MENTAL HEALTH (H+E)

Psychiatry Case Presentation

1) History
2) MSE
3) Physical Exam
4) Formulation
5) DDx
6) Management

Psychosis definition:

- Where the patient **incorrectly** evaluates the accuracy of their perceptions and thoughts and makes incorrect inferences about external reality (e.g. may hallucinate but can operate normally)
- RF: self-harm, homeless, substance abuse, PMHx

DDx:

- *Delusions* = firm fixed beliefs
- NMDA encephalitis
- Mineral issues- Cu (Wilson)
- Infection and drug use

Rx plan:

- *Stabilise Haem + de-escalate behaviour*
- ID medical cause
- Admit under MH act – scheduled? Sectioned?
- Call SW + NOK

Psychiatric History

Safety

- Check where duress alarms and closest exits are
- Obtain parental consent when interviewing child /adolescent

Intro

- **Explain purpose of interview** - *med student, really keen to learn more and become a better junior doctor*. Would I able to take a medical history from you?
- **Confidentiality** – "*I want to tell you that we discuss today is private, but if I feel that what you are telling me puts your safety or other's safety at risk, I may need to ask for further help. Would that be ok?*"
- **Obtain consent:** "*I'm going to ask a lot of personal questions today that may feel tough or tricky. If you feel uncomfortable or need a break, please let me know and we can stop.*"
- **If you/patient are feeling distressed** – *I'm wondering if this is unsettling for you, why don't we finish up here and I'll get one of the nurses to come and have a chat*"

PC

1. **DEMOGRAPHICS –** NAME, age, occupation, home life- *what do you do for work?, who lives with you?*
1. Presenting complaint **- Tell me about you? How can I help you? (avoid obvious questions)**

HPC

2. **When** were you last well? - what changed?
    1) **How** old were you when you 1st started **noticing** you had difficulties with your MH?
3. What are the **most troubling symptoms** for you right now?
    1) If I have a magic wand (which I don't), what do you think I could fix for you right now?
4. **Specific symptoms** (appetite, sleep, mood changes, weight)
    1) **Emotional -** mood swings,
    2) **Somatic/physical –** chest pain, SOB, palp, abdo pain, altered bowel habits
    3) **Behavioural** → concentration, irritable, flat, anhedonia
    4) **Cognitive_** → *?metabeliefs (beliefs about beliefs), persistent, episodes*
5. **Risk assessment (SAD PERSONS)**
    1) **Non-modifiable – (SAD)** → sex (male), age (older), depression
    2) **Modifiable – (PERSONS)** → **P**revious attempts, **Et**oH usage, **R**ational thinking, **S**ingle, **O**rganized plan, **NO** spouse/support, **F**uture suicidal plans

Diagnostic hierarchy

1) Organic
2) Medication / substance abuse
3) Psychotic spectrum disorder - *delusion, hallucination, hypomania, overvalued ideas*
4) Affective spectrum (e.g. depression – unipolar, bipolar)
5) Anxiety, PTSD, OCD and eating disorders
6) Personality disorders (PD)

SHx

Drugs /EtOH Hx ➢ Qty ➢ Why? ➢ With who?	➢ **EtOH**	**CAGE question – considered quitting, annoyed about drinking guilty, eye-opener**
	➢ **Illicit drugs**	What drug? ➢ When started? Who with? ➢ Last time used?
Forensic Hx	➢ Have you had any trouble with the law? – tell me more about that ➢ Previously driving under the influence ➢ If mania – *have you had any trouble with police before?*	
Developmental Hx	➢ **Hx of early family life**	• **Tell me about your upbringing in childhood** – where **ABOUTs** were you born? – *cultural background* • Who was in your family? Any separations • Complications in pregnancy/birth • Past-trauma/abuse/ACE – **Was there anything difficult in your childhood that still affects you now?**
	➢ **Personal relationships**	Tell me something about your personal relationships
	➢ **Work and education**	• How was school for you? How far did you get into school? • Have you had any trouble getting along with colleagues / peers? • What do you do for work? Do you enjoy it? • Are there are any challenges currently at work?
	➢ **History of traumatic events**	Were there any traumatic things that happened to you?
Social Hx	➢ **RELATIONSHIP status (*significant others*)**	• **What is your current living situations?** • Are you in any intimate relationship at the moment?
	➢ **Parental /carer status (*children, ages, contact, custody*)**	Do you have to take care of anyone at the moment?
	➢ **ADLs (*domestic tasks, personal care and mobility*)**	How are you managing things at the moment?
	➢ **Social support and network**	• **Is there anyone who supports you?** • Who would you call if you were in trouble?
	➢ **Financial status and occupation**	• What do you do for a living? • How do you support yourself?
	➢ **Accommodation (occupants, living situation)**	• Tell me about your living situation? • Who is at home with you?
	➢ **Domestic violence**	

PMHx

Past Psych Hx	1. **Time-course (Temporal nature)** = When were you **1st concerned** about your diagnosis? a. Acute vs gradual **onset AND** stable vs progressive (*has anything changed since 1st or index attack*) b. **Episodic** (how are they between episodes? – panic attacks, calm) vs **Persistent** (with or without fluctuations) c. When did you look up about your condition online? How did you feel? 2. **Severity = How many times were you admitted to hospital?** a. What were the **main diagnoses** that you understand you have diagnosed with? b. **How managed**? – *specialist looking after them? How has it affected your ADLs?*
PMHX	• **Endocrine** (thyroid, diabetes, pheo) • **Chronic issue** – CCF, **HTN (avoid SNRI, TCA)** Liver disease, CKD, IBD, Parkinson's, SLE • **Metabolic syndrome (T2DM)** → beware of use of **anti-psychotics (elevates BSL)**, insulin usage (over-medicate) • **Chronic pain / cancer**
Medications / Treatments (past/present)	• Check **compliance** → Misuse and polypharmacy usage • **Past consultations** (GP, psych) o Frequency, outcome, therapy (CBT, ECT) • **Lifestyle measures** (?effectiveness) • **Meds = Name, type and dose** (*BZD, Anti-psych, Anti-depr*) o Do you take it **everyday? (anti-dep)**, taken **PRN (BZD)** o **Caffeine, alcohol, cannabis, vaping**

Drug seeking behaviours

- Selling prescription drugs
- Forging prescriptions
- Doctor shopping
- Recurrent dose escalation
- Recurrent prescription loss
- Abuse of alcohol and other drugs

FHx

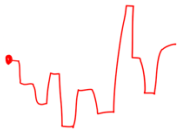
Family Psych Hx	**"Do you think anyone in your family has a psychiatric disorder or behaves similar to you?" (usu. OCD patients are right)** • Intergenerational trauma – ATSI • Depression + anxiety + Bipolar + schizophrenia + suicide + mood disorders • Recent sig. emotional event where family member is unwell
FHx	• Chronic pain

Mental State Examination (Psychiatric Physical Exam) – occurs DURING interview

Goal-directed

Circumstantiality

Tangentiality



Flight of ideas
?mania

Loose associations

Thought Blocking
"brief stop" ?schizo

Appearance (how they look?)

- **Age** & **Ethnicity** = appears younger/older than stated age.
- **Clean** = neatly groomed/shaen, unkempt, malodorous, signs of neglect **(hair, teeth, skin)**
- **Build** = emaciated --> thin --> normal --> overweight
- **Facial expression** = absent --> appropriate --> exaggerated
- **Artefacts** = tattoo, track marks, cuts, scars,
- **Dress** = dishevelled --> appropriate --> neat/immaculate --> bright / flamboyant /colourful

Behaviour

- **Attention**: distracted vs engaged vs seeker
- **Body language** - sedated (?drug-induced) psychomotor (agitation, tremor), Gestures/Tics/catatonia, rocking motion (?dissociated)
- **Cooperative** = - guarded -> normal --> overfamiliar / disinhibited
- **Eye contact** - absent, intermittent, acceptable
- **EPSE** - Parkinsonian, tardive dyskinesia, dystonia, akathisia
- **Posture / Pacing**
- **Response** = teary, deflective, defensive, intimidating, manipulative,

Mood (subjective - how patient feels)

- **How do you feel right now?**
- **How has your mood been in the last few days?**
- *dysphoric (depressed, irritable, angry)*
- *Euthymic (normal mood)*
- *euphoric (elevated, alated, anxious)*
- *Labile*

Affect (objective - stable vs labile)

- **Reactivity:** reduced --> normal --> increased
- **Quality :** depressed --> euthymic --> euphoric/elevated
  - *Anxious, irritable, perplexed, suspicious*
- **Range:** restricted --> normal --> expansive
- **Intensity of affect (spectrum from typical --> atypical)**
  - **Broad/full - normal (shows emotion they are feeling)**
  - **restricted - reduced emotion**
  - **blunted** - shows SOME emotion visually
  - **flat (nothing)** - shows NO emotion visually
  - **Fixed vs restricted vs labile** - degree of changing emotions
- **Congruence**: with mood vs content (incongruent = schizo?)
- **La Belle indifference (nonchalant)** = conversion disorder

Speech

- **Spontaneous vs latent**
- **Volume**
  - quiet (depression) vs loud (mania)
- **Rate/Speed**
  - slow (depression)
  - pressured = speaks quickly BUT still makes sense (NOT flight of ideas = many ideas unrelated to each other)
- **Rhythm/ Quality** -
  - **Articulate**
  - **slurred (enceph?, PD?,** MDD (psychomotor) or intoxicated**)**
  - Prosody - musicality of language
- **Quantity**
  - **Poverty of speech** (speaking a lot but does not make sense (depression),
  - Excess (mania, schizophrenia)
  - Longorrhea = XS repetition in topics
- **Tone**
  - monotonous (depression, psychosis, autism),
  - tremulous /stuttering (anxiety),

Thought Form and content

- **FORM (HOW are they thinking?)**
- **Linear and Goal-directed (logical vs illogical thinking)**
- **Circumstantiality** (takes a long time to make point - over inclusion of trivial details)
- **Tangentiality** - on topic then indirectly off-topic (no answer to question)
- **Flight of ideas** (concescutive thoughts moved from idea to next - pressured speech)
- **Thought blocking** (suddenly stop),
- **Perseveration** - repetition of phrases and ideas/actions out of context
- **Echolalia** = patient repeats words from therapist
- **Loose associations (derailment)** - logical flow then breakdown (words make sentences but sentneces don't make sense)
  - **Clanging** = sentences continue based on sound asscoiations rather than meaning
  - **Neologisms** = new words
  - **Word salad**- random string of words with no relation to one another

- **CONTENT (WHAT is the main theme)**
- **Theme types** (depressive, guilt, hopelessness, regret, homicidal, persecutory, grandiose, jealousy, erotomanic, somatic, mixed, religious, paranoia, nihilistic)
- **over-valued ideas** (acceptable idea that dominates their life)
- **Delusions** (firm fixed unshakeable beliefs about education, culture and social issue)
  - **somatic passivity phenomenon** = delusion of someone controlling their actions
- **Ideas of reference - innocuous bleiefs referred to have direct personal significance**
- Misidentification (capgras, fregoli's, intermetamorphosis, doppelganger)
- **obsessions /compulsions**- (persistent intrusive thoughts/idea/images causing distress)
- **phobias/plans/suicidal ideation** (thoughts of self-harm) => sexual safety / financial

- **POSSESSION (Thought alienation)**
  thought insertion (thought inserted into patient's mind),
  thought withdrawal (thoughts removed from patient's mind),
  thought broadcasting (pts believes their thoughts are understood by strangers without telling them) - thoughts read by others

Perception

- **Hallucinations = abnormal** (Can you **hear, see, touch and/or taste** things that other people cannot? - specific to person) - running commentatory, commands (big risk)
  - **MOST auditory** (?# of voices, 2nd or 3rd person (known?), gender)
  - Pseudo-hallucinations - same as hallucinations but patient AWARE it is not real
- **Illusions = normal** (misperception of external sensory stimuli e.g. thinking wire is a snake)
- **Dissociative / Depersonalisation** (patient no longer their "true self" and are someone different - "do you ever feel that you are not real or recognise the person you currently are?"
- **Derealisation** (do you feel this world around you isn't real?) -

Cognition (exc. delirium)

- **Orientated to Current date (DD/MM/YY), people and location (place, suburb country)**
- **Cognistive testing: MMSE, MoCA, RUDAS, ACE-III**
  - **Attention span** - say days of week backwards or subtract 7 from 100
  - **Short-term memory - 3-item memory recall (apple, basket, coat) + naming (language)**
  - **Semantic memory** - DOB, name of PM, US president that got killed
  - **Frontal lobe** = Luria's test (fist --> edge --> palm),

Insight & Risk

- **capacity to recognise and appreciate their problems and the implications of their problems.**
  - Insights into symptoms? into illness? need for Rx?
  - **Do you think you have a problem? - pre-contemplation**
  - Do you think you need help? Have you sought for help?
  - stages: 1) denial 2) slight awareness 3) blaming other 4) aware illness caused by something unknown 5) intellectual insight (cannot adapt) 6) emotional insight (can modify behaviour)
- **Are there risks of suicide and self-harm? ==> SAD PERSONS QUESTIONS**
  - Previous attempts --> EtOH intoxication --> Rational thinking / hope --> Single --> Organised plan (access to weapons location) --> NO spouse, social support, --> suicidal attempts

Judgement & Risk

- Assess what patient has said so far?
  - What would you do if you smelt smoke in your house?
  - What would you do if you had to cross the road?

General physical	General Ix
• General inspection – Vitals • CVS / RESP / ABDO • FULL NEURO – (esp. if TBI) • THYROID EXAM	• **Bedside** – ECG, Urine dipstick, bladder scan • **Bloods** – FBC, EUC, CMP, LFT, BSL, HbA1C, TFT, lipids, • **Septic screen (if febrile) –** CXR, urine M/C/S, swabs, blood culture (peripheral and central), STI? • **Urine drug screen** AND **STI screen** • **Infection** – HIV, Hep B/C, serology • **Imaging –** non-contrast CTB, MRI • **Additional →** autoimmune, , EEG, LP, porphyria, Wilson's (Cu), Mg, PO4

Formulation of judgement (5 P's)

4P factor model	BIOPSYCHOSOCIAL APPROACH		
	Biological	**Psychological**	**Social**
Predisposition (risk factors)	• **Genetic** (*bipolar, suicide, depression)* • **FHx** • **Age** • Gender • Sexual orientation • **Birth Trauma** • **Brain injury** • **Illness psychiatry, physical (e.g. concussions)** • **Meds** • **Drugs/alcohol**	**Attachment style (adult)** • **Secure -** nil • **Dismissive (self-reliant)** – avoids/*underreports or suppresses Sx (feels that they do not need help)* • **Pre-occupied –** Sx exaggerated and anxious to attract attention paradoxically distancing carers • **Fearful/disorganised -** unpredictable **Feelings of _____ since childhood** • **PERSONALITY** = Low self-esteem, *Invalidation, abandonment,* isolation, insecurity • **TEMPERAMENT** = ?unable to modulate affect or continues to have rigid/negative cognitive style **Family behaviour /mental hx and structure** • Modelling or rebelling against parent's behaviours	• **Hx of Trauma** (early *parental conflict/divorce)* • **Witnessed** domestic violence, maternal depression, antisocial traits • **Unstable home life –** abusive parents, low SES • **Hx of immigration , racism, discrimination,** • **Late adoption** • **Chronic job stress**
Precipitation (trigger event)	• **Meds** (misuse, non-adherence, poor response) • **Trauma** • **Major treatment/procedure** • **Drugs/ EtOH (recent use, qty, freq)** • **Acute illness (onset)** • **Onset of medical disorder** • **Pain** • **Sleep deprived**	**Stressors (new lifestyle / job / joined gang) that create** • **Cognitive** – chronic negative thoughts • **Dialectical** – emotional dysregulation, poor distress tolerance • **Interpersonal** – attachment difficulties, dysfunctional relationships / or interpersonal conflicts/ disagreements • **Psychodynamic** - recurring theme throughout one's life, primitive defences	**Loss/instability/NEW of:** • **Work** • **Finances/ SES** • **Relationships (**e.g. relationships) • **Accommodation** • **Support (GP, family)** • **Natural disasters**
Perpetuating (barriers)	➢ Substance misuse ➢ Chronic physical illness ➢ Immunosuppression	➢ Coping style ➢ Social support ➢ Compensatory behaviours ➢ Negative / maladaptive thoughts ➢ Avoidance behaviours	➢ Work/life rigidity /schedule ➢ Financial obligations ➢ SES ➢ unemployment
Protective (strengths)	• **Physical health** (*diet, exercise, sleep, smoking, alcohol)* • **?Medically healthy** • NO substance abuse • NO FHx of psych • Intelligence / talents	• **Engagement** • **Insight** *about conditions (e.g. delusions)* • **Adherence –** previous good response to therapy • **Coping strategies -**can modulate affect, • **Intelligence –** psychologically minded, reflective and capacity to change thinking	• **Work** (desire, support) • **Positive Relationships** • ***Social involvement*** *(church, hobbies, religious beliefs)* • ***Outpatient healthcare team*** ***(****GP, psych, social or case worker****)***

Present formulation & Prognosis

(Why *is this* ***particular person*** *presenting in this* ***particular way*** ***at this point in time (with these symptoms)*** *and what can we anticipate might happen in their recovery in the future****)***

Who? Issue?	***A XXX yo [occupation] admitted to XXXX presents with:*** ➢ *low mood?,* ➢ *Deliberate polypharmacy overdose* ➢ *1st episode of psychosis*
Context? What was Precipitating factors?	***In the context of:*** *1) loss of life/job/pet/house,* *2) separation/abandonment,* (partner of XX years) *3) medication failure/non-compliance,* *4) immigration,* *5) relationship/marriage breakdown,* *6) substance OD/WD,* *7) re-experiencing of trauma*
Current Bg	***> notable PMHx or psychiatric hx of****: _____ (inc. repeated hospital admissions)* *> genetic vulnerabilities for mental illness in her family history,* *> medication compliance (sub-therapeutic, poorly compliant)* *> long-standing substance abuse? Alcohol use?*
Predisposing & perpetuating factors	***XXX has biological /social predisposing factors including:*** ○ *FHx of depression? , alcohol/substance use disorder in the family* ○ ***Childhood trauma characterised by:*** *abuse, parental divorce, unstable home life, history of trauma / neglect (sex, emotional, physical)* • ***Which has contributed to her psychological struggles of:*** ○ *Fears of abandonment, invalidation, self-worth, self-esteem, external criticism* ○ *Temperament / personality* (dependent, invalidating experiences, unable to develop personal identity) ○ *Attachment difficulties → secure > preoccupied > dismissive (avoidant) > disorganized* • **These struggles are reflected in her adulthood leading to them to** think/ experience**:** ○ They are…, Others are…, The world is… ○ **Biological factors (**co-morbidities, ongoing alcohol abuse**)** ○ **Social (**financial struggles**,** unstable relationships**)** ○ **Psychological (**maladaptive Coping strategies, personality trait**s)**
Protective factors	**However, she displays a number of protective factors including"** • Social support, insight, coping skills, high functional status, adherence/compliance, engagement • Previous successful psych intervention
Prognosis	**Hence, I believe her overall prognosis is good/poor and will likely benefit from** • non-pharm strategies - CBT, positive lifestyle interventions, support groups, promote social interactions etc. • Pharm: SSRI, anti-craving agents

(1) Risk Considerations

Questions to ask

- Do you have suicidal thoughts or thoughts to hurt others (past vs present)
- Any plans to act on these thoughts?
- Do you feel safe at home?
- What would happen if you were to go home now?
- How do you feel at the moment?

Pre-disposing/Active

- Risk of self-harm, suicidality and harm to others (past, present and future)
  - Organised plan vs unplanned
  - Access to weapons!! (guns = report to police to determine if registered)
  - Harm to children, family, community
- Previous Forensic Hx – incarcerated, investigated.
- FHx of suicide, substance abuse and MH illness

Perpetuating

- Current MSE – guilt, regret, hopeless, paranoid, labile, disinhibited in actions/words
- Lack of insight, impulsivity and empathy, personality disorder
- Poor coping skills
- Medication non-compliance /adherences
- Low SES – housing, financials, occupation

Precipitating / triggers

- ?Loss of protective factors
- Loss of housing, occupation, significant other

(2) Risk Formulation

Understand the considerations and ask:

- **How serious is the risk**? Low, mod, high
  [have a low threshold to stratify higher]
- **How immediate is the risk**? Acute, chronic
- Is the **risk specific or general**?
- How **volatile is the risk**? Predictable, unpredictable
- What are the **signs of increasing risk**?
- Which **specific Rx or Mx plan**, can **BEST** reduce the risk?

NB: even if a person appears completely 'fine' after separate consultations, they still may be at risk since predicting suicide will almost always be difficult

(3) Managing Risks

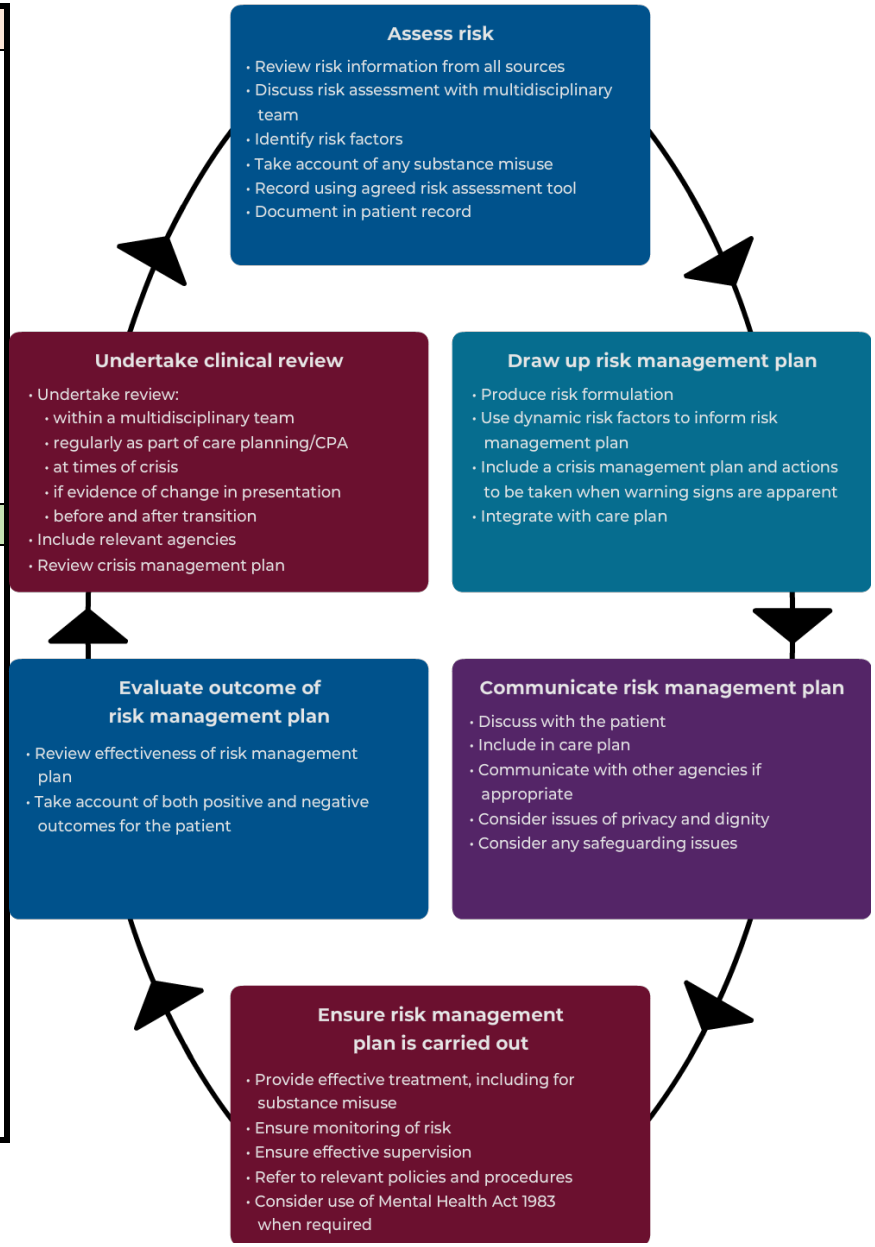
Aim to make the patient feel safer and less distressed (esp. use of empathy and compassion)

Key points

1. Need for ***scheduling*** under MHA 2007**? –** *do they have capacity --> under mental illness*
2. ***Detail level of observation*** need
3. Good ***communication*** with patient, carers, GP and healthcare team
4. ***Documentation*** of treatment plan
5. ***Any plans*** for social recovery and therapeutic optimism
   1) Outreach programs
   2) CTO
   3) Care programme

Mx pearls:

- Switch to agents that have least addictive potential
- Beware of co-morbidities
- Exclude or reverse organic causes



Mental health laws (NSW)

NSW MH act 2007 "schedule or section"

Vic MH act 2014 "section 351" (SLIGHTLY DIFFERENT)

3 criteria needs to be reached

1. ***Patient is DEEMED Mentally ill*** or ***Mentally disordered***
2. Significant **risk of self-harm** or harm to community DUE TO ABOVE
3. ***Least restrictive care that is safe and effective requires hospital admission*** *as patient cannot be safely managed in a community setting*

*Must be seen by a facility doctor not later than 12 hours after it is decided to keep you in the facility

Not applicable if:

- *Homeless*
- *Religious belief*
- *Political views*
- *Anti-social behaviours*
- *organic cause → intoxication, dementia or intellectual disability*

Process

1. Fill out **schedule 1** as JMO under advice from psych reg
2. Psych reg / consultant fills out **Form 1 for** admission or transfer to designate healthcare facility

	Definition	Process
MI	hallucinations, thought disordered, severe mood disturbance with **known mental illness**	1. Kept until **MH inquiry** (held ASAP – usu. held once every 2 wks) **2. MH tribunal** (to revoke or issue **inpatient treatment** order up to 3/12 or CTO up to 12mth
MD	severe disturbance out of character and **transient** (*e.g. acute crisis, acute psychosis, drug-induced, including those who have committed an offence*	**Kept up to 3x days AND seen at least once every 24 hrs** (*exc. weekends, public holidays*) Nb: cannot be detained as MD more than 3x in any mth

Purpose:

- **Can be revoked at anytime** if deemed safe
- 2x doctors (one a psychiatrist) need to be **INVOLVED** in decision making process and support capacity/autonomy of patient make decision regardless if involuntary/voluntary and how unwell/well → **imbue empowerment, motivation and control**
- **Interventions (e.g. ECT) can be given against will if deemed appropriate by tribunal**

Who can enforce?

- **Doctor**, paramedic, police or MH worker or family/carer (**S19**) (S20) (S22) (S23) (S26)
- **Must sign schedule and SPECIFY** if mentally ill or mentally disordered to ensure patient can be legally arrested by police
  (NO schedule signed = NO police assistance to help track down patient and bring back to hospital if they choose to leave

Importance of s73-79 – sharing info?

- Authorised JMO/SRMO **must** share info about:
  - Why detained, length of stay, to MH services
  - Shared with designated carer and primary care providers
- Any surgical intervention requires MH review tribunal to obtain consent

Guardianship Act

Pt **lacks capacity to make decision** about medical Rx, financial affairs or both (order of power below)

1. Advanced care directive
2. Enduring Guardian > Spouse > unpaid carer > friend / relative
3. Guardianship tribunal

Initial orders for up to 3 years at first before renewal for 5 years

Maximise patient autonomy

- Least restrictive environment
- Made by suitable person (family, kin) or public guardian
- Patient > PoA > spouse/unpaid carer/friend > MH tribunal

Protected Estates Act

Allow provisions for management of property and affairs of person who cannot manage own affairs

- Mentally ill people with addictions

Protective offices (**MH review tribunal**) makes decisions regarding – rent, accommodation, fees charge

- Ensure patient has roof over head

Mental Health (forensic provisions) Act, 1990

Assess **fitness** of mentally ill patients for trial

- Stepping stone to section 14 (medical and cognitive impairment act)

If unfit, will they be fit in one year

- Psychosis (sometimes)
- Intellectual disability /dementia (unlikely)
- May req. "no-bill" or special hearing w/ not guilty plea

Crimes Act

- **Involuntary intoxication** (e.g. stillnox, EtOh) – patient may not recognise intoxication when taking
- **Concealment of crime –** notify only if RoSH
- **Sexual abuse / touching**
- **Coercion for suicide**

- Medical negligence (duty of care)
- Offences related to capacity of victims, victims in care (including coercion to commiting suicide = offence)

Self assessment question 1

TRUE OR FALSE

Depression

1. Is usually part of bipolar disorder
2. Can be distinguished from normal grief
3. Can usually be identified in people who go on to commit suicide
4. Can be diagnosed using biological markers
5. Is a syndromal diagnosis based on the presence of 5 symptoms for two weeks

Answers: F,F,T,F,T

Self assessment question 2

TRUE OR FALSE

Anxiety disorder

1. Is the most common type of psychiatric disorder
2. Can be readily distinguished from depression
3. Is usually caused by childhood trauma
4. Usually responds to evidence based psychological treatments
5. Is defined by the presence of a disabling level of irrational fear

Answers: T,F,F,T,T

Self assessment question 3

TRUE OF FALSE

Schizophrenia

1. Is typically a neurodegenerative disorder
2. Presents with a split personality
3. Is caused by an imbalance of dopamine in the brain
4. Responds to treatment with medications that block the dopamine receptor
5. Is a syndrome of perceptual disturbances, abnormal beliefs, communication disorder and loss of volition

Answers: T,F,F,T,T

What is a CTO (community treatment order)?

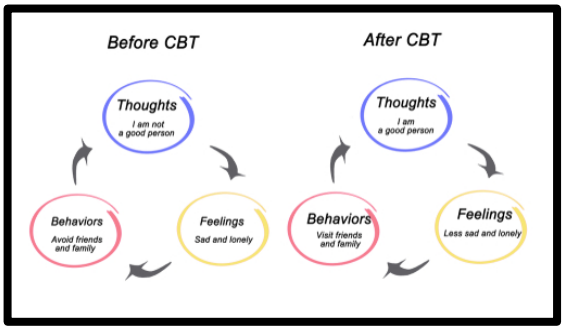
Legal order made by the MH tribunal entailing a specific treatment and management plan a patient must comply with (e.g. appointments, depot injections) to allow a patient to be treated outside of the hospital.

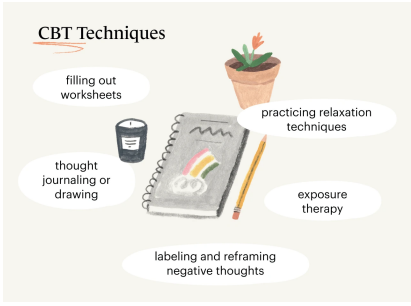
- CTOs can be from 6- 12 months and can be issued within the hospital or while in the community
- Renewal of CTO must be initiated before the CTO expires by the treating medical team and approved by the MH tribunal

*If the patient **breaches** this order (e.g. absenteeism, refusal for medications):*

1. **Verbal** warning (e.g. from case manager)
2. **Written** notice (aka breach notice from case manager)
3. **Detainment and transport to hospital for assessment, treatment, admission or discharge** (+/- assistance from police, who have the right to enter the patient's premises)

TYPES OF THERAPY / MANAGEMENT



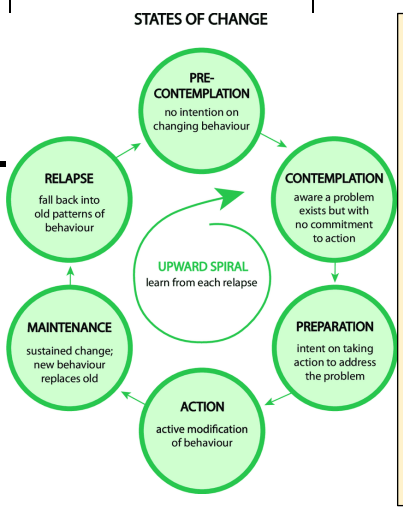


	CBT (cognitive behavioural therapy)	Dialectical behavioural therapy (DBT)	Acceptance and commitment therapy (ACT)	Graded exposure or trauma focused therapy	Flooding
Define	Umbrella term for many types of therapies	Type of CBT (most similar to CBT)	Type of CBT	Type of CBT	Type of CBT
Length	Can be **short or long -term**	Long-term	Long-term	Long-term	Short-term
Process	Centred around pt recognising connection between triad of: **Thoughts, Feelings, Behaviour** • **Compressed 6-8x** sessions (can be group or individual • **Over 12-20 weeks for 3-6/12** • Aim to set up for success • **Session 1-2** = goals (pt directed) • **Session 3** – achieving targets (from easiest progressing to hardest) **Homework may be given if it is in line with patient's character and perceived to be effective*	Develop strategies that combine the emotional and rational mind to **work together** (not in isolation) ➢ **Mindfulness mediation –** regulate emotions more effectively ➢ **Emotional acceptance of** who they are (accumulate positive mind, build mastery, cope ahead) ➢ **Build DISTRESS tolerance skills** to regulate emotions ➢ **Improve interpersonal relationships -** Objective (assertive/ negotiate) Relationship (gentle, interested, validate, easy going), self-respect	➢ Aim to **recognise and learn to accept** cognitions and emotions rather than control them ➢ Using **metaphors, stories and experiential exercises** to illustrate the uncontrollability ➢ Enable pts to tolerate thoughts and allow them to come and go without struggling with them ➢ Observing self and setting realistic goals **4 A's** ➢ Awareness ➢ Acceptance ➢ Action ➢ Adherence	➢ Keeping diary ➢ **Learn Calming techniques** (relaxation, breathing) ➢ **Small series of 'exposures'** to riggers ➢ Keep SUDs at comfortable level for patient (e.g. 20-40%) and gradually increase	➢ **Exposing the patient to worst fear for** intentionally prolonged period of time ➢ Kept At high SUD (subjective units of distress scale) to 100%
Adv	➢ Improved better long-term prognosis ➢ Reduced relapse rates (compared to use of SSRI) ➢ Evidence based	Same as CBT (general)	Same as CBT (general)	Same as CBT (general)	Works fast if effective
Disadv.	➢ Requires commitment ➢ **NOT for**: cognitive impaired, pt dissatisfaction, floridly intoxicated, organic brain injury	➢ Relies heavily on validation / needing to accept uncomfortable thoughts ➢ Requires commitment		➢ Requires commitment ➢ May not be for everyone	➢ If fails – hard to correct
Indication	➢ Anxiety disorders (esp. specific phobias) ➢ Depression ➢ Substance abuse ➢ Eating disorders ➢ Personality disorders ➢ Childhood conduct disorder / ADHD ➢ Chronic pain	➢ **PTSD and C-PTSD** ➢ Major depression ➢ **Cluster B disorders** – esp. borderline personality disorders	➢ **Complex grief** ➢ **Depression** ➢ **Substance use disorders**	➢ **Specific Phobia** ➢ **Eating disorder** ➢ **OCD** ➢ PTSD	➢ **Specific Phobia**

*SUDS = subjective units of distress scale (0-100%)

What is the difference between psychotherapy and CBT?

- Psychotherapy focused on a person's **past** and ID cause while CBT specifically focusing on the problems and difficulties in the **present**,
- CBT aim to **eliminate** negative thoughts and focus instead on **positive behaviour**, which leads to positive thoughts, creating a **virtuous circle**.



Motivational interviewing:

- Collaborative, non-confrontational **approach** NOT Rx that is patient centred to empower patient to commit and take action
- Involved in pre-contemplation and contemplation stage
- **Indication** – substance use disorders, lifestyle, medical screening, med compliance

5 main principles

- Express empathy
- Develop discrepancy
- Avoid arguments
- Roll with resistance
- Support self-efficacy