The Trainer's Guide To The Galaxy

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Part I: Nuts and Bolts

Nuts and Bolts of Training Call: The logistics of what we all need to know

What is included below is not the nitty gritty of each site (please see site specific PRONs for such details), but instead is an overview of what to cover on call with each trainee.

- Shift times
    - When to come in (Home call sites)
        - 30 minute expectation
- Inclement weather expectation (All sites)
- Medical Students on Call
    - When, where, and how to find them
- Locations of offices, resident work room, inpatient wards
- Where to sleep, park and eat
- How To's of Sign-Out
    - How to get keys
    - When and who to call/where to go/meet
    - Checking in with charge nurses
    - How to update CORES/Hand-Off
- How to Admit a Patient
    - Orders
    - Documentation requirements
- Assessing a pt in the ED/PES
    - Documentation requirements
    - Safety assessments
- Patient transfers from outside hospitals (site specific requirements)
    - What information to gather
    - How to decide to accept/not accept
- Consults on call
    - What information to gather
    - How to triage a consult
- Triage
    - Each PRON covers this in varying detail from the Spartan of the VA PRON to the verbal diarrhea of the HMC PRON.

Part II: Resident Competencies

Each sub-heading indicates one of the four ACGME determined competencies that all R1s must fulfill before moving from direct to indirect supervision. The goal is for R1s and new R2s to achieve competence by the end of their second week on psychiatry and to be able to demonstrate these competencies while on call.

Taking a Psychiatric History:

This is what we do… over and over every day. It's really the core of our assessment skills and a critical skill to teach physicians in training. Each of us does this a little differently with our patients, but there are core similarities and necessary pieces of information that need to be gathered during a standard assessment. While different assessments and situations call for modifications to a standard history, what is presented below is a standard, complete assessment. When teaching basic skills, focus on core, standard elements to develop the trainee's foundation. Once a trainee has mastered the basics, skills can be enhanced and fine-tuned and you can put in your two cents about your own style.

- Parts of a history: The Patient Interview
    - HPI
        - What is going on with this patient: Why are they here? Recent stressors/events. Predominant symptoms, severity of symptoms, impact of symptoms, patient safety and the safety of others
        - Psychiatric review of systems: Mood and anxiety symptoms, symptoms of psychosis, SI/HI
    - PPHx
        - Inpatient: How many admissions? Date of most recent admission? ITA admissions?
        - Outpatient: Who do they see? Why do they see them?
        - Suicide Attempts: When? How many? Means? Outcome of attempts?
        - Diagnoses: What diagnoses have they received in the past?
        - Medications: what the patient is prescribed, is taking, and has tried in the past
        - Substance use history: What the patient uses, how often, how much, history of problems with use and/or withdrawal
    - PMHx
        - Current illnesses/conditions the patient is treated for or has received treatment for in the past
        - Specific focus placed on illnesses which impact a patients life and/or psychiatric symptoms
    - FHx

        - Who has what in the patient's family? Specifically psychiatric illnesses
    - SHx
        - Just about everything else: Patient education and development history, family structure and significant others, social support, history of abuse, money, housing, legal
- Interview Skills: Beyond the nuts and bolts of the information one needs to gather from a patient is the way in which it is gathered. Often teachers are hesitant to give feedback on how a trainee speaks to a patient, but if the teacher never gives the feedback, the trainee never knows they need to get better. You can't trust that the trainee will just learn it somewhere else.
    - Body language
        - How does the trainee sit with the patient? Too close? Too far? Does s/he mirror the patient's body language? Does the trainee's body language enhance or hurt her/his interview?
    - Listening skills
        - How does the trainee manage hearing the patient versus gaining information? Open-ended questions? Reflective statements and verbal nods? Does the patient feel heard?
    - Supportive Statements
        - How does the trainee validate the patient? Can they connect and convey a feeling of empathy?
    - Paraphrasing/Reflecting
        - How does the trainee use summarizing, reflecting, and paraphrasing statements to recap the interview and move things along?
    - Reframing
        - Does the trainee rephrase the patient's statements in a therapeutic way?
    - Redirection
        - How does the trainee manage her needs versus the needs of the patient? How does she verbally manage an agitated/upset/preoccupied patient?

- Gather appropriate data/collateral: This is the post-interview phase of the assessment, which helps fill in the picture.
    - When you need collateral
        - Collateral is always useful, but particularly necessary in certain situations.
            - Situations when an incomplete history will affect formulation
                - Psychosis/Mania/AMS
                - Intoxication/Withdrawal

        - Suicide/Safety Concerns
    - What you want to know
        - Previous level of function/mental status
        - Safety concerns of others and safe discharge options
        - Medication compliance
        - Mitigating circumstances
        - Other sources of collateral
    - Legal considerations for data gathering
        - There are different considerations and requirements for information requests of outside sources based on the context. Specifically, encounters in the ER allow for information gathering outside of patient consent while inpatient collateral requests generally require consent.

Assessing a patient in the ED:

A much shorter version of taking a psychiatric history with pearls to be gleaned at each site, including how to maximize the many resources available in the PES, how to serve as an appropriately helpful consultant to ED physicians at UW, and how to navigate the considerable chaotic independence at the VA.

- Perform a psychiatric history adequate to formulate a comprehensive safety evaluation and evaluate disposition options
    - Focused history as outlined above with focus on:
        - What brought the patient in?
            - What is the purpose/goal of the patient in the ED?
            - Were they referred by self, family, police etc..?
        - Course to date and severity of symptoms
            - Is this a change from baseline or a chronic state?
            - What is the rate of symptom escalation?
        - Safety (specifically SI/HI)
            - Are there specific plans/recent attempts, specific people or targets?
            - Is the patient safe to leave the ED? Why not?
        - RESIDENT SAFETY DURING INTERVIEW
            - Safe distance from the patient during interview
            - Appropriate distance/position from the door
            - Concept of when things are escalating and what to do if this happens
    - Medical/Psychiatric decision-making
        - When is it safe to discharge a patient from ED?
            - Can the patient/family/case manager articulate reasonable disposition?
            - Does the plan include follow-up with outpatient mental health provider?

                - Do you feel good about the outcome? Will the patient or those around him be safe?
                    - Can you mitigate this with meds/follow-up/crisis planning?
    - Disposition options:
        - Next day appointment (NDA)
        - Established outpatient provider
        - Hospitalization
            - Voluntary: intention to cooperate with treatment, no contradicting history
            - Involuntary: not amenable to voluntary admission, history of poor hospitalization utilization
                - CDMHP process
                - Poor-faith voluntary criteria

Assessing a consult:

Often the junior resident's first introduction to consults, training call is frequently the first and only opportunity late R1s and early R2s have to experience consults before taking their first dreaded day call.

- Accurately receive a consult from primary team with a clear clinical question
    - The key to this is to understand the clinical question and what the primary team is asking you to do. Sometimes they need help to understand with what they need help.
        - Most common: safety, delirium, decisional capacity
    - Kindness goes a long way. Even if the consult and the clinical question are complete crap… be nice about it. This is an instance of customer service and we appreciate when consulting services are nice to us in return.
- Triage
    - Generally:
        - In-house suicide attempt/AMA discharge with security involvement
        - Discharge safety evaluation for patient after suicide attempt
        - Safety evaluation for patient remaining in-house after SA
        - Delirium, non-urgent decisional capacity, mood questions(demoralization!), new psychosis in the patient on prednisone burst
    - If there is not time for a consult and/or the acuity is not present, the consult will need to wait. This requires the knowledge of what can wait and what cannot as well as the knowledge of how to communicate to the primary team what you can and cannot do.
- Spend some time with the chart

- The medical chart is essential to understanding the patient you are about to see as a consult. Pay specific attention to:
    - The patient's diagnosis and hospital course
    - Pertinent laboratory findings (e.g. Chem 7, CBC, TSH, LFT's, Blood gas, LP)
    - Pertinent studies (e.g. EKG, EEG, CT, MRI)
    - Scheduled and PRN medications
    - Nursing, SW, and other provider notes on patient presentation and status
- Go see the patient!
  - Take a focused history sufficient to address the clinical question and to give specific, psychiatric recommendations. Keep the following in mind:
    - What is the clinical question?
      - What is the purpose of the consult? It is very easy to get lost in the patient and for the consult to get away from you. You are providing a limited service, not taking the patient home with you.
    - Is the patient alert and oriented?
      - Starting here can save you a lot of time if the patient has no idea where they are, who they are, or what the hell is going on with them
    - Course to date and severity of symptoms
      - Is this a change from baseline or a chronic state?
      - What is the rate of symptom escalation?
    - Safety (specifically agitation/SI/HI)
      - Are there specific plans/recent attempts, specific people or targets?
      - Is the patient safe to be inside or to leave the hospital right now? Why not?
        - Can this be mitigated by medication/restraints/follow-up/crisis planning?
    - RESIDENT SAFETY DURING INTERVIEW
      - Safe distance from the patient during interview
      - Appropriate distance/position from the door
      - Concept of when things are escalating and what to do if this happens
- Always staff new consults with the on call attending physician!
  - Presentation of patients should be clear and concise (see section on presenting a patient)
  - And add this to your note! ("The above assessment and plan was discussed with attending physician Dr. Leo Spaceman who is in agreement")

- Talk to the primary team with your recommendations, either phone or in person
  - Recommendations should be given in a clear and concise manner and documented in a clear and concise manner
    - Psychiatrists have a propensity towards verbal diarrhea… buck the trend!
  - Indicate if patient will be followed by psychiatry consult team

Presenting cases to a supervisor:
"…because as we know, there are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns -- the ones we don't know we don't know."

Presenting a case to an attending can be intimidating and anxiety provoking. Start by helping your junior resident minimize the unknown unknowns. When both you and the junior resident have an idea about what is going on, or what you have questions about, is the time to present. No one likes a presentation from a resident who has no idea what is going on.

- Good presentations are clear, orderly, concise, give an assessment, and have recommendations. As described earlier, it's best to start out with formal, orderly presentations to develop a knowledge base so start here with your trainee.
  - Includes appropriate history and findings. Presented in the following order:
    - CC – including consult question if one exists
    - HPI
    - PPHx
    - PMHx
    - FHx
    - SHx
    - Pertinent Meds
    - Pertinent Labs
    - MSE
  - Communicate formulation clearly – this is really the meat of being able to demonstrate that you know what is going on
    - If you're super cool you can even use a 4P or biopsychosocial formulation
  - Articulate a clear plan (this is what you actually want to do!) and reasoning that occurred to develop plan
- Often very helpful to offer junior resident the opportunity to practice presenting with you before calling the attending (but emphasize that everyone flubs up sometimes)

Asking for help appropriately:

This is one of the more difficult and important teaching tasks that you will undertake as a trainer. It has been very clear to residency faculty that while upper level residents are more likely to contact their on-call attending with questions and guidance, lower level residents are less likely to ask for help. Junior residents have the most to learn, from the on-call attending in these situations, but they are less likely to ask for help. This cavalier attitude likely stems from confidence, mixed with a desire to prove one's self, mixed with fear that an attending will be angered by being bothered, or worse, that the attending will think the resident incompetent. So how does one teach how and when to ask for help? Teaching two years of wisdom and experience in one night is impossible, but to start we can outline expectation management and offer guidance.

- Start with low hanging fruit (i.e. things that are easy)
  - There are certain situations when an attending always needs to be informed and a trainee should be aware of them
    - AMA discharges
    - New consults
    - Adverse outcomes
    - Just about everything at the VA
    - Complex patients presenting for inter-hospital transfer
  - There are other situations during training call when you will guide the trainee, but were you to not be there for guidance, the junior resident should call the attending
    - Discuss how the junior resident should call the on-call attending
    - Having the junior resident call the on-call attending as an educational exercise (even if you are certain of the right course of action) puts them into the practice of asking for help and demonstrates that it is ok to do so.
  - A conversation with a junior resident about how and when to ask for help goes a long way. Helping them understand the following will help move them past the junior resident mentality of "I have to go it alone" that we call remember.
    - Asking for help does not mean one is incompetent or can't make good clinical judgments
      - Asking for help actually shows better judgment
    - A resident and on-call attending work as a team, not as the attending bailing out the resident
      - If the pair are seen as a team, then keeping the team informed is essential
    - A resident's goal is to learn and calling the on-call attending is an opportunity for teaching and learning, not a demonstration of a lack of knowledge

Part III: Cases

The following cases are examples of common patient care scenarios in psychiatry. The richness and variety of cases seen on training call can vary from call to call, so the following cases are provided as a resource for training in the absence of real life situations. If training call allows for it, consider going through one or more cases with your trainee resident. The program expectation is that each trainee resident will have some familiarity with each scenario, from either real life training call experience or through case work with a training resident, by the end of their training call experience during residency.

Case #1: Management of an Agitated or Threatening Patient

Mr. X is a 55 y.o. man with a history of schizophrenia and COPD who was admitted to the medicine ward 3 days ago for pneumonia. Upon admission he was responding to internal stimuli and endorsed auditory hallucinations, however his outpatient providers confirmed that this was his psychiatric baseline. Over the last 24 hours he has been intermittently disoriented and increasingly paranoid. Today he pulled his IV. When his nurse attempted to intervene, he became agitated, threatening that he would "clobber" anyone who touched him.

Learning Objectives:

- Assessing and addressing safety risks when evaluating and treating an agitated patient
- Identifying and treating the underlying cause of agitation

What is important to address in the initial phone call?

- Where is the patient and what is the behavior of concern?
- When did the condition start? Has it occurred before?
- Is the patient a danger to self or others? Impeding life-saving medical care? Attempting to leave the hospital?
- Any injuries? Security or police involved? Access to potential weapons?
- Assess the patient's recent medical history: vitals, medical problems, medication changes, recent changes in care, new stressors, alterations in consciousness, illicit drug use/withdrawal
- Based on questions above, determine if emergent treatment needed - If ther is imminent risk of harm to self or others, order seclusion or physical restraints with direct observation. Report for further evaluation immediately.

Why is agitation a life threatening emergency?

- Associated with impulsivity and aggressive behavior
- Is uncomfortable and increases the risk of self harm and suicide
- Is often the first sign of lethal condition (intracranial bleed, tumor, PE, NMS, hypoglycemia)
- Can lead to exhaustion, dehydration, rhabdomyolysis, renal failure and death

Go see the patient!

- A "quick look" is important to determine safety risks and urgency of treatment
- Guidelines for a safe initial assessment
    - Have trained staff available in case of need for restraint or seclusion
    - Assure you can escape the room if the patient becomes threatening (position yourself between patient and the exit)
    - Remove dangerous objects from the room
    - Minimize any objects on yourself the patient can grab (tie, necklace, etc)
    - Limit overstimulation (noise, visitors, etc)
    - Avoid close contact with patient (for patient comfort and your safety)
    - Use clear and calm language
    - Attempt to use verbal de-escalation or voluntary PO/IV medications to calm the patient. (passive posture, offer food/drink, do not challenge, express you concern/experience, avoid direct eye contact)

What are imminent risks to safety that require treatment prior to further evaluation and assessment?

- Suicide/self harm
- Aggression/Assault
- Elopement (if patient in imminent danger without ongoing treatment)
- Agitation impeding or interfering with life saving treatment

If the patient is an imminent risk, how do you proceed?

- Initiate appropriate safety measures- start with direct observation, seclusion or restraints as indicated.
- Identify the etiology of the agitation as it will determine type of medication management and any procedures required to deliver this pharmacotherapy.
    - What is the differential diagnosis for agitation?
        - General Medical Illness or Delirium (see Case#6 for details)
        - Substance intoxication or withdrawal (see Case #4 for details)
        - Psychiatric Illness
        - Psychological Crisis

What are the pros and cons of common medication regimens for agitation?

- Benzodiazepines

    - Treatment of choice for ETOH/benzodiazepine withdrawal (CIWA or scheduled benzodiazepines).
    - Avoid in any case of delirium unless antipsychotics contraindicated.
    - Can be used for agitation with or without psychosis but will do little to address the underlying psychosis.
    - Risk of respiratory depression
- Antipsychotic (Typical and Atypical)
    - Useful for psychotic intoxication states or psychosis due to psychiatric illness.
    - Avoid in ETOH/benzodiazepine withdrawal due to lowering seizure threshold
    - Treatment of choice for agitated patients with delirium (IV haldol for patients with IV access, IM atypical for urgent involuntary treatment, PO atypicals for cooperative patients)
    - Cardiovascular risk (QTC prolongation, arrhythmias, CVAs, sudden death).

<u>Once the patient has been evaluated, the environment has been secured, the medical chart has been reviewed and the etiology of the agitation is conjectured, what if the patient does not want to take the treatment indicated?</u>

- For patients with agitation due to a general medical condition (delirium/substance intoxication/withdrawal) who are refusing medical treatment, perform a decisional capacity evaluation. See Case #5 for details.
- For patients with agitation due to a general medical condition requesting to leave the hospital against medical advice, please see Case #7 for details.
- For patients with agitation due to psychiatric or psychological illness, there must be danger to self, danger to others or grave disability to justify involuntary treatment. If these conditions are met, please see Case #8 for details.
- For specific treatment for patients with agitation due to substance withdrawal/intoxication, please see Case #4 for details.
- NOTE: In Washington, antipsychotics for psychiatric decompensation cannot be prescribed involuntarily by psychiatrists without an official involuntary detainment (determined by the CDMHPs). Once the patient is detained, two attending physician signatures are needed to compel the atypical antipsychotic involuntarily. Washington psychiatrists can recommend antipsychotics to other providers when consulted regarding medical conditions (delirium, intoxication, withdrawal, etc) however it is important to determine whether the patient has decisional capacity to refuse treatment before providing the treatment.

<u>Related references:</u>

Bernstein CA, Levin Z, Poag M, Rubinstein M: On Call Psychiatry. 3rd edition. WB Saunders,2006. Page 63-72 and 84-91.

Pasic Lecture "Violence in Psychiatry: Initial Encounter with the Patient", R2 Emergency Psychiatry Course

Case #2: Assessment, treatment and management of a suicidal patient in different settings (ER, med floor, psych floor) including risk assessment/crisis planning

1) You are called to assess a suicidal patient in the UWMC. The patient is a 42 year-old woman with multiple past psychiatric hospital admissions following suicide attempts that did not require medical treatment. She is involved in a DBT group and has seen her therapist for 18 years.

2) You are called to the medical floor to assess a 25 year-old man regaining consciousness after surgery for injuries sustained in a one-motor vehicle crash, car v. embankment. The patient has a history of depression and is currently experiencing stress with regards to a recent break-up with long-term partner as well as stress in his newly started graduate school program.

3) You are called to the psych floor to assess a 23 year-old woman with suicidal ideation not expressed since admission. The patient is admitted for suicidal statements made while intoxicated with alcohol. She has completed alcohol withdrawal and no longer requires benzodiazepines for medical safety. She states she is uncomfortable on the psychiatric unit and will kill herself unless she receives benzodiazepines to help with her discomfort.

<u>Learning Objectives</u>

- Know risk factors (and protective factors) for suicide
- Know questions to ask when assessing seriousness of intent/attempt
- Know how to successfully crisis plan with suicidal patients

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<u>What risk factors should you assess in a patient with suicidal ideation?</u>

Suicidal thoughts/behaviors: Suicidal ideas (current or previous), Suicidal plans (current or previous), Suicide attempts (including aborted or interrupted attempts), Lethality of suicidal plans or attempts, Suicidal intent

Psychiatric diagnoses: Major depressive disorder, Bipolar disorder (primarily in depressive or mixed episodes), Schizophrenia, Anorexia nervosa, Alcohol use disorder, Other substance use disorders, Cluster B personality disorders (particularly borderline personality disorder), Comorbidity of axis I and/or axis II disorders

Physical illnesses: Diseases of the nervous system, Multiple sclerosis, Huntington's disease, Brain and spinal cord injury, Seizure disorders, Malignant neoplasms, HIV/AIDS, Peptic ulcer disease, Chronic obstructive pulmonary disease, especially in men, Chronic hemodialysis-treated renal failure, Systemic lupus erythematosus, Pain syndromes, Functional impairment

Psychosocial features: Recent lack of social support (including living alone), Unemployment, Drop in socioeconomic status, Poor relationship with family, Domestic partner violence, Recent stressful life event

Childhood traumas: Sexual abuse, Physical abuse

Genetic and familial effects: Family history of suicide (particularly in first-degree relatives), Family history of mental illness, including substance use disorders

Psychological features: Hopelessness, Psychic pain, Severe or unremitting anxiety, Panic attacks, Shame or humiliation, Psychological turmoil, Decreased self-esteem, Extreme narcissistic vulnerability, Behavioral features, Impulsiveness, Aggression, including violence against others, Agitation

Cognitive features: Loss of executive function, Thought constriction (tunnel vision), Polarized thinking, Closed-mindedness

Demographic features: Male gender, Widowed, divorced, or single marital status, particularly for men, Elderly age group (age group with greatest proportionate risk for suicide), Adolescent and young adult age groups (age groups with highest numbers of suicides), White race, Gay, lesbian, or bisexual orientation

Additional features: Access to firearms, Substance intoxication (in the absence of a formal substance use disorder diagnosis), Unstable or poor therapeutic relationship

What protective factors should you assess in a patient with suicidal ideation?

- Children in the home (except w/postpartum psychosis or mood d/o)
- Sense of responsibility to family
- Pregnancy
- Religiosity
- Life satisfaction
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Positive social support
- Positive therapeutic relationship

How can you assess the for risk?

Start by assessing the context of a past attempt or of the thoughts themselves:

- When did you first notice such thoughts of self-harm or suicide?
- What led up to the thoughts (e.g., interpersonal and psychosocial precipitants, including real or imagined losses; specific symptoms such as mood changes, anhedonia, hopelessness, anxiety, agitation, psychosis)?
- How often have those thoughts occurred (including frequency, obsessional quality, controllability)?

- How close have you come to acting on those thoughts? Do you have a plan? Have you made preparations?
- Can you describe what happened (e.g., circumstances, precipitants, view of future, use of alcohol or other substances, method, intent, seriousness of injury)?
- What thoughts were you having beforehand that led up to the attempt?
- What did you think would happen (e.g., going to sleep versus injury versus dying, getting a reaction out of a particular person)?
- What do you envision happening if you actually killed yourself (e.g., escape, reunion with significant other, rebirth, reactions of others)?
- How did you feel afterward (e.g., relief versus regret at being alive)?
- If the patient is psychotic:
    - What do the voices say (e.g., positive remarks versus negative remarks versus threats)? (If the remarks are commands, determine if they are for harmless versus harmful acts; ask for examples)?
    - Have there been times when the voices told you to hurt or kill yourself? (How often? What happened?)
    - How do you cope with (or respond to) the voices?
    - Have you ever done what the voices ask you to do? (What led you to obey the voices? If you tried to resist them, what made it difficult?)

Next assess for risk factors not already known:

- Do you have guns or other weapons available to you?
- How does the future look to you?
- What things would make it more (or less) likely that you would try to kill yourself?
- What things in your life would lead you to want to escape from life or be dead?

Now assess for protective factors:

- What things in your life make you want to go on living?
- If you began to have thoughts of harming or killing yourself again, what would you do?
- What things would lead you to feel more (or less) hopeful about the future (e.g., treatment, reconciliation of relationship, resolution of stressors)?

Now assess for immediacy and intent:

- One a scale of 1-10, how strong is your intent to harm/kill yourself? What would change this?
- What is the same/different now compared to past thoughts/intents/actions?

How does one determine disposition and crisis plan for a patient with suicidal ideation?

1. **Admission generally indicated**
   a. After a suicide attempt or aborted suicide attempt if:
      - Patient is psychotic
      - Attempt was violent, near-lethal, or premeditated
      - Precautions were taken to avoid rescue or discovery
      - Persistent plan and/or intent is present
      - Distress is increased or patient regrets surviving
      - Patient is male, older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking
      - Patient has limited family and/or social support, including lack of stable living situation
      - Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
      - Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting

   b. In the presence of suicidal ideation with:
      - Specific plan with high lethality
      - High suicidal intent

2. **Admission may be necessary**
   a. After a suicide attempt or aborted suicide attempt, except in circumstances for which medical admission is generally indicated

   b. In the presence of suicidal ideation with:
      - Psychosis
      - Major psychiatric disorder
      - Past attempts, particularly if medically serious
      - Possibly contributing medical condition (e.g., acute neurological disorder, cancer, infection)
      - Lack of response to or inability to cooperate with partial hospital or outpatient treatment
      - Need for supervised setting for medication trial or ECT
      - Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
      - Limited family and/or social support, including lack of stable living situation
      - Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up

   c. In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or

history from others suggests a high level of suicide risk and a recent acute increase in risk

3. **Release from emergency department with follow-up recommendations may be possible**

    a. After a suicide attempt or in the presence of suicidal ideation/plan when:
        - Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department (possibly Case 2 given conditionality of SI)
        - Plan/method and intent have low lethality
        - Patient has stable and supportive living situation
        - Patient is able to cooperate with recommendations for follow-up, with provider contacted, if possible, if patient is currently in treatment

4. **Outpatient treatment may be more beneficial than hospitalization**
   Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing
   (Case 1)

Related reference:

APA Practice Guideline for the assessment and treatment of patients with suicidal behaviors

Case #3: Patients with Homicidal Ideation

Mr. Y is 29 year-old man with no psychiatric history who was brought in reluctantly by his parents. They report he has been agitated, depressed and sleepless since his girlfriend of two years abruptly ended their relationship and has made threatening statements about killing her in retaliation. Parents are concerned as he is drinking heavily and has a history of domestic violence. On interview, the patient on exam denies any homicidal ideation but is otherwise not forthcoming about this situation and difficult to engage. What do you do?

Learning Objectives:

- How to evaluate homicidal ideation
- Knowledge of risk factors for violence
- Have knowledge about Duty to Warn statute and its complexities

Evaluation of homicidal ideation

- Key is ***risk assessment.*** No clinician can predict if a patient will be violent. A clinician makes a treatment decision based on a thorough risk assessment.
    - A limited database on risk factors for violence exists, but researchers have concluded that, in general, the only factor associated with future violent behavior is a history of violence (1).
    - Epidemiology focuses on long-term prevalence rates of violence – say over 3 years - in the psychiatric emergency service, the clinician is concerned with short-term risk (in the next 24hr)

What comprises a Violence Risk Assessment

- *Make safety a priority*
    - Get patient screened by police
    - Evaluate in presence of police or staff if needed
- *Evaluate the patient's situational stressors*
    - Rejection or humiliation are an important risk factors – the patient may believe that the only solution to their situation is to resort to violence.
- *Obtain a detailed history of past acts of violence*
    - Talk with family, spouse or those close to the patient
    - Review chart for any documentation of prior violence
    - Identify where the patient is on the continuum of violence
        - Global aggressive thoughts ("I'll kill anyone who gets close to me")
        - Limited to homicidal ideation or fantasies?
        - Or a detailed, developed plan to harm an intended victim
        - Purchase of lethal means or otherwise made arrangements to carry out plan?
        - Any ideation of harm such as assault, rape, destruction of property
- *Assess for psychopathology*
    - Key here is whether the patient has lost reality testing.
    - A patient who is homicidal because of a delusional belief or a command hallucination is at high risk,
    - Symptoms such as feeling controlled by an outside force or the patient's believing that others wish him or her harm confer even higher risk of violence
    - Psychosis, mania, delirium, and substance abuse are known risk factors – conditions that may lower a patient's impulse control
- *Assess for suicidality*
    - Patients presenting with homicidal ideation are also at greater risk of self-harm
- *Assess for any deterrents*

    - Religious beliefs, fear of legal repercussions and capacity for empathy mitigate risk
- *Imagine the situation awaiting the discharged patient*
    - Try to think from the patient's perspective, what are his options?
    - Has your evaluation created new options for the patient?
    - Are drugs, alcohol, or weapons readily available to the discharged patient?
- *Get a second opinion*
    - Call your attending to discuss the case!

***From Bruce Gage's lecture on Assessment of Violent-Agitated Patient*:**
Risk factors (short-term)

- Violence within last few days (person or property)
- Agitation
- Paranoia
- Fear
- Hostility
- Violent fantasies
- Mania
- Psychosis
- Substance abuse
- Threats

What is Duty to Warn?

- The 1974 landmark decision of *Tarasoff v. Regents of University of California* imposed a duty on the mental health profession to warn and protect third persons from a patient's violent threats; in 1976, this case was redecided and duty to warn expanded to also taking steps to protect likely victims.
- 37 states have Tarasoff-like duty to warn and have diverse criteria with respect to imminence, identifiability of victim, level of threat, and person to whom the threat is conveyed
- Due to lack of consistency across jurisdictions as to *what* the duty to protect entails and *when* it applies makes it difficult to establish a methodological approach in assessment
- Psychiatry has accepted that some form of duty to protect others from harm exists, whether statutorily defined on the basis of case law or a common law duty
- Satisfying a duty to warn can range from phone calls to certified letters to a potential victim's address. Every situation must be discussed with an attending for guidance as the variables are so great.

Our duty as psychiatrists:
We cannot predict violence. We can do a risk assessment for violence.

Related References:

1. Thiehaus OJ and Piaseki M. Emergency Psychiatry : Assessment of Psychiatric Patients' Risk of Violence Toward Others. Psychiatr Serv 1998; 49:1129-1147
2. Fox, PK. Commentatry: So the Pendulum Swings – Making Sense of the Duty to Protect. *J Am*

Acad Psychiatry Law 38: 474-8, 2010.
3. Gage, B. "Assessment of Violent-Agitated Patient". R2 Emergency Psychiatry Course, August 2009.
4. Appelbaum PB. Tarasoff and the clinician: problems in fulfilling the duty to protect. *Am J Psychiatry*
1985; 142:425-429

Case #4: Evaluating and Treating Substance Intoxication and Withdrawal States.

Ms. Y is a 58 year old woman without known psychiatric history who was admitted to the hospital 3 days ago due to abdominal pain and fever. Gallbladder perforation was discovered prompting urgent cholecystectomy. Over the last 24 hours her treatment team has noted increased anxiety and sleep disturbance without clear cause. Today she began complaining to the nurses about ants in the room and her bed. She has disturbed her IV on several occasions. When questioned about the IV, the patient mumbles about ants in her bed that have not been identified by hospital staff. Over the last 4 hours she has developed tachycardia and hypertension.

Learning Objectives:

- Demonstrate thoughtful and comprehensive approach to evaluating and treating a patient with likely substance intoxication or withdrawal
- Demonstrate familiarity with common substance intoxication/withdrawal presentations as well as a general approach to treatment
- Demonstrate ability to assess for and manage alcohol or benzodiazepine withdrawal

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What is important to address in the initial phone call?

- Patient vitals, behavior, level of distress and level of consciousness?
- History of substance abuse or dependence? Last use? Signs of drug use?
- Reason for and time elapsed since admission? Medication changes?
- BAL, serum toxicology or urine toxicology on admission or currently?

What to consider and assess on initial evaluation with the patient?

- Important to make a brief immediate assessment to gauge level of urgency for treatment and safety precautions.
    - NOTE: For detailed management and approach to agitation/aggression associated with substance intoxication/withdrawal, please refer to case #1.
- If possible, perform complete substance abuse history? Which substances? Last use? Amount used? Signs of drug use? Route? Length of habitual substance use? History of withdrawal symptoms? Over the counter supplement use or abuse? Hx of chemical dependency treatment?

- Selective physical exam- pupils, tremors, full mental status exam, piloerection, muscle twitching, incontinence, reflexes, gait.
- Regularly reassess/monitor heart rate, blood pressure, respiratory rate and body temperature for changes.
- Medical record review:
    - Psychiatric, Substance, Pain Treatment History
    - Admission studies (CBC, lytes, LFT, thyroid, RPR, B12, folate, head imaging, blood cultures, CXR, ECG, LP, EEG)
    - Historical toxicology results

What is the substance differential if the patient appears lethargic or in a coma?

- Opiates intoxication
- Sedative-Hypnotics intoxication: benzos, barbiturates, zolpidem, GHB
- Alcohol intoxication

What is the substance differential if the patient appears restless or agitated?

- Alcohol or Benzodiazepine Withdrawal
- Alcohol Intoxication
- Psychostimulants: cocaine, amphetamines
- Hallucinogens: PCP, LSD
- MDMA
- Marijuana

Which withdrawal states are life threatening emergencies?

- Alcohol
- Benzodiazepines
- Barbituates

How does one recognize and treat alcohol and benzodiazepine withdrawal?

- Signs/symptoms-
    - Agitation, anxiety, insomnia, restlessness, tremor, GI distress, hallucinations, illusions, tachycardia, HTN, sweating, hyperreflexia, tonic clonic seizures, delirium (delirium tremens)
- Time Course-
    - Symptoms can begin 4-12 hours after use or reduction. In uncomplicated withdrawal (without delirium), symptoms peak near second day and remit by third to fifth day. In complicated withdrawal with delirium tremens symptoms begin 48 hours to a week after discontinuation and can last 1-5 days or longer.
- Management
    - Monitor and ensure hydration, electrolytes
    - CIWA protocol or scheduled benzodiazepine taper to lower seizure threshold, treat withdrawal and provide sedation. If not using CIWA,

it is important to monitor level of consciousness and vital signs regularly. Long acting benzodiazepines have a more consistent steady state and lend themselves to gradual taper. Consider lorazepam if significant comorbid illness where respiratory depression contraindicated (shorter half life).

- Thiamine 100mg IM x one dose then 100mg PO daily for at least 7 days to prevent Wernicke-Korsakoff syndrome.
- Folic acid 1mg PO daily for 7 days
- Multivitamin daily for 7 days
- Management of Withdrawal Seizures
  - Seizures occur in 5-15% of patients between 24 hours and 7 days after substance discontinuation. Lorazepam, administered intravenously, usually aborts status epilepticus. Dilantin loading may be done if necessary, but this should be administered with cardiac monitoring. Urgent Neurology consultation for treatment recommendations is important.
- Management of Delirium Tremens
  - Medical emergency with untreated mortality of 20%.
  - If seizures occur, tend to precede DTs.
  - Defined by disturbances in consciousness, cognition, hallucinations, agtitation, marked autonomic hyperactivity.
  - Secure IV access
  - Repeated Lorazepam 2-4mg IV qhour (or more if DTs very severe) until symptoms clear. Use total first day dosage to start a 4 day taper on the second day.
  - Antipsychotics generally avoided as they lower seizure threshold.
  - Avoid restraints and if used monitor for rhabdomyolysis and renal function.
  - Encourage nutrition and PO fluid intake.

Important treatment considerations for other common intoxication and withdrawal states:

- If unconscious- start IV fluids , maintain airway and monitor vital signs
- If conscious- a quiet environment and reassurance is important
- If agitated or violent- consider seclusion, restraint or medication. In general benzodiazepines for agitation, antipsychotics for severe agitation or psychosis (except alcohol/benzodiazepine withdrawal).

- Alcohol Intoxication- remember thiamine, folate and to watch for withdrawal
- Stimulant (cocaine, amphetamine)-
  - Intoxication- Monitor for MI, stroke, intracranial hemorrhage or severe adrenergic reactions (diaphoresis, tachycardia, hyperpyrexia, hypertension)

    - Withdrawal- monitor for depression, suicidal ideation and persistent psychotic symptoms
- Opiates
    - Intoxication
        - If unconscious- maintain airway and treat with naloxone (0.4mg-2mg IV q 2-3 min until stable respirations). Watch for re-emergent symptoms due to short half life of naloxone.
    - Withdrawal- uncomfortable but not life threatening, opioid replacement therapy vs. supportive prns (clonidine, antiemetics, etc)

Related references:

Bernstein CA, Levin Z, Poag M, Rubinstein M: On Call Psychiatry. 3rd edition. WB Saunders,2006. Page 63-72.

Pasic Lecture "Assessment of the Intoxicated Patient", R2 Emergency Psychiatry Course

Case #5: Assessment and recommendations for patients refusing treatment on the medical floor (decisional capacity).

A 24 year old man admitted to the ortho service with osteosarcoma of his left leg. The tumor has progressed, is infected, and the patient has been unable to walk for over a month. The primary team is recommending amputation, and the patient has declined this. Psychiatry is consulted to assess decisional capacity.

Learning Objectives:

- Define decisional capacity
- Know how to assess decisional capacity
- Practical steps regarding patients undergoing evaluation for decisional capacity (documentation, communication with the primary team, sign-out).

Definition of decisional capacity:

Decisional capacity is the ability to consent to or refuse care. It is closely related to competence, which can only be determined in a court of law. Decisional capacity is decision-specific. A patient may have capacity to make some decisions, but not others at exactly the same point in time.

There are 4 elements related to decisional capacity:

- The ability to communicate a choice.
- The ability to understand the relevant information.

- The ability to appreciate a situation and its consequences.
- The ability to reason rationally

What do you need to ask the team?

- Clarify the patient's current diagnosis
- It is often helpful to inquire as to why the team is concerned about decisional capacity (is it because the patient carries a diagnosis of schizophrenia? Or because the patient has been confused at night and pulling out lines, refusing care overnight, but consenting to care during the day?).
- Ensure that you understand the various treatment options, risks, and benefits for the patient, clarify whether the team has discussed this with the patient (and to what extent).
- Clarify with the team their reasons for the recommended treatment, and the potential consequences they see if the patient declines or accepts treatment.
- Remember to talk with nursing staff about how the patient has been presenting in the hospital, including whether the patient is eating, sleeping, and the nature of the patient's interactions.

What should you ask the patient?

- Assess for delirium. Establish whether the patient is oriented, review the chart for signs of waxing and waning mental status.
- Ask the patient to tell you his understanding of the medical situation, the recommendations by the team, the risks/benefits of consenting to or refusing the treatment.
- Ask the patient to tell you his decision, and explain his reasoning.
- Assess whether the patient appreciates the potential consequences of either decision (for or against treatment).
- If collateral information (parents, friends, siblings) are available, ask them for their assessment of the patient's thinking, their impression of the stability of the patient's decision over time, and their assessment of the patient's baseline functioning. If the patient's decision is consistent with decisions the patient has made throughout his life, this may lead you down a different path than if the patient's decision is a clear departure from his former thought processes.

If it is unclear whether the patient has decisional capacity, what do you do?

- At times, it is difficult to gauge whether a patient has decisional capacity. This may occur when the team is providing different history than the patient or nursing staff, or if the patient is unwilling to speak with the consulting psychiatry team. In some of these cases, serial interviews are helpful. If the decision required is not urgent, one option can be to sign-out to the next shift to again attempt evaluation for decisional capacity, making sure to document clearly the details of the initial evaluation, and to also convey this in a detailed manner to the incoming shift.
- It may make sense in some cases to involve the hospital ethics team.

- As always, consult with your attending!

If a patient lacks decisional capacity, what do you need to do?

- The answer may depend on the reason the patient lacks decisional capacity (ie If the patient is delirious, the delirium should be treated if possible).
- If a patient lacks decisional capacity, and there is no clear reversible cause, the primary team may need to refer to the hierarchy of decision makers for the state of Washington.
    1. Legal guardian with health care decision-making authority.
    2. Individual given durable power of attorney for health care decisions.
    3. Spouse.
    4. Adult children of patient (all in agreement).
    5. Parents of patient.
    6. Adult siblings of patient (all in agreement).
- Reinforce with the primary team the ongoing need to discuss medical decisions with the patient, and the goal of obtaining assent from the patient even if another individual will be officially consenting.
- Note, if there is am *emergent threat to life or limb*, and the patient cannot communicate a choice (ie clearly does not have decisional capacity at that time), there is no requirement to refer to the hierarchy of decision makers. Instead, two attending physicians can independently assess and document that the procedure is required in order to save the patient's life or limb, and proceed.

Documentation:

- Document whether the patient is able to communicate a choice and maintains this choice over time.
- Document if the patient understands the relevant information regarding treatment.
- Record whether the patient appreciates the situation and its consequences.
- Note whether the patient is able to manipulate information rationally.
- It is often useful to reinforce the point that decisional capacity is decision-specific, and evaluated at a given point in time, by stating, "At this time, and in regards to the decision about whether to proceed with [treatment], this patient appears to have/not to have decisional capacity for the following reasons:…"

Related references:

Appelbaum PS. Assessment of Patients' Competence to Consent to Treatment. New England Journal of Medicine 2007;357:1834-1840.

http://depts.washington.edu/uwmedres/patientcare/objectives/hospitalist/Decisional_capacity.pdf, by Dr. Susan Merel.

Case #6: Evaluation and treatment of Delirium in the ER.

You get a call about a 66 year-old woman who has a history of PTSD, and was admitted 3 weeks ago to a nursing home to recover from a left hip fracture that was surgically corrected. Her recovery was complicated by a wound infection, which was treated with IV antibiotics 2 weeks ago, and it has reportedly resolved. Nursing staff are concerned about the patient's talkativeness, erratic sleep, and constant shopping on QVC. The patient also has a belief that she has an undiagnosed infection, so she has been saving her feces in a plastic bin in order to "culture" them. Nurses are concerned that the patient has inadvertently infecting herself due to handling her feces and are calling 911 to bring her in for a psychiatric evaluation. You immediately think this is likely delirium or is it new-onset mania?

Learning Objectives:

- Define delirium.
- How to evaluate and treat delirium.

What is delirium?

- A neuropsychiatric syndrome defined by disorders in perception, thought process, and level of consciousness with an acute onset and fluctuating course
- Common: 15-20% of all general admissions to a hospital
- Higher frequency in elderly, preexisting cognitive impairment, postoperative patients
- Associated with greater morbidity and mortality, particularly if unrecognized and untreated

Main symptoms of delirium:

- Clouding of consciousness
- Difficulty maintaining or shifting attention
- Disorientation
- Illusions or hallucinations
- Fluctuating course

What is the differential diagnosis of delirium?

- Dementia
    - Onset is likely more gradual
    - In general, patients with dementia have intact alertness and attention
- Primary neurological insult
    - New neurological abnormalities present are sometimes present on exam

- Substance intoxication or withdrawal (see Case #4 for details) – this is actually delirium, but the cause is important to consider seperately
    - Acute onset
    - Occurs immediately or 1-7 days after admission
    - History of substance use or withdrawal
    - Often accompanied by changes in vital signs
- Primary psychiatric Illness
    - Conciousness, memory, orientation generally unaffected
    - Premorbid diagnosis or history
    - More gradual onset (days to weeks)

What is important to address during your evaluation?

- Consider the most common causes if you suspect delirium, such as a change in or newly prescribed medication, withdrawal from alcohol or other sedative-hypnotic drugs, an infection, or a sudden change in neurologic, cardiac, pulmonary or metabolic state.
- Clinical history is key.
    - Any acute or subacute onset of new behavioral, cognitive or psychiatric symptoms suggest delirium
    - Obtain collateral information from those who know the patient; call the nursing home, family, caregiver and review the chart
- Review the patient's medical history: vitals, medical problems, medications, medication changes, any recent changes in care
- Review psychiatric history: prior and current diagnoses, medications, substance abuse
- Ensure a complete physical, including neurological exam has been completed.
- Diagnostic studies
    - serum chemistries, thyroid studies, electrocardiography, serum troponin level, arterial blood gas, urinalysis with culture, complete blood count, chest radiography, and lumbar puncture.
    - Neuroimaging is generally not indicated unless there are focal neurological findings
    - Electroencephalography is rarely needed, unless the cause of delirium is unclear and occult seizure is suspected

Treatment:

- The standard approach to the management of delirium is to determine and to correct the underlying causes of the disorder, while controlling the symptoms of delirium.
    - Pharmacologic treatments generally help control symptoms and in some cases can treat the primary cause
        - Antipsychotics (Typical and Atypical)
            - Haldoperidol is considered the drug of choice because of its lack of sedative, autonomic and cardiovascular

(hypotensive) effects and its availability in oral, tablet, liquid, IM or IV)
    - Atypicals are considered to be as effective as haloperidol in controlling delirium and have a lower incidence of extrapyramidal adverse effects: Risperidone, Olanzapine, Quetiapine have been studied the most
    - From Cochrane: Haloperidol (<3.5 mg/d), risperidone, and olanzapine were equally effective in treating delirium, with few adverse effects. Parkinsonian adverse effects were common with higher dose haloperidol (>4.5 mg/d) compared with olanzapine
- Benzodiazepines
    - No adequately controlled studies to support its use in non-alcohol withdrawal related delirium
    - May worsen symptoms, cause paradoxical agitation, cause intoxication
    - Considered the primary treatment for delirium due to ETOH/benzodiazepine withdrawal

Related references

Lonergan E, Britton AM, Luxenberg J. Antipsychotics for delirium. *Cochrane Database of Systematic Reviews* 2007, Issue 2.

Meagher, DJ. Delirium: optimizing management. *BMJ* 2001; 322:144-9.

Case #7: Assessing a patient who requests to leave the hospital against medical advice.

Mr. ZZ is 40 year old man with history of paranoid schizophrenia who was initially admitted to surgery for treatment of multiple lower extremity fractures incurred when he jumped off a highway overpass to evade the FBI agents he believes have been tracking him. He has a history of several life-threatening accidents and moves often. At the time of transfer to psychiatry, MR. ZZ was motivated for ongoing psychiatric care due to a belief that his previous residence was no longer safe (had been discovered by the FBI). He was transferred to psychiatry as a voluntary patient. He has spoken to the nurses several times today regarding his concerns about wire-tapping, cameras and suspicious men on the unit. He is now requesting to leave the hospital. Records from today's note indicate considerable disorganization and fear that his medications have been tampered with by the FBI.

Learning Objectives:

- Demonstrate ability to evaluate and formulate the appropriate outcome for a voluntary patient requesting discharge against medical advice.

How does a psychiatrist determine manage a request for AMA discharge from a voluntary inpatient psychiatric unit?

1. Assess whether the patient who wants to leave is a candidate requires involuntary psychiatric treatment.
    - Determine if the patient is an imminent danger to self, imminent danger to others, or gravely disabled and refer to the CDMHPs if indicated (see case #8 for details)
        - Review medical record
        - Interview the patient
        - Interview staff for any objective measures of risk prior to request for AMA discharge
    - NOTE: Risk factors for post AMA morbidity include recent discharge from a psychiatric hospital, substance abuse, recent significant loss, panic attacks, acute anxiety, and global insomnia. Protective factors include strong support system, an intact family, and a positive therapeutic alliance.

2. If the patient is not a candidate for involuntary treatment, inform the patient of the consequences of an AMA discharge while assessing and documenting the patient's understanding of these risks and benefits.
    - This is the equivalent of performing a decisional capacity evaluation for AMA discharge (see case #5 for details)
        - If a patient on a psychiatric ward does not have decisional capacity you can consider using this information in an affidavit as increased risk to self or others based on lack of insight. May want to discuss this with the CDMHPs.
    - If a patient on a medical ward does not have decisional capacity and is requesting to leave AMA even if they are at imminent risk without treatment, the standard of care would be to document that the patient does not have decisional capacity and that a surrogate decision maker must be determined (LNOK vs guardian). At times if the patient's lack of decisional capacity is due to chronic dementia or TBI you may be instructed based on hospital policy to pursue psychiatric involuntary treatment by writing an affidavit to the CDMHPs (currently the policy at HMC).
    - NOTE: While those without decisional capacity may be at greater risk than they perceive, those with full decisional capacity can still pose a significant risk to themselves.

3. If the patient does have decisional capacity and there is no indication for involuntary treatment (or the patient is referred and not detained), assess if there is a duty to warn others upon discharge.
    - The American Psychiatric Association's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* states (section 4) that it is permissible to reveal confidential information if it is the psychiatrist's clinical judgment that there is a "significant" risk of danger. "Significant" is not synonymous with the imminence required for involuntary hospitalization." See case #3 for details on Tarasoff/Duty to warn.
    - Consider relaying crisis information and specific risks to the family if you have concerns despite the patient not meeting criteria for involuntary detainment. Disclose only the minimum necessary information.

4. Finally, if the you decide to discharge the patient against medical advice, it is important to attempt to develop and document an after care plan
    - Often patients aren't interested in crisis planning during an AMA discharge however, at a minimum, these patients should be offered a list of referral sources for follow-up outpatient treatment and crisis services.
5. Consult with your attending and remember to document all steps in an AMA discharge note.

<u>What can be done to prevent AMA discharges or assist the physician who will be possibly performing an AMA discharge evaluation?</u>

- Engage patients and include them as active participants in their care
- Educate all patients—preferably at the time of admission—about advanced directives with respect to psychiatric care.
- Develop a discharge plan early in each admission.
- When possible, include the family in the patient's care from the outset.
- Perform and document thorough assessments for the risk of violence and suicide. Repeat these assessments according to the needs of each particular patient.
- Obtain prior hospitalization records as soon as possible after admission.
- Consider a substitute decision maker for patients who lack the capacity to appreciate the risks and consequences of an AMA discharge, especially in those cases where the symptoms or characteristics that contribute to the patient's diminished capacity also increase the patient's risk of danger.
- Update CORES regularly with a current and accurate risk assessment as well as any guides to management in case of AMA request.

SPECIAL NOTE ABOUT MEDICAL AMA DISCHARGES AT HMC:
If you are at Harborview evaluating a patient on the medical wards who:

1. Has expressed consistent desire to leave the hospital against medical advice…
   AND
2. Lacks decisional capacity…
   AND
3. Is taking action to leave the hospital…
   AND
4. Has an organic, mental, or emotional impairment that is either effecting the patient's decision to leave the hospital or their ability to care for themselves after leaving the hospital.

Please follow Harborview's specific protocol, which indicates that this patient should be referred to the CD-MHP for ITA assessment due to grave disability.

Related references:

Robert, J. Discharging a Psychiatric Patient Against Medical Advice. Emergency Medicine News: August 2010 - Volume 32 - Issue 8 - pp 10-13

Gerbasi, J. Patients' Rights and Psychiatrists' Duties: Discharging Patients against Medical Advice. Harvard Review of Psychiatry; Nov2003, Vol. 11 Issue 6, p333-343, 11p

Case #8: Assessing a patient for involuntary psychiatric treatment and writing an affidavit.

Mr. Z is a 28 year old male with a history of bipolar disorder who is brought to the ER by the police after he was found yelling incoherently and running naked in traffic. His urine tox screen is negative, but he is unable to cooperate with an interview in the ER, mumbling to himself and avoiding eye contact. He does state repeatedly that he wants to leave and refuses any medication, food or water. His mother who presents later reports he has been walking incessantly for the last three days, not stopping to eat or drink.

Learning Objectives:

- Demonstrate clear understanding of conditions for referral for involuntary psychiatric treatment.
- Demonstrate understanding of the role of the psychiatrist in evaluating and referring the patient for evaluation by the CD-MHP.
- Ability to compose an effective and efficient affidavit.

What is the law regarding involuntary psychiatric treatment in Washington state?

- RCW 71.05 (the "involuntary treatment act" or "ITA") is the legal document that defines involuntary psychiatric treatment statutes, rules and case law in

Washington State. In Washington, the final decision about whether the patient will be detained for involuntary psychiatric treatment is the responsibility of the County Designated Mental Health Professional (CDMHP). Psychiatrists and mental health clinicians participate in the process by referring the patient for CDMHP ITA evaluation through a legal document called and affidavit.

What patients need referral to the CDMHP for involuntary psychiatric treatment?

Any patient who…

1. Has psychiatric symptoms due to a "mental disorder" (see definition below) as defined by the RCW 71.05 law,

AND

2. Those psychiatric symptoms lead them to meet one or more of the following criteria:
    a. They pose a **danger to themselves**, with an *imminent* risk of suicide, as evidenced by statements made during the interview, recent behaviors, collateral information and/or past history, OR
    b. They are an imminent **danger to others**, as evidenced by statements made during the interview, recent behaviors, collateral information and/or past history, OR
    c. They are **gravely disabled** and are at *imminent* risk of significant injury or even death, as evidenced by recent dangerous or disorganized behaviors (e.g., walking in traffic) or medical issues requiring on-going attention (e.g., infection requiring antibiotics, dehydration, electrolyte imbalance).

AND

3. One of the following is true:
    a. The patient is unwilling to be admitted voluntarily, OR
    b. They are unable to consent to voluntary hospitalization, OR
    c. You believe they are a "poor-faith voluntary" (see definition below)

If your patient meets these criteria and he is not a voluntary patient, then psychiatric treatment, including psychotropic medications, cannot be legally provided against the patient's will unless determined necessary by the evaluating CD-MHP.

What is the RCW 71.05 Definition of "mental disorder"?

- "A mental disorder is any organic, mental or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions"
    - Clinically this includes all DSM IV conditions
    - However legally, under 71.05, "persons who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering

from dementia have a mental disorder but they cannot be detained or committed solely because they have been diagnosed with one of these conditions".

- EXAMPLE- a patient with chronic alcohol dependence who has depression and suicidality is not detained based on his alcohol dependence but rather on his substance induced mood disorder and associated significant suicide risk.

What should occur before the CDMHPs are called?

- Any significant medical issue that would require urgent care prior to psychiatric hospitalization should be provided (aka the patient should be "medically cleared");
- For patients who are "tiered" with one of the community mental health centers, the On-Call Case Manager for the patient (if one exists) must evaluate the patient
  for less restrictive alternatives to hospitalization and agree to MHP referral;
- Affiants, those who will write the affidavit, must be determined. The affiant must
  have first-hand knowledge of the patient's threats or behaviors. If you have evaluated the patient, you should provide an affidavit to provide your clinical judgment and opinion. Others who have first-hand knowledge of the patient's threats or behaviors should write an affidavit as well.

How do you make a referral to the CDMHPs?

To make the referral, call the CD-MHP office (296-4013 weekdays during daylight or 461-3210 nights and weekends). Be prepared to give the patient's date of birth, address, and a compelling argument regarding the need for involuntary treatment. Be sure to document the referral in your note, assure that your affidavit is complete before the MHP arrives and that any quotes you use in your affidavit are *identical* to the quotes you used in your documentation.

What are the essential components of an affidavit?

Your affidavit should include the following:

- Identification:
  "My name is Dr. Erasmus St. James, University of Washington psychiatry resident."
- The nature of your interaction with the "respondent" (a.k.a., the patient) and the location of your evaluation:
  "I evaluated the respondent, Mr. Justin Case, in my capacity as on-call resident at Harborview Medical Center."
- Summary of the respondent's presenting problem, psychiatric symptoms and relevant past history, using patient quotes that indicate dangerousness to self, others or grave disability when possible:
  "Mr. Case was brought to Harborview after waving a knife in front of the Seattle Police Department, and says "Suicide by cop, man, why didn't those bastards just f-----g shoot me?" He has a mental disorder

characterized by depressed mood, suicidal ideation, command auditory hallucinations . . . He has a history of six suicide attempts and previous treatment for schizoaffective disorder. . .”

- Reason(s) why respondent should be detained involuntarily
  “The respondent’s long history of serious suicide attempts, ongoing endorsement of suicidal plan with intent to carry it out, psychotic and impulsive behavior on evaluation today, as well as his recent suicide attempt today make his risk suicide or self harm very high without psychiatric treatment for safety and stabilization.
- Summary statement:
  “In summary, I believe Mr. Case should be detained involuntarily as a danger to self. I would be willing to testify to the above in court”
- Signature, date, location (hospital and city):
  “Dr. Erasmus St. James, 1/17/11, Harborview Medical Center, Seattle”

General tips for affidavit composition:

- The statements, quotes and examples in the affidavit have to be *IDENTICAL* to those in your clinical note.
- Limit the use of medical or psychiatric jargon and avoid diagnostic acronyms or abbreviations
- Write the affidavit on the special affidavit form which can accessed at the UW Psychiatry Resident Website under “Clinical Tools”. http://psychres.washington.edu/clinicaltools/clinicaltools.asp
- Sample Affidavits for Involuntary Treatment can be found in any of the PRONs

What does “poor faith voluntary” mean?

If a patient requests/agrees to voluntary hospitalization, but he is unlikely to abide by the rules, unlikely to comply with treatment or likely to attempt to leave against medical advice, then the patient is considered a “poor faith voluntary” patient. If you feel inpatient care is necessary, they would need to be referred to the CD-MHPs. Your affidavit would not only describe the need for involuntary treatment (as in the examples above) but also should explain why you are unwilling to simply admit them as a voluntary patient. Appropriate arguments for the need for involuntary treatment of a “poor faith voluntary” patient include:

- Non-adherence to recommended psychiatric treatment.
  - History of AMA discharge from hospital;
  - Protracted failure to follow through with outpatient tx;
- Inability to give informed consent.
  - A patient who is unable to understand or unwilling to sign the voluntary treatment agreement cannot be admitted voluntarily. As with any informed consent procedure, a potential voluntary patient must be able to appreciate the procedures, risks and benefits involved

in hospitalization. This potentially excludes certain demented, delirious and severely manic or psychotic patients. (See Case #5)

- Ambivalence about entering the hospital
  - E.g., the patient who repeatedly changes their mind about being admitted. These patients are likely to elope or request AMA discharge long before we fix their considerable problems.
- Assaultive behavior. This includes:
  - Recent violent behavior;
  - History of assault in treatment settings; or,
  - Inability of patient to agree to not harm others.
- Inability to stay safe on the unit.
  - Self-harm behavior in the PES (banging head on wall, eating soap);
  - History of self harm or getting into dangerous spots while hospitalized;
  - Inability to follow staff re-direction.

What is a Non-Emergency Detention?

In cases of where there is a chronic condition that leads to a level of risk (to self or others) or grave disability that does not meet the definition of imminent risk, there is a process where-by the patient is detained on a non-emergency detention (or NED). This more often occurs in the inpatient setting. It is a rare condition that would need to be negotiated with your attending and the CD-MHPs. The NED is issued by a judge rather than a CD-MHP.

Related references:

Harborview Medical Center Psychiatry Resident On-Call Manual (2008/2009 version)

Shafer Lecture "Evaluating Patients for Involuntary Emergency and Non-Emergency Detention", R2 Emergency Psychiatry Course

Case #9: Scenario where staff raise a medical concern without giving full information or all pertinent positives (testing the ability to assess for medical severity. Ex/ nurse calls with a SOB complaint but says she will just start O2 though RR is 45).

You are on call at UWMC, and have just returned home after admitting a patient. The nurse calls you at 1am quite panicked as patient on the unit "has collapsed." She does not offer any other information but states you need to come in immediately and that she does not have time to talk with you about the case.

Learning Objectives:

- Know the questions to ask of staff
- Know how to evaluate the patient from afar
- Know who to call for help

What action should you take?

- Even though you have limited information, you should assume you will need to return to the hospital. Let the nurse know you are on your way.
- As it will take some time to get back to the hospital, you should ensure that the staff has adequate medical support before you arrive. Suggest they call a rapid response, the stat RN, or you can call the on-call medicine team.
- The more you can learn about the patient, the easier it will be to call for consultant assistance if need be. However, it may be most important that a physician get to the scene promptly, in which case you may need to call for in-house evaluation by the medicine team, rapid response or STAT nurse while you are in transit before you've had a chance to learn about the patient's history.
- Let your attending know about the medical situation on the floor, and the preliminary information you have gathered (see below).

What questions should you ask?

- Even though the nurse has stated she cannot talk with you, let him/her know you need to have more information in order to get help quickly for the patient.
- Ask for the patient's current mental status and vital signs, including oxygen saturation→ if vitals are abnormal, consider suggesting the RN call the stat team, or a code.
- Other useful information to obtain if possible:
    - What medications has the patient received?
    - What happened before the collapse?
    - Is the patient currently responding?
    - Did the patient hit his/her head?
    - What medical problems does the patient have?
    - Has this occurred with this patient before?
    - Were any abnormal movements observed?
    - Did the patient complain of any pain or symptoms prior to the collapse?
    - Does the staff feel they have adequate help to ensure other patients are safe while they tend to the collapsed patient?
- Think about what orders you can start with before you arrive. For instance, there may be some labs the staff can draw while you come in (in the case of a patient losing consciousness, would think about chem10, CBC, ABG, tox screens, LFTs, ammonia), and EKG, or imaging may be helpful.

When you arrive:

- Continue the work-up, and call for assistance from medical services as needed. It is often useful to run these cases by the on-call medical team even if you

believe the patient is now stable. They can offer work-up suggestions, and may even do a formal consult at that time or the following day.
    - Even if another team has arrived, or the patient is being transferred to another service, you remain the patient's physician until that transfer is complete, and will also continue to be important as a consultant to the new primary team if the patient is transferred.
- Document the sequence of events, work-up, and any pending labs/studies.
- After the patient is stable, this may be a good time to talk with staff about how they felt the situation was handled, and debrief a bit. Also update your attending appropriately.

Related references:

Bernstein CA, Levin Z, Poag M, Rubinstein M: On Call Psychiatry. 3rd edition. WB Saunders, 2006.

Case #10: Defining a question when called for a "psych" consult:

You are on your nightfloat rotation and a medicine intern calls you requesting a psychiatric consultation for a patient she is admitting from the ER. She states the patient has schizophrenia and pneumonia, and asks if you can see the patient tonight.

Learning objectives:

- Develop some strategies to help yourself, and the primary team, identify the question at hand.
- Define a clinical question sufficiently to be able to generate appropriate recommendations that will help the primary team, and to help triage a consult safely.

Before you let the intern hang up the phone…:

- The consulting team does not always express (or understand) clearly why they are requesting psychiatric assistance. At times, this can make it appear as though the consult is not indicated, or can be postponed. Try to give the team the benefit of the doubt, and dig a little further.
- Sometimes it is helpful to state, "I am happy to try to help with this patient. Is there a specific question I can help answer or a concern you have right now about this patient?"

- If this yields nothing better than, "Well, he has schizophrenia, and my resident wanted to me call you guys tonight," you may need to begin asking about specific concerns we often assist with:
    - First, ask if the team is worried about the patient's safety. This includes asking about suicidality, and about behavioral disturbance. If they have concerns about this, the patient clearly needs to be seen, and it may be useful to recommend a sitter immediately.
    - Is there concern about the patient's current mental status? If so, the consult may be to address possible delirium vs. psychosis. In other words, there may be a psychiatric vs. medical diagnosis question at-hand with which you can assist. Gathering information about the patient's behavior and medical condition may help you get this consult started.
    - Is the team concerned about the patient's medications? They may be looking for short-term or long-term medication recommendations in the setting of medical illness or suspected non-compliance with psychiatric medications prior to admission. This may involve consideration of drug interactions or changes in smoking or substance use during inpatient stay.
    - At times, the patient (or the patient's family) is difficult for the primary team in one way or another. Examples include declining treatments, being hostile, being silent, or providing inconsistent histories. This may have prompted the call for help. Soliciting a description of the patient's behavior may help to clarify whether there is a question of decisional capacity, or perhaps a request for help with a challenging patient.
    - Without offering transfer to psychiatry, it may be helpful to clarify whether the team is looking for possible psychiatric admission for the patient, or perhaps just hoping to obtain some help with dispo planning and psychiatric follow-up.
    - Occasionally, the patient requests a psychiatric consult. In this case, it is helpful if the primary team can clarify why the patient is interested in speaking with psychiatry so that you can appropriately prioritize and triage this consult, though often this is a situation in which you may simply need to see the patient to identify the issue.
    - Asking when the patient is set to be discharged, and assessing for safety, treatment compliance, and behavioral control, can help you begin to ascertain if the consult question is acute.
- Still unclear? Consider discussion with your on-call attending for any suggestions for getting to the bottom of the mystery.
- If the reason for the consult remains mysterious despite careful questioning of the primary team, a review of the chart, discussion with staff, and visit with the patient should help identify how/where psychiatry can be of use. When you suspect you have an understanding of how we can help, discuss this with the primary team to confirm that you will be answering the appropriate question in your note and recommendations.

- The will likely be times when your ability to see a patient as urgently as the primary team would like does not match up with the primary team's expectations. In these cases, it is appropriate to assess the urgency of the consult, inform the primary team how they will be helped in the future, and be as respectful as possible in communicating your current limitations in the assistance you can currently provide.