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## 1. Angry/anxious relative or patient

ENTER – SHOW BADGE TO EXAMINER, nod and quiet *“Thanks”* (start off well!)

As you go in the station the relative/patient will often be standing up.

*“Hello my name is Dr -----, Thank you so much/very much for agreeing to see me today, do you mind if I take a seat. (you sit down)”*

(This is the simplest way of starting off for almost all stations. If you stand up for too long talking then it looks confrontational. If they are calming down invite them to sit down but not before as they will just refuse and it's not smooth! If they refuse to sit down don't repeat the invite!)

*“First of all thank you so much for coming to see me today. It's so important that there is good communication between patient relatives and the psychiatry team. It's something that we really value.”*

*“I can't imagine how difficult it must be as a mother/ father/ sister/ carer etc to see your mother/ daughter/son etc suffering like this.”*

If angry with another staff for not caring/communicating. *“I will talk with that member of staff straight after”* and/ or *“Thank you for telling me. It is really important that we know this. We will look in to it as soon as possible.”*

Eg: side effects of medications;

Mention that we do have an official complaints procedure if you wish to take this further.

If: *“I'm leaving”* then reply:

*“I can see that you're really anxious, perhaps we could sit down and talk about it. Im here to help. You're in a safe place now.( if mentally unwell)”*

DO NOT BLOCK THE EXIT IF THEY START TO LEAVE!!

If: *“I'm not mad Dr”* then reply:

*“I'm absolutely not suggesting you are mad but I can see that you are suffering and I'm here to help. It must be very distressing for you; perhaps we can sit down and talk about it.”*

If: *“can you get me off the section?”*

*“I do understand your concerns but the decision to remove the section is not just up to me, it's more of a team decision. I can assure you that as soon as it is felt by the team that you no longer need to be on a section then it will be lifted. Have you been told how you can appeal against the section?”*

If: *“I wanted to speak to a male / female Dr”*

Reply: *“I'm sorry there isn't another doctor available right now, but we could ask for a male/ female nurse to be present if that's ok? May I ask why you feel uncomfortable with a male/ female Dr?”*

Then just continue the interview with something like *“...you seem quite distressed at the moment, could I ask what's been troubling you?”*

**Tip:** To increase the sense of empathy lower the tone and volume a bit of your voice and look extra attentive with eye contact at the patient/relative. This makes you sound much more convincing!

**Tip:** Ending the stations – when you hear the bell start thinking about wrapping the station up. This is an art! Ideally a perfect short 3 line summary with an ST4 level twist at the end. The ST4 twist the examiners are looking for is a hint of your basic management of the situation you have encountered in the station. This management bit changes your level from old OSCE to new CASC!

If you find it difficult to summarise, come up with a standard quick line like:

*“We have touched on a number of important issues here which I would like to explore further with you in greater depth. We need to look carefully at safety, your support networks and some of the help that we can offer in our service (psychology, carers assessment, Occupational therapy, medication options, etc.)  
THANK YOU VERY MUCH FOR TALKING TO ME TODAY I REALLY APPRECIATE IT”* (very important to thank the actor)

FINALLY LOOK TO THE EXAMINER, NOD AND MUMBLE A QUICK THANKS!

## 2. Cannabis

- Long term use associated with double the risk of developing **schizophrenia**
- Starting regular use before age 15 associated with 4X risk of developing schizophrenia.
- An Australian study has linked regular cannabis use in 14/15yr olds to increased risk of developing **depression** over 7yr period.
- 3 out of 10 in the UK have used cannabis at some point.
- 6% in the UK are current users.
- ¾ get cravings if heavy users of cannabis.
- Problems with **pregnancy** – eg small babies
- Problems with **fertility** – low sperm count
- Removal of cannabis would reduce the amount of Schizophrenia by an estimated 8%

### Intoxication

- Red eyes, dry mouth, difficulty speaking, coughing, poor driving.

### Withdrawal

- agitation , insomnia

Help – Drug and Alcohol service, [Talktofrank.co.uk](http://Talktofrank.co.uk), Home Office website re quitting-

1) find reasons why to give up 2) find ways how to 3) prepare for withdrawal 4) back up plan.

### 3. School refusal

How old is XXXX? Did he not wish to come to the appt? Who's looking after him now?  
Known to CAMHS/ Social services?

**Start** – link

Duration

Childs view of cause/ Parents view/ schools view

Refusing other situations?

**Note:** if separation anxiety then anxious leaving carer in all situations. Follows carer at home, worries about safety of carer.

**Risk** – self/ to others / from others / neglect

D and A

Impact – home, school – academic, friends –truant??

**MSE**

Mood –low?

Psychotic?

Anxiety - bullying? Checking/washing/counting? Something about that school or teacher?

Developmental Hx

Psychiatric Hx

Meds

**PMHx**

FHx

**Management**

- graded back to school
- liason with school, addressing bullying.
- May need to involve educational social worker and educational psychologist.
- Incentives for going to school
- If falling behind consider group tutorials.

## 4. Conduct Disorder

Name, age, known to CAMHS/Social services? Where now and who is looking after?

Start date (before age 10? = early), link with anything? (Is it adjustment- onset less than 1 month after stressor and less than 6 months duration?)

- violence to others (incl. sexual )/animals
- destruction of property
- deceitfulness/stealing
- break social rules – run away overnight x2, truant under 13yrs, out late under 13yrs  
(need 6 months of this behaviour for ICD10)

Accepted by peers?

Reading disorder?

ADHD symptoms? ( hyperactive, can't keep his mind on things he enjoys, impulsive – interrupts, doesn't wait his turn)

**Risk** – to self, to others (bullying, fire, sexual), from others, neglect.

D and A

Impact – family, school – academic, friends, bullying

### **MSE**

Depressed?

Psychotic?

PTSD/ Adjustment

Developmental Hx – Statement of special needs? Mainstream school? Preg, delivery, early dev.

Psychiatric Hx

Meds

PMHx – epilepsy, HI

FHx – criminality , mental illness.

### **Differential diagnosis**

Subcultural deviance

Adjustment disorder

ADHD

Mood disorder

Psychosis

LD/Autism

### **Management**

*Child focused*

- Anger management and social skills training.

*School*

- School liaison- address bullying/truancy, educational psychologist, education social worker . Remedial teaching if reading disorder.

*Family*

- Parent management training (if under 12yrs) - clear rules and boundaries, consistent and positive approach to child.
- Multi systemic therapy ( low caseload 3 months intensive, changes the environment)
- Family counselling, family therapy? And social services (for £, accommodation etc.)



## 5. Overdose (OD) and Sexual abuse

*Thank you for meeting with me. I know it can be very difficult to talk after taking tablets so I really do appreciate it. Pause.*

*Would be able to tell me how long you had been planning this overdose please?  
(If impulsive – had you been drinking?)*

*Any suicide notes? Any preparations for your death like saying goodbye to people (if older include paying bills)*

*Where did you take the tablets? Did you lock any doors/windows/ make sure nobody would find you?*

*How did you get hold of the tablets?*

*Did you think this many tablets would end your life?*

*What happened next? How did you come to be in hospital? Did you let anyone know?*

*In hospital did you accept treatment?*

*Are you disappointed it didn't end your life?*

*How do you feel about ending your life now? Would you feel safe going back home?*

*Would you feel safe on the ward?*

*What do you think triggered taking the tablets?  
(She will say nothing)*

*Who is at home normally?*

*It must be difficult with your mother being away.*

*How have things been with your stepfather?*

*You seem very distressed, has he been abusive to you in any way?*

*Physically or sexually?*

*(She hands over the note, or you just notice it in her hand!)*

*That's absolutely terrible; no wonder you are so distraught.*

*Thank you for being brave and telling me this. That's a very distressing word. It's best that we don't go into the details of what happened as such right now, but I would like to know what you understand by that word.*

*Are we talking 1 time or more?*

*Do you think your sister/brother etc. is safe?*

*Thank you. I will speak to the hospital's child protection officer who is specially trained for this situation. You mustn't worry that from here we will work to keep you safe.*

### **Management**

- speak to nurse in charge
- Inform child protection officer – will liaise with police
- Social services will be involved – will liaise with police
- inform consultant.
- Special child protection interview takes place. If intercourse suspected – paediatrician examination may take place after.
  
- Child may be placed under emergency protection order or police protection order for child to be in a safe place. A child care order may have to be considered.

To father/abuser

- I've had to speak to social services about concerns we have. I can't give further details at this point unless social services give us permission.

### **Sequelae of sexual abuse:**

Short term – Social isolation, depression, anxiety, sexualised behaviour

Long term – low self-esteem, self-harm, impact on relationships, link with eating disorders and PD.

## 6. ADHD

Name, age, mainstream school? Couldn't come to appt? with? Known to CAMHS or social services?

Onset, link?

- overactive – please give example
- keep his mind on a task – please give example
- can't wait his turn – please give example

More than 6 months at home **and** at school before age 7?

**Drugs and Alcohol? Impact** – friends, academic? Home – on family. **Risk** to self – from e.g. crossing road, risk to others – bullying? Risk from others – bullying? How do you control his behaviour? Do things ever get physical? Neglect? Is he missing meals, not washing etc. due to this?

### MSE

Depression/mania

ODD/CD – What does he do when you say “no” to him? Is he more naughty than other children? What's the naughtiest thing he's done?

Tics – unusual movements?

OCD – checking/ washing/ symmetry?

Psychosis – saying anything strange or bizarre, appearing to be responding to a conversation when there is no one in the room.

Dev- prob in pregnancy, birth or early development . Delay in walking or speech? Loss of skills? Special needs? Play with others? Unusual interests?(autistic spectrum)

FHx – siblings? ( siblings have 2 X the risk if one has confirmed ADHD)

PPHx

Meds

PMHx – HI, epilepsy, sensory impairment?

**Classic questions:** Is it my fault? *“It's not your fault or xxxxx's fault. We really must focus on how we can support you both now.”*

I heard ADHD was caused by food additives? *“In a minority of cases food additives may play a role but we don't routinely recommend their elimination. If you think that there may be a link in your son's case we recommend the use of a food diary. If the food diary suggests there is indeed a link we will then make a referral to our dietician.”*

### Assessment:

- see child, examine child,
- With permission gather info from school.
- Connors rating scales<sup>1</sup> and strengths and difficulties questionnaire for parent and teacher

### Management

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<sup>1</sup> <http://www.attentiondeficit-add-adhd.com/adhd-connors-test.htm>

- Stepped care approach.
- Refer to parent skills course if suspect
- Mild- consider watchful waiting. Advice on balanced diet and reg. exercise.
- If moderate consider in addition, group (or individual if older child) CBT for child
- If severe, 1<sup>st</sup> line is stimulant medication – esp. methylphenidate (90% respond- esp. hyperactivity and attention)
- (but beware stimulant diversion, and if tics.)
- 2<sup>nd</sup> line medication Atomoxetine
- If medication refused then go for CBT.
- Consider Melatonin for sleep problems.
- Carer's assessment- practical and emotional support. Leaflets, support organisations e.g. ADDISS

### **Methylphenidate**

- Side effects – decrease in appetite, abdo pain, headache, dry mouth, irritability.  
Growth suppression
- (so try and take with food, also consider drug holiday on weekend and school holidays)
- caution in thyroid problems, cardiac problems, glaucoma, epilepsy
- In clinic gradually titrate up over 6 weeks. Monitor pulse and BP and measure height on a centile chart and review Connors scale. Then review at least 3 monthly.

### **Atomoxetine**

- Side effects- nausea and abdo pain, dry mouth, rare liver problems (1 in 50,000), painful passing water and sexual dysfunction.

**Prognosis** – one quarter of children with ADHD will have ADHD symptoms at age 30

## 7. Tics

Name, age known to CAMHS or Soc Services?

*Describe it please.*

*When did it begin? Link onset with anything?*

*Movements only or movements and sounds?*

*Is it done on purpose? Can it be controlled at all?*

*Does it serve any purpose?*

Vocal tic- any swearing, parroting speech (own or others)? Complex sentences?

Motor tic- any swearing gestures? Complex actions?

**Note:** if less than 1 yr then it's a transient tic. If pure motor or vocal tic for >1 yr then it's a chronic motor/vocal tic. GTS needs multiple motor tics and at least one vocal tic lasting >1yr with no remission of >2 months. Around 50% have ADHD and 50% have OCD so look for these. It's tricky to distinguish a tic from an OCD compulsion. Generally in GTS there will be simple tics too though.

Tic onset peak age 7; 80-90% resolve within 5yrs.

GTS M:F 3-4:1

### MSE

Screen quick for ADHD – *hyperactive? Impulsive? Able to stay focused?*

Screen for OCD – *checking/ washing/ counting/ symmetry/ hoarding/ frequent reassurance*

Depression – *seem down/miserable? Able to enjoy things?*

Psychosis – *saying anything strange or bizarre, appearing to respond to imaginary conversations?*

### Developmental History

– *Problems in pregnancy, birth or early development? Delayed speech? Plays with others?*

*Special interests?*

PPHx

Meds

PMHx – HI, epilepsy?

**Impact** – family, school – academic/ bullying/friends

Drugs and Alcohol – I know it's unlikely but could he be getting his hands on Drugs and Alcohol from older children

**Risk** – to self, to others –bullying, from others – bullying, how do you control his behaviour at home, does it ever get physical?, neglect

### Plan

- Need to see child, examine, and do some tests.
- With permission liaise with school

- Involve paediatrician
- Treatment is stepped care approach i.e. depends on severity
- Mild- consider watchful waiting, if more severe then CBT with Habit reversal training (HRT) where competing action is practiced which is incompatible with tic e.g. deep breathing when you feel the vocal tic is coming on, or Massed Negative practice (deliberate over practice of tic movement)

## 8. Autism worries coming from parent

How old, mainstream school? Known to CAMHS/Social services?

Quickly why does she believe child has autism?

Shall I explain a little about autism and then see how this applies to your child?

Childhood autism is one of a group of problems with development

Affects approx. 6/10,000. There is a spectrum of autistic features though with up to 1% of the population being affected.

3 main areas affected:

- i. Verbal communication
- ii. Social Interaction
- iii. Restricted interests and repetitive behaviour

For childhood autism these features must be present before the age of 3.

*Let's see if these relate in any way to your child.*

*Any problems in pregnancy or delivery?*

*Any delay in walking? When?*

*Any delay in speech? When first words? How about now? Parroting? Pointing? Unusual gesturing? **Gaze** avoidance/unusual angle of gaze?*

*Interaction with other children? Prefers own company? What games? Has he ever done **pretend play**? How does he react to you **cuddling** him? Does he ever come to you when he's **hurt**?*

*Unusual interests? **Reaction to change**? Unusual relationship with toys? Interest in twirling/spinning? Hand movements?*

**PMHx** - Unusual physical characteristics?

**Any loss of skills?**

Has he had his **vision/ hearing** checked?

Epilepsy? (Though peak for autism is age 11-14, while in LD it's earlier)

If time explore Impact, risk, MSE

**Plan** – will need to see child, and examine, if suspected with permission will be liaising with paediatrician in a special clinic and involving school with your permission, involve education social worker, educational psychologist.

**Notes:** 10-20% complete school and work independently.

10-20% dependent at home

60% residential care

3% risk to sibling, (but 10% of siblings may have 'traits')

Autism NOT associated with MMR, 'bad' parenting, or SZ.

**Diff. Diagnosis** – deafness, LD, communication disorder.

**Management** – special nursery from age 2-3, most need special school. Challenging behaviour managed with contingency management. Support for family and carer assessment; National Autistic Society.



## 9. Dementia – explain

*Dementia is an illness of the brain where all its functions gradually decline. In some cases this may be reversible but for the most part it is progressive.*

*It can affect all functions of the brain especially memory, skills, orientation, speech and personality.*

*There are different types; the most common is Alzheimer's which accounts for 60%*

*Vascular accounts for 20 to 30 % and LBD 15-20 %*

### **Risk of dementia**

- 1 in 5 over 80
- 1 in 3 over 95
- Most people who develop dementia don't have known family /genetic factors that increase risk.

### **Cognitive enhancers**

- 40 to 60 percent benefit from them
- 1/3 slightly improve, 1/3 plateau for a period, 1/3 no effect.

## 10. Assess risk of wandering in known patient with dementia from carer

*When did this begin? How many episodes? Getting more frequent?*

*Daytime/ night-time?*

*Does she go for a walk every day?*

*Where does she go? Same place? Doing what? - Drinking/spending lots of money?*

*Who has been bringing her back and at what time?*

*I'll need to gather reports from others incl. Social services, A and E notes, Police report etc., previous psychiatric and medical notes. Any medical conditions like epilepsy or diabetes? Details of meds/drugs. And current care package.*

### **Risks-**

- To self – crossing road, falls/ Head injury as a result?
- To others – aggression, sexual, increased risk at night time
- From others – aggression, physical/sexual/financial abuse including carer abuse
- Neglect – not taking medication?, missing meals, not clothed properly on walks,

### **Management**

- Need to rule out acute on chronic condition – confusional state secondary to infection dehydration, subdural etc. So needs MSE including capacity assessment, O/E and Ix.
- Consider assistive technology if possible first e.g., bracelet, alarm necklace, alarm on door radio-linked to carer, tracking devices.
- If abuse suspected, inform police and social services.

## 11. Patient found wandering. You are asked to assess in A and E

Where were you trying to get to?  
What is your address?

Drugs and Alcohol?  
Orientation and memory (3 word recall) and concentration check (world backwards)

### **MSE**

Depression/mania  
Psychosis  
Anxiety?  
Insight

**Risk** – to self, to others, from others, neglect (find out home circumstances)

**Impact** – home circumstances,

**Drugs and Alcohol** (if not yet mentioned)

Driving

PPHx

Meds- recent change?

PMHx – head injury, epilepsy, DM. Fully checked out by A and E??

Forensic – pending court case?

Diff Diagnosis – organic/delirium/dementia.

Drug and alcohol/ meds change or non-compliance?

Psychiatric illness

## 12. Challenging behaviour in dementia in care home.

Previous diagnosis of dementia? Age?

Onset? **Link** with anything? **ABC** chart needed – (certain carers, time of day?) **Gradual / sudden?**

Organic – physical symptoms, incl. continence, constipation, dentures, sensory. Worsening 5 A's (memory, skills, disorientation, speech, personality.)

Psychiatric – depression, psychosis, insight

Medication/drugs – changes?

Social – family changes, staff changes.

Risk – to self (falls?), to others (aggression, sexual), from others (elder abuse), neglect

Impact – on care staff, family

Mx

- Needs assessment for MSE and capacity.
- Physical examination, bloods, MSU? CXR?
- Obtain family view and collateral Hx.
- Aim to identify cause and treat this appropriately e.g. UTI/depression.
- Any covert meds have to be care planned at an MDT, must be if patient lacks capacity and meds are in best interest and regularly reviewed. Also check with pharmacy re crushing etc.
- Optimise physical health and sensory impairment.
- Optimise non pharm interventions for dementia and delirium.
- Consider judicious use of medication where justified due to risk issues or lack of results of non-drug interventions.
- If home cannot meet needs despite non drug measures or risk is too great consider MHA and admission.

### 13. Vascular dementia history

- Onset, link
- Course – stepwise?
- 5 As – memory, skills, disorientation, speech, personality.
- Vascular – ask more cardiac risk factors (getting treatment for this?), worse at night?
- LBD – ask about visual hallucinations, stiffness/slowness (other is cog. Decline and fluctuating mental ability. Secondary is falls and sensitivity to antipsychotics)
- Frontal – ask re apathy, social disinhibition, poor multitasking and then 3 'I' s Irritability, impulsivity, insight.
- **Risks** – to self (falls) to others (aggression, sexual) from others (abuse/violence) and neglect
- **Drug and alcohol.**
- **Impact** – care home and family
- MSE
- PPHx
- Meds
- PMHx
- Forensic

#### Mx

- manage risk in least restrictive setting.
- O/E and bloods incl. TFTs, B12 and folate, ECG, CXR, CT head.
- optimise cardiac risk factors
- consider Doppler of carotids and echo.
- Some advocate aspirin if no contra indications, evidence contradictory.
- Social assessment- housing, meals, carers, power of attorney, will, respite
- Functioning assessment- OT and physio assessment- (safety, home aids, mobility), -
- Carers assessment- practical and emotional support – support groups, respite, crossroads, + education re illness.

Note – shorter survival than AD, most common onset is 7<sup>th</sup>-8<sup>th</sup> decade, more common in Far East.

#### Frontotemporal dementia

- A group of related types of dementia which affect the front of the brain.
- Frontal bit affects personality, behaviour and drive more. Temporal part affects language in particular.
- 2<sup>nd</sup> most common under 65s, 7 % of over 65s, mostly onset age 45-65
- Prognosis – very variable 2-20 yrs, average survival 8yrs.

## 14. Alzheimer's Dementia

- 6/100 over 65; 1 in 5 over 80; over 400,000 in the UK, risk doubles every 5 yrs.
- M=F
- If first degree relative with , risk increases by 3-3.5 times which translates to a risk of 1 in 5-6 ( but negligible increased risk if the relative suffered AD beginning over 90) Overall 4 in 10 have a positive family hx of AD.
- Illness of the brain where all mental functions gradually and progressively deteriorate.
- Prognosis variable, average 5-8yrs from time of diagnosis. Worse prognosis -male, affecting specific part of brain early -( parietal), rapid progression thus far.

Risk factors – genetic e.g. Apo E4, Downs syndrome, CVS disease, Head injury, FHx

Protective factors – genetic – Apo E2, NSAIDS?

### Management

- Manage risk in least restrictive setting, promoting independent living with optimum quality of life and sufficient support.
- O/e, bloods (incl. TFTs, B12, folate) , ECG, CXR, CT head, neuropsychological assessment.
- **Social assessment**- accommodation, finances, carers, day centre, advice re power of attorney, will.
- **Carers assessment**- Respite, including education, voluntary groups – e.g. Alzheimer's society, crossroads, Saturday lunch clubs, age concern
- **Functional assessment**- home adaptations (incl. white board, clocks, calendars), assistive technology, meals on wheels, compliance aids. CAPE assessment, **DRIVING!!**
- **Medical**- Optimise **physical functioning** – mobility – physio, reduce cardiovascular risk factors, address any sensory impairment.
- **special therapies** – aromatherapy, multi-sensory stimulation, music therapy, animal assisted therapy, reminiscence therapy, validation therapy.  
consider **cognitive enhancers** (memory boosting medication) if moderate.  
3 main types – donepezil (aricept), galantamine, rivastigmine. Side effects- nausea, headache, insomnia , confusion, agitation, urine incontinence.  
Cautions in epilepsy, GI bleed/ulcers, cardiac conduction/bradycardia, COPD /asthma (Contraindicated for donepezil but rivastigmine safe)
- Address complications of dementia e.g. psychosis
- Address comorbidities e.g. depression (use Cornell scale for depression in dementia, 50% get symptoms while 10% get major depression of people with dementia are also depressed), alcohol.

After Px, CPN monitors in community. Pt then brought back to clinic in one month.  
Dose reviewed, then review at least 6 monthly in clinic (checking mmse, MSE, functioning, side effects eg ?bradycardia?. Stop if mmse <10 or if no benefit perceived or intolerable side effects.  
Can switch to alternative if side effects.

Note – MCI mild cognitive impairment. Is a description rather than a medical term, memory problems apparent to individual and others but not fulfilling criteria for dementia. 10- 15% convert to dementia each year. Increase physical activity, and brain activity eg crosswords etc.

Note – pseudodementia

Tendency for “I don’t know answers”

Prominent subjective worries re memory ( true dementia often try and cover up)

Poor attention.

Depression features ( esp if predate onset of memory disturbance)

Note – paraphrenia

- Partition delusions common, persecutory delusions predominate. Affective features common.

Diff diagnosis – **Psychae** -SZ, SZaffective, delusional disorder, mood disorder,

**Medication / drug** ,

**Organic**- delirium, dementia, organic psychosis – HIV, neurosyphilis

If speaking to the relative, ask about FHx (though much less in paraphrenia)

Ask about PMHx- including sensory impairment (though Charles Bonnet is well formed elaborate external space visual hallucinations with no dementia/delirium or other features of psychosis), meds- **is she compliant?** , PPHx – incl. paranoid traits - suspiciousness, grudges, personal rights and schizoid traits – prefers own company, rich fantasy inner world.

Tx – antipsychotics – poorer response. 50-75% have partial or no response. Low dose depot can be useful if accepted and compliance is good.

CBT may be tried but no current good evidence for it working in this age group.

## 15. Lewy-Body Dementia

- a type of dementia
- Dementia is an illness of the brain where all functions progressively deteriorate.
- Sometimes reversible but in LBD progressive.
- 15-20 %
- affects M>F, especially over 65s
- associated with apoE4
- 4 main features- progressive mental decline, fluctuating mental abilities, visual hallucinations, stiffness/tremor. Also falls and sensitivity to certain drugs ( antipsychotics)
- Prognosis: similar to AD i.e. 5-8 yrs average, but can be quicker than this.

### Management

- manage risk in least restrictive setting
- optimise independence in the community as far as possible
- Optimise physical health – sensory impairment, compliance with physical meds, district nurse etc.
- Social assessment- housing, carers.
- functional assessment – OT- aids at home, meals on wheels, physio
- carers assessment- support groups, education, respite, crossroads
- consider rivastigmine ( not licensed as treatment but NICE suggests could be considered for help with behavioural sequelae of the illness)
- Consider Clonazepam for severe sleep disturbances.

### Tips for relative/carers.

- Use simple clear language and repeat, allow more time. Decrease background noise.
- Visual cues, labels on doors
- Use body language, gesture.
- Split activity into stages
- Try not to contradict
- Talk about the past and comfort. Compile a life story book
- Massage, music, aromatherapy.
- Clocks, calendars, white board
- Help maintain skills but ensure independence and dignity isn't undermined
- OT review, Social services review,
- Get support yourself – Alzheimer society, respite, crossroads, age concern.



## **16. Downs, LD and dementia**

- 1 in 5 people with LD have Downs syndrome
- 55 percent of those age 60-69 with Downs have dementia (2 percent of age 30-39)
- Dementia is overall increased in LD by x4

## **17. Borderline PD who is requesting admission**

- needs psychiatric assessment
- If not necessary then ask: how useful were previous admissions? What happened?  
Dealing with the problems outside of hospital with support can improve your confidence and be more empowering for you. This can strengthen your mental health and foster more independence in the long term.

## 18. Challenging behaviour in LD in care home. Assess.

Name, age, why in home, degree of LD and diagnosis.

Onset, link? ABC chart?

Risk – to self, to others, from others, neglect,

Impact – family, staff in care home ( how coping?) are they meeting his needs –  
overstimulation/ under-stimulation, attention seeking, escaping unpleasant situations, other  
residents- vulnerable , bullying?

Drugs and Alcohol

MSE

Depression? – Low mood, energy, enjoyment. Eating, sleeping,  
Wandering /searching behaviour, change in continence,

Psychosis

Insight – what does pt say is the matter?

PPHx

Meds

PMHx – thyroid, **epilepsy**, head injury, DM

- pain, sensory, teeth, constipation

-delirium, dementia,

-sleep apnoea, GI

Forensic – police/violence?

**Note:** Challenging behaviour is behaviour of sufficient frequency/intensity that it impairs –  
physical safety of that person with LD, - safety of others – make participation in the  
community problematic.

20% in LD Child and Adolescent. 10% in LD Adults.

Aetiology – Psychae illness (4X more common in LD population), Physical illness, Social  
disruption, Meds/drugs

Downs problems to be alert to: vision problems, hearing problems, heart problems, thyroid,  
sleep apnoea, leukaemia, dementia, infections, and GI problems.

## 19. Patient with LD – pregnant on methadone

Confirmed? LMP? Planned? If so congratulations

Degree of LD? IQ?

Take detailed drug history including Alcohol, smoking, heroin, etc.

Dependence?

Risk- to self – self harm/suicide, physical consequences of drug use (local e.g. abscesses/skin infections and systemic e.g. sepsis, PE)

Sharing needles/equipment? Clean needles? Lemon juice? Safe sex?

to fetus – from drugs, from violence, from infections.

to others - violence

from others – domestic violence

neglect – poverty, lack of care.

### Driving

Impact – partner, support, work?

### MSE

Depressed?

Psychotic?

Insight – motivation for help and change?

PPHx - ?

Meds

PMHx – HI , epilepsy, thyroid

FHx

Forensic?

### Management

- Advise continue and optimise methadone. If insists on detox, then 2<sup>nd</sup> trimester.
- If on other drugs advise inpatient detox.
- Urgent USS scan
- MDT liaison incl. obstetrician (Dr who looks after the delivery), midwife, social services, anaesthetist.

Postpartum psychosis/ PND

*“Thank you for meeting with me today, I know it can be really difficult to speak about things when there is a lot going on so I really do appreciate it.”*

## 20. Eating disorders

### General risk factors:

- Female, previously overweight, low self-esteem.
- Sensitive/ anxious people who have difficulty being independent.
- Families find change or conflict difficult and may be unusually close or overprotective.

### Relative of anorexia signs

- weight loss,
- Avoiding food/ fattening food, avoiding public eating. Plus exercising.
- believing fat
- periods stopping

plus physical signs – tired , dizzy, palpitations

plus mental signs – anxiety , depression, perfectionism, poor concentration.

Plus – over-involvement with parents.

### Bulimia History

From relative:

- food disappearing in cupboards
- bathroom straight after eating

plus physical signs – teeth caries, parotid swelling, chest pain, palpitations

*From patient:*

- *I know it can be difficult to talk about eating sometimes so I do really appreciate it.*
- *Please talk me through a typical days eating for you*
- *Do you ever crave food, periods of overeating (more than 2X per week for >3/52?)*
- *Counteracting behaviour – vomiting? Purging? Alternate periods of starvation? Pills/medication?*
- *How do you feel about your present weight? How would you feel about putting on more weight?*

Physical symptoms – tiredness, hand calluses, facial puffiness, teeth problems, palpitations, periods??

Self-esteem, childhood obesity, impulsive behaviour – stealing? Empty? Self-harm?

Previous eating disorder?

Oversleeping?

Risk – to self, to others, from others, neglect

Drugs and Alcohol

Impact – family? School- bullying ?

### MSE

- depressed?
- Psychotic?

PPHx

Meds

PMHx - periods of oversleeping?

FHx – eating disorder

Forensic – stealing food?

### **Management**

- Manage acute risks – physical – dehydration, hypokalaemia, hypochloroemia. Alkalosis and self-harm/ suicide risks.
- Stepped care, MDT, aim for good therapeutic relationship and good support and communication for the family.
- Mild -Education, guided self- help,
- Moderate- CBT modified for bulimia / IPT
- Severe – CBT/IPT plus SSRI ( can give a kick-start to psychotherapy)

### **Anorexia**

Explain to relative

- An illness where there is a problem in the pattern of eating. Women 10x more.
- Mostly late teens develops.
- Cause – family – female siblings 10x more likely than general pop.
  - Identical twin 6/10 chance
  - Family factors – more dependency on parents or even over involvement.
  - Psychological – stress
  - Cultural – stress on thinness
- Low weight expected for that person, self-induced through avoidance, altered body image, hormonal changes. No bingeing or craving.
- Go through symptoms – tired , dizzy, palpitations, skin changes- dry, scaly , orange, lanugo hair, ankle swelling.
- Danger – Risk to self - suicide and medical complications (heart failure, salt imbalances, infections, weak bones, decreased fertility)

### **Anorexia- take a personal and family history**

Where brought up? By whom? Natural parents?

Brothers and sisters?

Describe relationship with each one. **Overprotective/ overinvolved?**

Relationship between parents

Relationship of siblings to parents.

Anyone in family suffer from eating disorder or mental illness/suicide attempt?

**Childhood obesity?**

WHAT WAS GOING ON AT TIME OF FIRST EPISODE OF EATING DISORDER? ( any evidence of a need to maintain control? Self-punishment?)

Puberty age

First kiss, first relationship, first sexual relationship.

School – primary and secondary experiences – bullying? Academic? (Look for perfectionistic traits and rigidity in rules and change, control)

Overall any physical/sexual/emotional abuse in childhood?

Higher education – experience?

Interests- modelling?

Current work – relationship with colleagues, boss?

How has childhood shaped your current personality? **Sensitive/anxious?** If you had children what would your wishes be for them in 20yrs time?

Risk – to self, to others, from others, neglect

Drugs and Alcohol?

Impact – current support/relationships with friends and family.

What's recently been happening in terms of your family relationships?

**Anorexia patient – take a history**

*I know it can be difficult talking about eating patterns so I really do appreciate it.*

*How much do you weigh? Height?*

*What's the least you've ever weighed? What's your ideal body weight? How much lost in last month?*

Restricting food in any way? (Fatty food, calories?)

*How do you feel about your body when you look at yourself in the mirror?*

Regular periods? -if not – If young woman, have you had periods before? It's a very routine question I'm afraid but is there any possibility that you may be pregnant?

- If yes then are you taking the oral contraceptive pill or equivalent?

*Any craving for food or bingeing?* (Needed to be negative in ICD 10 for AN diagnosis)

Other behaviours to lose weight? e.g. vomiting (feature of bulimia), exercise, laxatives, drugs?

Physical symptoms – tired, dizzy, palpitations, difficulty getting up from sitting, hair loss/fine downy hair upper body and face, teeth problems, **headache**, skin changes –dry, orange pigment, tummy swelling / pain, constipation, swollen ankles.

Impact – home support Risk – to self, to others, from others, neglect D and A

PPHx – previous eating disorder?

## Meds

PMHx – thyroid, Bowel problem like Crohns, Diabetes – thirst/ passing lots of urine?

FHx – eating disorder

Personal – childhood obesity, personality traits – rigid, perfectionistic, sensitive, anxious,  
family traits- overprotective, overinvolved.

Forensic - stealing food?

## MSE

Depression

Anxiety – panic attacks

Psychosis screen

Insight – and motivation for change

## Management

- Manage risk in least restrictive setting that is suitable. Most cases are treated in the community.
- Practical and emotional support for patient and family. Support groups, leaflets.
- Consider special eating disorder service if available.
- Physical monitoring
- Dietician
- Psychological therapy – Family therapy (esp. if younger) CBT, IPT, CAT, focused psychodynamic.
- Medication – little evidence for working.
- Hospital is considered when high risks of self-harm, rapid or severe weight loss, or physical complications e.g. electrolyte imbalance, low temp, low BP and pulse, infections.
- Address comorbid issues e.g. Drugs and Alcohol

## Hospital

- will need to be admitted to an age appropriate ward.
- Correct U and Es, bloods include  $Ca^{2+}$ ,  $Mg^{2+}$ ,  $PO_4^{2-}$ , CK. ECG, Stabilise physical condition, involve dietician, aim for weight stabilisation first, then gradual weight gain beginning at 0.5kg per week.

## Prognosis

- Over 50 percent make a recovery. Usually unwell for 5-6 yrs though.
- 15 percent go on to develop bulimia.
- 10-15% mortality over 10yrs. (2/3 physical complications, 1/3 suicide. )
- Up to 1 in 5 of most severely hospitalised will die.

Note: if age under-18 use centile charts. BMI below 2.4<sup>th</sup> centile indicated underweight. Or those who fail to gain weight during expected growth spurt of puberty.



## 21. Temporal Lobe Epilepsy (TLE)

Onset, link with anything? Sleep deprivation, stress, strobe lighting

- Aura – GI? Smell?
- Decreased responsiveness to environment
- Panoramic, dream-like, déjà vu, emotional change – fear/anxiety, automatic movements e.g. lips, hand rubbing.
- Violence?
- Generalisation to full seizure? Biting tongue, loss of continence, physical injury. Limb movements.

## 22. Grief

- Sorry for your loss, when? Over 6 months?
- Sudden, expected? Close?
- Initial reaction? When started grieving?
- **Getting steadily better or steadily worse?**
- **General ability to function?**
- Hallucinatory experiences? (More than deceased image or voice? bizarre?)
- Mummification experiences? (Excessive?)
- Excessive guilt?
- **Suicidal?**
  
- **MSE**
- Mood, energy, anhedonia – are there **any lighter moments?**
- Speed of thoughts
- Psychosis screen – worries re: health? Symptoms of deceased? Money?
- Insight
  
- **Drugs and Alcohol, Impact** – social support? **Risk** – to self , to others, from others , neglect.
- PPHx
- Meds
- PMHx – thyroid
- FHx
- Forensic

### Mx

- Risk – manage in least restrictive environment
- Treat depression or abnormal grief if present with antidepressants.
- Consider psychological input – CBT, CRUSE. <sup>2</sup>

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<sup>2</sup> <http://www.crusebereavementcare.org.uk/>

### 23. Frontal lobe testing

- **Chaperone**, gel (if present)
- Any problems with hearing or vision?
  
- Difference between apple and an orange?
- Difference between boot and slipper?
- How high is the ceiling?
- Have you heard this proverb "*too many cooks spoil the broth?*" What does it mean?
  
- Could you please perform this set of hand movements – fist , edge, palm
- Could you please continue this pattern –
- Could you please place your hand on the table and raise one finger when I tap once. When I tap twice (under the table) could you please keep still?
  
- I'm going to time how many animals with 4 legs you can name in 30 sec, normally I'd do it for 1 minute. I will record how many every 15 seconds.
  
- Could you please hold your hand on your lap, I'm going to run my pen gently across your palm while I distract you if that's ok, please don't grab the pen.
  
- What would you do if there were a fire?
- Do you think there is anything the matter with your memory or thinking?
  
- WORLD backwards to test attention.

If patient touches or is forward "*I'm sorry but it is inappropriate to touch me*" (and ask for a chaperone if forgotten!)

If patient edges their seat toward you say "*I'm sorry but could you please move your chair backwards*" (or else they will pin you to the edge of the cubicle!)

## 24. Depression following MI

Onset of low mood linked with MI? Depressed before?

Getting worse?

Energy, anhedonia?

**Is depression affecting rehab?** – appts, healthy living, compliance with meds etc?

Sleep – details, initiation, early morning wakening? Going back to sleep?

Appetite and weight change

Psychomotor change?

(Libido change)

Concentration, confidence, (motivation), guilt, suicide?

**Impact** – social support?

**Risk** – plans?

**Drugs and Alcohol**

MSE

Note: 1 in 5 get major depression following MI. Risk of mortality doubles over 7 yrs if suffering from major depression following serious coronary event (SADHART trial).

Antidepressants help with the depression but there is no strong evidence yet that they help reduce the mortality. Perhaps the studies to date have been too underpowered to detect.

## **25. Adult with (possible) Personality Disorder believing they have ADHD**

Criteria for ADHD – overactivity – please give example

- inability to keep focused on a task – please give an example
- impulsivity – please give an example

more than 1 domain, onset before age 7, ( plus over 6 months)

Antisocial PD – fights, easily wound up.

Borderline – impulsive, emotional episodes, empty, abandoned, stormy relationships, goals in life change.

Paranoid PD – suspicious, hold any grudges? Conspiratorial

Histrionic – like to be at the centre of things?

Narcissistic –

Drug dependent?

Impact- social support,

Drugs and Alcohol

Risk

MSE

Depression

Psychosis

Insight

PPHx

Meds

Pmhx

Fhx

Forensic

## 26. Body Dysmorphic Disorder (BDD)

Are you absolutely convinced it is misshapen? Is there any possibility it could be normal?  
Know anyone in the family with anything similar? Reading about it?

How long do you spend examining it?  
What steps taken to hide it?  
What steps to correct it so far?

Reassured by Dr?  
Plans now?

Hypochondriasis screen – due to particular illness?  
Somatization screen – other symptoms? How often see GP?  
Bulimia (if young anxious woman) binge eat or vomit?

### MSE

- Mood? which came first
- Anxiety – **PTSD?** (Flashbacks to accident/incident, jumpy? On edge?) **OCD?** (Is this thought your own thought? does this thought make sense to you? Unpleasant? Do you try and resist it?) **Social phobia?** (fear of being focus of attention/doing something embarrassing? or avoidance . fear of blushing, vomiting, urgency. can be additional secondary diagnosis) **Agoraphobia?** **GAD?**
- psychosis – screen
- insight
- **Impact, Risk, Drugs and Alcohol**

### Management

- Adults with BDD with moderate impairment should be offered either course of SSRI or CBT(+ERP). If SSRI effective, then should be continued for at least 12 months.

## 27. Conversion disorder

Sorry for your loss, sorry to hear about your loss in vision/ sensation etc

(If vision – ask 1 or both eyes, red? Painful? Fluctuating vision loss?)

What do you think has caused this?

Happened before?

Do you think it might be linked with recent stresses in your life?

Do you know anyone with this, anyone in the family with this or have you read about it?

Reassured by the Drs?

Do you think you have a particular illness?

Apart from this do you have any other physical symptoms? How often do you see the GP?

What now? Treatment or believe you need investigations?

How have other people reacted?

Any court case pending?

Drugs and Alcohol? Impact – i.e. social situation- off sick? – stresses Risk – to self, to others,  
from others, neglect

### **MSE**

Depression?

Anxiety – PTSD, GAD, OCD

Psychosis

Insight

PPHx

Meds

PMHx- thyroid, HI, epilepsy

FHx

Forensic – any court case pending?

For Dissociative seizures: include – any tongue biting, physical injuries sustained during  
seizures? Any incontinence? When to they occur **ABC**?

Non epileptic seizures are common in people who have epilepsy.

## 28. Inappropriate touching

(IF THEY DENY EVERYTHING KEEP ON PROBING THE WHOLE HISTORY!)

Confidentiality- *“everything we discuss is confidential between yourself and the psychiatry team but if I’m concerned about risk issues I will need to speak to the right people.”*

ABC

- A- Planning, target victim, Drugs and Alcohol? Aim? Was it near a school/children area?
- B- Erect/ flaccid, mental state, what stopped going further?
- C- Remorse, how do you think they felt? Remorse? How were the police involved, what happened next?

**Done this before** or similar sexual/violent crime? Police record?

**Plans to repeat?** If not – what’s changed.

Drugs and Alcohol, Risk – to self, to others , from others, neglect, impact – social environment i.e. children at home children at work, relationship with partner sexual and emotional

MSE

Depressed?

OCD?

Psychotic?

Insight?

Memory?

Personality – fights, easily wound up? Impulsive? Big deal?

Past Psych hx

Meds

PMHx

Forensic

Plan – Permission to speak to next of kin. Physical, bloods, urine drug screen, Psychology report, consider CBT for fantasy modification. Obviously treat any mental illness.



## 29. Erotomania

### Confidentiality

#### ABC

- A- Planning, aim? Do you believe she loves you? On what basis? Are you absolutely convinced?  
What would you have done if rejected your advances today?  
Have you been following her? Know where she lives? Know her friends?  
Know where friends live?  
Sexual /violent fantasies?  
How does a woman let a man know she is interested?
- B- Weapon on person? (If so – would it be ok if we hand it in to security now? If refuses, - I will need to ask someone else to be with me for the interview if that's ok, then ask examiner for security.
- C- Plan now? What would you do if you weren't allowed?

Done this before?

Trouble with police, hx of violence/sexual violence?

Drugs and Alcohol? Impact – who's at home? Risk – to self, to others, from others, neglect

#### MSE

Depressed/ Manic?

Psychotic?

Insight?

Personality – impulsive, Fights Easily frustrated Low threshold for violence, blame, Remorse, victim empathy, Denial, minimisation? Grudges, suspicious?

#### PPHx

Meds

PMHx- Head injury, epilepsy, mainstream school.

FHx

Link station – speak to victim of erotomania

- Mr X has a belief that you are in love with him. Were you aware of this?
- Have you suspected anyone following you/calling you or anonymous calls/ writing or anonymous cards/ trying to contact your friends?
- Can only give details relating to risk due to confidentiality.
- Confidentiality is for your benefit too as sometimes knowing a lot can make you worry unduly and affect your judgement of the situation.

Advice – don't speak / agree to meet with pt.

- If any contact call police and record.
- If you see him, make your way to a public place.
- Any mail, try not to handle too much but read it in case any threats and place in plastic bag. Notify police.
- Avoid unlit and deserted places.

- Keep mobile phone with you at all times
- Tell people your plans before going out
- Warn friends and family.
- Support from Suzy Lamplugh trust.<sup>3</sup>
- Hospital trust can provide accommodation and transport. Will speak to trust manager straight after.

If she asks a question you don't know, then say *"that's a very good question. I'm not sure, I will ask the police on your behalf straight after this."*

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<sup>3</sup> <http://www.suzylamplugh.org/>

### 30. Personality change following head injury

I'm sorry to hear about the accident.

Please tell me what happened. LOC? Open head injury? Time in hospital?

How long did it take for memory to return to normal?

How did he change from before in terms of personality and behaviour?

Memory? Skills? Orientation? Speech? personality?

Apathy? Lack of social appropriateness? Poor multitasking?

Irritability? Impulsivity? Insight?

#### **MSE**

Depression? –mood, energy, enjoyment

Anxiety – PTSD? Flashbacks, avoidance, on edge, jumpy, sleep? Angry outbursts? (Within 6 months)

Psychosis – responding to voices or visions? Saying anything bizarre?

Insight

**Risk** – to self, to others, from others, neglect **Impact**- family (any children?), career, friends

#### **Drugs and Alcohol**

PPHx

Meds

PMHx- **seizures**?

FHx

Forensic

Note: 2.5% suffer psychosis following severe HI

Plan – need to interview pt and collateral hx. Neuropsychological testing. Support from e.g. Headway.<sup>4</sup>

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<sup>4</sup> <http://www.headway.org.uk/home.aspx>

## 31. Delusional jealousy

“I think she might be having an affair”

Confidentiality.

Why do you believe this?

Are you absolutely certain of this? Could it be just friends?

Have you been looking for evidence? Underwear, phone bills, private detective?

Confronted wife or man?

Have you been following either of them?

Have you been controlling your wife’s movements at all? E.g. changing locks

Any plans to harm either of them now? Why not? **Any weapons on you now? /in your bag?**

Have you suspected her of infidelity in the past? Were you violent?

Have you suspected previous partners of infidelity in the past? Were you violent?

Previous violence/ trouble with the police?

Drugs and Alcohol, Impact – children at home, sexual relationship with wife? Risk – to self, to others, from others, neglect

**MSE**

**Depression? Mania?**

**Psychosis?**

**Insight?**

Personality – generally quite impulsive-- fights, easily wound up? Denial, minimisation, victim empathy remorse blame — suspicious in general, hold grudges---would violence be a big deal?

PPHx

Meds

PMHx epilepsy, HI, thyroid

FHx

Forensic-

How would you feel about coming into hospital? Would it be ok if I spoke to your wife? I will need to ask some of my colleagues to interview you as well if that’s ok?

**Link-**

I’ve just been speaking to your husband and he’s agreed for me to speak to yourself regarding some of his worries.

Before I start could you please tell me what your understanding of the situation is?

Your husband isn’t thinking clearly at the moment and needs to come into hospital right away for a period of assessment. How do you feel about that?

He is convinced on the basis of the flimsiest or evidence that you are having an affair with xxxxx.

If he refuses then we will be requesting a second opinion from a specially trained social worker and another doctor that knows him ideally such as his GP. This would be a special meeting called a mental health act assessment which if all 3 are in agreement could request your husband under the law to be admitted.

Has he been following you or xxxxx?

Has he been threatening you or xxxx?

Has he been controlling your movements?

Has he been going through your personal items?

**Has he accused you or previous partners before?**

**Has he been violent to you or anyone else before? Has he got access to weapons? Police /  
Prison record?**

### **Drugs and Alcohol?**

Impact – children at home, emotional/sexual relationship?

Risk – to self , to others, from others, neglect

PPHx

Meds

PMHx – epilepsy, HI, diabetes

FHx?

Forensic – if forgotten.

MSE

- Recently not looking after himself?
- **Depressed? Manic?**
- Odd behaviour , **psychotic?**
- Personality traits – impulsive, minimises previous violence, denies previous violence, fights in the past, low frustration tolerance, low threshold for violence, suspicious, grudges?
- Insight

Plan – recap. Admit, treat mental illness. Antipsychotics may be tried. Wife will need support through all of this with good communication from the psychae team.

## 32. Frontal lobe and Forensic risk

ABC

- A- Planning, aim?
- B- Erect/flaccid? How did you feel they felt? What stopped going further?
- C- Remorse, how stopped?

Done it before? (Forensic hx/violence/sexual violence?)

Plan to repeat?

Risk – to self, to others – own children , other children access? From others? Neglect?

Impact – whose at home? Support?

Drugs and Alcohol?

**MSE**

Depression/ mania?

Psychosis?

Insight?

Plus apathy, lack of social appropriateness, multitasking, irritability, insight, impulsivity.

PPhx

Meds

PMHx – epilepsy, HI, thyroid

FHx

Forensic

### 33. Anxiety station

Onset, link with anything?

What situation?

**Social phobia** – fear of being focus of attention/ fear of doing something embarrassing?/fear of speaking in public?/fear of blushing/vomiting/urgency urine/faeces?/panic attacks?

**Agoraphobia** – fear of not being able to escape from a situation – esp. fear of crowds, public places, travelling alone or away from home.

**PTSD** – following a life threatening trauma

**GAD** – all the time, constant muscle tension

Panic disorder – out of the blue panic attacks, not situation specific

**OCD** – plagued by thoughts/images/ doubts/inability to make decisions/symmetry that keeping coming into your head

Risk – to self, to others, from others, neglect Impact- work, social support?

Drugs and Alcohol

MSE

Depression/mania

Psychosis

Insight

PD – anxious generally?

PPHx

Meds

PMHx – thyroid, HI, epilepsy.

FHx

Forensic – court case

## 34. PTSD

Sorry to hear about the accident

How long ago? ( PTSD should begin within 6 months)

Brief details of accident/trauma – were you driving? children involved? Death? Extent of injuries?

Note: If head trauma – loc? Length of time for memory to return to normal? Beware this may be personality change station after head injury rather than a PTSD station! See the head injury station ive done!

Any pending court case? ( best ask now I think or else will run out of time/forget!)

Any flashbacks or replays of the accident?

Do you avoid anything to do with the accident? Could you please give me an example?( eg driving in the same area etc)

Any memory gaps for the accident?

Angry outbursts?

Sleep – nightmares?

Tend to feel “on edge”?

Tend to feel “on guard”?

Impact – family/work/ social support?

Risk- to self, to others, from others, neglect

Drugs and Alcohol – used for coping?

MSE

Depression? Before the accident or after? Mood/energy/anhedonia >2 weeks

Psychosis – v. quick screen

Generally quite anxious person before the accident?

Insight

PPHx – previous Hx?

meds

PMHx

FHx

Forensic – court case ( if forgotten at the beginning)

Tx – if less than 4 weeks and mild – watchful waiting and review in 4 weeks

- if severe and less than 3 months then trauma focused CBT
- if more than 3 months then trauma focused CBT or EMDR
- Medication is 2<sup>nd</sup> line – paroxetine/mirtazapine first –could be Px by GP , then amitryptiline/MAOI by specialist only second.
- Treat any comorbid depression or drug and alcohol
- Social support, support groups, leaflets, carers assessment

Note: worse prognosis if female, trauma man made, mutilation, children involved, social isolation.



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### **35. Suicide risk before ward leave in Schizophrenic pt.**

Plans for leave? - where to, children? How long for?  
Who will be with you? Left alone at any time?

MSE

Depression/mania

Psychosis – command hallucinations, controlled? Persecution?

Insight

Risk – to self?( Whats stopping? )To others from others , neglect

Drugs and Alcohol

Impact – social support while on leave, engagement with CRISIS/Home Tx team?

PPHx – previous hx self harm/suicide

Meds – compliance

PMHx – HI, epilepsy, thyroid

FHx – suicide?

Forensic – violence hx?

## 36. Assess for psychopathology – paranoid/ hearing voices

-“It must be very distressing, Im here to help, perhaps we can sit down and talk about it, youre in a safe place”

- what do you mean when you say.....?

- can you see them/hear them/ smell them/ taste them/ feel them?

- unusual or scary experiences for example – hearing voices when there is no one in the room. Seeing visions, funny taste, funny smell, unusual sensations?
- (if hearing voices – from outside or inside your head? Does it feel like its not your own thought? One/several? Talk about you ? talk at you? Give an example? Tell you to do things? Im sure these experiences are very real to you and please don't take this the wrong way but could it be your mind playing tricks on you?)
- Hear own thoughts out aloud?
- Muddling in your thinking? – thoughts taken away from you, put in your mind, others can read your mind?
- Feeling youre being controlled in some way? Thoughts/feelings/actions/impulses.
- Is your body being interfered with in any way?

At what point did you become absolutely convinced?

Thoughts people are ganging up on you?

Special powers?

Mood – depression/mania

Insight?

Drugs and Alcohol?

Impact – work/social – recent major stress?

Risk – to self, to others, from others, neglect

PPHx – previous hx?

Meds – compliance?

PMHx – epilepsy , HI, thyroid

FHx – SZ?mood?

Forensic – pending court case?

Psychotic depression

- When start? Link with anything? Like BEREAVEMENT?
- expore the delusion, absolutely convinced? at what point did you become completely convinced? Special powers? GUILT, POVERTY, HEALTH?
- 1st rank, hallucinations – hearing, vision, funny smell, funny taste, sensations? If auditory – from outside your head ? more than one? talk to each other, comment on your actions? Talk direct to you? Command?
- thought echo
- Thoughts being muddled – insertion, withdrawal, broadcasting?
- Control ? emotions, impulses, actions?
- Mood – depression/mania

- Anxiety- OCD, agoraphobia, social phobia

Insight? Pts plan now?

Impact- social support? Risk – to self to others, from others, neglect?  
Drugs and Alcohol

## 37. ECT explain

Whats your understanding?

- Well established, 70 % overall effectiveness
- Consists of giving a short acting general anaesthetic and muscle relaxant and then passing a small amount of electrical current across the brain in order to induce an electrical fit.  
Shaking is reduced to a fine trembling, there is no tongue biting because of the muscle relaxant and the plastic airway in the mouth.
- Used for treating severe or resistant depression and some other conditions eg catatonia, mania
- 6 to 12 treatments, usually 2x per week. Stopped if pt refuses or get better.
- Short term side effects – headache, sickness, feeling muzy, tearful/frightened usually responds in a few minutes to nursing reassurance and light refreshment. Sometimes people complain of some memory gaps just before and just after the procedure.  
Older people may complain of confusion which can last 2 to 3 hrs, this can be helped in some cases by changing the way we give the ECT  
Small physical risk of serious injury or death in 1 in 50,000
- long term side effects. Some people complain of long term memory loss, loss of skills and even previous personality. This usually resolves after the course and once a few weeks have passed. Some people complain of longer standing problems though. Its controversial how much is due to the ECT and how much is due to the underlying mental illness.
- What we do know is that the more ECT one receives, the more likely one is to have memory problems.
- There is no evidence to date of structural brain damage.
- Let me offer you some of our leaflets after this.

### **38. Systematic desensitization – explain**

Whats your understanding?

It's a special type of therapy which helps teach you to gradually unlearn your phobia at your own pace.

Works in 2/3 of people.

Sessions with therapist are at home or in a clinic

1 ) Relaxation training – abdo breathing, progressive muscle relaxation, visualisation

2) Construct a hierarchy of feared situations from the least to the most anxiety provoking. Lets apply this to yourself and draw a diagram.(draw diagram of stepped increase from left to right)

3) then we break down each step in to several bite size steps. Lets apply this to yourself. ( eg getting to the front gate, going down the end of the street etc)

ARE YOU WITH ME SO FAR? PLEASE LET ME KNOW IF THERE IS SOMETHING YOU DON'T UNDERSTAND.

4) Anxiety will go up initially then tail off. The tendency with agoraphobia is to escape from the situation, avoid it , or seek reassurance when this anxiety peaks, but if you stay with it , it will eventually go back down. Then next time it will be less. Let me draw the diagram.

5) need to practice at least every day for 2 weeks 30 to 60 minutes each day.

6 ) can be done in the imagination first.

Classic questions: I worry Im just going to be put on a bus or be put in a terrible situation.  
Reply “ This therapy is all about going at your own pace, one that you personally feel is manageable.”

## 39. Clozapine

- What's your understanding of clozapine?
- 2<sup>nd</sup> line medication treatment for schizophrenia due to serious potential side effects. Must have tried 2 different antipsychotics at adequate dose for 6-8 weeks and at least one must have been an atypical.
- 3/10 benefit in 1<sup>st</sup> 3 months then further 2 out of 10 improve by 6 months and a further 2 out of 10 by 1yr.
- Overall risk of death for people on this medication is reduced compared to other people with SZ, mainly due to the decrease in suicide rate.
- Works by stabilising the chemical imbalance in the brain through a blocking action on parts of brain cells. By blocking parts of cells called serotonin and dopamine receptors, the drug helps to control the amount of dopamine chemical in the brain. Clozaril is also thought to affect other chemicals in the brain such as GABA.
- Risks : Can upset the blood in 2-3 out of every 100 people. Decreased production of cells in the bones 1% can be fatal in <1 in 5000. Clot in the lung 1 in 4500 fatal. 2 heart conditions – myocarditis and cardiomyopathy up to 1 in 1000 (myocarditis usually within 6-8 weeks, cardiomyopathy average time is 9 months)
- Risk of seizures up to 3%
- Risk of Metabolic syndrome – Bp cholesterol, weight, blood sugar problems.
- Liver/Kidney problems
- Overall people with SZ on Clozaril have lower mortality rates than other patients with SZ.

### Common side effects:

increased saliva production ( can be life threatening), sedation, weight gain, dizzy, headache, Anticholinergic side effects( dry mouth, blurred vision, constipation, urine retention etc), urine incontinence, anti – adrenergic side effects ( sexual, post hypotension) bp and heart rate changes.

### Before starting Clozaril:

- 1) Review diagnosis. Truly Tx resistant? 2 antipsychotics adequate dose at least 6-8 weeks.
- 2) Assess comorbidity eg Drugs and Alcohol incl. physical comorbidity.
- 3) Assess compliance eg previously needed depot?

### Plus

- 1) physical contraindications/cautions eg myelodysplasia, blood dyscrasia, previous serious reaction to clozaril , uncontrolled epilepsy, diabetes liver/kidney/prostate/glaucoma-closed angle- trouble, not for under 16s, rare hereditary conditions eg Lapp lactase deficiency . Pregnancy – not to be started during pregnancy but if already on then NICE recommends switching, but MAUDSLEY says the relapse following switching will be great so “usually should be continued” – p347 10<sup>th</sup> edition, in other words it has to be a risk – benefit decision based on the latest available evidence, pt wishes etc. not to be given in breastfeeding though.
- 2) ? Tried family therapy, CBT?

- 3) On other interfering meds like Carbamazepine? Complementary therapies?

#### Starting

- 1) In community or as an in pt? (pt preference and resources)
- 2) Pt needs counselling of need for blood tests and reporting of fever sore throat infections asap. No doubling of missed dose and if missed for > 48hrs then will need to restart at 12.5mg.
- 3) Needs registering with CPMS or equivalent
- 4) Baseline MSE incl. consider rating scale like BPRS. O/E incl. weight, MSE, ECG, Bloods
- 5) Lower doses needed for females, elderly and non smokers.
- 6) If in- pt, then first dose 12.5mg, monitor hrly for 6 hrs. bp /pulse/temperature
- 7) Then daily monitoring of pulse bp temp before and after morning meds for 2 weeks or until no unacceptable side effects, then alternate days until stable dose. Then weekly monitoring of vital signs.
- 8) Needs at least weekly doctor review for first month
- 9) Needs weekly FBC for 18 weeks then 2 weekly until the end of the year then monthly thereafter.
- 10) Will need regular blood pressure monitoring and clinical review.

Augmentation – amisulpiride, aripiprazole, lamotrigine, omega 3.



## 40. Physical examinations

### Thyroid

With your permission I would like to perform a brief physical examination in the company of a chaperone, would that be ok?

I'll be needing to check quite a few things like your hands, your neck and ankles. Shouldn't be painful or uncomfortable but if you do feel any discomfort at any time please just let me know and I'll stop the examination straight away. Thanks.

Chaperone, Gel

Could you please hold out your arms (assess tremor)

Could I please see your hands. Looking for thyroid acropachy, distal joint changes subcutaneous nodules, sweating, temperature, dry skin?

Check pulse

Ideally I would like to check bp and temperature now, I will leave this to the end .

Check hair, any thinning ?

Any eye changes? From side , from above . Lid retraction? Lid lag – finger in front of eye then drop. Then do figure of H. Any double vision?

Any facial swelling

Expose neck. Observing the neck – pulsations and vein distension

Could you please take a sip of this water , hold it in your mouth and swallow when I say.

Swallow, thanks

I'll need to examine your neck now if that's ok. I shall be coming behind and a bit to the right.

From suprasternal notch , examine outward for nodules etc. Feel the trachea – central?

Check for lymphadenopathy.

Could you please take a sip of water and then swallow when I say? Thanks ( while feeling thyroid the whole time)

Percuss the sternum from above → bottom

Listen for carotid bruits and thyroid bruits.

Could you please show me your lower legs? ( pretibial myxoedema – non pitting oedema)

Could you please cross your legs – then do ankle reflex on each side

Thankyou.

### **GEL**

Noticed the heat or the cold particularly ? periods? Memory? Anxiety? Family history of thyroid problems?

COULD I PLEASE ARRANGE A BLOOD TEST FOR YOU TO CHECK YOUR THYROID HORMONE LEVELS?

### Cranial nerves

With your permission I would like to perform a brief physical examination in the company of a chaperone, would that be ok?

Could I please have a chaperone? **GEL**

Do you need reading glasses or a hearing aid normally?

First of all general inspection of face looking for any wasting, tremor, scars, change in shape of face or head etc

- 1) any change in your sense of smell?
- 2) Could you please cover 1 eye and look at my eye here. Tell me when you can see my finger moving. (cover your own eye obviously, then swap sides)  
Blind spot? Red pin down the vertical and rpt across the horizontal.  
Whats the lowest line you can read? (test with each eye and hold card 2 ft  
Away.  
Fundoscopy – “ I ll need to come quite close to your face if that’s ok, if you feel uncomfortable just let me know and I ll stop “  
check red reflex about 2 ft away from pts eye (with ophthalmoscope next to your eye) then home in at an angle  
Ideally check colour vision with Ishihara charts  
3,4, 6) Test light and accommodation reflex, comment on ptosis, pupil size and shape.  
Figure of H, any double vision? Check for nystagmus at extremities.
- 5) Check CN5 – use cotton wool on the 3 areas comparing right to left for each one.  
Please clench your jaw (feel masseter) Please clench jaw again (feel temporalis) Ideally jaw jerk and corneal reflex (leave for now)
- 7) note any asymmetry. please raise your eyebrows, close your eyes tightly don’t let me open them, blow out cheeks, give me a big smile.
- 8) please cover 1 ear (and then rub 2 fingers to uncovered ear) If time Webers and Rinnes at the end.
- 9 and 10) Please open your mouth and say “ah” (shine torch), please swallow .  
please say “99”
- 11) please raise your shoulders while I try and push down. Please turn head to the left, then rpt to the right while I gently push against chin.
- 12) please stick out your tongue (observe for fasciculation and wasting) and then ask to move it from side to side.

## **GEL!**

Thank you. The examination was normal.

### **Alcohol examination (= abdo + cerebellar + Korsakoffs)**

(may need to be shortened if doing the lot)

Abdo

- With your permission I would like to perform a brief physical examination in the company of a chaperone, would that be ok?

Could I please have a chaperone? **GEL**

Ill be needing to check quite a few things like your hands, your tummy and ankles. Shouldn’t be painful or uncomfortable but if you do feel any discomfort at any time please just let me know and Ill stop the examination straight away. Thanks.

- please stretch out your arms (observe for tremor) then could you please cock your hands back (observe for flap of hepatic encephalopathy)
- checking for clubbing, palmar erythema, dupuytren’s contracture
- pulse

- ideally bp and temp now, but will leave to the end of examination
- any hair loss noted?
- Facial flushing?
- Look in mouth at tongue –( dehydration and enlarged tongue in anaemia)
- Parotid swelling?
- Lymphadenopathy incl. subclavian fossae
- Expose the chest – spider naevi ( look front and back) and note gynaecomastia
- Observe the abdo – distension, caput medusae. Any pain? – palpate 9 areas  
Then deeper palpation, then feel for liver and spleen while asking to breathe in .  
Then feel for kidneys, then percuss liver and spleen and ascites. Please roll to your left  
– re-percuss ascites on right side.
- ideally I would like to examine external genitalia, PR and hernial orifices.
- Check ankle oedema
- Ideally would like to check peripheral sensation in limbs ( could quickly check on  
lower legs – can you feel this ? – quick touch either side of lower leg)

#### Cerebellar ( and a bit of wernickes!)

- please follow my finger tip - figure of H , looking for ophthalmoplegia , nystagmus.  
Any double vision?
- Please say “ baby hippopotamus”
- Finger nose test
- Dysdiadochokinesia
- Heel shin rub
- Gait
- Ideally heel to toe and then rombergs – feet together (get ready to hold if  
unsteady!) and close eyes please
- ideally tone if more time!! ( some hypotonia in cerebellar)

#### Korsakoffs

- 3 word recall
- show me how you brush your hair, brush your teeth
- what school did you go to ?
- who is US president?
- Working memory – could you please say these digits backwards 452, then 6235,  
then 73668 etc
- ( in korsakoffs, anterograde affected first, then retrograde more. Working memory  
and procedural memory relatively ok.)

Thankyou. **GEL!**

#### **EPSE**

Chaperone, **GEL**

#### ANY PAIN ANYWHERE?/ in JOINTS?

- observe head to toe – looking for facial expression, posture
- walk to end and back
- anything in mouth? Pain? Open mouth, close, open close – looking for pooling of  
saliva in mouth . Stick tongue out , in , out, in.

- assess tone in upper limbs, rotate wrist, fingers, bend elbow, shoulder.
- Ability to rapidly tap each finger with thumb on same hand and rpt.
- Sit on bench and swing lower leg, or lie down and assess tone by raising knee and let drop. Also can roll legs. And check foot rotation.
- Observe sitting with hands on knees for 15s , then with hands in between knees (or if wearing skirt , then hands dangling over knees)
- Ideally complete Barnes akathisia scale , simpson angus for parkinsonism and aims scale for tardive dyskinesia.

**GEL**, thanks

#### 41. IPT explain

- is a special type of talking therapy which concentrates on the present rather than the past and looks at your personal web of relationships.
- The angle isn't necessarily that these relationships are the cause but that they can certainly influence the course and evolution of mental illness.
- Used in depression (non – psychotic) , HIV, Bulimia
- Focus is on one of four main areas – grief, role transitions, interpersonal deficits ( eg unfulfilling relationships) and interpersonal disputes ( differing roles and expectations in relationships)
- Technicalities – 12- 16 weekly sessions, stage 1 – orientation to therapy and completion of interpersonal inventory. Stage 2 – Specific techniques from IPT manual eg” embracing the challenges of the new role”. Review symptom progress weekly. Stage 3 anticipating end of therapy, progress has been “earned” by patient, therapist is only a facilitator for change.
- **Leaflets and video**

## 42. CAT

A specialised form of talking therapy, looks at the here and now and also how past relationships influence the present. Used for depression, anxiety, and interpersonal difficulties.

Identifies unhealthy ways of coping which were learnt from the past. Especially looks at 3 patterns.

- traps ie negative assumptions- I wasn't born to be successful
- dilemmas – false choices – either I will be the best in the world or must resign myself to unhappiness.
- Snags – goals are abandoned because of eg conflict of expectation of others

3 “R”s – Recognition, reformulation, revision ( last 2 formulated in story and picture form)

Technicalities : about 12 sessions

early sessions – orientation, keep a mood and feelings diary, begin a “psychotherapy file”

Middle sessions – reformulation and how to change

Ending- recap and goodbye letters and possible review in 3 months.

It can be a lot to take in so I will give you some leaflets and a video.

### 43. DBT- Explain

DBT is a special type of talking therapy initially devised in order to help people with  
A condition called Borderline PD.

It fuses western psychological techniques with some eastern philosophical ideas.  
Tries to get the balance right as a therapy between encouraging “acceptance” and  
encouraging “ change”.

Borderline PD seen as a result of combination of emotional vulnerability and an  
“invalidating” childhood environment. Children can’t trust their emotions leading to  
extremes of behaviour. Certain skills aren’t learned e.g. distress tolerance. Unrealistic goals  
are set with self-hate if not achieved.

4 main components:

Individual therapy – weekly 1hr session where therapist seeks to understand behaviours.  
Helping to validate them while also showing how they may not be helpful in the long run.

Group therapy – this is a 2-2.5 hr weekly session where group skills are taught.

- mindfulness – i.e. being aware of the moment
- interpersonal effectiveness – social skills training including assertiveness training
- emotional modulation and
- distress tolerance

Telephone consultation – telephone support from therapists.

Therapist consultation groups – meetings for therapists to support each other.

Technicalities:

Usually lasts approx 1 yr.

First focus is on reducing self-harm behaviour

Then reducing behaviours that interfere with therapy.

Then emotional processing of the past.

Lastly self-esteem and future goals.

Give leaflets and lend a video

#### 44. Suitability for psychotherapy

- **insight and motivation** – could you commit to regular therapy, whose idea was it to have therapy?

**psychological mindedness** – does the idea of seeing your problems in terms of the past or focusing on how relationships are important for them, make sense to you?

, **ego strength and distress tolerance** – how do you cope when stressed? Can you think of a particular achievement for which you are proud?

, **ability to sustain relationship**- are you able to keep relationships going like friendships for any length of time?

- no Drugs and Alcohol, no suicidal or severe PD, severe depression / psychosis



## 45. Lithium

Uses – Treatment and prevention of Bipolar.

Preventing recurrent depression

Used in schizoaffective disorder

Used in some cases of aggressive behaviour or self-mutilating behaviour

Used in steroid induced psychosis

Rationale – prevents suicide by 80% in BPAD and depression

- in resistant depression works in 1 out of 2 people, response usually seen within 2 weeks.

Reduces relapses of bipolar by 30-40% but depends on number of previous manic episodes (if more then less effective – college leaflet)

CI/Cautions- cardiac problems, kidney/thyroid illness. **TERATOGENIC**- Check family planning ? contraception and LMP

Counselling – need for compliance, at least 3 yrs commitment ideally. Need for regular blood tests – li 3 monthly and TFTs, Kidney (inc. estimated GFR) every 6 months. Counsel re need for regular fluids esp. in hot weather, adequate salt intake. See GP urgently if unwell or sick and inform re lithium- . Teach re side effects.

Work up- O/E incl. Weight, Bloods, ECG.

Initiation – start at 400mg, (200mg in elderly) then check bloods in 5 days (check levels 12 hrs post dose) adjust dose and recheck in 5 days. When 2 weeks are the same then go to monthly and then 3 monthly intervals.

Stopping – must be slowly over at least 1 month.

Side effects – common – metallic taste, dry mouth fine tremor, thirst and passing water more ( in 1/3) Wt gain, ankle swelling, acne worse, occ. mild tummy upset, hair loss.

If concentration rises – severe tremor, sever tummy upset and sickness, staggering, slurred speech. **This can be lethal.**

Long term – thyroid ( 1 in 5 will get underactive) kidney ( 1-2 out of 10 some reversible kidney damage, in 1% more serious kidney failure over 10yrs) Risk reduced by regular blood test ideally 6 monthly.

**Pregnancy**- if mood stable and stopped at conception 70% likelihood of relapse perinatally.

Risk of Ebsteins abnormality of the heart is 10-20 X general pop. Risk ie 1 in 1000

Greatest risk in weeks 2-6.

If continued will need USS level 2 at 6 and 18 weeks.

Considered safer after 26<sup>th</sup> week but associated with neonatal lethargy, hypotonia, cardiac arrhythmias and neonatal goitre

Mother will need regular U + Es with monthly li levels checked, weekly Li + levels after 36 weeks and within 24 hrs of birth.

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- it's a lot to take in, would you like some leaflets? If you like I can also explain things again in more detail with your partner present if you wish.

## 46. Motivational Interviewing

- I'd like to try and help you achieve the positive goals you wish to achieve. Try To acknowledge and respect their position.
- what's good about alcohol etc. for you?
- Is it a problem – physical, mental, social?
- How would you like to see yourself in a few years' time? Discrepancy?
- ROLL WITH RESISTANCE!
- Find motivational stage – **precontemplation**- raise doubt, increase perception of risk, **contemplation** –help tip the balance for them but don't dictate! YOU CAN DO IT! , **action**- help process and support, **maintenance**- help strategies to prevent relapse , **relapse**

## 47. Alcohol – assess pattern of drinking and impact

Could you please talk me through how much you're drinking per day? (Ideally work out the units per week)

Any more on the weekend?

How long have you been drinking this much?

### Assess dependency –

Control and compulsion

Tolerance and withdrawal

Persistence and salience

(Difficult to control the amount you drink after you have started? Craving drinks in between sessions? Needing to drink more over time to get the same effects? Get sweats and shakes if you miss a drink or first thing in the morning? Does it worry you that Alcohol may be causing you some harm? Is alcohol taking increasing priority over other things in your life like leisure activities/friends etc.?)

### Impact

- social – who's at home? Is relationship with wife affected? **Domestic violence?**  
Anger/aggression toward **children?**
- **Work?**
- **Debt?**
- **Police/forensic?**
  
- Psychae – **depression** –mood/energy/anhedonia? WHICH CAME FIRST?  
Mania?? **Psychosis** quick screen, **memory** impairment? Could you please say these 3 words and then keep them in your memory banks, Ill ask you again in a few minutes?
  
- physical – problem with memory? Epilepsy? Coordination? Painful/numb limbs?  
Problem with ulcers/bleeding from the gut?/liver problems-gone  
Yellow?  
Erection problems? High blood pressure? Heart problems? Stroke?

**Drugs and Alcohol** – any other drugs?

**Risk** – to self/ to others/ from others/ neglect

**Driving?**

Motivation for change – which stage? (see above)

Plan – Would it be ok if I performed a physical examination and arranged some blood tests?  
I will talk to you after this about alcohol support groups including Alcoholics Anonymous and our addiction management group.

## 48. Drug use in pregnancy

Confirmed? Planned? Congratulations! How many weeks?

Have you come to clinic of your own accord or under a drug treatment order? Eg DTTO (drug treatment and testing order)

List of all drugs INCLUDING ALCOHOL and SMOKING

Dependency? (Control and craving, tolerance and withdrawal, persistence and salience – do for opiates and quick screen for the rest. If not using every day then unlikely to be dependent)

If heroin – route? Every day? How much spending? Share needles/equipment? **Funding?**

Motivation for change?

Impact – Social environment – whose at home? Any children in care? Domestic violence.

Does partner use drugs? Who else comes the home to use drugs? Any children in care?

Risk – to self –suicidal/self-harm behaviour? **Accidental ODs?** To others – violence from others- violence , neglect – poverty , self-care -nutrition

Driving

MSE

Depression/mania

Psychosis?

Insight? – **motivation for help?**

PD fights , easily wound up? Impulsive? Suspicious? Hold grudges?

PPHx- suicide? Admissions? Previous engagement with Drugs and Alcohol services/detox?

Meds

PMHx- HIV, Hep B,C Current skin infections? Clots?

Forensic Hx

Plan –

Essential to work closely with pt and MDT team and ideally partner/family.

Confirm pregnancy, and urine drug screen fresh, physical examination, blood tests – (need to check LFTS for methadone) urgent GUM clinic appt ( need to counsel and check for HIV, Hep B, C and STDs – offer Hep B immunization, partner – testing? / safe sex?)

If on heroin will need admission for methadone stabilisation. Also education re safer injecting technique, harm minimisation, safer disposal of needles etc.

If benzo dependent Px least dose of Diazepam.

Smoking cessation interventions – may need to consider nicotine replacement therapy.

If Alcohol dependent – offer detox.

Cocaine, cannabis and amphetamines – simply stop.

Urgent USS scan to be arranged.

Early MDT with eg social services, Drugs and Alcohol team, Dr who looks after delivery (obstetrician), midwife, paediatrics, anaesthetist all needing to be involved.

Education re health of mother and baby needed aswell as community support and interventions – consider couples/family therapy.

Near delivery – anaesthetist involved re pain relief.

On delivery, babies go to special baby unit where they are treated for withdrawal.  
( irritability, hyperactivity, feeding probs, occasionally seizures)  
Child protection and support must be in place.

**Smoking** – miscarriage, prem, small baby, cot death + *cong. malformations*

**Cocaine/crack** - miscarriage, prem, small baby, cot death + *placental abruption*

**Opiates** – miscarriage, prem, small baby, cot death

Benzo- oral cleft 1<sup>st</sup> trimester, floppy baby syndrome, breathing difficulties.

Alcohol – Foetal alcohol syndrome FAS ( facial problems- slant and small eyes,  
upper lip abnormality) and lowered IQ. Fails to thrive.

Cannabis – no evidence of safety in pregnancy – risks of the tobacco , risks of psychosis and depression, decreased motivation.

### **Bipolar and pregnancy**

- Previous Hx of bipolar – at least 25% chance of affective psychosis following childbirth.

## 49. Akathisia

Previous contact with psychae services? Diagnosis?

Onset? If you got rid of this restlessness would you have any other worries? Link with anything like change in medication?

What symptoms were being treated, how are they now?

What have you taken medication/drug wise since then?

EPSE screen – any pain/temperature/ stiffness/ tremor/ unusual movements of mouth?

MSE

Mood- agitated depression? Mania? Thoughts speed, energy, **sleep sex, spending, special powers , plans ?**

Anxiety – GAD? Panic disorder? OCD? Recent trauma?

Psychosis ?

PD- anxious generally?

Insight – including compliance with meds?

**Risk** – to self, to others, from others, neglect. **Drugs and Alcohol, Impact** – support, family, work Driving?

PPHx

Meds

PMHx

FHx

Forensic – pending court case?

Plan – need to review your notes, speak to CPN on the phone, physically examine, BARNES akathisia scale, do blood test and urine drug screen. Need to talk about least restrictive place to manage after risk assessment. Review medication

Maudsley protocol if akathisia – decrease dose/ slow rate of increase, change to quetiapine/olanzapine, consider anticholinergic med ( if parkinsonism features too)

Then consider propranolol, cyproheptadine, benzo, clonidine.

## 50. Resistant depression

- after at least 2 antidepressants each for 6 weeks despite BNF max. or 1 antidepressant + ECT
- Plan – review diagnosis and MSE, assess compliance, assess comorbidity and capacity, maximise psychology and social interventions, consider Li<sup>+</sup>, Mirtazapine, T3 augmentation, consider ECT especially if not eating/drinking and psychotic depression.
- Consider repeat physical examination and repeat bloods / ECG . Collateral history from eg CPNs , family ( with permission)
- STAR-D trial showed that we have to be flexible in the medication approach and that success with medication isn't necessarily very well predicted on the basis of the chemistry of the drug or previous response.

Note: If its an older pt not eating or drinking – think compliance? Psychotic?(believing body is dead already, staff are poisoning him?) are staff monitoring how much you are eating and drinking? Are they encouraging fluids and offering build up drinks? When was the last time he spent a penny?/had a drink?



## **51. Explain what a PD is**

- Personality refers to the way each one of us thinks, feels and behaves.
- normally our unique personalities are fully formed by our late teens or early twenties. Sometimes though, there is an exaggeration of personality which causes that person distress and difficulties in their relationships with other people. It affects 1 in 10 of us.

## 52. Self harm

Very common.

Due to “unbearable inner turmoil”

Up to 1 in 10 people will self harm at some point in their life.

More common in young women, and some groups like the gothic subculture.

Most are not suffering from a mental illness at the time ( figure is possibly 1/3). Nearly half of DSHers have a PD though – esp. borderline, paranoid, anankastic.

In hospital, recent study showed 80% OD and 15% cut (reversed ratio in community)

1 in 3 will repeat in that year.

3 in 100 will end their life over 15 yrs.

Treatment – Risk assessment. Must have 7 day follow up offered. Individual problem solving therapy – help with coping with stress in their personal environment. Therapist led therapeutic groups.

Obviously if mental illness present, this should be treated.

For Borderline PD, risk assessment. Consider community options first – Crisis team/ Home treatment team. Psychological therapy -consider DBT, Brief psychodynamic interpersonal therapy.

Admissions should be ideally short if deemed necessary after risk assessment. Longer term ?therapeutic community?

Books – The scarred soul – Tracy Alderman, Healing the hurt within – Jan Sutton.

Phonelines- Samaritans, Childline, NHS Direct.

### self harm in police custody

- ABC? – triggers, behaviour, regrets/plans?
- Have they been examined by the police surgeon?
- Has the cell been searched?
- Drugs and Alcohol, impact, risk – to self to others from others neglect.
- PPHx meds, PMHx –HI epilepsy mainstream school, Forensic Hx
- MSE + look for PD
- Options include increased obs levels, admission to hospital.

Note: 1/3 of deaths in police custody are due to self-harm/ suicide

## 53. Borderline PD

2-5% in community, up to 15% in-pts.

Risk factors – physical and sexual abuse in childhood

Features

- impulsive, emotional
- feeling of emptiness, abandonment in relationships
- stormy relationships
- self destructive behaviour eg self harm
- goals change.

Prognosis

– 1 in 4 in 20s from higher social classes still meet criteria in middle age. Worse prognosis if  
Drugs and Alcohol and Criminal record.

Treatment

- MDT
- Address comorbidity eg drug and alcohol.
- Psychological – DBT , Therapeutic community,
- Social support
- Medication – has some role in crisis for stabilising symptoms (eg antidepressants  
and mood stabilisers for mood and antipsychotics for aggression) but no long term  
evidence.
- Carers assessment

Therapeutic community

- a type of residential group therapy
- used for PD and drug rehab
- small group therapy, individual therapy and creative activities take place
- clients and staff live together.
- **Democracy**- everyone has a say
- **Permissiveness**- non judgemental attitude
- **Reality confrontation**- honesty encouraged re self deception
- **Community**- you all chip in.

## 54. Explain schizophrenia to a relative

- Is a serious mental illness which affects peoples thinking feeling and behaviour.
- 1 in 100 at some point in life, M=F but men affect men a bit earlier, 15-30 vs 25-30 on average.
- At first there is often subtle change in behaviour or withdrawal before the main symptoms com on. We call this a “prodrome”
- 4 main groups of symptoms
- hallucinations – experiencing sensations that aren’t real
- delusions – believing things that aren’t true
- muddling of thinking – for example feeling that thoughts are being removed
- so called negative symptoms – lack of emotion, lack of motivation, poor self care, preferring own company.
- 1<sup>st</sup> 3 are called positive symptoms and the last one refers to negative symptoms but its nothing to do with whether they are good or bad.

### Causes

- individual predisposition – the same amount of stress tips the balance into experiencing symptoms earlier for some people than others.
- Chemical imbalance in the brain – imbalance of a chemical in the brain called Dopamine. Too much in certain parts can short circuit the brain causing eg hallucinations while too little in other parts can cause problems like lack of motivation.
- Various risk factors include:

Runs in families – identical twin has 50:50 chance. 1 in 10 with SZ has at least one parent with the condition.

Urban environment

Recent immigration

Infection in pregnancy

Drugs – amphetamines and cannabis ( 2x risk with regular use)

Prognosis – 2/10 will not have a second episode, 5/10 will have a relapse within 2 yrs and have remissions and relapses, 3/10 will always have symptoms that wax and wane, 2/10 will suffer chronic severe symptoms. These don’t add up to 10 because there is some overlap in the middle categories.

Better prognosis with – females, shorter duration, good premorbid, quick and later onset, family hx of mood disorder, positive symptoms, compliance.  
7% on average commit suicide.

Side effects of antipsychotics

- Can be divided into different groups:
- one group affects the muscles – pain, stiffness, tremor, restlessness, unusual movements of mouth/tongue
  - one affects sleepiness and weight gain
  - another affects sexual function and dizziness
  - another can cause dry mouth, blurred vision, urine retention, constipation
  - metabolic syndrome
  - rarer side effects like liver problems, sensitivity to sunlight, rashes, **nms**

Mx – Will be by **MDT**.- managing illness and risk in the least restrictive environment.

**Social assessment** – accommodation, finances , **carers assessment** . Voluntary support groups – MIND, National Schizophrenia Fellowship.

**functioning assessment** - daily skills, vocational and day centre, local support groups, hearing voices group -OT will help.

**Medication** with regular physical review.

**Coordination** – by care coordinator as part of CPA ( CPA involves assessment , care coordinator, care plan and regular review)

**Note:** DSM4 diagnosis requires the following: ( in case you are getting grilled!)

2 or more of the following for 1 month ( one if bizarre/running commentary/voices discussing):

delusions

hallucinations

disorganized speech/behaviour/catatonic behaviour

neegative symptoms

and social/occupational disturbance for 6 months.

Classic questions: does that mean he will be violent?

Reply: most people with SZ are not violent and are more likely in fact than other people to be victims of violence. Overall there is a slight increased risk of violence among people with SZ, but this needs to be put into the correct perspective. Its not as high as the media generally makes out. If SZ were eradicated today, the amount of violent crime would reduce by 1%. The risk is greater if there is drug and alcohol abuse and previous history of violence. All patients are assessed for risk issues regularly by their team.

Is it my fault?

Reply: its not your fault and its not his fault. Its an illness and the focus now needs to be on how well we can support both him and family.

How long does he need to be on the medication?

Reply: Its very difficult to say at the moment. Its recommended that the medication be continued for at least 1-2 yrs after the first episode. If there have been several episodes the medication needs to be continued. Without the medication there is a much higher chance or relapse, severity of relapse, and suicide risk ( increased 4X).

Any future stopping of meds requires a thorough risk –benefit analysis.

## 55. nms

- affects 1 in 500 , mortality 5-10%
  - Mainly associated with antipsychotics but also some antidepressants and Li+
  - Increased temperature, muscle rigidity, decreased level of consciousness plus changes in body regulation (autonomic instability) – bp/pulse etc.
  - risk factors – rapid change in dose, high potency antipsychotics, previous nms, Parkinsons, LD, psychomotor agitation, withdrawal of levodopa/amantadine, hyperthyroidism.
  - treatment is ABC, physical examination, stop the antipsychotics. liase and transfer to medics, Investigations – bloods – raised CK, raised WCC, raised LFTs, ECG, CXR
  - supportive treatment – fluids, consider ventilation. Meds- consider dantrolene, bromocriptine.
- 
- Wait until all symptoms resolved before restarting the antipsychotic and ideally once a further 1-2 weeks have passed. Restart cautiously, ideally avoid depot.

## 56. Puerperal psychosis/ PND

Thank you for seeing me today. I know it can be really difficult to talk when theres a lot going on so I do appreciate it.

I understand you have a baby. Whats his name? Planned? Known to CAMHS/Social services?

How are you getting on with xxxxxx?

( says nothing )

Is there anything wrong with the baby?

( says something odd)

What do you mean by that?

How do you plan to sort that out?

GO STRAIGHT FOR RISK TO HERSELF AND TO THE BABY AND TO OTHERS.

Explore psychosis

-don't forget -- command hallucinations, control, persecution

Explore first rank

Explore mood – mania/ depression – incl. sleep even if baby isn't crying?

Tearfulness/guilt/inadequacy feelings?

Insight? – How long have you been feeling like this? Can you link it with any recent setbacks?

Drugs and Alcohol,

Impact – support - family, whos at home? Are you alone with baby in the day? **Health visitor?**

Risk – to self, to others, from others, neglect- of self and baby.

PPHx

FHx

Meds

PMHx – Are you **breastfeeding**? Problems in pregnancy or delivery, development//?

**C- section?** Thyroid, HI epilepsy

Forensic – police, previous violence?

Mx – psychosis

Treat in least restrictive setting taking into account risk assessment.

If psychotic/ high risk of self harm will need admission to mother and baby unit.

There will be extra monitoring of mother and mother-baby interaction and support.

Need to rule out organic causes – infection, delerium etc

Anti- psychotics (taking into account breastfeeding wishes ) and 2<sup>nd</sup> line ECT.

Carers assessment and leaflets.

Mx-PND

Assess risk – treat in least restrictive setting suitable for situation.

Rule out organic causes – thryroid , delerium etc.

CBT/IPT (but can provoke anxiety) and/ or SSRI

Consider hospital, teaching of coping skills,  
Support organisations eg CRY-SIS, Meet –a- Mum association, Association for postnatal  
depression.  
Carers assessment and leaflets.

Notes:

Puerperal psychosis 1 in 500  
Puerperum is 6 weeks postpartum  
Usual onset day 4 to 2 wks,  
70% recover fully  
average length of hospital stay 2-3 months

PND affects up to 1 in 10  
Usually within a month but can be up to 6 months later.  
Edinburgh Postnatal Depression Scale can be used.  
Risk factors – single, older, C- section, premature, unsupported, PPHx/FHx depression.  
70% recover



## 57. Social phobia

5 in every 100, women at least 2-3x more than men, increased risk if stammered as a child or high standards for behaviour in public.

Fear of being centre of attention/  
Fear of doing something embarrassing

OR

Avoidance of the above situations

Check for blushing/shaking  
Fear of vomiting  
Urgency

Must cause emotional distress.

Need to exclude OCD/mood/SZ

Note Specific social phobia – performing or talking to a crowd is affected.

Mx – support and info. Relaxation training, social skills training, Graded self exposure (works in half) CBT – Should be tried before meds and helps with unhelpful assumptions eg I'm boring and looks at safety behaviours eg avoiding eye contact.

Meds – SSRI – usually work in 6 weeks but can take up to 12 weeks. Half get worse when discontinued. Other meds that have been used include MAOI and beta blockers.

Leaflets and website – college website and shyness and social anxiety section on [patient.co.uk](http://patient.co.uk)

## **58. Communicate with colleague re Schizophrenia pt**

Diagnosis

Current care plan and support in community.

Early warning signs.

When was he last reviewed? And by a psych. Dr? Last mse?

PPHx Last admission, number of previous admissions. Suicidal history.

Meds

Medical issues

Family issues/children/partner

Forensic issues

If colleagues says its tough/ or complaint has been made, say “ Im sorry to hear that a complaint has been made. Perhaps we can support you and look at the complaint together if you wish with the team”

## 59. Delerium

(patient will start of agitated and confused)

sit down, observe.

“you seem very distressed could you please tell me what the matter is?”

“ you are in a safe place, Im here to help, perhaps we could sit down and talk about it,

“you appear to be seeing things , what are you seeing?” (if hearing things, its probably a psychosis station)

describe vision- see it ?- size (lillipution?), see from corner of eye? hear it ?

taste/smell/hear?

Why you ? why now? –(delusion?)

How long for ?

----quick alcohol question “ drink alcohol regularly ? how much ? when was last drink? Any street drugs??

Orientation – time / person/ place

3 item recall

world backwards.

1<sup>st</sup> rank screen

mood screen –mania/depression

insight

Drugs and Alcohol (done) Risk – to self ,to others, from others ,neglect. Driving, Impact – home (children )and support

Plan – O/E, Ix- Bloods, MSU, Urine drug screen. If alcohol – will arrange alcohol detox as an in-pt and and B vitamins. Also will attend to good hydration/nutrition and elimination.

Note: Transient Global amnesia - pt bewildered, anterograde memory poor, procedural memory intact, hypoperfusion.

Dissociative fugue state – purposeful travel beyond the usual everyday range. Amnesia – either partial or complete for the journey. Behaviour may appear entirely normal to independent observers.

## 60. OCD

M=F ( except more in prepubertal males)

Clue! They don't shake your hand!!

Could you please tell me a little bit about what is worrying you at the moment?  
Any fears of contamination / germs on your hands?

### **Thoughts and images, doubts and ruminations, perfectionism**

Own thoughts? Unpleasant? Resistance? ( must be at least some)

### **Rituals and checking, hoarding and reassurance, avoidance and correcting obsessional thoughts.**

Unpleasant? Resisted?

how much of day taken up? Getting worse? Link with anything?

Impact- children, involving others in rituals? On work? On family?

Risk – to self, to others, from others, neglect

Drugs and Alcohol

Driving?

MSE

Mood – depression ( which came first?)/mania

Other anxiety – GAD, PTSD, Social phobia, panic attacks

Psychosis screen

Personality traits – adhere to rules/regulations? Resistance to change, stubborn? ( in anankastic PD the traits are egosyntonic as opposed to egodystonic in OCD. Also in anankastic PD there isn't the degree of disruption to daily life seen in OCD.)

Insight – what does pt believe ? willingness to engage?

PPHx

Meds

PMHx- recent sore throat?

Forensic Hx – court case

Mx –

Manage risk in least restrictive environment. MDT.

Social – address housing, finances, hoarding issues. Carers assessment. Education about illness and support groups. Leaflets.

Mild/moderate – CBT with ERP (exposure and response prevention). Can be done as group or individual. For milder, guided self help too can be considered. At least 10hrs initially. ¾ improve though ¼ cannot complete. ¼ relapse.

Medication if pt prefers this over psychology or if CBT hasn't helped. SSRI high dose. If no effect after 3/12 , switch to different SSRI or try clomipramine. Overall 6/10 improve but ½ relapse on discontinuation. Has to be taken for 1yr.

Severe- consider using CBT with ERP and medication at the same time. High dose SSRI.

Other strategies: clomipramine + citalopram, add antipsychotic, addressing comorbidity and family issues.

Leaflets and websites  
OCD Action and OCD UK

Prognosis – worse if early onset and depression. Mild OCD – many improve. Mod-severe OCD more chronic without Tx.

## **61. GAD**

Prognosis- 30% remission after 3yrs. Higher unemployment and marital dysfunction.

## 62. Assess personality

How would you describe your own personality?

How would others describe your personality?

**Hobbies / interests/ beliefs/ fantasy?**

**Reaction and coping** with stress and

General temperament? Eg emotional , impulsive, quick tempered.

Drugs and Alcohol, violence, forensic

### Relationships

Plus home in on the likely PD

Paranoid – Bear anyone any grudges? Do you find yourself being suspicious of others? Do you look out more than others for your personal rights? How well do you take setbacks in life?

Schizoid – friendships? Like to daydream?

Schizotypal – unusual interests? Psychic abilities?

Dissocial – easily frustrated, quick tempered, difficulty keeping relationships/friendships going, violence, police?

Emotionally unstable – impulsive – emotional, impulsive

Borderline – in addition – feel empty inside, worries re

Abandonment, self harm, stormy relationships,

Histrionic – like to be centre of attention, ever been accused of being dramatic in displaying emotion? Easily influenced?

Anankastic – cautious, stubborn, rigid, like to stick to rules and regulations a lot. Like to do things your way.

Avoidant – generally prone to worrying? Does it worry you a lot what other people may think of you?

Dependent – is it difficult to make decisions without the help of others. Do you worry about not being able to cope on your own?

Risk – to self (ask re suicide), to others (ask re violence and forensic) from others, neglect.

Drugs and Alcohol

### 63. Psychodynamic psychotherapy – explain

- Is a well established special form of talking therapy used for helping people reduce their psychological pain. Helpful for a range of difficulties including depression, loneliness, difficulties with relationships.
- Central premise is that our past relationships can affect our present relationships and functioning.
- The patient or clients relationship with the therapist is crucial. To some extent the therapist acts as a “blank canvas” which encourages the patient to project deep emotions and past relationships on to the therapist. The therapists job is to be aware of what is happening and of their own reaction to this. The therapist is then able to feed this back to the patient thereby making them more aware of their unconscious feelings and ways of behaving.
- This insight helps the patient understand themselves better and helps them deal more effectively with relationships.

#### ARE YOU WITH ME SO FAR?

( if no, give example of “have you ever walked into a room and taken an instant liking of that person and wondered why, and then later realised that they reminded you of one of your favourite relatives? Well this therapy is based on similar principles in that past relationships can influence present ones.)

- technicalities – first you have to be assessed for suitability for this therapy to maximise the chances of it benefiting you. – insight and motivation, ego strength and distress tolerance, relationship ability, and psychological mindedness.
- Can be done as a group, couple or alone.
- Therapist have different backgrounds with specialist psychotherapy training on top.
- Confidential with therapist and supervisor but with issues of risk must speak to the right people.
- 50 minute appts once per week variable length. Often 1 or 1 ½ years. If 16 sessions then called brief psychodynamic psychotherapy.
- 1<sup>st</sup> stage orientation to therapy, rapport
- 2<sup>nd</sup> stage uncovering relationship patterns.
- 3<sup>rd</sup> stage anticipating end of therapy, closure.

Its quite a lot to take in so I will also give you some leaflets and lend you a helpful video.

Note : the “dynamic” in psychodynamic refers to the relationship between our conscious and unconscious selves.



## 64. Suicide –

Note : 1 in 5 who attempt will try again. 10% of these will eventually take their own life. Suicide is most common cause of death in men under 35yrs. 5-6000 suicides in UK per year with 140,000 attempts per year (19,000 are young people) 3X more common in men than women.

3-4% of men and 7-8% of women have moderate to severe depression at any one time.

Suicide risk – increasing risk – predisposing (older, living on own, terminal illness,  
)precipitating (recent bereavement) maintaining (poor social support, pain)

- reducing risk – predisposing ( no previous attempts), precipitating (not  
planned), maintaining ( willing to engage with team)

## 65. Depression in pregnancy

Need to take into account degree of depression, Drugs and Alcohol, risk issues, past Hx ( bipolar??) medication history, wishes to breastfeed. But in general,

If not on antidepressants – and mild depression- consider CBT, social support.

- and mod to severe depression- use CBT and antidepressant  
after counselling.

If on antidepressants and high risk of relapse- continue antidepressant during and after pregnancy. ( 7/10 relapse if antidepressants discontinued in pregnancy vs 3/ 10 who continue with antidepressants in pregnancy)

Most experience with **amitriptyline , imipramine** ( but sedation, constipation, toxic od, )  
And **fluoxetine** ( new data suggesting risk of earlier delivery and decreased birth weight)

SSRI in general associated with neonatal withdrawal eg agitation, irritable and may increase risk of “persistent pulmonary hypertension of the newborn”

Paroxetine has been associated with heart defects in 1<sup>st</sup> trimester (atrial and ventricular septal defects risk less than 2%)

Resistant depression in pregnancy – ECT favoured over drug combinations by NICE

For breastfeeding – **paroxetine** and **sertraline**

( citalopram and fluoxetine not recommended in breastfeeding and of the TCAs avoid particularly doxepin but imipramine and nortriptyline are acceptable. In general give consideration to age, weight and nature of feeding of baby – partially weaned? Infant should be closely monitored by health visitor)

Note: clomipramine in pregnancy associated with cardiovascular defects. Lofepamine is the least toxic TCA in overdose.

Advice can be sought from UKTIS ( UK teratology information service )

## 66. Bipolar in pregnancy

- if stable and long period since relapse then consider withdrawing or switching mood stabiliser to safer one (antipsychotic) before conception and at least the 1<sup>st</sup> trimester. (Maudsley)
- If severe illness or known to relapse quickly with discontinuation of their mood stabiliser should be advised to continue their medication following discussion of risks to mother. (Maudsley)
- Generally valproate and combinations of anticonvulsants should be avoided.
- The ideal mood stabiliser is an antipsychotic eg olanzapine? (note- linked with gestational diabetes)
- acute mania – treat with antipsychotic and then ECT
- bipolar depression – treat with CBT for moderate depression and SSRI for more severe (Maudsley)
- one study showed if euthymic bipolar pts discontinued mood stabilisers after conception risk of relapse was increased by 2X and ill for 5X as long.
- Risks of teratogenicity must be balanced against risk of relapse and subsequent poor self care, lack of obstetric care, self harm, harm to foetus or neonate ( neglect /infanticide)

In general anticonvulsants increase risk of major congenital malformation by 2-3X  
Valproate risk of congenital malformation is 7%, also associated with decreased intelligence.

Risk of spina bifida in Valproate is 1-2%

Risk of spina bifida in Carbamazepine is 0.5-1% ( with CBZ, vitamin K will need to be given to mother and neonate just after delivery)

If valproate or CBZ are continued then prophylactic **folic acid** should be prescribed

Lamotrigine associated with cleft palate.

Background general population risk of congenital malformation is 2-3%

**Lithium-** if mood stable and stopped at conception 70% likelihood of relapse perinatally.

Risk of Ebsteins abnormality of the heart is 10-20 X general pop. Risk ie 1 in 1000

Greatest risk in weeks 2-6.

If continued will need USS level 2 at 6 and 18 weeks.

Considered safer after 26<sup>th</sup> week but associated with neonatal lethargy, hypotonia, cardiac arrhythmias and neonatal goitre

Mother will need regular U + Es with monthly li levels checked, weekly Li + levels after 36 weeks and within 24 hrs of birth.

### **Benzos in pregnancy**

1<sup>st</sup> trimester – oral cleft

3<sup>rd</sup> trimester – floppy baby syndrome

also links to low birth weight.

Also recent links to pylorostenosis and alimentary tract atresia (needs replication – maudsley)

For rapid tranquilisation – unlikely to be problematic unless immediately before birth (maudsley)

## 67. Agoraphobia

- is really a cluster of phobias related to being around crowds, public places, travelling alone or away from home.
- Especially worry about being in a situation from which escape or help would be impossible or embarrassing in the event of a panic attack.
- Divided into agoraphobia with panic attacks – 4-5% of population, and without panic attacks approx 2% men and 4% women.
- Physical , psychological and behavioural effects.
- Physical – dizzy, sweaty, trembling, ringing in ears, hyperventilation
- Psychological – fear of dying, of losing sanity or control, of being embarrassed
- ( plus related often – low self esteem, fear of being left alone in house)
- Behavioural – **safety behaviours** eg alcohol, medication, **reassurance** eg only going out with people, **avoidance** and **escape**.

Hx

- **Why do you avoid going out?** ( if to avoid social situations does SOCIAL PHOBIA explain things better or are there both diagnoses? 55% also have social phobia, if to avoid germs THINK OCD –( OCD trumps agoraphobia)

Tx – CBT with desensitisation therapy ( sometimes called cognitive delivered exposure) This is 1<sup>st</sup> line. Works in 2/3

SSRIs are 2<sup>nd</sup> line or sometimes used in combination with CBT but not great benefit of having the 2 combined. ( other meds TCA – imipramine, clomipramine and MAOIs)

## 68. Serotonin syndrome

- a condition caused by too much of a certain brain chemical in the brain called serotonin.
- Usually caused by high doses of medication or medication combinations.
- Symptoms include fever, sweating, increased heart rate, shaking, agitation, confusion, muscle jerks and spasms, incoordination, and increased reflexes on examination.
- Mx – ABC, examination, stop serotonergic meds, liaise with medical colleagues and consider transfer.
- Ensure hydration, vital sign monitoring, and consider cooling blankets, anticonvulsants, clonazepam for myoclonus, nifedipine for increased bp
- In extreme cases may need artificial ventilation.

## 69. Adolescent depression

- becoming more common and starting at a lower age.
- 1% of prepubertal and 3% postpubertal children.
- Isle of Wight study showed 10% of 10 yr olds and 40% of 14 yr olds are “miserable”

### Hx

- Name, age, known to CAMHS or Social services? Not wish to come to this appointment?
- onset, link with anything? ( adjustment disorder if onset within 1/12 and duration <6/12)
- mood, energy, enjoyment?
- concentration, confidence, guilt and suicide/self harm behaviour, psychomotor change , sleep , appetite/Wt change
- Gothic subculture?
- Think is there ADHD, Conduct disorder, OCD here?

Impact – home –family ? school – academic ? bullying? Teacher issues?

Drugs and Alcohol?

Driving if 17+

Risk – to self, to others, from others – family/bullies, neglect

### MSE

Mood – should have been covered

Anxiety – ptsd? Social phobia? Agoraphobia? OCD?

Psychosis screen

Insight

**Dev** – mainstream school, probs with pregnancy /birth /development? Unusual interests, sociable?

PPHx – suicide attempts? Previous self harm?

Meds

PMHx – epilepsy, head injury, feeling hot or cold

FHx – suicide, mental illness

Forensic – trouble with the police?

### Mx

- stepped care approach with input from MDT. Aiming to ensure good therapeutic relationship with the young person and good communication with the family. Offer carers assessment.
- If mild, consider watchful waiting and F/U in 2/52. Otherwise consider non directive counselling, guided self help, or group CBT. Try this for 2-3/12
- If moderate/severe – CBT/IPT/ short – term family therapy for 3/12. Afterwards or if no response at all at 6/52 and pt aged 12 plus, may consider fluoxetine at 10mg OD. If age 5-11 then fluoxetine may be tried but very cautiously.
- 2<sup>nd</sup> line psychological therapy includes child psychotherapy – 30 weekly sessions or systemic family therapy – 15 fortnightly sessions.
- Admission ( to age appropriate ward ) – to be considered if pt has suicidal ideation, psychosis or not eating / drinking.

### Prognosis

- 10% recover in 3/12
- 50% recover in 1yr

### Note on capacity/competence:

If age 16 or over can consent to Tx ( as long as has capacity )

If age 16/17 – can't refuse Tx if court / responsible parent decides its in best interest.

15 and under – can be competent if sufficient understanding and maturity to understand procedure. Again cannot refuse Tx if court/ responsible parent decides its in best interest.

## 70. Prison officer – get a collateral history regarding an inmate.

Could you please tell me about your concerns regarding Mr XXXX?

How long in prison? remand or sentenced? why, first time?

Single cell? Bullying?

Behaviour changes depending on company / unobserved? ABC? Related to court case appearance?

( If mute – talking to anyone? Interpreter? Talking to Imam/religious leader?)

Drugs and Alcohol?

Risk – to self, to others, from others, neglect.

Impact/family – any visits?

Depression screen – seems down? Low energy? Enjoying anything? Eating/sleeping? Worse any time of day? Manic?

Anxiety screen – PTSD – jumpy, on edge? OCD – checking / washing/ counting/ symmetry?

Psychosis – appear to be having private conversations / seeing things when there is no one in the room? Muddling in his thinking? Saying anything bizarre? Acting bizarrely?

Malingering – do officers suspect that hes putting it on? Why?

PPHx – known?

Meds?

PMHx ?

**Forensic hx ? Malingering?**

Plan – I will need to gather more information from the GP, his prison reports, immigration etc, and then would like to arrange an appointment to see him very soon with an interpreter etc. In the meantime please increase observation levels.



## 71. Sexual side effects of SSRIs

Scenario – “ I want to stop my tablets, I don’t think I need them anymore”

= (for casc) sexual side effects!

“Is it due to side effects?”

“Its quite common to suffer from different side effects like nausea, insomnia and sexual side effects, have you suffered from any of these?”

Since starting the tablet, have you noticed a change in sexual drive, erection difficulty or ejaculation?

If erection – difficulty obtaining or sustaining? Partial or complete ?

Were you suffering from this before the tablet? Even before the depression came on?  
How long ago was it when there was no problem at all?

Impact – emotional relationship with wife? Faithful to wife? Are you physically attracted to her at all?

Risk – to self , to others, from others, neglect?

**Drugs and Alcohol** – (cause and coping)

PPHx ---

Meds – **antihypertensives?**

PMHx – **DM**, MI/angina ?

MSE

- (not usually required)
- **Depression – is it getting better or worse?**
- Psychosis
- Insight ?

Plan

– it seems as if the erection difficulty has got a bit better if anything since starting the fluoxetine. Depression in itself can cause sexual difficulties in terms of sexual drive , erection and orgasm.

- watchful waiting for a few more weeks- as the depression lifts then the difficulties may go away. Also even if the tablets are having a negative effect on erection, then in a proportion of people these will wear off anyway.
- consider reducing dose as long if euthymic and therapeutic dose
- consider switching antidepressant to mirtazapine. (bupropion would be another choice but unlicensed in the uk.)
- I will also be writing to your GP who may wish to perform a physical examination and arrange some tests if things don’t get better. Its important to rule out common conditions which can affect sexual function such as diabetes and high cholesterol. Note – only the GP or consultant in GU should be prescribing Viagra.
- You may wish to consider RELATE and if difficulties persist, referral to an NHS sexual therapist.

## 72. Delirium management – explain to nurse on ward.

They will say “ we can’t manage Mr XXXXX on the ward he needs to be transferred today.”

Reply “ Thank you very much for meeting with me now, I know you must be very busy and Im keen to be as helpful as possible and support you. Could you please tell me what nursing staffs understanding is of his present condition?”

They will say “ Its obviously psychiatric”

Reply “ Ive just reviewed Mr XXXXX on the ward and he appears to be suffering from a delerium” ( if relevant add– “most likely due to alcohol withdrawal although there could be more than one cause”)

Features of delerium – acute onset, altered and fluctuating conscious level, disturbed sleep wake cycle, transient hallucinations/delusions.

Causes – (many) infection, intracranial, illicit or prescribed drugs, dehydration.

“So why cant he be managed on your ward?”

Reply “Unfortunately our psychiatric ward in not physically equipped to look after patients suffering from a severe delerium and although some nurses are dual trained, many don’t have the medical nursing training that you have.”

“ but I know people who have an infection and the don’t get this confused?”

Reply – unfortunately the more frail and elderly we get, and the more medical problems we have –especially dementia, and the more drugs we are on, the more likely we are to get acutely confused when there is another problem like infection.

“but we cant cope”

Reply “after we have given some PRN , Mr xxxxx should begin to settle within the half hour. PRN is a last resort and we should look out for risk of falling and (for benzos) disinhibition. Im confident that there will be significant improvement. I will regularly review on the ward and I will be checking the bloods and liasing with the medical doctors”

**Plan** – needs medical treatment. Untreated up to 10-20 percent mortality.

**Need to identify and treat the cause aswell as providing nursing input.**

Nursing – attention to hydration , nutrition, elimination.

- ideally nurse in side room,
- ensure safe environment in room
- adequate lighting in day, and small nightlight at night
- family photos
- encourage family visits if safe and practicable to do so
- staff to introduce themselves by name each time they speak to patient and ideally it should be a small number of the same staff who provide nursing interventions.

- If patient tries to leave and confused, then under Mental Capacity Act, can be asked to remain on the ward. If agitated may need PRN lorazepam or haloperidol. (last resort, lowest dose, try oral first). Note - Mental health Act is not appropriate for delirium.

Note if its DTs from Alcohol, then

- pt may need a stat dose of benzo eg lorazepam if acutely agitated.
- Reducing scale of chlordiazepoxide over 5-7 days
- IM or IV B vitamins ( Pabrinex )
- If liver failure consider Lorazepam or Oxazepam instead.
- Be alert to any seizures.

“but we cant cope”

Reply “after we have given some PRN , Mr xxxxx should begin to settle within the half hour. PRN is a last resort and we should look out for risk of falling and (for benzos) disinhibition. Im confident that there will be significant improvement. I will regularly review on the ward and I will be checking the bloods and liasing with the medical doctors”

“ I would be happy to support you if you feel it is necessary to request more medical nursing staff for your shift”

“ I can speak to my psychiatry nursing manager with regard to your request for psychiatric nursing support, but I cannot promise anything without speaking to them first”

## 73. CBT – explain

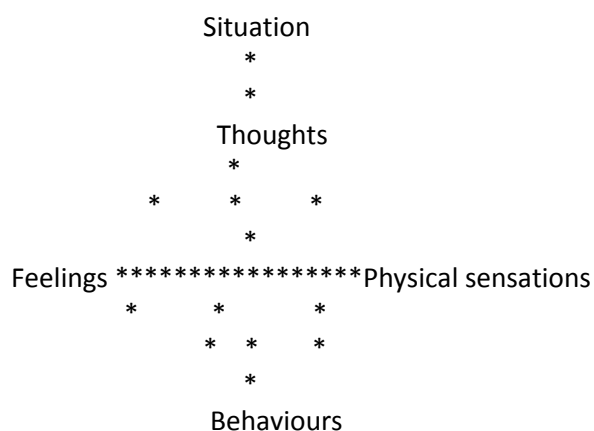
Before we begin, **whats your understanding of CBT?**

CBT stands for cognitive behavioural therapy and is a special form of talking therapy which concentrates on what we call the “here and now” in other words the present rather than the past.

Proven effective for many different conditions including – depression, anxiety ( OCD, PTSD), bulimia, even pain relief!

For moderate depression , just as effective as meds.

Probably easiest if I draw a diagram to explain how it works.



As you can see by this model, our thoughts, feelings , behaviour and sensations are all interlinked. So anyone of these will affect the rest.

This is called the “hot cross bun model” !

For it to make more sense to you , lets see how this might apply to your situation, (eg if bulimia – how do you feel when you overeat or binge?

If depression – what thoughts go through your mind when you are feeling low?)

In CBT we try to break the vicious cycle by helping you modify thoughts and behaviours.

Thoughts – eg challenge unrealistic or unhelpful thoughts like “Im worthless”

Behaviour – look at alternative ways of acting in certain situations. Eg. Experiments like seeing what happens when you phone your friend.

Learn skills which can be used when therapy is over.

### Technicalities

- can be done as guided self help including computer use – mood gym is free but fear fighter (phobias) beating the blues (depression) need prescription, individually or in a group
- 8 – 20 sessions , weekly , each 50 minutes.
- Special exercises are given like mood diary, thoughts diary, behaviour experiements, listening to the recorded last session.
- Top up CBT can be arranged later on, fewer sessions usually needed.

I will give you some **leaflets** and lend you a **video**. The British association for behavioural and cognitive psychotherapies keeps a register for accredited therapists.

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## 74. Fitness to plead

6 criteria!!

- understand what the police say you've done?
- understand what is meant by "guilty" and "not guilty"
- understand what you can do if you aren't happy with a juror
- know the role of the judge and the jury
- be able to follow court proceedings
- be able to tell your lawyer your side of things and give instructions.

Plus include an MSE, Drugs and Alcohol and LD screen.

Note: "fitness to plead" refers to this cross section in time, whereas "fitness to stand trial" is longitudinal and refers to the likelihood of being able to be fit to plead over the length of the trial ie without relapsing.

Fitness to be interviewed

- need to do MSE
- check not under influence of drug and alcohol
- screen for learning disability – ask a few leading questions on matters not to do with index offence.

## **75. Testamentary capacity**

- know what a will is?
- Know the extent of your estate and wealth?
- Know who has a claim and how you wish to divide it?
- No impairment of mind that will affect the above.

## 76. Arson

I know it can be difficult to speak about it so I do really appreciate it.

ABC

When did you start the fire, what triggered it off? Why?

(think revenge, sexual excitement, tension release, boredom, profit, suicide, delusion)

“I saw something on TV”

What was it? Explore etc

Did you use anything to help the fire along like petrol?

How did you feel – excited ( + sexual?) , sad , tension release?

Where you on your own?

Did you think that it might endanger others lives?

How did you feel afterwards, how did the police find out it was you?

Any regrets/ remorse? Victim empathy? Blame?

**Would you do it again** – if not whats changed?

**Have you done this before?** Whats the biggest fire you’ve caused?

History of violence?

Usual triggers - ( past case was reminders of sexual abuse)

Drugs and Alcohol?

Impact – current support, any children? Any abusive experiences as a child? Did you go to a mainstream school? (triad of sexual abuse, fire setting and LD )

Risk – to self , to others, from others, neglect

MSE

Depressed/manic?

Psychotic?

Insight?

PD – impulsive ----fights, low frustration tolerance ,easily aggressive---denial, minimisation, victim empathy, ---grudges, suspiciousness.

PPHx

Meds

PMHx – Head injury, epilepsy, Thyroid

Forensic – if forgotten!

Mx

- I need to gather some more information from other people now, hostel, police etc
- Treat mental illness if present.
- Pyromania – ( fires induce euphoria, there is tension release, relief afterward, often fixate on institutions of fire control ie fire engines etc. ) behaviour modification.  
Other tx includes psychodynamic approach, family therapy has been used and SSRIs.



## **77. Anxious man, partner recently diagnosed HIV positive**

Whats the situation? Partner – affair? Male/ female, sexual relationship what sexual practices?

Pt married? Do they know about affair , about pts worries?

MSE

+screen for PD – impulsive, anxious, dependent?

Drugs and Alcohol

Impact – family situation, current support

Risk – to self (suicide) to others (revenge , or to wife – infection) from others , neglect

PPHx

Meds

PMHx

Forensic

Plan – HIV counselling and testing. In the meantime no sex/safe sex with wife. If positive they need to inform all their sexual partners. Consider antidepressant and offer psychological support options.

## 78. Capacity

Is English your first language? (need interpreter)  
Any trouble with your hearing?

Whats your understanding of the situation?  
Why don't you wish to have the operation?  
What have they said the advantages/disadvantages are?  
What do you think the advantages/disadvantages are?  
Tell them something they might have missed out and remember 3 objects  
-apple , table, penny

Do a quick MSE  
-depression/mania  
-psychosis

Drugs and Alcohol  
Impact – does family know? Aware of risks? Cultural/religious beliefs?  
Risks – to self, to others, from others, neglect.

PPHx  
meds  
PMHx- learning disability? Head injury, epilepsy?

### **CAN YOU REMEMBER WHAT I MENTIONED REGARDING XXXXXX RISK? AND 3 OBJECTS**

If pt doesn't want the procedure- Would it be ok if I **returned later** today and tomorrow with the surgeon to see if you are of the same opinion? I will also now give you some **written info** about the procedure if you haven't had so already.

Would it be ok if I spoke to your **next of kin** about the situation?

I would also like to perform a memory test called a **MMSE** now (if appropriate) and then I will be checking through your **medical notes**, blood test results, and speaking with the medical/surgical team.

If relevant mention that low mood/ (psychotic) beliefs may be interfering with ability to weigh up the choices properly.

If pt does now want the procedure – I will give you some written info on the procedure and see if the surgeon is now available so that you can ask any further questions.

## 79. Fragile X

- large ears, velvety skin, double jointedness, flat feet, testicular enlargement after puberty, speech “cluttered” attentional deficit, hand flapping, IQ – 80% of boys IQ less than 80. Autistic traits. CGG repeats over 200.
- Support –MDT. Speech and language, physio, psychological techniques for teachers/parents, look at educational needs. family support –carers assessment.

## 80. Catatonia

- means increased muscle resting tone
- can be organic- eg postencephalitic states, drug related, viral
- can be mood related – up to 50% esp. mania
- can be SZ – 10-15%

For catatonic SZ, 2/52 of at least one of stupor/ excitement, posturing/waxy flexibility (catalepsy), negativism/automatic obedience and rigidity.  
May be oneiroid state in addition.

## 81. Tardive dyskinesia

lip smacking, tongue protusion, choreiform movements of hands , pelvic thrusting.

- risk factors – elderly females with affective illness.
- 5% per year on antipsychotics (1 in 20) but less on second generation antipsychotics
- increased mortality rate
- approx 50% are reversible.
- Tx used to be to withdraw anticholinergics and decrease dose of antipsychotics but Cochrane shows little support. More psychiatrists are now switching the antipsychotic. Clozapine has the most evidence for this but also data for Quetiapine and also Olanzapine.
- Tetrabenazine is the only licensed Tx in UK but depressogenic, akathisia and drowsiness.

## 82. Psychosis and early intervention services

Psychosis is a mental condition where people find it difficult to distinguish what is real and what is not real.

1 in 200 experience in our lifetime.

Properly speaking it's a symptom and can be due to many different causes and illnesses.

Mental illness – eg SZ, bipolar

Physical illness – eg parkinsons disease, HIV

Drug and Alcohol/Medication

Even severe stress, sleep deprivation.

Features of psychosis

- Hallucinations – sensing something that's not there
- Delusions – believing something that's not true
- muddling of thinking/behaviour
- so called negative symptoms – absence of emotional response or inappropriate emotional response, lack of drive, preferring own company.

Why?

- chemical imbalance in the brain esp. Dopamine
- associated with less grey matter cells in the brain.

Tx

- support
- psychology – CBT can reduce the intensity and anxiety of psychosis
- medication – antipsychotics.
- Stop illegal drugs and alcohol, sleep hygiene, stress reduction.
- EARLY INTERVENTION SERVICE – strangedays in Sheffield
- Aims to help people with psychosis within 12 months of onset of their symptoms. Helping people earlier has been shown to improve outcome. They can visit you in your own home. Work as a team with many different Professionals.

### 83. Schizophrenia out-pt review

- current care plan overview – how often seen by CPN/SW, Dr, support worker  
daily routine, day centre, known triggers to illness? How were they managed  
before?
- assess current mental health – MSE + **INSIGHT**

If pt says that they are “anxious” THINK!!!! – why!!!! ?delusional jealousy, erotomania,  
psychotic delusion re neighbours etc etc.

If they are mentally unwell, ask them if they’ve told their CPN/SW etc.

- Drugs and Alcohol,
- Impact-social support sufficient? **Benefits/£ ?? accommodation-** meeting needs?  
**Family-** Partner/children? **Working?**
- , driving,
- risk- to self to others from others neglect
  
- PPHx, meds
- – **COMPLIANCE and SIDE EFFECTS!!!,**
- PMHx
- Forensic

## 84. Depression

3% of Adolescents.

15% of people at some point in their lives

Core features - Mood, energy, enjoyment

Concentration, confidence

Guilt, suicide

Psychomotor changes, sleep and appetite/wt change

ICD10 mild 2/3 core at least total 4

Moderate 2/3 core at least total 6

Severe 3/3 core and at least total 8

Somatic features – include decreased libido and emotional blunting

If psychosis present then its severe.

### Causes

- chemical imbalance in the brain – serotonin and noradrenaline
- runs in families, 1 in 5 have the gene which makes them more likely to get depressed after a stressful even for example ( short form of 5 HTT)
- illegal drugs – cocaine and alcohol.
- prescribed drugs eg propranolol

### SAD

- 1 in 50 in the UK ( 1 in 8 get winter blues –milder Sx)
  - 2X more in women esp age 18-30
  - cyclical for 3 yrs.
- mood – more reactive, swings energy – low, anhedonic  
carbohydrate craving, tired in the day, disturbed sleep

Tx – antidepressants, CBT, light therapy – needs minimum of 2500 lux for 30min to 3hrs, facing it but not looking directly at it, every morning. Usually improvement in 3-4 days but may need up to 6 weeks. ( if hasn't worked by then, then stop)

General advice – get max. natural sunlight, sit near windows when indoors, regular exercise outdoors if possible.



## 85. Mental Health Act – 2007

Sec 5(2) – up to 72 hrs , applied by 1 doctor if believes needs consideration under MHA in an emergency.

Sec 5(4) – RMN nurses holding power for up to 6 hrs.

Section 2 - up to 28 days for assessment. Can be renewed for a further 28 days.

Requested by nearest relative or AMHP. 2 doctors one of which has Special experience with mental illness. Must assess within 5 days of each Other and within 14 days of when request was made.

Section 3 - initially 6 months for treatment. Can be renewed for a further 6 months Then yearly.

Section 136 – up to 72 hrs, made by police, conveying person from a public place (includes A and E) to a place of safety –hospital or police station (if risk of violence is high) during this time should be assessed by AMHP and Doctor (ideally sec 12 approved) – together is good practice. Before decisions are made it is good practice to discuss with the most senior doctors on call/ consultant. If patient has a LD or is under 18, the consultant in that speciality should be contacted.

If no mental illness – d/c from section 136

If mental illness agrees to informal admission

If mental illness – needs assessment for sec 2 or 3 or exceptionally a 4.

Challenging a section:

- responsible clinician can d/c
- apply to 1<sup>st</sup> tier tribunal in England or Mental health tribunal in Wales
- apply to the hospital manager to d/c , managers hearing will be convened
- nearest relative can d/c however this can be overridden by the doctor on medical grounds. Nearest relative can also apply to a 1<sup>st</sup> tier tribunal/ mental health tribunal for pt to be d/c.

All 4 options can be tried at the same time in theory.

MHA

- if pt has a mental disorder, at risk to self or others, needs treatment in hospital, not consenting to informal admission.

## 86. Bipolar

- 1 in 100 suffers at some point
- M=F
- Most common onset in late teens to early 20s
- 15% suicide
- Up to 1/3 young people initially diagnosed with depression will develop bipolar.
- Bipolar 1 – at least one manic episode >1/52, bipolar 2- hypomania and depression ( more than once ) and Rapid cycling- 4 or more highs or lows per year. (risk factors- female, thyroid problems, LD, MS)
- On average 5-6 episodes over 20yrs
  
- Causes – runs in families – 10-15% have a near relative with the condition.  
Chemical imbalance in the brain  
Stressful life circumstances trigger.

### Tx

- Gather collateral hx
- Social assessment – incl carers assessment
- Functional assessment – skills, vocation
- Psychology – CBT which is adapted to include education re early warning signs, mood monitoring, coping strategies and education about the illness. 16 one hr sessions over 6-9 months.
- Managing mania – assess risk, likely to need admission. Medication – review – stop antidepressant, consider antipsychotics/mood stabiliser. Youngs mania rating scale.
- Managing depression – assess risk, review medication – consider antidepressant with mood stabiliser cover or if not on a mood stabiliser consider quetiapine , in bipolar 2 also consider lamotrigine, consider CBT.
- Prophylaxis – most evidence for Li+ ( which also has good evidence for suicide reduction - about 7% wont get a relapse on it , about half of the rest reduce their symptoms and the rest continue as before. 30-40% reduction overall in relapses (college leaflet). Need counselling re side effects and cautions. ) also consider valproate ( but avoid in women of child bearing age ) and Olanzapine.
- NICE recommend Li+ and Valproate combo 1<sup>st</sup> line for rapid cycling.
- 2<sup>nd</sup> line prophylaxis is combinations of mood stabilisers or 3<sup>rd</sup> line Carbamazepine.
- Consider prophylaxis after single manic episode if it was severe  
After 2 or more acute episodes of bipolar 1  
In bipolar 2 if episodes frequent, functional impairment or risk of suicide.  
Need to factor in capacity, likely compliance and family planning.

## 87. CVA – sequelae

- Personality- decreased emotional and intellectual flexibility. Irritability common
- Mood – depression – risk factors – size of infarct , age, female. Up to 60% between 3 and 24 months usually.
- emotional lability “pathological emotionalism” -4-6/52 post CVA esp left frontal infarcts. Emotional outbursts, disinhibition
- Psychosis – esp following right hemisphere infarcts. Peduncular psychosis involves visual and auditory hallucinations associated with pons/midbrain infarcts.
- Korsakoffs – rare complication of subarachnoid haemorrhage.

Tx – Antidepressants may help reduce depression and speed up rehab. SSRI – citalopram if on warfarin ( + consider proton pump inhibitor) Nortriptyline, mirtazapine (small effect on INR). Increasing evidence of prophylactic effect eg fluoxetine. Note amitriptyline can be used for post stroke pain.

## 88. Hoarding

Known to psychiatry services? Diagnosis?

How difficult is it to move around?

Accumulating items on purpose?

why is it difficult to discard items?

When did this begin? Link with anything – like **bereavement**?

Memory difficulties? (**dementia**) Whats the date today?

**OCD** – does the thought make sense? Is it your own thought? Do you try and resist the thought/action? Is it pleasurable in any way?

Checking /washing/counting/symmetry/rituals?

Impact – whos at home with you? Social support? Able to shop, bathe? House dirty, unhygienic kitchen? Last time worked? **Mainstream school**?

### **Drugs and Alcohol**

Risk – to self to others (dependents?) from others (abuse) neglect driving

MSE

**Depression** /mania

**Psychosis**?

Insight – willing to accept help?

**PD** – How have others described your personality in the past? previous fights, grudges suspicious, cautious rules regulations stubborn

PPHx

Meds – compliant?

PMHx – head injury, epilepsy, thyroid, **Learning disability**?

Forensic

Plan – would it be ok if I spoke to your next of kin? Ill need to gather more information from GP, social services etc if that's ok.

## 89. Folie a deux

Unlikely station I think but hey.

- usually one of them is the more dominant, the other may be LD/ dependent personality.
- OR both got psychotic at same time.
- Psychosis – organic- infection, intracranial, delerium, dementia
- Meds/drugs
- Psychae- delusional disorder, SZ, SZaffective

In hx – ask about mainstream school, LD, who normally makes the decisions? Would it be difficult to run the household without X?

MSE –quick screen for PD, memory? **Ideally would need to do full MMSE**

**Impact-** Ask about **ADLs**, weekly routine, current support and family. **Risk.** D and A driving.

PPHx

Meds –compliance

PMHx

Forensic

Plan- Joint DV with Soc services/ CPN. Get collateral Hx. separation of the 2 and Ix/ Tx of the index case. How would you feel about coming into hospital for a brief period? IQ testing?

Sheltered accommodation in same area?

## 90. Breaking bad news

Thank you for meeting with me today.

I was keen to speak to you about your mother/relative etc

Could you please tell me what your understanding is of the present situation?

**“Im afraid it looks more serious than we had hoped”**

pause

We have some results from today which show that...

**“Its a lot to take in, it must be very difficult”**

pause

**“ please tell me if Im going to fast for you.”**

Pause

May I ask if you have any prior understanding of cancer /brain cancer?

I will be trying hard to ensure that there is good communication between the different professionals and yourself so that we can all work together to ensure the best quality of life for your mother etc.

I have prepared some written material, helpful websites and leaflets which you may find useful and I shall give you my secretarys telephone number so that we can book another longer appointment at your convenience. Would you like me to break the news to anyone else in the family?

<http://www.skillscascade.com/badnews.htm>

Classic questions:

Whats the outlook/prognosis? - Its very difficult to say at this stage and will depend on a number of factors eg how big the damage is and how aggressive the illness is. I will be working very closely with my medical colleagues who have special expertise in this area.

Can she go home? – We can certainly talk about that, and how we can help support her at home as soon as practical. Our next step should be to arrange for my medical colleagues to review her on the ward as soon as possible as they may wish to carry out further tests. Are you aware of any previous wishes or **advance directive?**

Is she suffering? – That’s something we have to be very alert to. She will be constantly monitored for signs of distress and pain. If her behaviour is settled she is unlikely to be in pain but it is very difficult to know how someone is actually feeling inside when they are confused.

## 91. Aspergers syndrome- assess

Why do you think he has Aspergers syndrome?

Anyone in the family?/ mental illness?

Whats your understanding of Aspergers syndrome?

Outline

– its one a group of developmental disorders called Pervasive developmental disorders.

Some people believe it is on a spectrum with childhood autism.

Common – figures vary – 1 in 300, more in males.

Deficits in social interaction and repetitive behaviour/restricted interests with normal language development (although there can be some speech differences like pedantic or stilted speech)

Also some mild delay in motor skills common eg riding bike and clumsiness.

Lets see how this relates to your child

Development – pregnancy/ birth/ early dev problems walking age, **clumsiness**/delay in riding bike/catching ball? speech dev? – parroting?

Social – pointing, gaze, pretend play, play alone?

Interests- unusual relationship with toys, special interests? how would he respond if hurt, respond to a cuddle?

Unusual physical characteristics, hand movements? Sensitivity to sound, touch?

At school – mainstream school, academic performance? IQ test? special interests or hobbies? Friends? Difficult to interrupt?

Work?

Relationships?

MSE

Depression?/mania

Psychosis? – responding to hallucinations, saying anything bizarre?

RULE OUT TICS, OCD, ADHD, ANXIETY (often comorbid. Also SZ and Bipolar are more common)

Insight?

Impact, Risk, Drugs and Alcohol

PPHx

Meds

PMHx – Head injury, epilepsy, thyroid

FHx – if forgotten!

I cant diagnose whether your son has Aspergers syndrome right now. I will need to see him first and complete an assessment which will involve other professionals. If we suspect your

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son has Aspergers, we may then arrange for the psychologist to do further tests and Aspergers rating scales.



## 92. Opiate management

Motivation for change? Why?

Detox ( needs to be a part of a planned package of care with social situation conducive) or maintenance?( harm reduction and stability)

plan – check urine drug screen fresh ideally 2X, physical examination, blood tests – need to check LFTs (consider starting substitution while waiting for results if not aware of likelihood liver disease)

If female ask re LMP and counsel re pregnancy.

GUM referral

Counsel re safe sex, safer injection technique and harm minimisation, inform re supervised consumption ( risk of OD greater on non supervised if takes alcohol, and Benzos)

Detox: - plan includes goals , start date, rehab, counselling, support groups, education – esp risks of accidental OD on relapse due to loss of tolerance, ongoing support etc. “A return to maintenance is not a failure”

Supervised consumption needed. Consider community detox with some exceptions:

polydrug use, physical/mental health/social probs, previously didn't work.

If community detox – do alcohol detox first.

If benzo dependent – pt preference if to be done at same time.

CONTINGENCY MANAGEMENT should be considered.

Try to ensure clear distinction between detox and substitution.

When starting Tx – name of drug user needs to go to regional National Drug Treatment Monitoring System (NDTMS)- database in anonymised. Role is only to monitor drug trends.

If already on maintenance therapy ( the ideal and preferred scenario):

Methadone or buprenorphine

- choice depends on pt preference, ideally same opiate as currently taking
- for methadone to buprenorphine, first go down to 30mg/ day or less of methadone.
- (lofexidine not recommended here as poor evidence for effectiveness, can't easily go back on maintenance and more suitable for smaller opiate amounts)

If plan is straight detox from street heroin,

- buprenorphine is the drug of choice
- (lofexidine sometimes used but bp and pulse needs regular checking as dose increased)

Maintenance

- Warn about risks with alcohol, benzos, other opiates.
- Risk of death statistically highest during titration phase.
- **If alcohol intake is very high, it may not be appropriate to start methadone.**
- Caution in pregnancy (admit) and liver disease (admit?)
- methadone is gold standard and cheaper.
- Buprenorphine consider if previous probs with using heroin top ups for their methadone and wish to detox eventually.
- For those who will proceed to detox soon.
- For those on Tx with meds which induce/inhibit liver enzymes.
- For those with previous probs with methadone.

- Note: buprenorphine can be injected so liable to abuse. Supervision in pharmacy can be tricky as takes 5-10 minutes to dissolve under tongue. Crushing is outside of license.

Alcohol – binge drinking particularly dangerous . Impaired LFTs decreases metabolism of methadone.

Benzos – very dangerous with opiates, alcohol. “in some drug users short term Px of 30mg or less of diazepam may offer some benefit in supporting them to control their intake and stabilising their lives ( unlicensed for detox or maintenance though and need at least 2 urine tests and clear goals. NOT FOR LONG TERM)

If on cocaine/crack - warn very dangerous if used on top of methadone/buprenorphine.

Cocaine /crack medical issues – heart failure, MI , CVA hyperthermia.

Alcohol and cocaine – cocaethylene – increased risk liver/heart disease, epilepsy, CVA

Cocaine and Ketamine/sildenafil – increased CVS/CNS complications.

Note: heroin in urine – 48hrs, methadone in urine – up to 9 days. False negative – pregnancy and low dose methadone, false positive – loperamide, quinolones.

6 out of every 1000 use opiates.

Mortality for heroin dependent users – 10-20% after 10yrs.

50% are abstinent after 10yrs however.

Methadone withdrawal after 36hrs, peak day 3-5

Heroin withdrawal after 6hrs, peak by 36-48 hrs.

### **93. Depot**

- Test dose given first and wait a week or so.
- injection of antipsychotic medication every 2-4 weeks.
- Complications – redness, swelling. It can take 4 injections or so for dose changes to be noticed.

## 94. Somatization

- medically unexplained symptoms affecting multiple organ systems first presenting before age 40

How can I help you today?

Whos idea was it to be referred?

List of complaints – mostly pain? (somatoform pain disorder)

Other physical ailments in the last 2 years? Fluctuate/vary – depending on...?

How often see GP? Reassured by doctors?

Alternative therapies? Healers?

Do you ever worry this could be all caused by a particular illness? Whats causing this?

Focus more on Ix or Tx?

Can you link the onset with any particular events or traumas in your life?

Do you know anyone with this –friends/family, or read about it?

Dislike a particular part of body?

Court case pending?

MSE

Mood- depression/mania

Anxiety – OCD – do you try and resist these thoughts? Seem odd to you? Own thoughts?

Unpleasant? Do anything to counteract these thoughts?

Psychosis

Ideally PD screen – fights, suspiciousness, impulsive, anxious, dependent,empty?

Insight – whats your explanation, could it be your mind converting psychological distress into physical distress? Would you be interested in psychological therapy?

Impact – family responded? (secondary gain?)

Drugs and Alcohol – coping?

Driving

Risk – to self to others from others neglect

PPHx

Meds

PMHx – LD, epilepsy, Head Injury. Conditions diagnosed by GP ?

Forensic – any pending court cases or claims?

Diff. diagnosis

- undiagnosed physical illness
- other psychiatric illness – mood, psychosis
- other somatoform illness – somatoform pain disorder, hypochondriasis/BDD conversion
- factitious, malingering.

Plan

- Its clear that you are in a lot of distress and Im here to help.

- “Focus must be on maintaining day to day skills despite symptoms.”
- “The danger of too much reassurance is that it can create dependence and I think we should be wary of that”
- distress is real but no structural abnormality has been found.
- Important to maintain social contacts
- Investigate objective signs only and stop unnecessary meds.
- Regular review via single named doctor.
- All secondary referrals through 1 individual.
- Disseminate management plan, consider case conference, with permission link with family.
- CBT may be helpful if pt engages . This will help suggest new ways of thinking about symptoms and reacting to them which studies show can benefit both patient and family. CBT can help with many conditions including illnesses we tend to think of as more physical. For example pain relief in arthritis.

#### 95.Panic disorder

##### Tx

- Basic advice re panic attack:
- Try not to fight it.  
Slow abdo breathing, cup hands over mouth and nose, concentrating on something else in the environment, visualisation. Carrying a personal object with you. Even jogging on the spot.
- Exercise – for tension release
- Anxiety management – includes relaxation therapy.
- CBT
- Antidepressants – SSRI ( also 2<sup>nd</sup> line consider TCA –imipramine, clomipramine and MAOI)
- Support groups, leaflets, websites.

## 95. Gambling

- affects 6 per 1000
- prognosis – 1/3 improve on their own, 2/3 chronic often deteriorating course

Tx – CBT, 12 –step programmes, (antidepressants only if depressed)

Wed phone 01278 720 220 ask for learning and development