." or Ms." In front of it. Use titles, such as "Sir" and "Ma'am"
- 10) Offer a drink of water
- 11) If Security is not there, always call them before you need them
- 12) Never negotiate with the patient about whether you will call security: many of the violent patients are intoxicated and irrational at the time. Therefore, reasoning with them may just increase their agitation since they feel frustrated at not getting their way.
- 13) Get people to be there with you for a show of force
- 14) If possible, make a plan with security before entering the room
- 15) If the patient attempts to leave, have security bring them back to the room
- 16) If medication is needed, try to offer the patient some semblance of choice:  
(Would you prefer a shot or a pill / liquid?)
  - a) In our population, the use of PO medications for aggression and agitation is fairly limited in the PCU as patients tend to escalate without informing the nursing staff first, and many are so focused on discharge that it is difficult to calm the patient with PO medications. However, if the patient does agree to take PO meds to calm down, the following are good choices for this:
    - o Ativan 2mg PO Q 4-6 hours. Although we try to avoid giving benzodiazepines to the patients, it does help to relieve agitation, akathisia, withdrawal, and anxiety from paranoia. Also the ER physicians claim that Ativan is one of the few benzodiazepines that does not suppress central respiratory drive, but the patient still needs monitoring. Please be careful with patients that are intoxicated.
    - o Zyprexa zydis: 10mg PO Q 8 hours for agitation. More than 30mg per day has not really been studied and if it does not work by 20mg, chances are that 30mg PO will not help either. However, it is a fast acting oral medication that may



help calm the psychotic and/or manic patient. Excellent choice if zyprexa is the patient's regular medication and he/she has not been compliant with it. Also, unlike the IM shot, zyprexa zydis can be given with IM Ativan without worry of over sedation.

- Vistaril: 50mg PO Q 6-8 hours. Good for anxiety and allergic reactions.
- Please adjust medications dosages for patient's age, physical stature, and medical conditions.

17) Intramuscular choices for agitated patients: Usually done in combinations of antipsychotic, benzodiazepine, and Benadryl, but each can be given alone as well.

a)

- Geodon 20mg IM Q 12 hours
- Ativan 2mg IM Q 4-6 hours
- Benadryl 50mg IM Q 6-8 hours
  - This combination is often given in the emergency room prior to the patient going up to the PCU. Please read the ER notes under the procedure section to see whether that was given.
  - This is a good combination, fast acting, but Geodon needs to be dissolved into a solution which takes some time to prepare.

b)

- Haldol 5-10mg IM Q 6-8 hours
- Ativan 2mg IM Q 4-6 hours
- Benadryl 50mg IM Q6-8 hours
  - This is the most often used combination of medication in this institution. It is fairly fast in action, and tends to last longer the the Geodon combination. It can also be given more often than Geodon as well.

c)

- Abilify 9.75mg IM Q 8 hours
- Ativan 2mg IM Q 4-6 hours
- Benadryl 50mg IM Q 6-8 hours
  - Rarely used, but supposed to leave patient awake enough to be interviewed. However, this is often not the case

d) Thorazine (Chlorpromazine) 50mg IM Q 3-6 hours, but has a very wide dose range. Often also given with Ativan and Benadryl, but one has to be very careful with it. It already has much anticholinergic activity in itself, thus a propensity for orthostasis and cardiac arrhythmia. Can also consider for hyperthermia from Serotonin Syndrome.

18) PRN Medications: these are the typical meds that one would find in a medicine cabinet. Please limit the opioids no matter what the patient states. Patients that are on chronic opioids are required to have one physician to prescribe the medication and can be verified via the controlled substance database.

- a) Ibuprofen: please be careful with patients on lithium.
- b) Vistaril
- c) Trazodone
- d) Milk of Magnesia
- e) Benadryl
- f) Nicotine replacement



**Chapter 4**  
**ADMITTING A PSYCHIATRIC PATIENT**

**A. From the PCU:**

It is important to note that the admission policy may change in the future.

Make sure that the following is completed and documented in EPIC:

- 1) PEC or FV form, documented in orders
  - o Please be careful about the individual that is offered a formal voluntary admission. What a formal voluntary admission means is that the person knows that he is a danger to himself or others or knows that he is gravely disabled, recognizes it, and admits him or herself to the hospital.
- 2) Admission form signed
- 3) Complete H & P
- 4) Lab results if applicable
- 5) Admit orders including precautions and PRN meds when they get to the unit as well as code status and allergies.
- 6) Generally, if a patient is psychotic or suicidal, they would not be considered to have the capacity to declare themselves DNR (do not resuscitate). So as a general rule, the majority of patients will be Full Code.

**B. From the Main Hospital:**

Usually not done at night.

If necessary, the patient is discharged from med/surg team, and the patient is re-admitted to psychiatry with above forms in A completed.

**C. Direct Admissions:**

If there are open/available beds, patients on PEC's, OPC's or RPC's are brought directly to the unit from the main ER. It is still the resident's responsibility to complete a full evaluation similar to an ER consult. If unstable medically, call appropriate consult urgently. (This form of admission is rare)

**D. Transfers from LSUHSC to Another Hospital**

When an ER patient is determined to require inpatient psychiatric care and there are no beds available here, then the patient should be admitted to the closest facility with a bed available.

PROCEDURE: After completing evaluation, call house supervisor who will check on the availability of beds at other facilities. If another facility with an open bed refuses a transfer for inappropriate reasons, then complete a variance form (or tell the administration to help with such) and give to attending.

**Chapter 5**  
**INPATIENT PSYCHIATRY ON CALL**

**A. Psychiatry Inpatient Requesting to be Discharged**

You should check the status of the patient. If the patient is involuntary, then they should not be discharged. All patients that sign a formal voluntary form are educated that the physician needs a 72 hour written notice when the patient no longer wishes to be a voluntary patient. Therefore, there should be very few emergency discharges when the primary team is not around.

If the patient is voluntary:

- 1) Assess the patient for safety issues, placement issues and support system.
- 2) If not suicidal or homicidal, and patient is not gravely disabled, then they may be discharged. This must be approved by the on-call attending
- 3) If + SI/HI or gravely disabled, then have patient sign objection to FV and allow primary team to evaluate in a.m.

**B. Seclusion Orders and Emergency Administration of Chemical Restraint:**

- When patients get agitated and place themselves, staff, or other patients in harm they should be secluded.
- You must remember that putting a patient in seclusion is for their protection.
- There must be an interview within one hour of the restraint and it must be documented in the patient's chart. Call your backup if needed.
- In addition to this documentation, there are also orders in EPIC for Seclusion or Restraint that must be put in.
  - In all cases of seclusion and restraint, the patient must be informed of the reason for such actions, and what he/she needs to do to come out of the restraint/seclusion and what needs to happen in the future to avoid it.
  - Also if medications are given to the patient for agitation or safety while in restraint or seclusion, they are called emergency medications, not PRN medication.

**C. Mechanical Restraints:**

- A mechanical restraint is anything that restricts the movement of the whole body or a portion of a body. They should only be used as an emergency measure to protect the patient from injuring self or others when other intervention strategies have been attempted and failed.
- They shall not be used as punishment or solely for the convenience of the staff.
- Restraints should be maintained as long as the patient is exhibiting unacceptable behavior that is dangerous, but must be re-ordered and re-assessed every 4 hours. Again, documentation with specific reasoning and plan must be completed within one hour. It must be dated and timed.

- Make sure the patient understands the reason for his/her restraints, what he/she has to do to get out of them, and what needs to be done to avoid them in the future. Also make sure the patient was not injured while being restrained.
- Keep in mind that physically restraining victims of kidnapping, rape, and PTSD may have its own consequences.

#### **D. Patient Search Policy:**

Body searches should be performed in the ER by campus police, and patient's belongings searched upon admit. There is usually a document that has patient belonging listed in it.

#### **E. Medical Emergencies:**

If a patient has a medical emergency it is your responsibility to assure that an adequate evaluation is performed. If necessary, call for a consult from the appropriate specialty and notify your attending of results. In addition, there is a rapid response team in the hospital at all times, with specific code criteria.

The following may be helpful in certain situations, but always use your clinical judgment.

- 1) **Chest Pain** – Ddx: angina, MI, pericarditis, TAA, PE, PTX, GERD, esophageal spasm, cholecystitis, chest wall
  - a) Obtain VS over the phone, order pulse ox and EKG over the phone, get patients medical history from the nurse to aid in your differential diagnosis, sublingual NTG may repeat x 3 q5min if pain continues (may hold NTG for SBP<90), chew ASA 325mg, order hepllock over the phone, go see the patient and review EKG, call medicine START team
- Bleeding** – manifestations – epistaxis, hematemesis, hemoptysis, hematochezia, hematuria, melena, vag bleeding, post procedure, anemia.
  - a) Obtain VS over the phone including orthostatics, ask quantity (this is usually overestimated), order hepllock if abnormal vitals or mod-large quantity or for continued bleeding, Go see patient, if significant, order CBC, PT/PTT, Type and Cross 4U PRBC, call Medicine START team.
- 3) **Glucose:**
  - a) Hyperglycemia: use SSI, get FSBG in 30-40 mins. If FSBG is <400, may need to get chemistry and serum ketones. IF ketones + treat as DKA-call medicine if this is suspected. Need to get AG closed.
  - b) Hypoglycemia: get VS, IV access, D50(amp) or juice, repeat prn then IVF with D5W.
- 4) **Hypertension** – is patient having CP, HA, nosebleed, MS changes, papilledema, (any signs of end organ damage), find out what patients BP usually runs. If no signs of end organ damage, control with clonidine 0.1mg, recheck BP, may need to repeat clonidine. May give at one hour intervals not to exceed 1.0mg. If w/ signs of end organ damage-call medicine START team.
- 5) **SOB** – think CHF, PE, Pneumonia, Asthma, Pneumothorax-obtain vitals, pulse ox, go see patient CXR if indicated, medicine consult if indicated.
- 6) **Nausea/Vomiting** – is patient having belly pain, when was last BM? Go see patient if needed. Can use phenergan or compazine, but remember these are

also phenothiazines and may cause dystonia, may need pm benadryl or cogentin.

- 7) **Seizures** – ensure safety of patient while patient is seizing and then call Neurology consult. If related to EtOH or Bzd withdrawal, call internal medicine. The patient will likely be admitted to the MICU. Consider Ativan 2mg IM or IV stat.

**Chapter 6**  
**MEDICAL CONCERNS WITH PSYCHIATRIC INPATIENTS**

**A. Alcohol Intoxicated Patients**

When an intoxicated patient is in the ER, many times you will be called because the patient has expressed suicidal ideation. While these patients obviously have problems of a psychiatric nature, their suicidal tendencies and ideation often remit when they sober up. It is best to wait until the patient is sober enough to make a reliable decision about his or her own mental status before disposition is made. Unfortunately, this often is in discord with the wishes of the ER faculty, who want a quick disposition of a patient who is often unruly and persistently disruptive. There are some guidelines to use:

1. Always have the consulting MD get a serum alcohol concentration to aid in your assessment of the intoxicated patient. If you are uncertain of whether the patient has been drinking, get one anyway. In general, the alcohol level should drop about 15-25 mg/dl per hour.
2. An assessment of the intoxicated patient can be done immediately for safety and general status. However, a psychiatric assessment will not be considered accurate unless the patient is sober, despite whatever the patient states. The decision to assess patients with higher alcohol level is left to your clinical judgment but you cannot make a disposition before the level is below the legal limit for intoxication.
3. Intoxicated patients can be brought to the PCU as a disposition until they are sober enough for evaluation. Ensure that a complete substance use hx is obtained and if necessary proper medications used to prevent life threatening withdrawal.
4. The other services tend to underestimate the prevalence and seriousness of DT's, so it is your duty to make this assessment. For example, you will often hear "the blood alcohol level is 180, he will not withdraw" but keep in mind that many of our patients live at a baseline of 400, so the withdrawal chance is very high.
5. In general, it is better to be cautious and treat high risk individuals for possible DT's. One quick way to assess this using the CIWAA scale which can be brought up by typing .ciwaa in epic. A score of 12 or greater indicates increased risk for DT's.

**Delirium Tremens Policy (DT):**

When there is even a remote possibility of this occurring, please do not hesitate to contact the medical team for an evaluation. In addition, make sure the patient's electrolyte disturbances are corrected, including potassium and magnesium. Finally, also give thiamine.

It is the responsibility of the Department of Internal Medicine to care for patients with DT's when the patient meets all four of the criteria below:

- 1) Has recently abstained from the chronic use of significant amounts of alcohol, or has recently reduced the amount.
- 2) Is disoriented as to either time or place
- 3) Is either hallucinating or is tremulous.
- 4) Has significant elevation of one of more vital signs (SBP>180mm Hg, P> 110/minute or T $\geq$ 38 degrees C or DBP>100mm hg.)

Risk factors that increase the chances of delirium tremens:

- Prior ethanol withdrawal seizures
- History of DTs
- Concurrent illness
- Daily heavy and prolonged ethanol consumption
- Greater number of days since last drink
- Severe withdrawal symptoms at presentation
- Prior detoxification
- Intense craving for alcohol

When a patient with DT's is admitted to Internal Medicine, the Psychiatry Consultation Service will be glad to see the patient in consultation until the patient becomes medically stable.

The on call PCU resident will see many substance patients, and is required to obtain a substance history. Questions which are directed toward obtaining a chemical dependency HX are:

- Agents and patterns of use.
- Date first used and date last used for each substance.
- Previous periods of abstinence for each substance.
- Reasons for prior periods of abstinence.
- Methods used to control or abstain from use.
- Past and present withdrawal symptoms.
- Recovery programs attended, recovery programs completed, longest period of sobriety afterword's, after care attendance, and trigger identification and control. These questions will give you an idea of the patient's commitment to recovery as well as their ability to follow through with a difficult task.
- Medical problems that may complicate withdrawal, e.g. seizure d/o.
- Problems related to use.
- Specific precipitators of seeking treatment.
- H/O Blackouts.
- Remorse.
- Guilt.
- Unplanned use.



### **“CAGE” Questions**

Do you ever feel the need to Cut down?

Do others Annoy you about your use?

Do you ever feel Guilty about your use?

Do you need an Eye-opener in the morning?

\* 2/4+ is highly suggestive of abuse if not dependence

### **CRAFFT Questions for Adolescents:**

C: Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs.

R: Do you ever use alcohol or drugs to relax, feel better about yourself or fit in.

A: Do you ever use alcohol or drugs while you are by yourself, alone?

F: Do you ever forget things you did while using alcohol or drugs?

F: Do your friends and family tell you that you should cut down on your alcohol or drug use.

T: Have you ever gotten into trouble while using alcohol or drugs.

The difference between dependency and abuse is that a dependent patient spends the majority of his time obtaining, using, and recovering from a substance. The amount of effort that a patient will go through to obtain and use a substance can almost be thought of as a compulsive disorder.

If you feel the patient is not a suicide threat, encourage them to contact a local substance abuse program.

If you feel that the patient continues to be a threat to self, and your disposition is to admit, it is important that your admission orders contain the following:

- Order a benzodiazepine (Librium or Ativan) for prophylaxis against withdrawal symptoms.
- Order Thiamine up to 500 mg PO QDay depending on the probability of DT.
- Order MVI with folate 1 PO qd
- If needed place patient on suicide and seizure precautions.

### **B. Delirium:**

Delirium can be defined as: “Widespread disturbances in cerebral metabolism characterized by confusion, disorientation, short-term memory deficits and fluctuating state of arousal.”

It is common for a surgeon or internist to misidentify delirium as “psychosis” or “acute onset of mental status change with agitated behavior”. You should remember that delirium is a medical, not a psychiatric emergency. Once the DX of delirium has been made and the patient’s immediate safety assured, the possible causes of delirium should be investigated.

In most cases, deliriums are caused by CNS problems, systemic problems, and/or intoxication or withdrawal from pharmacological or toxic agents. You should assume that any drug can cause delirium, so check the temporal relationship between the change in mental status and the start of a drug.

Do a good review of the patient's chart, especially vital signs, neurological examination and hospital course.

The use and documentation of the MMSE can be used to follow the cognitive impairment and provide a baseline from which to measure the patient's clinical course.

Work up you should consider after seeing the patient, getting an HPI, and doing a physical exam:

- Vital Signs: Temp, BP (lying/standing if dehydration is to be ruled out). Pulse, Respiration
- Blood/Serum: BCB with MD, CMP, ammonia, RPR, thyroid function test, sed. Rate, B12, folate, HIV.
- Urine: urinalysis, drug screen, culture
- CSF: culture, glucose, protein, cell count, RPR, Gram stain.
- Misc: EEF, ECG, MRI, CT.

### **Pharmacotherapy of Delirium**

- Use low dose, high potency antipsychotics such as risperidone or haloperidol.
- Low dose of Seroquel at night (although having high anticholinergic activity) often helps the patient since sleep is disturbed in a delirious patient. However, if delirium occurs on your service, one of the best options is to discontinue all meds that are not essential, including those given as PRN. If the delirium is from the medication, it will clear rather quickly. However, please recognize that a delirium may last for several months after a hospitalization.
- Discontinue meds that may contribute (if possible)

### **C. Neuroleptic Malignant Syndrome (NMS):**

A consult to evaluate a patient with the possible diagnosis of NMS can be one of the more challenging consults you will receive. This is because most people have never seen a true NMS, and meningitis is in the differential diagnosis.

NMS is a rare condition that can occur when a patient has been given neuroleptics. NMS is a syndrome manifested by: Fever (usually > 40 C). Rigidity – Parkinsonism (refractory EPS, Autonomic instability (labile B/P, tachycardia, diaphoresis), and impaired consciousness (delirium, obtundation, catatonia). There is usually increased WBC, but the most characteristic laboratory finding is an elevated CPK. Rhabdomyolysis with myoglobinemia can be present in about 3/4 of the patients.

It should be noted that other non-neuroleptic drugs like Reglan, Asendin and Reserpine can cause NMS. Also, it may occur with withdrawal of dopamine agonists such as: Sinemet, Levodopa, Amantadine or Bromocriptine.

Risk factors for NMS include the presence of organic mental disorder, agitation, dehydration, concurrent psychotropics (particularly lithium) and male gender.

In most cases NMS occurs within the first 2 weeks of initiation of neuroleptics. Progression of full symptom complex occurs within 24-48 hours of onset.

Whenever you get a call from the psychiatric unit about an altered mental status or high fever, please consider this possibility. If there is even a mild suspicion of it, please consult medicine as true NMS often requires ICU treatment.

### **TREATMENT OF NMS**

Immediate discontinuation of neuroleptic and supportive care (i.e. lowering body temperature, hydration, control of B/P). You should also try to determine if other abnormalities like metabolic disorders or infection are present.

Suggested Labs: Follow CPK, CMP and Urine Myoglobin

May Consider: Dantrolene (initial 2-3 mg/kg over 10-15 minutes)  
Bromocriptine (initial 2.5-10 mg TID, Max 60 mg/day)  
Amantadine (200-400 mg/day in divided doses)

In most cases recommend supportive care until the faculty on C&L can assess in the a.m.

### **Recreational Drugs:**

#### **Cocaine:**

FYI: Peak toxicity about 60-90 minutes after swallowing, 30-60 snorting and within minutes IV or smoking. Adverse effects can occur minutes or hours later.  
Half-life is about one hour, but may be modestly prolonged with the use of ETOH.

Effects: CV-multiple type of arrhythmia's, constriction of coronary arteries (smoking tobacco can aggravate cocaine-induced coronary vasoconstriction), and severe hypertension.  
CNS- Anxiety, agitation, paranoia, delirium, seizures, cerebral vasculitis and thrombotic hemorrhagic stroke. Hyperthermia and rhabdomyolysis can occur.  
Resp.- The valsalva maneuver often used to heighten the effects of cocaine  
Smoking may cause pneumothorax or pneumomediastinum.

TX: Most of the toxicity is too brief to treat. Benzodiazepines can be used to treat the anxiety, agitation, seizures and at times hypertension.  
Hyperthermia can be managed with rapid cooling.  
Depression/suicidal ideation are transient with cocaine withdrawal, and so SSRIs are typically unnecessary. However, increased monitoring is warranted as this is the reason for many of the suicide attempts in rehab centers and jails. Psychosis must be treated immediately with antipsychotics. Please avoid non-specific beta blockers in cocaine addicts.

**Amphetamines:**

- FYI: Depending on form can be swallowed, injected or smoked. Common examples are: Dexedrine, Ritalin and ephedrine.
- Effects: Similar to that of cocaine, but longer in duration, lasting up to several hours. Cerebral and systemic vasculitis and renal failure have occurred.
- TX: Similar to that of cocaine. Elimination does require adequate urine output and acidification of urine would also assist in clearance. Neuroleptics should not be used in patients with amphetamine overdose because they lower the seizure threshold.

**Opioids:**

- FYI: Traditionally, The most common opioids were Heroin, Methadone, Darvon, Demerol, and Talwin. However, these potent medications are fairly difficult to obtain and therefore the most common opioids seen today are the oxycodons, lortabs, lorcet, and other similar drugs. It is important to find out exactly how much of these medications these individuals are abusing. Often times, they will take up to 300mg per day of lortabs, completely ignoring the fact that there is a great deal of Tylenol in a lortab tablet. Furthermore, standard methadone dosages are up to 30 mg per day for pain and 60-100mg for dependence. If a patient is taking a greater amount than that, there is a very high probability that he/she is abusing it. Legitimate methadone patients have one prescribing physician, usually only one pharmacy, can be found on the controlled substance database, have negative drug screens, can tell you their follow up and aftercare plans, may have identification cards, and can tell you about their pill counts.
- Effects: Heroin overdose leads to respiratory depression, pulmonary edema, coma, bradycardia and hypotension. Acute toxic effects of Methadone may persist for several days. Demerol may cause delirium. Acute opioid withdrawal is associated with anxiety, piloerection, yawning, sneezing, rhinorrhea, nausea, vomiting, diarrhea and abdominal cramps, which may be uncomfortable but are not life threatening.
- TX: An initial dose of 2 mg of Narcan IV will reverse the toxicity of most opioids, but usually only done in the emergency room. The intensity of the reaction usually indicated the severity of the addiction. If necessary, the dose can be repeated at 2 to 3 minute intervals up to a total of 10 mg. For acute opioid withdrawal clonidine may be helpful. Typical opioid detox regimen: clonidine, motrin, flexeril, loperamide. Ibuprofen, and Phenergan. In addition, an agent to help the person sleep can be indicated.

**Sedative-Hypnotics:**

- FYI: Oral benzodiazepines are rarely lethal, but they can be dangerous when taken with ETOH or other CNS depressants. One should also be careful with patients abusing barbiturates and similar narcotics (fiorinal).

Withdrawal from barbiturates oftentimes can only be treated with phenobarbital.

Effects: Major toxic effect is respiratory depression and coma.

TX: Respiratory depression can be managed with intubation if needed. The benzodiazepine antagonist Flumazenil reverses the effects and is useful in managing overdoses, but may precipitate withdrawal symptoms or seizures in patients who have also taken seizure-threshold-lowering drugs such as TCA's or cocaine. At that point you should treat the seizure.

### **Phencyclidine (PCP):**

FYI: Although classified as a dissociative anesthetic, PCP has stimulant, depressant, hallucinogenic, or analgesic effect, depending on the dose and route administered.

Effects: Overdose, which can last for days, may cause psychosis or violent behavior; restraints and benzodiazepines may be needed. Large overdoses may cause coma, seizures, hypo or hypertension, and muscular rigidity accompanied by severe hyperthermia and rhabdomyolysis. Vertical nystagmus is also a clue of PCP use.

TX: Treatment is supportive, including diazepam for seizures and external cooling for hyperthermia.

### **Hallucinogens:**

FYI: Drugs like LSD or Mescaline produce a hypersuggestible state that can be managed by providing a calm, supportive environment.

Effects: Sympathomimetic effects like: Tachycardia, hypertension, hyperthermia, papillary dilation, hyperreflexia, nausea and muscle weakness can be seen.

TX: Supportive calm environment.

### **Marijuana:**

FYI: High doses may precipitate clinical onset of previously latent schizophrenia.

Effects: Tachycardia, decrease in salivation, intraocular pressure and skin temperature can be seen. In older patients, acute dysphoric reaction, panic attacks have been reported.

TX: Usually no specific treatment is needed. Psychosis can occur and should be treated with antipsychotics.

### **Other Problem Substances:**

- 1. Synthetic Marijuana:** best known by the brand names K2 and Spice. These are now different mixtures that contain synthetic cannabinoids. These are usually smoked in an attempt to produce a similar high to that of marijuana. However, in our patient's it often produces a prolonged manic/psychotic state. The urine drug screen is often negative, so this substance is now starting to spread to those that get tested frequently, such as athletes and parolees.
- 2. Bath Salts:** Up and coming problem narcotic that is a cathion derivative, usually a designer drug. The actual term bath salts can refer to any number of various cathion

derivatives, thus the exact substance is difficult to test for. In our patients, it produces an extremely agitated prolonged psychotic state, often with resulting cognitive deficits if used IV. Therefore, an an extensive review is warranted:

**Introduction:**

1. Often obtained for hedge shops and online retailers.
  2. It is a psychoactive stimulant with effects similar to cocaine, amphetamines, methylamphetamine, and MDMA.
  3. Has allegedly been linked to a number of fatalities.
- 
3. **THC dipped in Embalming Fluid:** “Wet daddies”: this is done to get a longer high. However, often times the patient becomes extremely psychotic and ends up with a cognitive disorder with poor attention, concentration, and planning.
  4. **Energy Drinks:** This was fairly common in 2009-2010, and Four-Loko was the best example. Usually a combination of alcohol, caffeine, sugars (Taurine), and in some cases Theophylline. These drinks tasted very sweet, were cheap and came in large quantities. Individuals would become intoxicated fairly quickly and some became very aggressive and psychotic. After media attention and regulation, their popularity has decreased.

## Chapter 7 Legal Documents

### **A. Commitment for Treatment:**

Commitment requires a formal hearing before a judge with the patient having legal counsel present. These hearings take place on campus once a week. Physician's Emergency Certificates (PEC) allows a patient to be held involuntarily for 72 hours. In that time the Coroner or Deputy Coroner (a state psychiatrist) will evaluate the patient and make a decision on whether further commitment is needed, which is documented in a Coroner's Emergency Certificate (CEC). A PEC/CEC or EC is good for 15 days starting at the date and time of the initial document. During that time, the patient's status must become voluntary, commitment proceedings initiated, or the patient must be released. If a decision is made to seek commitment, please complete a timely report to court summarizing (in a paragraph) the patient's need for commitment.

### **B. Criteria for Involuntary Commitment:**

In order for a patient to be committed for mental illness, reports of mental illness must be completed by two physicians certifying that in their opinion the patient is mentally ill and as a result of mental illness the patient is (this is the PEC/CEC):

- **Dangerous to Others** - "Dangerous to others" means the condition of a person whose behavior or significant threats support a **reasonable** expectation that there is a **substantial** risk that he will inflict physical harm upon another person in the **near** future.
- **Dangerous to Self** - "Dangerous to self" means the condition of a person whose behavior, significant threats or inaction supports a **reasonable** expectation that there is a **substantial** risk that he will inflict physical or severe emotional harm upon his own person in the **near** future.
- **Gravely Disabled** - "Gravely disabled" means the condition of a person who is unable to provide for his own basic physical needs, such as essential food, clothing, medical care, and shelter, as a result of serious mental illness or substance abuse and is unable to survive safely in freedom or protect himself from serious harm. This category does not apply to patients in OCDD custody (organization that cares for MR patients) as by definition, they are gravely disabled.

### **C. Preparation of a Commitment Evaluation:**

An appointed faculty (or resident with a full license) will complete an evaluation of the patient for court and determine whether the patient requires continued involuntary inpatient treatment or can be released. There is a document regarding guidelines for resident completion of forensic requirements in the Green Book. Please see Dr. Colon for questions. A sample commitment evaluation:

### Civil Commitment Guidelines.

1. Read over the petition PEC which was filed; make note of the allegations in the petition and what boxes are checked and what the inpatient recommendations are.
2. Review the chart and hospital course, have in your mind what you would put in the discharge summary. Make sure to note medications the patient has taken or refused and UTOX.
3. On the morning of the court, please review the chart for any alterations in medications, behaviors, or any PRN meds than needed to be given. Please pay attention to the court proceedings as well.
4. Call attending and determine the treatment plan for the patient in regards to court and current status before starting your evaluation.
5. Go to the 10<sup>th</sup> floor and perform evaluation of patient.

### **The Interview Process**

- A. Inform, patient of the non-confidential nature of interview.
- B. Ask for a brief HPI, eg. “What brought you into the hospital?” “What do you remember before being brought to the hospital” “How to patient was transported to hospital” and Events leading up to the hospitalization. Can summarize these events no quotes needed.
- C. Ask about the allegations of the petition and have those answers in quotes “”
- D. Specifics standard questions have their answer/reason in quotes “”

Do you believe you have a mental illness?

Do you believe that you need medications for your mental illness?

Are you taking your medications here at the hospital?

Are you going to follow-up outpatient when released?

Do you believe that you need court ordered treatment?

When you are discharged from the hospital what are your plans?

- E. Perform full psychiatric evaluation. With MMSE
6. Call for collateral information if necessary from RPC filer.
7. Before court call attending again and see if discharge plan has been solidified, make note of medications the patient took before going to court in the chart before the hearing.
8. See patient as a follow-up to note current condition mental state or if any changes from your evaluation
9. Go to court.



Sample Text.

Disclosure Statement:

I informed the patient that I have been appointed by the court to do a psychiatric evaluation and to assess him for the presence of mental illness and whether he is dangerous to self, others or gravely disabled secondary to his mental illness. He was informed that this evaluation is not confidential and that a report would be presented to court. He was also informed that he has the option of not participating in the interview and if he chooses to do so, his medical record would be used to prepare a report in accordance with the law. He agreed under those conditions.

Recommendations:

The patient continues to be stabilized on the inpatient psychiatric unit by the inpatient team. The patient continues to refuse medications for treatment of his mental disorder. His medications will be continued to be offered to the patient. The patient will be provided a safe environment. Side effects from the medication will be monitored.

The patient currently does not meet the criteria for being dangerous to self or others. The patient is not endorsing any type of suicidal/homicidal ideation during the evaluation and is not a significant threat to himself or others in the near future.

The patient does meet the criteria for being gravely disabled. The patient lacks the insight to realize that he has a serious mental illness which requires treatment. The patient is unable to provide for his basic physical needs evident by not following up for his medical and mental health issues. His psychosis and continued substance usage alters his sense of reality where he believes that he was tortured in the PCU. Thus he is unable to survive safely in freedom or protect himself from serious harm. He will need judicial commitment for continued inpatient stabilization with DHH.

**Other Recommendations usually on Note to Court, but some recommendation options are as follows:**

Judicial commitment for continued inpatient stabilization with DHH (Department of Health and Human Services).

Judicial commitment for outpatient treatment and follow up with SBHC (Shreveport Behavioral Health Center).

Judicial commitment for outpatient treatment with Pines Substance Treatment Center.

**Can schedule another hearing to decide a change of placement once stabilized inpatient.**

Judicial commitment to SBHC for outpatient management.

Judicial commitment to treatment at Red River Treatment Center with outpatient follow-up with SBHC

Judicial commitment to outpatient follow-up with private psychiatrist.

**Questions court will ask?**

State your name for the court.

Doctor, can you briefly tell me about how and why the patient is in the hospital?

Are you the patient's treating physician?  
Do you believe that the patient is suffering from a mental illness?  
Do you believe that the patient's condition will improve with treatment?  
What kind of treatment would you recommend?  
Do you believe that the patient is DTS? DTO? GAD?  
Can you tell me the Axis I diagnosis of the patient?  
What are the recommendations to the court?  
Is this the least restrictive environment?

**On cross examination.**

Was the patient on any drugs on admission? Would this be the cause of the patient's psychotic symptoms?  
What medications is the patient currently taking?  
Would these medications adversely affect the patient's ability to stipulate in court?  
When was the last time you saw the patient?  
What did you personally observe the patient do?

**D. Formal Voluntary Admission**

- To be offered to a patient if he/she has the capacity to understand the terms of admission and the rules of the inpatient unit, and he/she agrees to abide by said rules.
- Prior to patient signing this form all information must be discussed with the patient.
- The patient must also have the capacity to sign a 72 hour release of formal voluntary admission.
- If at any time during admission the patient loses capacity to sign a 72 hour release of formal voluntary, then at that time the treating physician will initiate involuntary commitment.

**Chapter 8**  
**PSYCHOPHARMACOLOGY**

**A. Neuroleptics (Antipsychotics):**

These are the drugs that you should be most familiar with.

Classically, neuroleptics can be divided roughly into two groups: typical or first generation and atypical or second generation. The first generation tend to be selectively more potent at the D2 receptor, while the atypicals have varying receptor profiles.

However, recent research has shown that many of the typical antipsychotics are not as selective as once thought. The first generation medications can be separated into High Potency and Low Potency neuroleptics (see Table 1). High potency are those medications that are very selective for D2 and have little anticholinergic effects, while the low potency are more sedating, have more anticholinergic effects and produce more orthostatic hypotension. Low Potency neuroleptics also lower seizure threshold more than High Potency neuroleptics. The first and second generation neuroleptics have fairly equal efficacy for positive symptoms, but the atypicals are tolerated better and lead to less noncompliance. In addition, some of the atypicals carry indications for various mood disorders and therefore, one is able to decrease the number of medications that a person is taking. However, with atypicals, one has to be careful of metabolic syndrome, orthostasis, and sedation.

**Table 1**

**Commonly used Typical Neuroleptic Medications**

<b>Generic Name</b>	<b>Trade Name</b>	<b>Relative Potency</b>	<b>Dose Range</b>	<b>Side effects</b>
Haloperidol	Haldol	High	1-20mg	EPS TD QTc prolongation
Fluphenazine	Prolixin	High	1-20mg	Same as haldol
Trifluoperazine	Stelazine	High	15-50	Same as haldol, more prone to Qtc prolongation and seizure
Thiothixene	Navane	Medium	2-60mg	Anticholinergic
Perphenazine	Trilafon	Intermediate	16-64mg	Anticholinergic
Molindone	Moban	Intermediate	30-100	Anticholinergic, less weight gain.
Chlorpromazine	Thorazine	Low	300-1000	Anticholinergic

**Table 2: Commonly Used Atypical Antipsychotics**

Generic Name	Trade Name	Relative Potency	Dose Range	Side effects
Risperidone	Risperdal	High	0.5-8mg. Has a depot form	Similar to haldol, but more weight gain.
Invega	Paliperidone	Medium	3-15mg. Has a depot form.	Active metabolite of Risperidone. Supposedly causes less sedation
Ziprasidone	Geodon	High	80-160, maybe greater	Akathesia. Requires a 500cal meal to be absorbed.
Iloperidone	Fanapt	Medium	2-24mg	Orthostasis, Akathesia
Aripiprazole	Abilify	High-	5-30mg	Akathesia, orthostasis
Lurasidone	Latuda	Medium	40-120mg	Orthostasis, Akathesia
Olanzapine	Zyprexa	Medium	5-30mg, but often more. Has a depot form.	Metabolic syndrome, weight gain, sedation.
Clozapine	Clozaril	Low	300-900mg	Metabolic syndrome, sedation, sialorrhea
Quetiapine	Seroquel	Low	600-800 mg	Weight gain, sedation.

**Table 3**

**EPS**

Syndromes	Symptoms	Treatment
Acute Dystonic Reaction	Abnormal involuntary movement of various types and oculogyric crises	Cogentin 1-2 mg Or Benadryl 25-50 mg PO / IM
Akathisia	Compulsion to be in motion, restlessness	Reduce neuroleptic and use above meds or propranolol. Can use Amantadine as well.

Parkinsonism	Tremor, rigidity and Akinesia or bradykinesia cogwheel rigidity	Reduce neuroleptic and use above meds
Tardive Dyskinesia	Orofacial-lingual dyskinesia, choreoathetosis in limbs and trunk	No consistently effective Tx. Lower neuroleptic dose. May add Vitamin E. Consider change to atypical antipsychotic. Consider clozaril. Get neurology consult.

**B. Antidepressants:**

There are several classes of antidepressants, and even within the same class, drugs may vary considerably in structure, and side effects. When selecting an antidepressant, you will mostly focus on safety and side effect profile.

Initiating antidepressant treatment in the ER is not done. The only exception is if the patient can be followed up in one of our outpatient clinics within a week. If this is the case, then the use of a Serotonin-Selective Reuptake Inhibitor (SSRI) or Serotonin-Norepinephrine reuptake inhibitors is the safest choice. It is almost never justifiable to prescribe a Tricyclic Antidepressant (TCA) or Monoamine Oxidase Inhibitors (MAOI) in these situations. Less than a week's supply can be a fatal dose.

When selecting an antidepressant, the main side effects to consider are: sedation, anticholinergic effects, postural hypotension and impaired cardiac conduction (See Table 3), as well as cost. Many of the SSRI's are on the Wal-Mart \$4 list.

**Table 3**  
**Antidepressant Profile**

Generic Name	Trade Name	Sedation	Anticholinergic Effects	Postural Hypotension	Impaired Cardiac Conduction	Dose Range (mg/d)
<b>SSRI</b>						
Fluoxetine	Prozac	0/+	0	0	±	10-80
Fluvoxamine	Luvox	0/+	0	0	±	50-300
Paroxetine	Paxil CR	0/+	0	0	±	12.5-50
Sertraline	Zoloft	0/+	0	0	±	25-200
Citalopram	Celexa	0/+	0	0	±	20-60
Escitalopram	Lexapro	0/+	0	0	0	10-20
<b>SNRI</b>						
Venlafaxine	Effexor	0/+	0	+	0	75-375mg (rarely go that high)

Desvenlafaxine	Pristique	0	0/+	0	0	50-100mg. Need to check liver function
Duloxetine	Cymbalta	0/+	0/+	0	0	30-90mg. Need to check liver function
<b>TCA</b>						
Amitriptyline	Elavil	+++	++++	++	+++	100-300
Amoxapine	Asendin	++	+	+	++	200-300
Clomipramine	Anafranil	+++	+++	++	++	50-250
Desipramine	Norpramin	+	+	+	++	100-300
Doxepin	Sinequan	++	++	+	+	100-300
Imipramine	Tofranil	++	++	++	+++	100-300
Nortriptyline	Pamelor	++	+	±	++	50-150
<b>Atypical</b>						
Bupropion	Wellbutrin	0	0	0	0	150-300
Nefazodone	Serzone	+	0	+	0	---
Trazadone	Desyrel	++	±	+	PVC's	50-300
Mirtazapine	Remeron	++	0	0	0	15-45
<b>MAOI</b>						
Phenelzine	Nardil	+	0	++	0	
Tranlycypromine	Parnate	0	0	++	0	

### C. Mood Stabilizers:

Lithium (Therapeutic range 0.6 – 1.2 mEq/L)

This is the first line therapy for Bipolar disorder. Before you initiate treatment, get a good history on renal, cardiac and thyroid disease. If patient is female in her reproductive years, ask about her last menstrual period. You should also obtain these labs: CBC, Chem panel, Thyroid function tests, Beta HCG, and ECG.

There are different routines the faculty uses to start a patient on lithium. In general, for a healthy adult, a starting dose of 900 mg qd in 3 divided doses is reasonable. Check steady state levels 4 to 5 days after the last increase in dose. Serum level should be checked about 12 hours after last oral dose.

Valproic Acid (Therapeutic range for Bipolar/Schizoaffective D/o: 90-125 ug/mL  
Seizure Disorder: 50-100 ug/mL)

During therapy with this drug, blood tests to follow: CBC, platelet and liver function should be done. Generally, you can initiate therapy with 20-

30 mg/kg/day loading dose for 2 days, then decrease to maintenance dose of 16-20 mg/kg/day.

\* Remember that Depakote ER is 80 % bioavailable compared to regular Depakote, adjust dose accordingly.

Carbamazepine (Therapeutic range 9-12 ug/mL)

This drug is structurally related to TCA's and thus may have some of the same side effects. Due to its hematologic and hepatic effects, a baseline RBC, WBC, platelet and liver functions should be obtained before initiating treatment. Start at 200 mg PO BID.

All of these Mood Stabilizers require several days to become effective. Neuroleptics may be used to reduce psychotic agitation initially. The need for continued antipsychotic treatment should be reevaluated at specific times. Newer atypicals may be used as mood stabilizers.

If the patient is agitated but not psychotic, Ativan 1 to 2 mg PO or IM is preferable.

#### **D. Benzodiazepines:**

It is strongly discouraged that benzodiazepines be prescribed from the ER. The only real exceptions are if the patient is known to the service and is currently on them. You could give them enough till they can contact their doctor for follow up. The other possible exception: the patient will be seen in one of our out patient clinics within the next few days. Here again only give enough till their clinic visit. Remember any of these dispositions need to be cleared by your on-call faculty.

In choosing a benzodiazepine, the factors which you may wish to consider are metabolism, and half-life, (see Table).

Benzodiazepines metabolized by oxidation will have active metabolites, which will increase their half-life making them long acting. Their half-life can thus be correlated to the liver function history of the patient. The major advantages of long-acting drugs include less frequent dosing, less variation in plasma concentration, and less severe withdrawal. The disadvantages include drug accumulation and increased risk of daytime sedation.

Benzodiazepines that are conjugated generally have no active metabolites, and are short acting. Advantages to these drugs are no drug accumulation and less daytime sedation. The disadvantages include more frequent dosing, earlier and more severe withdrawal symptoms. Remember to warn patients about driving after taking a benzodiazepine.

## Benzodiazepines

Generic Name	Trade Name	Number of Active Metabolites	Half-Life (hours)	Acting	Approximate Dose Equivalents
Alprazolam	Xanax	2	12	Short	0.25
Chlordiazepoxide	Librium	4	100	Long	10
Clonazepam	Klonopin	0	34	Long	0.5
Clorazepate	Tranxene	2	100	Long	7.5
Diazepam	Valium	2	100	Long	5.0
Flurazepam	Dalmane	2	100	Long	5.0
Lorazepam	Ativan	0	15	Short	1.0
Oxazepam	Serax	0	8	Short	15
Prazepam	Centrax	2	100	Long	10
Temazepam	Restoril	0	11	Short	5.0
Triazolam	Halcion	0	2	Short	0.1

Your major use of benzodiazepines will be to decrease the agitation of patients. In most cases, Ativan 1-2 mg PO or IM is a good choice. For elderly or debilitated patients, you should start at a lower dose like 0.5 mg.

The other frequent use of benzodiazepines on-call will be prophylactic use to prevent alcohol withdrawal. The choice of benzodiazepine will vary from person to person. In most cases, you should respond with medication on the parameters of the patient's B/P, pulse, and confusion. Keep in mind that alcohol and benzodiazepines have an additive effect. Also, withdrawal symptoms will not appear until the alcohol level drops. Thus, benzodiazepines should not be given to intoxicated patients.



## Chapter 9 Inpatient Psychiatry

### **A. Initial Evaluations**

1. All new admits need a History and Physical. Information gathered in the PCU can be helpful to see how the patient has progressed from initial presentation, however, the H&P cannot be copied from the PCU documentation, and another physical exam should be completed.
2. All evaluations should take place in the designated team office, not in patient rooms or the hallway to protect patient privacy.
3. All patients on antipsychotics need a documented AIMS upon initiation of antipsychotics and every 6 months thereafter.

### **B. History and Physical Format**

CC: This is in the patient's own words such as "I don't know, the police brought me"

HPI: This should begin with identifying information (35yo single, unemployed AAM presented to ER on Request for Protective Custody for threatening behavior, has a documented history of schizophrenia and THC abuse. This is the patient's 5<sup>th</sup> admission in the past 2 years). Also identify your informant and their reliability.

After the identifying information, proceed with a concise history of the current presenting problems, symptoms and severity placed in chronological order. Symptom onset, duration, timing, context, modifying factors, and associated symptoms are also important. This section gathers information used in medical decision making and diagnosis. Also included in this section are life stressors, changes and/or conflicts, the chronicity or acuity of illness, longitudinal course, and the effect on life functions.

Then present a full psychiatric review of symptoms including pertinent negatives. (Patient denies depressed mood and neurovegetative symptoms, no history of manic episodes...)

Past Psychiatric History: This includes previous diagnoses, previous medication trials, suicide attempts, hospitalizations, outpatient and substance abuse treatment.

Please remember to perform a medical and psychiatric review of systems and ask questions about sleep apnea as well.

Past Medical History:

Past Surgical History:

Social History:

- Living situation – married? Children? alone? with family? Assisted living? Group home?

- Income - employed? Disability? Medicare/Medicaid benefits? (This is important to know prior to prescribing expensive medication that the patient will not be able to pay for)
- Education - special education vs. regular classes, highest grade completed, if drop out, why?, frequent fights or disciplinary action?
- Abuse – physical, sexual, emotional, neglect
- Substance use, frequency and patterns
- Legal – arrests, probation, current pending charges, incarcerations
- Military
- Developmental – birth history and milestones, if known, family constellation (who were they raised by? Why?)

Family History: psychiatric and medical, as well as response to specific psychiatric treatments

Medical Review of Systems

Current Medications

Current Labs

Physical Exam: includes the mental status exam and complete neurological Exam

Pain Assessment/Suicide risk assessment/Strengths and weaknesses of patient.

Any psychiatric or psychological contraindications to restraint or seclusion.

Assessment: This includes a brief biopsychosocial formulation followed by Axis I-V diagnosis

Plan: Should include medications, social work interventions, substance treatment needed, etc... as well as reasoning for all decisions being made

### **C.Mental Status Exam (the bread and butter of psychiatry):**

General Appearance - hygiene, grooming, tattoos, piercings, body habitus, scars, apparent age

Behavior – mannerisms, gestures, eye contact

Patient-Doctor Interaction – cooperative, hostile, defensive, seductive, evasive

Consciousness - Awake, alert, somnolent, sleepy, lethargic, comatose, delirious, orientation (situation, person, place, time)

Speech – rate (increased, pressured, slowed), tone (soft, angry), volume, language (vulgar, cursing), articulation, spontaneity

Mood – overall emotional state described by the patient (euthymic, dysphoric, euphoric, expansive, irritable, anhedonic, alexithymic)

Affect – witnessed emotional state (mood congruent/in-congruent, full, labile, inappropriate, constricted, blunted, flat)

Thought Process – Organized, linear, logical, circumstantial, tangential, perseverative, verbigeration, loose associations, flight of ideas, derailment, clang associations, blocking

Thought Content – poverty of content, delusions (bizarre, systematized, mood-congruent, nihilistic, somatic, paranoid, grandiose, erotomanic, persecutory) thought broadcasting/insertion/withdrawal/control, ideas of reference, compulsions, ruminations, preoccupations, phobias, suicidal ideations/plan, homicidal ideation/plan

Perceptions – auditory, visual, olfactory, gustatory, and tactile hallucinations, illusions, synesthesia, trailing phenomenon

Attention – distractibility, selective inattention, hypervigilance

Memory – immediate, recent and remote

Insight – Ability to understand true cause of a situation/illness (“What is your main problem?” “Why are you here?”)

Judgment – ability to assess a situation correctly and to act appropriately within that situation

Abstract thinking

Intellect

Psychomotor activity – echopraxia, catatonia, agitation, hyperactivity, tics, akathesia, retardation of movement, include an assessment of gait

Motor

Neuro: Cranial nerves, gait, posture, tone

### **D.Folstein Mini-Mental State Examination**

#### A. Orientation

1. “What is the year?”
  2. “What is the season?”
  3. “What is the date?”
  4. “What is the day?”
  5. “What is the month?”
- 1 point for each correct  
5 points total

#### B. “Where are we?”

1. State
  2. Country
  3. Town
  4. Hospital
  5. Floor
- 1 point for each correct  
5 points total

#### C. Registration

Name “rose, umbrella, fear”  
Ask patient to repeat all three

1 point for each correct  
3 points total

#### D. Attention and Calculation

Serial 7’s. Stop after 5 responses  
(100, 93, 86, 79, 65)

1 point for each correct  
5 points total

#### E. Recall

Ask to recall 3 objects

1 point for each correct  
3 points total

#### F. Language

1. Show pencil and watch to patient  
Have Patient name them
  2. Have patient repeat sentence:
- 1 point for each correct  
2 points total  
1 point total

- No if's, and's or but's.
3. Give patient 3 part command: 1 point for each correct  
 Take a paper in your right hand, 3 points total  
 fold it in half, and put it on the floor.
  4. Write, then ask patient to read and 1 point total  
 Obey: "Close your eyes"
  5. Write a sentence 1 point total for noun, verb,  
 Making sense, spelling and punctuation do not count
  6. Copy a design 1 point total for 2-5 sided  
 Figures intersecting to give a 4-sided figure

**Averages:**

Normal Subjects	≥ 27
Uncomplicated Depression	~ 25
Cognitive Impairment	19
Dementia	10

**E.Old patients**

1. All old patients receive a daily note in the SOAP note format.
2. Treatment team takes place once a week on a designated day for each team.  
 Patient's must sign a treatment form stating that their plan of care was discussed, as well as goals and expected date of discharge.

## **Chapter 11** **Resident Resources**

1. [www.amion.com](http://www.amion.com) – this has all schedules, resident and faculty phone numbers, e-mail addresses and pagers
2. LSU Library website – contains journals, on-line textbooks, and databases for psychiatry as well as other specialties.
3. Green Book (CD) – handed out during orientation, contains all necessary documents for supervision, patient logs and more. On-line version also available.
4. Process Group – confidential group session held on Fridays where you can get advice from upper levels on difficult situations, as well as ask any questions that you may have regarding a rotation.