

Psychoses

Emergency Treatment,
Stabilization and Monitoring

Psychoses

- Dr. Barb Kane
- Nothing to disclose/no conflict of interest
- Psychiatrist in Prince George for 19 years
- Prior to that, 4 years at VGH and 1 year at London Psychiatric Hospital
- Did family medicine and psychiatry at UWO

Joe

- 21 year old single male
- Lives alone in a town of 5,000
- Works at grocery store as a labourer

Presenting Complaints

- Presented at the hospital with his sister because he told family that day he was depressed and anxious
- Said he drank a herbal cocktail elixir containing estrogen that prevents the transition of estrogen to testosterone
- Said it was a purple drink that friends gave him to trick him

Presenting Complaints

- Has been thinking of hurting his family since them by pushing them into concrete walls or playing too rough with his nieces and nephews
- Talked about harming himself by injecting air into his neck with a compressor from the garage
- Has been having these thoughts for about 4 weeks

Mental Status Exam

- 6 ft. 4 in, 250 lbs, stocky, muscular
- Abrasions on his arms from trying to peel his skin off with a razor blade (not slashes)
- Intense eye contact
- You are getting a scary feeling from this guy—there is irritation just below the surface

Safety

- Cut the history short if not safe—listen to your gut!!!

Assessment

- Safe environment
- Escape route for everyone
- RCMP or other backup if needed
- Have a plan ahead of time as much as possible regarding what you will do if things get violent

Assessment

- You and the other staff have to feel safe. You can't listen to their concerns if you are afraid.
- 'Real communication only occurs when people feel safe.'
- Need to be careful how you say things if people are volatile
- Yell at them through a locked door if necessary.



More History

- 1 week ago, he thought he was depressed, saw his GP and was prescribed Celexa
- Longstanding problems with sleep
- No voices
- Visual hallucinations for the past 5 weeks—sees shadows in the blinds

More History

- Getting good and bad messages from the TV, especially Fox TV
- When asked about intrusive thoughts, said "I can feel the pain of others"
- Feels he can control others' minds

Alcohol and Drug Use

- Using marijuana since 2006, ½ oz. per week
- Drinking 3 beer a day

Family Psych History

- 2 uncles with depression
- 1 uncle bipolar
- Father has chronic depression

Diagnosis

- The history and pattern of onset can be a clue to the diagnosis
- Any other information you want?

Course/Pattern

- Really Acute ie. 1-2 days
 - ?drug-induced
 - ?withdrawal
- Acute ie 4 days-2 wks.
 - ?acute onset of mania/psychosis
- Several months
 - Better than usual function followed by psychosis = hypomania into mania
- Insidious decline over years
 - Schizophrenia

Diagnosis

- An organic problem vs. a psychiatric problem?
- Alcohol or drug induced?
- A primary psychotic disorder vs. a primary mood disorder?
- Other comorbid diagnoses
- Social factors

What to do?

- Investigations in ER?
- Admit or send home? Or send elsewhere?
- Certify or voluntary?
- Meds?
- Other?
- Early psychosis options?

Voluntary or Involuntary?

- The Sleep Test
 - Are you going to sleep at night or are you going to worry all night if you send them home? If you're going to worry and be up all night, certify them.
- What do the family/friends think/want?
 - Usually, although not always, they have a pretty good idea of what is needed
- Past history

Breaking the Bad News

- Telling an agitated, psychotic patient they are being committed can be a tense moment
- Don't tell them until everything is ready to go ie. bed or ambulance transfer or seclusion room and other staff are all prepared for any fallout

Breaking the Bad News

- I usually say things like:
- 'I don't think you are going to like this but I feel you need to be in hospital.'
- 'We may have to agree to disagree but you have to stay. I'm committing you against your will. I don't like having to do this but I feel this is the safest thing to do.'

Voluntary or Involuntary?

- Once you have made your decision, it's over. Don't bother with a long negotiation with the patient about whether or not to stay. If they want to leave and you want them to stay, they will never see your side and a long discussion of this will only agitate them more. Be firm and be brief at this stage.

Treatment

- Antipsychotic medication
- Have some backup with you if you think this discussion is going to be contentious. Be ready with oral and IM meds.
- Offer oral medication first even if you think they will refuse. Sometimes given the choice between a needle and pills, people will reconsider and take oral meds.

Treatment

- Agitated, combative patient unwilling to take oral meds
 - Clopixol Accuphase 50-200 mg IM
 - One dose lasts 3 days
 - Takes a few hours to kick in sometimes
 - Can be given with IM lorazepam 1-2 mg
 - Order benztropine (Cogentin) 1-2 mg bid to qid IM or po prn for possible EPS, especially in young males

Treatment

- Agitated, may be combative, psychotic but willing to take oral meds
 - Olanzapine—an atypical antipsychotic
 - Other options—haloperidol, loxapine

Olanzapine

- Comes in 2 forms:
- Pill Zyprexa
 - 2.5, 5, 7.5, 10, 15 and 20 mg
- Dissolving wafer Zydys
 - 5 and 10 mg
- About \$1 per mg
- Special Authority drug but usually available in ERs

Treatment

- Olanzapine, either in pill or dissolving form, usually takes about 2 hours to kick in
- Dissolving form almost impossible to cheek so advantageous in ER
- Use oral lorazepam 1-2 mg SL or po at the same time you give the olanzapine as that will start working earlier

Ancillary Meds

- For the next 24 hours:
- Order benztropine 1-2 mg po or SL bid prn
- Order olanzapine 2.5-10 mg po qid prn
- Order lorazepam 1-2 mg po/SL/IM bid-qid prn
- Ongoing management depends on how they are responding

Treatment

- Helps the rapport sometimes if you ask them if they are hungry and want something to eat
- Kindness sometimes goes a long way even if they are really agitated and psychotic.
- Regard their anger as a symptom. Don't take it personally (easier said than done, of course).

The Runaway

- ID: 14 year old female, living with mother and maternal grandparents, dropped out of grade 8 just prior to June exams
- Brought in to ER by her mother because she was suicidal
- What do you do now?

Case 2: The Runaway

- Recent history
 - Medications
 - Drugs and alcohol
 - Stressors
- Past Psychiatric History
- Family Psychiatric History
- Long-term functioning
- Medical History

Case 2: The Runaway

- Recent History: In ER 2 weeks previously with suicidal ideation—said she had been abused by her father in satanic rituals but this had been thought to be untrue (?delusional).
- Suicidal thoughts x 1 ½ yrs, increased over the previous few weeks.

Case 2: The Runaway

- At the first ER visit, she was referred to the child and adolescent mental health centre. Two days later, she ran away and did not return until this ER visit two weeks later. She phoned her mother that day and said her boyfriend had dumped her and that she was suicidal. Hadn't slept for 4 days. On no meds for 2 weeks. Living at a drug dealer's place.

Case 2: The Runaway

- Past Psychiatric History: Started seeing a psychiatrist about 6 months previously, started on Prozac 20 mg od, her mood then got 'too happy' so the dose was reduced to 10 mg and melatonin was added. She then got more irritable and suicidal and Seroquel was added.

Case 2: The Runaway

- Family psychiatric history: Mother bipolar, on Tegretol and Celexa, mother diagnosed at age 13. Maternal grandmother bipolar when younger, now has Alzheimer's. Maternal aunt unipolar. Father has ADHD.
- Long-term functioning: Family unstable, bullied at school, poor at math, good in art, started going to detention in grade 2.

Case 2: The Runaway

- Mental Status Exam:
- Stocky 14 year old, dressed all in black with very thick black makeup. Claimed she had lost 32 lbs. recently but didn't look it. Good eye contact, normal motor activity.
- Mood 'like crap', irritable, tired, suicidal but not imminently

Case 2: The Runaway

- Thought content: Talking about witchcraft, satanic worship, Wicca, denies voices but says friends have been calling her names (?). Says people hate her.
- Thought process: Says she can't concentrate but otherwise it seems fairly normal in the interview.

Diagnosis

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What to do?

- Investigations in ER?
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- Certify or voluntary?
- Meds?
- Other?
- Early psychosis options?

Case 2: The Runaway

- Needs at least a short-term admission, under certification, given her runaway behaviour.
- Not sleeping so she may need something to sleep, could be prn but in a smaller hospital with fewer resources, a regular dose may be better

Med Options

- Benzodiazepine
 - I generally don't find them very effective in people with insomnia due to major mental illness
- Atypical antipsychotic
- Antidepressant

Atypical Antipsychotics

– Quetiapine: Seroquel 25 mg qhs with repeat prn (low dose given her lack of agitation and the fact that she is relatively cooperative). My philosophy is start low, go slow in someone you are probably going to want to keep on meds for some time. Starts working in 20-30 minutes usually so a good choice for someone with a propensity to psychosis and insomnia

- Covered by Pharmacare

Atypical Antipsychotics

- Olanzapine
 - Zyprexa in pill form—2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg
 - Zydys in dissolvable form—5 and 10 mg—thought to have less potential for weight gain
 - Start with 2.5 mg
 - Either form takes up to 2 hours to kick in
- Special Authority outside of hospital

The Next Day

- Settled, got some sleep, wants to leave
- Willing to take meds
- Continue on ?Seroquel, titrate to sleep
- Hook up with mental health resources
?early psychosis team
- See weekly for awhile

Are you going to start
an antidepressant?

Other Suggestions

- This is likely a long-term illness at the beginning of its presentation given the presentation and family history so....
- Put in a referral for a comprehensive assessment, no matter how long the wait—this problem isn't going away
- In the meantime, what to do depends on your local resources.

The Visiting Daughter

- Busy Saturday night in the ER
- 50 y.o. female BIBP screaming obscenities, handcuffed to stretcher
- Paranoid, thinks people trying to kill her
- Spitting at nurses and you

The Visiting Daughter

- Took an overdose of 3 clonazepam and 8 trazepam(?) after a cocaine binge of 1-2 days, about \$240 of cocaine
- Moved to your town 2 weeks ago with frail 74 year old mother 'to get away from drugs'
- No apparent medical coverage
- Hep C positive

The Visiting Daughter

- What information do you want in the ER?

The Visiting Daughter

- Vitals
 - BP 121/84
 - HR 85
 - RR 18
 - GCS 14/15
 - Sats 97%
 - Temp normal

The Visiting Daughter

- Bloodwork
 - Normal CBC, glucose, BUN, Cr, GFR, lytes, AGAP
 - ALT, AST twice normal
- Urine drug screen
 - Positive for benzodiazepines, cocaine

The Visiting Daughter

- History from boyfriend in Alberta is that she has extreme mood swings and a cocaine problem

What now?

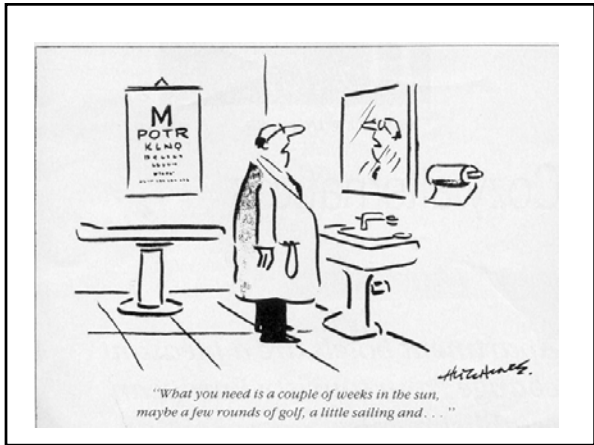
- Other medical?
- Certify?
- Treat?

What could be done: Orders

- Zydys 10 mg po stat
- Zydys 5-10 mg po qid prn
- Clopixol Accuphase 50-100 mg IM stat if she refuses oral meds
- Lorazepam 1-2 mg po/IM/SL bid prn
- Seclusion/locked room/4 point restraints/1:1 care aide



"...and he says I should cut down on my workload."



"What you need is a couple of weeks in the sun, maybe a few rounds of golf, a little sailing and..."
