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The Psychiatry Information Card: A pocket resource to assist students' transition into psychiatry clerkship

La carte d'information en psychiatrie : une ressource de poche pour faciliter la transition des étudiants vers l'externat de psychiatrie

Hiba Rahman, Aarondeep Shokar, Mariam Alaverdashvili et Dawn De Souza

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Résumé de l'article

Énoncé des implications de la recherche

La carte d'information en psychiatrie (CIP) est une ressource pratique, structurée et concise destinée à renforcer la confiance, les connaissances et l'autoréflexion des étudiants en médecine au cours de leurs stages en psychiatrie. Son utilité réside dans le fait qu'elle apporte un soutien ciblé aux étudiants qui passent de l'apprentissage en classe à la pratique clinique, et qu'elle aborde les défis particuliers qui se posent au cours de cette phase critique de l'éducation médicale. En offrant des données accessibles et pertinentes qui s'harmonisent aux objectifs du stage, la CIP permet d'accroître les connaissances avant et après le stage, et d'améliorer l'expérience d'apprentissage. L'acceptabilité de la CIP est démontrée par le taux de recommandation élevé (90 %) parmi les participants, qui ont approuvé son intégration dans les stages. En outre, le faible coût et la facilité de distribution de la CIP en font une ressource rentable, ce qui confirme la faisabilité de sa mise en œuvre à grande échelle. Par conséquent, nous recommandons son intégration officielle dans le programme d'études.

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You Should Try This!

The Psychiatry Information Card: a pocket resource to assist students' transition into psychiatry clerkship

La carte d'information en psychiatrie : Une ressource de poche pour faciliter la transition des étudiants vers l'externat de psychiatrie

Hiba Rahman,[1,2] Aarondeep Shokar,[1,3] Mariam Alaverdashvili,[1] Dawn De Souza[1]

[1]Department of Psychiatry, University of Saskatchewan, Saskatchewan, Canada; [2]Department of Psychiatry, University of Western Ontario, Ontario, Canada; [3]Department of Psychiatry, University of Calgary, Alberta, Canada

Correspondence to: Dawn De Souza, Room 184, Ellis Hall. Royal University Hospital, Saskatoon Saskatchewan S7N 0W8, Canada; email: hfr782@usask.ca

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Implication Statement

The Psychiatry Information Card (PIC) offers a practical, structured concise resource to enhance medical students' confidence, knowledge, and self-reflection during psychiatry rotations. Its utility lies in providing targeted support for students navigating the transition from classroom learning to clinical practice, and addressing specific challenges encountered during this critical phase of medical education. By offering accessible and relevant information aligned with rotation objectives, the PIC increased knowledge pre and post rotation, and enhanced the learning experience. The PIC's acceptability is demonstrated by the high recommendation rate (90%) among participants, who endorsed its integration into the rotations. Additionally, the low cost and ease of distribution make the PIC a cost-effective resource, further supporting its feasibility for widespread implementation. Therefore, we recommend formal integration into the curriculum.

Énoncé des implications de la recherche

La carte d'information en psychiatrie (CIP) est une ressource pratique, structurée et concise destinée à renforcer la confiance, les connaissances et l'autoréflexion des étudiants en médecine au cours de leurs stages en psychiatrie. Son utilité réside dans le fait qu'elle apporte un soutien ciblé aux étudiants qui passent de l'apprentissage en classe à la pratique clinique, et qu'elle aborde les défis particuliers qui se posent au cours de cette phase critique de l'éducation médicale. En offrant des données accessibles et pertinentes qui s'harmonisent aux objectifs du stage, la CIP permet d'accroître les connaissances avant et après le stage, et d'améliorer l'expérience d'apprentissage. L'acceptabilité de la CIP est démontrée par le taux de recommandation élevé (90 %) parmi les participants, qui ont approuvé son intégration dans les stages. En outre, le faible coût et la facilité de distribution de la CIP en font une ressource rentable, ce qui confirme la faisabilité de sa mise en œuvre à grande échelle. Par conséquent, nous recommandons son intégration officielle dans le programme d'études.

Introduction

This innovation in medical education aims to impact the complex transition from pre-clinical to clerkship years, which is regarded as the most challenging period for medical students.[1] The transition is a drastic adjustment from classroom learning to work based learning (clinical rotations). According to literature, transition challenges include adjustments in roles, learning environments, teaching styles, and frequent rotation changes.[2,3]In addition, communication with psychiatry patients is cited as a significant source of stress compared to other patient populations.[4] Cognitive psychology and situated learning theories indicate the necessity for targeted interventions to support students identify, and navigate critical transition points during training.[5,6]

Description of the innovation

To alleviate the stresses encountered during psychiatry rotations and to support greater learning, we created the PIC specifically for third-year medical students starting their mandatory psychiatry rotation. The PIC aims to enhance students' confidence, knowledge, and self-

reflection. It serves as a practical, structured, and concise information resource aligned with psychiatry rotation objectives of our medical institution. Ethical approval was obtained from the University of Saskatchewan Behavioral Research Ethics Board, and informed consent was ensured from all participants. Perceived benefits of the PIC during rotations were assessed through questionnaires. These were administered to participants pre and post rotation, in both the PIC and no-PIC groups. The questionnaires included items specifically designed to gauge participants' perceptions of the PIC's utility, relevance, and effectiveness in enhancing their learning experience during psychiatry rotations. Participants were asked to rate their confidence and comfort levels in applying their knowledge and skills in clinical settings.

Outcomes

Descriptive statistics, including mean scores and standard deviations, were computed to summarize participants' responses to various questionnaire items. Comparative analyses, such as ANOVA, examined differences in outcomes between the PIC and no-PIC groups, allowing for statistical inference regarding the effectiveness of the intervention. The knowledge scores significantly increased at post-rotation compared to pre-rotation in both groups, PIC and no-PIC, (p < 0.05) (Figure 1). Despite relatively higher knowledge growth in the PIC group, there was no difference between groups when participants' sex and pre-rotation scores were considered in data analysis (p > 0.05). However, 76.7% of participants self-reported that the PIC enhanced their overall learning experience during the rotations and 90% recommended it should be formally integrated in the rotations. The small sample size (n = 53) and time constraints may have affected the statistical power of the study. While statistical significance might not have been attainable within this sample, calculations suggest that a larger sample size, approximately n = 103, could yield statistically significant outcomes with ANCOVA, especially when accounting for covariates like gender and pre-rotation scores.

Suggestions for next steps

Despite its effectiveness, limitations such as small cohort size and absence of objective assessment highlight areas for improvement. Future research could explore larger studies, other training sites and alternative formats, such as apps, to enhance accessibility and effectiveness. Nonetheless, the PIC remains a unique and valuable resource for supporting medical students during psychiatry rotations, offering targeted support to enhance learning experiences.

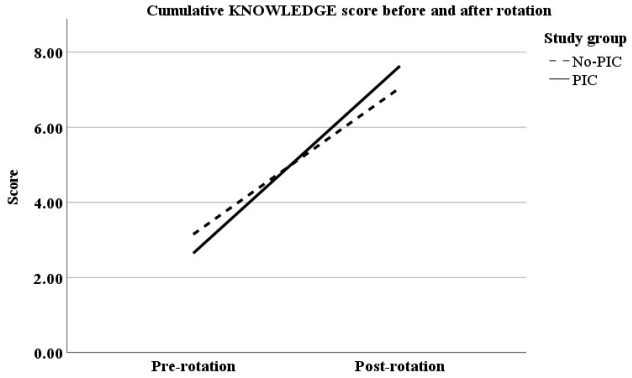

Figure 1. Self-reported KNOWLEDGE cumulative scores before and after 6-week psychiatry clerkship rotation.

KNOWLEDGE was rated across three questions from 0 = Not at all to 4 = Extremely. The cumulative scores ranged from 0 - 12. The KNOWLEDGE scores significantly increased at post-rotation compared to pre-rotation in both groups with and without PIC ($p < 0.05$). Despite relatively higher knowledge growth in the PIC group, there was no difference between groups when participants' sex and pre-rotation scores were considered in data analysis ($p > 0.05$).

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Treatment of Common Conditions

General Principles

These are some of the common first line medications. They are not arranged in any particular order. qD=qDaily, HS=at bedtime
In patients who are sensitive to medication side effects, lower starting doses and slower titrations can be helpful.

SSRI/SNRI medications can cause **hyponatremia** especially in elderly patients. Elderly patients generally require lower doses and careful dosing based on renal and hepatic dysfunction.

SSRI can be increased qWeekly or more quickly if pt tolerates it. **SNRIs** should be discontinued slowly over weeks to prevent withdrawal. SSRI can be discontinued somewhat quicker, but can still result in **Antidepressant Discontinuation Syndrome.**

Anxiety disorders require higher SSRI/SNRI dosing. Response takes longer to achieve. Benzodiazepines can be helpful in the short term.

Common 1st Line medications for MDD

SSRI (mostly hepatic clearance)	Starting Dose	Dose Range
Sertraline	25mg-50mg qD	50-200mg
Escitalopram (qt prolongation)	5-10mg qD	10-20mg
Fluoxetine	10mg-20mg qD	20-60mg
SNRI (renal+hepatic dosing)		
Duloxetine	30mg qD	30-60mg
Venlafaxine (Can be activating)	37.5mg qD	75 -225mg
Others		
Mirtazapine (↑ Appetite + Sleep)	7.5-15mg HS	15-45mg HS
Bupropion (NDRI) Activating	150mg qAM	150-300mg qAM

ADJUNCTIVE MEDICATION FOR DEPRESSION

To be added on vs changing the primary medication when: 2 or more antidepressant have been tried, partial response (25-50%↓Sx) with the initial tx, other side effects that can be targeted by the adjunctive medication

Drug	Starting dose	Dose range
Aripiprazole (activating)	1mg qAM	2-15mg qAM
Quetiapine (sedating)	12.5-25mg qD/HS	150-300mg qD/HS
Risperidone	0.5-1mg qD/HS	1-3mg daily/HS

Common 1st line medications for GAD

Drug	Starting dose	Dose range
SNRI (renal + hepatic dosing)		
Duloxetine	30mg qD	30-60mg qD
Venlafaxine XR	37.5mg qD	75 -225mg qD
SSRI		
Sertraline	25mg-50mg qD	50-200mg qD
Escitalopram (qt prolongation)	5-10mg qD	10-20mg qD
Paroxetine (anticholinergic)	10mg qD	10-50mg qD
Gabapentinoids (renal dosing)		
Pregabalin (can ↑ sleep/sedation)	25-75mg BID	25mg - 300mg BID

Common 1st line medications for Panic Disorder

Pts

require higher dosing for panic disorder, AIM HIGH

Drug	Starting dose	Dose range
Citalopram	10mg qDaily	10-40mg qD
Escitalopram	5mg qDaily	10-20mg qD
Fluoxetine	5-10mg qDaily	20-60mg qD
Paroxetine	10mg qDaily	20-60mg qD
Sertraline	25mg qDaily	50-200mg qD
Venlafaxine XR	37.5mg qdaily	75-225mg qD
Fluvoxamine	25-50mg daily	100-200mg qD

GLOSSARY: Apraxia: Inability perform skilled movement. **Abulia:** Lack of will/drive for action/speech/thought. **Anhedonia**: Inability to experience/anticipate future pleasure. **Asociality:** Lack of motivation for social interactions **Avolition:** inability to initiate goal directed activity. **Alogia:** Poverty of speech and thought. **Aphasia:** Acquired d/o of language. **Agnosia:** inability to rec objects **Catalepsy**: Muscular rigidity, fixity of posture **Cataplexy:** Sudden loss of motor tone.

PSYCHIATRIC SYNDROMES

NEUROLEPTIC MALIGNANT SYNDROME (NMS)

Rare reaction to antipsychotic medication likely due to D2 blockade leading to impaired Ca2+ mobilization resulting in muscle rigidity, autonomic dysfunction, and sympathetic nervous system activation. dDx: Malignant catatonia, Serotonin syndrome, ETOH /Bzd W/D, CNS infxn, DIMS.
Presentation: Gradual onset vs serotonin syndrome. **T>38C, muscle rigidity**, **confusion**, agitation, tachycardia, tachypnea, hyper/hypotension, diaphoresis, sialorrhea, tremor, rhabdo, met acidosis. Tx: **Stop offending agent**, cooling, ICU/CTU level care, Dantrolene**benzos**\amantadine\bromocriptine\levodopa med options. Labs: CBC, Lytes, **CK**, LDH, VBG, CRP, **DIMS WORKUP!**

SEROTONIN SYNDROME

Rare, lethal condition caused by initiation/dose ↑ of serotonergic med. Likely due to various mechanisms that increase qty/activity of serotonin through increased precursors, increased release of serotonin (MDMA), decreased metabolism (MAO inhibitors), reuptake inhibition, direct serotonin receptor agonism or other mechanisms
Presentation: Acute onset confusion, agitation, coma, myoclonus, rigidity, tremors, shivering, **hyperreflexia** (lower>upper), ataxia, **hyperthermia,** nausea, diarrhea, mydriasis, **tachycardia, hyper/hypotension, rhabdo. Tx:** Stop offending agents, supportive care, likely ICU/CTU.

ANTICHOLINERGIC TOXIDROME

Mad as a hatter, hot as hell, red as a beet, dry as a bone, and blind as a bat.

A delirium caused by anticholinergic drugs.
Presentation: These patients can present with confusion, psychotic symptoms, dry skin, erythematous skin, fever, mydriasis, tachycardia, restlessness, and visual hallucinations. **Treatment:** General approach is stop the anticholinergic drugs, IV reversible cholinesterase inhibitors, benzos, and supportive care. CTU/ICU level care.

EXTRAPYRAMIDAL SYMPTOMS (EPS)

A group of conditions caused by excessive D2 blockade

ACUTE DYSTONIA

A neurologic hyperkinetic disorder characterized by repetitive/sustained muscular contractions. Most likely to occur in the first week of starting a D2 blocking drug or with a significant dose ↑ . Can affect the head, neck, trunk, and limbs. **Presentation:** twisting, repetitive movements, and fixed postures. Most likely in head and neck. Can present with torticollis, trismus, tongue protrusion, jaw opening, blepharospasm, grimacing, opisthotonos. **Treatment:** IV anticholinergic drug such as benztropine 1-2mg IV/IM, Diphenhydramine 25-50mg IV/IM.

OCULOGYRIC CRISIS

A dystonic reaction that results in extreme upward deviation of the eyes. The eyes can also converge, deviate laterally, or downward. **Treatment: IV anticholinergic drugs as above.**

PSEUDOPARKINSONISM

Blockade of D2 receptors in the nigrostriatial dopamine pathway can mimic parkinsonism. **Presentation:** Can occur with acute or prolonged treatment resulting in masked faces, short shuffling gait, decreased arm swing, rigidity, bradykinesia, tremor, sialorrhea, etc. **Treatment:** Discontinue the higher potency antipsychotic and change to lower potency (less D2 antagonism). **Parenteral anticholinergics useful.**

TARDIVE DYSKINESIA

Occurs due to long term use of high potency antipsychotics, possibly due to ↑ dopaminergic transmission in the nigrostriatal pathway due to ↑ sensitivity to dopamine, ↑receptor count/sensitivity, striatal GABA hypofunction, and/or dopamine/cholinergic imbalance. **Presentation:** Peri-oral movements of the tongue lips and jaw are most common. Axial trunk twisting, torticollis, retrocollis and other forms of increased muscular contraction. **Treatment:** Do not stop the antipsychotic as this is a problem of ↑dopaminergic activity, therefore acute cessation of the agent could worsen symptoms. Anticholinergic drugs could worsen symptoms. Slow ↓ of the offending agent, and replacement with a low potency antipsychotic is preferred. TD is usually permanent, but can have some improvement with clozapine. Other agents that deplete monoamines such as tetrabenazine can be helpful. Benzodiazepines can help.

AKATHISIA

Inability to sit still/psychomotor restlessness. Intense unease/inner restlessness due to antipsychotic treatment, **common with aripiprazole.** Can occur with many drugs. Treatment: Reduce/stop offending agent, propranolol 20-40mg PO mg TID, benzodiazepines.

PSYCHIATRY INFORMATION CARD (PIC)

H. Rahman[1,2], A. Shokar[1,3], D. De Souza[1], M Alaverdashvili[1]
[1]Department of Psychiatry, University of Saskatchewan, Saskatchewan, Canada; [2]Department of Psychiatry, University of Western Ontario, Ontario, Canada; [3]Department of Psychiatry, University of Calgary, Alberta, Canada

GENERAL INFORMATION

Welcome to psychiatry at the UofS. As a clerkship student, you will learn how to diagnose, treat, and manage patients suffering from a wide range of medical and psychiatric illnesses.

EXPECTATIONS

PROFESSIONALISM: Be on time. Ask ahead to find out start times/ expectations are for each component of your rotation
Inpatients: Rounds start 9am 1/2nd floor Dube. OutPts: Varies
ILLNESS/LEAVE: Communicate with the PGME/Clerkship coordinator/ preceptors when you are ill/away
ON CALL: Weekday call starts at 4:30pm. Handover occurs virtually, see rotation info for link. Weekend call starts at 8am with handover via virtual platform.

COMMON NOMENCLATURE USED IN PSYCHIATRY

CERTIFICATION: Involuntary admission to mental health facility under 1-2 medical certificates (FORM G). 1 Certificate = 72 hours, 2 Certs = 21 days from midnight of the 1st certification.

FORM G: Completed by physicians with admitting privileges to a mental health facility (usually a psychiatrist). One form may be completed by a resident in psychiatry. "**Involuntary admission"**

FORM G Timeline: Second form G must be completed by the **end of the third day** following the issuance of the first form G.

FORM A: Completed by physician (or prescribed health prof) if they feel the person should be examined by psychiatry for potential admission. A person may be examined at their residence, a doctor's office or, more usually, at a hospital ER by an ER doc/Family doc. Person must be taken to hospital within 7 days of initial examination (when doctor completed out form A). "**mandated psychiatric assessment".**

SECTION 20: A peace officer may apprehend a person without a warrant and convey that person as soon as is reasonably practicable to a place where they can be examined by a physician, if the peace officer has reasonable grounds to believe that the person is: **a.** suffering from a mental disorder **AND b.** likely to cause harm to himself or herself or to others or to suffer substantial mental/physical deterioration if not detained in a mental health center. **Physician must examine within 24 hours or the order expires.**

FORM H: H3.H4: 2 forms that your attendings' may complete (two psychiatrists). These forms allow for the issuance of a "Community Treatment Order" aka **CTO**. A pt under a CTO can be involuntarily taken to hospital for assessment with the issuance of a **FORM H7** at the discretion of their primary community psychiatrist. **CTO mandates treatment of some sort.**

FORM C: Pt refuses voluntary exam. Family/person submits a form B on basis of sworn evidence to a judge. Judge can issue a **form C**/warrant which allows a peace officer to take the pt to be examined by a physician with admitting privileges to a mental health center.

Mental Health Approved Home: A home with not more than five people, where the operator + building have been licensed to provide care for a person with a mental illness.

LAI: Long acting injectable medication

CMHN: Community Mental Health Nurse

EPS: Extrapyramidal Symptoms. **TD:** Tardive Dyskinesia

PSYCHIATRIC HISTORY

ID: Name, gender, age, occupation/income sources/social services, living arrangements, marital status/past marriage/divorce, # children (age and custody), highest level of education, pronoun if applicable

Community contacts: Psychiatrist, Family Doctor, CMHN, therapist, **CTO STATUS**

Source of referral/mechanism: ER Doc? (who), H7? Section 20?

Chief Complaint: Helpful to use patients own words in quotes

HPI: Onset of symptoms, progression, number of episodes, TIMELINE!!

COMMON CONDITIONS TO ALWAYS SCREEN FOR

Depression

2 wks persistently low mood **OR** anhedonia. Total of 5 symptoms of: low mood, anhedonia, +/- sleep, +/- appetite or wt gain/loss (5% Δ), psychomotor agitation/retardation, fatigue, worthlessness/inappropriate guilt, ↓concentration/++indecisiveness, ++ thoughts of death/suicide/any suicide attempt

Mania

7 days of persistently elevated/expansive/irritable mood and increased goal directed energy/activity. **3 SX** of grandiosity/ ↑self esteem, ↓sleep, pressured speech, racing thoughts/flight of ideas, distractibility, ↑goal directed activity (work, school, sex) or psychomotor agitation, +++ involvement in activities with painful consequences. **(4 Sx if irritable mood).**

Psychosis

Auditory, visual, tactile, gustatory, olfactory hallucinations, paranoia, delusions, thought insertion/withdrawal, ideas of reference, thought broadcasting, mind reading, abnormal abilities, religious ideation.

Generalized Anxiety

6 MO excessive worry in multiple domains of life (work, relationships, school, finances, etc) **with** difficulty controlling worry **AND 3 SX:** restless, easily fatigued, ↓conc/mind going blank, irritability, muscle tension, sleep disturbance (initiation, maintenance, restfulness)

Panic Disorder

Recurrent AND unexpected panic attacks defined by abrupt surge of intense fear/discomfort reaching peak within minutes with **4 sx**: palpitations/++HR, diaphoresis, shaking, SOB, choking, *CP*/discomfort, nausea/GI sx, dizzy/presyncope, chills/heat, paresthesia's, derealization/depersonalization (feeling detached from ones body/self), fear of going crazy, fear of death

OCD

The presence of obsessions, compulsions or both. **OBSESSIONS**: Recurrent + persistent thoughts, images, urges that are intrusive/unwanted = anxiety/distress **AND** attempts to ignore/suppress obsession/anxiety with thought/action or compulsion. **COMPULSIONS**: Repetitive behaviour or mental act pt is driven to perform rigidly to reduce anxiety/distress. e.g. hand washing, organizing, checking locks/stove, praying, repeating words/phrases, etc. **Sx consume 1hr+/day**

SUICIDE/HOMICIDE

Suicidality: thoughts (onset, intensity, frequency, distress), plans? Current suicidal actions? DID they take any suicidal action?! Overdose/self-harm. **Homicidality:** Thoughts, plans, ideas to harm others? **DUTY TO WARN/Protect, firearms?**

PAST PSYCHIATRIC HISTORY - Historical diagnoses, past suicide attempts, past psychiatrists, previous admissions, past certifications, previous ECT/TMS/KETAMINE, previous therapists/therapy (CBT/IPT/PD)

PAST MEDICAL HISTORY - All past medical history including: surgeries, DM, HTN, dyslipidemia, chronic kidney disease, ICU admissions, head injury, sz, cancer

MEDS - Current/past psychiatric medications and doses. Why were they changed?

ALLERGIES - Med allergies and reaction severity, EpiPen?

FAMILY HISTORY- Psychiatric diseases, **suicide!!!,** medical illness, addictions

SUBSTANCE USE Hx\FORENSIC\GAMBLING - Drug - AMOUNT, 1st use?, frequency, route (IV, insufflation, smoked, vaporized, oral). Past addictions treatment (rehab or detox stays). Nicotine, alcohol, psychedelics, cocaine, meth, cannabis, THC\concentrates. Include **criminal charges/incarceration/gambling.**

SOCIAL - Prenatal Hx\gestation time, developmental milestones, location of birth, location of childhood. **School**, academic achievement, bullying. Experience w/parents at different stages of development, parental occupation, **physical/emotional/sexual abuse.** Sexual/gender history

CONSULT STRUCTURE

1.HISTORY

2.MENTAL STATUS EXAM - **ASEPTIC**

A - APPERANCE

Race, gender, appear stated age?, cleanliness (well kempt, unkempt, disheveled), hair, clothes, malodourous, Behavior: agitation, cooperation, **Eye contact**
Psychomotor agitation/retardation
Gait (brisk, slow, ataxic, shuffling, etc)/Abnormal movements (tics, lip smacking, grimacing)

S - SPEECH

Rate of speech: Pressured, increased response latency, slowed
Rhythm/Prosody : normal, stuttering, pitch/intonation
Volume of speech, Articulation: accent, slurring, dysarthria

E-EMOTION

Mood: elevated, low, normal/good
Affect: what you observe (flat, restricted, euphoric, euthymic)?
Is their affect congruent or incongruent with their stated mood?
Is their affect appropriate for the situation/questions/conversation?
Is there excessive lability or a lack of affective variation?

P-PERCEPTION

Are they responding to unseen stimuli? Evidence that they are hallucinating/psychotic?
Auditory, visual, tactile, olfactory hallucinations

T-THOUGHT PROCESS

Linear: logical progression of thought without deviation from topic
Circumstantial: Excessive/unnecessary detail provided in response with eventual return to the original inquiry
Tangential: significant deviation from the topic discussed/asked with no return to topic and/or no response to original inquiry
Loosening Associations: Unlike tangentiality, the ideas lack any reasonable connection
Flight of ideas: Rapid shift in topics discussed
Thought blocking: Sudden termination of speech for no apparent reason/explanation
Perseveration: Repetition of phrase, words, or sentence

T -THOUGHT CONTENT

Poverty of thought: overall reduction of thoughts
Overabundance of thought: Increased quantity of thoughts
Delusions, obsessions, suicidal thoughts, homicidal thoughts

I-INSIGHT

Full/intact > partial > limited > absent - *Does the pt know they have a mental illness? How much understanding do they have? Do they feel they warrant hospitalization or treatment?*

C-COGNITION

Can be formally assessed using MMSE, Mini mental, MOCA or informal impression of cognition: "No obvious gross cognitive deficits". Comment on LOC/GCS/Orientation

3.DIFFERENTIAL DIAGNOSIS

List from most to least likely (DSM 5 Dx). ***Suicidal ideation/attempt is not a diagnosis.***
Historical diagnoses can be listed here as "historical diagnosis of:"
If a Dx is of particular interest and requires further inquiry, a "rule out:" specifier can be added with explanation

4.IMPRESSION/FORMULATION

Imp/formulation can be written as a case summary with a biopsychosocial approach.
The biopsychosocial factors can be categorized into predisposing, precipitating, perpetuating, and protective factors that led to the development of the current presentation. Some factors can be included in multiple areas.

Biological factors	Age, FHx, med compliance, OPt F/U, duration of illness, substance use, med illness
Psychological factors	Attachment style, personality disorders, temperament, trauma, childhood, bullying, factors affecting self esteem, gender identity
Social factors	Relationships (loss or support), employment, education, immigration

PLAN

The plan can be structured using the "safety, biopsychosocial framework"

Safety:	**Discharge vs Admission. Voluntary vs Involuntary.** Safety can include, certification, nursing observation, ICR, restraints, vitals, neurovitals etc.
Bio:	Medications, neurostim(ECT/TMS). **BW**(CBC, lytes, cr/urea, LE/LFTs,TSH, B12) **Drug levels** (lithium, epival, clozapine, etc). Lipids, HgbA1C. **Prolactin** if on D2 Antagonists, **PREG TEST**. Urinalysis/Utox Consider HIV, HEP C, Syphilis RPR, Chlamydia/Gonorrhea. Head imaging if applicable. Consider ECG.
Psycho:	CBT, IPT, DBT, psychodynamic, group therapy, etc). Cognitive testing?
Social:	Finances, housing, family interventions, educational supports, etc

ADMISSION PROCESS

1. Print Consult Note x2
2. Fill out fax cover sheet (include consulting + outpatient psychiatrist + Family Doctor). Check off adult department of psychiatry or child
3. Put consult note w/cover sheet in fax bin located behind psych nursing desk.
4. Call bed line and admit patient (8004)
5. Print admission order set -> FORMS ON DEMAND -> SEARCH PATIENT -> INPUT PT INFO -> ALL FORMS-> PK_Dube_ER_*ADULT/CHILD_INPATIENT_ADMISSION*

COMMON MEDICATIONS

ANTIPSYCHOTICS

Acutely agitated patients can be treated with any antipsychotic, however olanzapine or haloperidol are preferred agents at RUH for acute treatment.

OLANZAPINE 2.5-10mg PO/IM BID PRN (MAX 20mg/24HR)
QT prolongation, cannot give IM preparation within 2 hours of parenteral benzo

HALOPERIDOL 2-5mg PO/IM QID PRN. *IV dosing ↑ risk of arrhythmia/QTC↑
Risk of acute dystonia/eps, can give w/bzd e.g. 5mg Haldol/2mg Ativan PO/IM

RISPERIDONE 0.5-1mg PO qD/BID,↑ 1-2mg/d q2-5d. Target range 2-6mg/day.
Risk of dystonia/eps, prolactinemia, full effect from dose Δ > 1 week.

QUETIAPINE IR Initial: 25mg BID, ↑ 50mg/d q2-5d OR 300mg **XR** daily,↑ q2-5d 100-300mg/d. **Target 400-800mg/d for IR/XR in schizophrenia**

ARIPIPRAZOLE: Initial 2-5mg qDaily**.** ↑ 5mg/d q1-3 weeks. Max 15-30mg/d. **Risk of akathisia**

ANTICHOLINERGICS

BENZTROPINE: 1-2mg IM/IV TID for acute dystonia
IV route preferred for acute dystonic crisis, transition to oral after resolution, taper slowly

BENZODIAZEPINES **Avoid in elderly, risk of delirium, ↑ risk resp dep w/OPIOIDs**

LORAZEPAM: 0.5-2mg PO/IM/IV QID PRN: **Renal excretion**

CLONAZEPAM: 0.25-0.5mg PO BID: long acting, typically scheduled not prn

DIAZEPAM: *Initial:* 5-10mg PO/IV PRN. **Hepatic metabolism, poor IM absorption, ++ active metabolites**

MOOD STABALIZERS (ACUTE MANIA)

Always draw trough blood levels after start or dose change

LITHIUM: Initial 600mg-900mg DIV BID/TID: lower for geri. **(Check AM Level 5 days after dose Δ).** *Target level 0.8-1.2, 0.4-0.8 geri, ↑ 300-600mg q5d*

VALPROATE: Initial 250-500mg PO BID. ↑ 250-500/day q3-4d
Target level 350-875, lower for geri. **(AM trough 3-4 days after dose Δ)**

ANALGESICS

ACETAMINOPHEN 500-1000mg TID PRN max 3g to 4g/24hr for adults
Peds 10-15mg/kg/dose, max <75/mg/kg/day & <3000mg/day. Adults: max 2g/day if liver dysfunction. Avoid if alcoholic hepatitis or actively drinking.

IBUPROFEN 200-400mg QID PRN max 3200mg/24h
Avoid if on lithium, AKI, CKD, CVD/MI hx. 10mg/kg dose peds MAX 40/mg/kg/day or 2400mg whichever is lower.

NAPROXEN 250-500mg BID PRN PO
Avoid if on lithium, AKI, CKD, CVD/MI hx, age>65

ANTIEMETICS

DIMENHYDRINATE 25-50mg PO/IM/IV QID PRN
Avoid in elderly, delirium, restless legs

ONDANSETRON 4-8mg PO/IV Q8-12H
QT prolongation, constipation risk

METOCLOPRAMIDE 5-10mg PO/IV Q6H PRN
QT prolongation, EPS/DYSTONIA (use with caution if other D2 antagonists), TD

ANTACIDS

RANITIDINE 150mg PO qD/BID PRN
ALMAGEL 10-20ml PO QID PRN

NRT-See preprinted order

DISCLAIMER: The medication doses/treatments listed here are a guide only. Please consult the relevant updated guidelines and product monographs for correct/updated dosing. Pharmacy can be consulted to ensure safety.