Psychiatry and Depression

By Ileen Aiken, NP

Objectives

- Difference between psychiatry and psychology
- When to refer or call a consult to psychiatry
- Involuntary hold vs inability to consent
- Depression signs and symptoms
- Depression, now what?
- Questions

Medicine

Psychiatry

Psychiatry

- Education: Psychiatrists are trained medical doctors that specialized in psychiatry
- Differentiating between medical issues and psychiatric issues
- Diagnosing mental illness using specific criteria laid out in the DSM-5
- Main focus is on medication management
- Average length of appointment is 15-30 minutes and an hour for initial appointment
- Patients may be seen monthly at first then every 3 months to 6 months (individualized).

Psychology

- Education: Psychologists have a doctorate degree with a focus study on behavioral/personality development, the history of psychological problems, and the science of psychological research. There are also varying master degrees in psychology and social work where a therapist/counselor may practice.
- Can diagnose mental illness using the criteria laid out in the DSM-5
- Main focus is on behavioral treatment through testing, problem solving, different methods of treatment (Cognitive Behavioral therapy, Dialectic behavioral therapy, mindfulness)
- Is also known as therapy or counseling
- Average length of an appointment is an hour and patients may be seen biweekly, weekly, monthly.

When to refer or call a consult to Psychiatry

Appropriate

- Psychiatric hx and need psychiatric medication management 2/2 current medical condition
- Concern for possible psychiatric medication mismanagement (ie pt is on multiple antipsychotics or antidepressants)
- No psychiatric history and mental illness is suspected and medical causes have been R/O
- Pt is suicidal or homicidal
- Pt is actively psychotic
- Has been trialed on two antidepressants and both have failed or if psych medication regimen is becoming complicated. (out pt)
- Pts with complicated withdrawal, agitation from delirium
- With any questions (telephone consult)

Not appropriate

- Just to remove a patient from white papers (if CL not already following)
- To place a patient on ITC unless there is question of capacity or ethical issue then appropriate.
- If pt is stable on psychiatric medications and there are no contraindications to continuing the medications during hospital stay

Consult modalities available to Prisma Health sites

- Telephone or Telmediq
- Psych Consult-Liaison for inpaitents- after consult placed in EPIC need to call via telmediq under either “adult psych consult” or “child psych consult”. This is a provider to provider call to verify question.
- Telepsych is no longer for the ED only. The consult liaison service has initiated telepsych services for inpts at the other Prisma hospitals.
- Consult a psychiatrist from MD office (adult and child)
  - Adult
    - Prisma Health Office- place a referral in Epic to Ambulatory Psychiatry Services
  - Child
    - Prisma Health Office- place a referral in Epic to Ambulatory child Psychiatry Services
- Feel free to give the Connect Center a call at 864-455-8988

Barriers to Psychiatric Consult in the Office

- Pt refuses to be referred out
  - Discuss the pt's concerns about why he/she does not want to be referred out.
  - Stigma of psychiatry
  - Fear of abandonment from the PCP or that PCP is giving up on them
  - Affordability- www.psychologytoday.com and the refine button
  - Time frame until pt is seen/ lack of psychiatrists in the area
- Send pt to the ED if suicidal or homicidal via law enforcement or ambulance. Can use trusted family member, but there is concern the pt could talk the family member out of going to the ED or may attempt enroute (jumping out of the car).

When to use involuntary hold

- White Papers and Pink Papers
  - What are these? Court documents filled out when a person is an imminent danger to himself or others due to a psychological condition (white) or an addiction disorder (pink).
  - Per the SC code of laws 44-23-10(13)- This is described as (13) "Likelihood of serious harm" means because of mental illness there is:
    (a) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm;
    (b) a substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior and serious harm to them; or
    (c) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that the person is gravely disabled and that reasonable provision for the person's protection is not available in the community.
  - There are 2 parts to this paperwork.
    - Part 1 is completed by the mental health center or social work if in the hospital (only good for 24hrs prior to part 2 being completed)
    - Part 2 is completed by a physician (NPs are not allowed to sign this paperwork)- does not have to be a psychiatrist
    - This paperwork does not go into judicial effect until pt is admitted to the psychiatric facility if the patient is currently in the hospital.
    - Everything must match for the paperwork to be valid
    - Pt may be removed from involuntary hold prior to being admitted to a psychiatric facility if the pt no longer meets the criteria listed above

Part 1 of the commitment papers (“White Papers”)

PART I — **PAGE 1**

AFFIDAVIT FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS AND ORDER OF DETENTION

FOR HOSPITAL USE ONLY	
Date Admitted:	
Hospital Register No.	
Approval of Hospital Official	
Signature	Date

STATE OF SOUTH CAROLINA)
COUNTY OF ______________)

IN THE MATTER OF: (Person Alleged to be Mentally Ill)

First Name | Middle Initial | Last Name | Sex | Birthdate | Age | Race | Height | Weight | Marital Status

Residence (if known) | City | State | Zip | Phone Number | Length of Time Residing There

If residence is unknown, where is the person alleged to be mentally ill currently located or where was he/she found prior to presentment to the Affiant:

Location Name or Description | Address | City | State | Zip | County

TO THE HOSPITAL DIRECTOR: Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the above-named person to a Psychiatric Hospital for the following reasons:

1. The undersigned believes that the above-named person is mentally ill, and because of this mental condition is likely to cause serious harm to self or others if not immediately hospitalized.
2. The specific type of harm thought probable is:
   - (a) ☐ Threats and/or attempts at suicide or serious bodily harm,
   - (b) ☐ Homicidal or violent behaviors that could cause serious harm,
   - (c) ☐ Self-neglect, inability to care for self, and/or protect self if not immediately hospitalized, and/or
   - (d) ☐ Other: ______________
3. The Affiant bases his/her belief that the above-named person needs INVOLUNTARY EMERGENCY ADMISSION to a hospital based on the following grounds (provide specific details of the suspected harm and/or details of the harmful actions he/she has exhibited in front of you):
4. The Affiant is:
   - (a) ☐ Able to have the person alleged to be mentally ill examined by a physician pursuant to S.C. Code § 44-17-410(2).
   - (b) ☐ Unable to have the person alleged to be mentally ill examined by a physician and he/she will need to be taken into custody pursuant to S.C. Code § 44-17-430 for the examination to occur.
     - (i) The reason for this is:
     - (ii) A law enforcement officer can find the alleged mentally ill person at the following address:

Location Name or Description | Address | City | State | Zip | County

The next-of-kin of the person alleged to be mentally ill is:

Name | Relationship | Address | City | State | Zip | Phone Number

If the next-of-kin of the person alleged to be mentally ill cannot be contacted, notify:

Name | Relationship | Address | City | State | Zip | Phone Number

SWORN to before me this ______ day of ______________, 20___.

Notary Public for the State of ______________

My Commission Expires: ______________

WHEREFORE, the undersigned requests that the person named above be admitted to a psychiatric hospital for treatment as authorized by law.

AFFIANT'S SIGNATURE (This must be signed by the person providing the above information)

Name of Affiant (type or print)

Address of Affiant

Telephone Number of Affiant

Relation to the Person Alleged to be Mentally Ill or Title

SCDMH FORM
APR. 89 (REV. APR. 18) MH-FCC-2 M-130 Pg. 1 of 2

PART I — **PAGE 2**

AFFIDAVIT FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS AND ORDER OF DETENTION

IMPORTANT NOTICE: All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Full Name:	Full Name at Birth, if Different:		
Social Security Number:	Occupation:	Monthly Income: $	
Employer's Name:	Address:	If not employed, source of income:	
Retirement: $	Public Assistance: $	Other: $	
HOSPITALIZATION INSURANCE Coverage including group insurance, Medicare, Medicaid, Military medical care, etc.			
Policy No. or HIB:	Name of Insurance Co.	Address:	If group insurance, name & address of

MILITARY SERVICE					
Branch:	Service Number:	Dates of Service:	Type of Discharge:	Monthly Pension: $	VA Claim Number:

FINANCIAL REPRESENTATIVE (if applicable) Please list the name, address, and telephone numbers of the person to receive financial statements and other media related to the personal financial affairs on behalf of the patient.

Full Name:	Relation to Patient:	Address (Street, City, State, and Zip):	Telephone #:

NOTE: **ADMINISTRATIVE PROCEDURE – FORMS:**
Pursuant to S.C. Code § 44-17-430, if an Affidavit of Emergency Admission (Part I) has been completed, but the person cannot be examined by a licensed physician to complete the Certificate of Licensed Physician (Part II) without being taken into custody, a copy of Part I should be presented to the probate judge for the county in which the individual is present. The probate judge may issue an Order of Detention. Upon taking the person alleged to be mentally ill into custody, the law enforcement officer must take the person along with the original Affidavit of Emergency Admission (Part I) to be examined by a licensed physician.

SCDMH FORM APR. 89 (REV. APR. 18) MH-FCC-2 M-130

STATE OF SOUTH CAROLINA)
COUNTY OF ______________)

IN THE PROBATE COURT

EX PARTE:

(Affiant)

IN THE MATTER OF:

(A Person Alleged to be Mentally Ill)

ORDER OF DETENTION

Upon reading the attached Affidavit dated this ______ day of ______________, 20___, it is

ORDERED, ADJUDGED, and DECREED that:

A. That any officer of the peace shall take ______________, a person alleged to be mentally into custody for a period not to exceed twenty-four (24) hours, during which detention said person shall be examined by a licensed physician. If within the twenty-four (24) hours the person in custody is not examined by a licensed physician or, if upon examination, the physician does not execute the certification required, the proceedings must be terminated and the individual in custody must be immediately released, pursuant to S.C. Code § 44-17-430.

B. The Order automatically expires after seventy-two (72) hours from the date and time of issuance. If the above-named person is not taken into custody within those seventy-two hours, this Order is no longer valid.

Dated this ______ day of ______________, 20___.

______________, South Carolina

Time of Issuance: ______________

Judge of Probate Court or Special Probate Judge for the above-named County

SCDMH FORM
APR. 89 (REV. APR. 18) MH-FCC-2 M-130 Pg. 2 of 2

Part 2 Commitment Papers (“White Papers”)

NOTE: THIS CERTIFICATE EXPIRES THREE (3) CALENDAR DAYS AFTER THE DATE OF THE EXAM.
A PERSON MAY NOT BE ADMITTED TO A HOSPITAL BASED ON THIS CERTIFICATE AFTER IT HAS EXPIRED.

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

		Greenville		
NAME OF PERSON EXAMINED	SEX	COUNTY OF RESIDENCE	DATE OF BIRTH	AGE

Greenville Health System, 701 Grove Rd., Greenville SC 29605
PLACE OF EXAMINATION

HOUR AND DATE OF EXAMINATION

I, THE UNDERSIGNED LICENSED PHYSICIAN, have examined the above-named person and am of the opinion that the said individual:

IS MENTALLY ILL and because of this mental condition CURRENTLY POSES A SUBSTANTIAL RISK of physical harm to self and/or others to the extent that INVOLUNTARY EMERGENCY HOSPITALIZATION is recommended.

My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate mental illness and probable risk of harm:

- ☐ Threats and/or attempts at suicide or serious bodily harm,
- ☐ Homicidal or violent behaviors,
- ☐ Self-neglect, inability to care for, and/or protect self if not immediately hospitalized, and/or
- ☐ Other

Provide your reasons for selecting the above boxes and the specific symptoms exhibited by the above-named person that contributed to your finding that he/she is in need of immediate psychiatric inpatient treatment:

Are there prior admissions to mental health treatment facilities? ☐ YES ☐ NO ☐ UNKNOWN	Where?	When?
Are there criminal charges? ☐ YES ☐ NO ☐ UNKNOWN	If yes, give details (including county and type of charge).	

The medical condition of the Patient is:

PAGE 1 AND PAGE 2 MUST BE COMPLETED.
All information MUST be typed or clearly printed.

CERTIFICATE OF LICENSED PHYSICIAN

Is the patient medicated prior to transporting? ☐ YES ☐ NO	If yes, give type, amount, route, and when last administered.
Patient's Current Medication:	

HEALTH OF PATIENT

Disease	Yes	No	Date(s)	Disease	Yes	No	Date(s)	Disease	Yes	No	Date(s)
Paralysis or Crippled Limbs				Cancer				Homicidal or Suicidal Tendency			
Blindness or Eye Trouble				TB or Lung Disease				Mental Retardation or Dementia			
Deafness or Ear Trouble				Heart or High Blood Pressure				Syphilis			
Epilepsy or Seizures				Tremors or Abnormal Movements				HIV			
Diabetes				Hepatitis				Alcohol Abuse			
Serious Allergies				Head injury				Drug Abuse Type of Abuse:			

Patient's Operations:

Name of Treatment Facility Accepting Admission:	Name of Treatment Facility Physician Authorizing Admission:

PHYSICIAN'S VERIFICATION

ON THE BASIS OF MY PERSONAL EXAMINATION, I BELIEVE THAT THE PERSON IS IN NEED OF INVOLUNTARY EMERGENCY PSYCHIATRIC HOSPITALIZATION. FURTHERMORE, THE PERSON HAS NO MEDICAL/SURGICAL CONDITIONS OR DISABILITIES THAT PRESENTLY REQUIRE A GENERAL HOSPITAL OR NURSING HOME LEVEL OF CARE AND IS MEDICALLY STABLE AND PHYSICALLY ABLE TO PARTICIPATE IN PSYCHIATRIC TREATMENT. I HAVE CONSULTED WITH THE ADMITTING PHYSICIAN OF THE RECEIVING HOSPITAL REGARDING THE APPROPRIATENESS OF ADMISSION AND THE PERSON'S MENTAL AND PHYSICAL TREATMENT NEEDS.

- ☐ I have consulted with the local community mental health center regarding the commitment/admission process and the available treatment options and alternatives in lieu of hospitalization at a state psychiatric facility. (SC Code § 44-17-460)

OR

- ☐ I have not consulted with the local community mental health center, because (state a clinical reason for your failure to do so):

THE PERSON THEREFORE NEEDS TO BE TRANSPORTED TO THE FOLLOWING FACILITY FOR INVOLUNTARY EMERGENCY ADMISSION:

NAME OF PSYCHIATRIC HOSPITAL — ADDRESS

, M.D.
SIGNATURE OF LICENSED PHYSICIAN — SC LICENSE NUMBER
TYPE OR PRINT NAME — PHONE NUMBER
Greenville Health System, 701 Grove Rd., Greenville SC 29605
ADDRESS

NAME OF CENTER
SIGNATURE OF FACE TO FACE SCREENER AND DATE
PRINT NAME OF SCREENER, TITLE AND ID #

TO FRIENDS AND RELATIVES:

It is the responsibility of an officer of the peace to provide timely transportation of the person alleged to be mentally ill to the designated mental health facility. However, by freely signing this statement, you can choose to assume that responsibility. Transportation must begin immediately. You are not entitled to any reimbursement from the State for the cost of such transportation. **This form must be hand delivered by you to the admissions office of the designated mental health facility at the time of admission.**

DATE — SIGNATURE

TO POLICE AND OTHER OFFICERS OF THE PEACE:

THIS CERTIFICATE OF LICENSED PHYSICIAN AUTHORIZES AND REQUIRES YOU TO TAKE THE PROPOSED PATIENT INTO CUSTODY AND TRANSPORT HIM/HER TO THE HOSPITAL DESIGNATED BY THE CERTIFICATION PURSUANT TO SC CODE § 44-17-440, UNLESS A FRIEND OR RELATIVE HAS SIGNED ABOVE AND IS WILLING TO TRANSPORT THE PATIENT.

NO FURTHER ORDER IS REQUIRED FOR YOU TO TRANSPORT THIS PATIENT. HOWEVER, NO PERSON SHALL BE TAKEN INTO CUSTODY AFTER THE EXPIRATION OF THREE DAYS FROM THE DATE OF THIS CERTIFICATION.

ANY OFFICER ACTING IN ACCORDANCE WITH THE PROVISIONS AS SET FORTH ABOVE SHALL BE IMMUNE FROM CIVIL LIABILITY.

Part 1 Chemical Dependency ("Pink Papers")

PART I PAGE 1

AFFIDAVIT FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR CHEMICAL DEPENDENCY

FOR HOSPITAL USE ONLY	
Date Admitted	
Hospital Register No.	
Approval of Hospital Official	
Signature	Date

STATE OF SOUTH CAROLINA)
COUNTY OF)

IN THE MATTER OF:

Person alleged to be chemically dependent | Sex | Birthdate | Age | Race | Height | Weight | Marital Status

Residential Street Address (if known) | City | State | Zip Code | Phone Number | Length of Time Residing There

If residence is unknown, where is the person alleged to be chemically dependent currently located or where was he/she found prior to presentment to the Affiant:

Location Name or Description | Address | City | State | Zip | County

TO THE FACILITY DIRECTOR: Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the above-named person to a treatment facility for the following reasons:

1. The undersigned believes that the above-named person is suffering from chemical dependency, and as a result of this condition, poses a substantial risk of physical harm to self or others if not immediately provided with involuntary emergency care and treatment.
2. The specific type of harm thought probable is:
   - (a) ☐ Recent overt acts or recent expressed acts of violence;
   - (b) ☐ Episodes of recent serious physical problems related to the habitual and excessive use of drugs or alcohol, or both;
   - (c) ☐ Incapacitation by drugs or alcohol, or both, on a habitual and excessive basis as evidenced by numerous appearances before the Probate Court within the preceding twelve months, repeated incidents involving law enforcement, and/or multiple prior treatment episodes; and/or
   - (d) ☐ Other:
3. The Affiant base his/her belief that the above-named person needs INVOLUNTARY EMERGENCY ADMISSION to a treatment facility based on the following grounds (provide specific details of the suspected harm, details of the harmful actions he/she has exhibited in front of you, and/or information received from a family member or member of the community):
4. The undersigned believes that the above-named person is incapable of exercising judgment concerning emergency care.
5. The immediacy of the above-named person's situation and the safety of the above-named person does not allow initiation of judicial proceedings for involuntary commitment under S.C. Code § 44-52-70.
6. The Affiant:
   - (a) ☐ Was able to have the person alleged to be chemically dependent examined by a physician within the past forty-eight hours pursuant to S.C. Code § 44-52-50(3) and the written Certificate of License Physician (Part II) is attached.
   - (b) ☐ Was unable to have the person alleged to be chemically dependent examined by a physician and he/she will need to be taken into custody pursuant to S.C. Code § 44-52-50(3) for the examination to occur.
     - (i) The reason for this is:
     - (ii) A law enforcement officer can find the alleged chemically dependent person at the following address:

Location Name or Description | Address | City | State | Zip | County

The next-of-kin of the person alleged to be chemically dependent is:

Name | Relationship | Address | City | State | Zip | Phone Number

SWORN to before me this ____ day of ____, 20__.

Print Name:

Notary Public for the State of:

My Commission Expires:

WHEREFORE, the undersigned, being duly sworn states that I have read the Affidavit, the allegations of which are true of my own knowledge, except those stated on information and belief.

FURTHERMORE, I understand, that if I am a family member, I may be required to cooperate with and participate in the treatment process if requested by the treatment facility and ordered by the court.

AFFIANT'S SIGNATURE (This must be signed by the person providing the above information)

Name of Affiant (type or print)

Address of Affiant (Street, City, State, and Zip)

Telephone Number of Affiant (including area code)

PART I PAGE 2

AFFIDAVIT FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR CHEMICAL DEPENDENCY

IMPORTANT NOTICE: All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Full Name		Full Name at Birth, if Different	
Social Security Number	Occupation	Monthly Income	
Employer's Name	Address	If not employed, source of income:	
	Retirement: $	Public Assistance: $	Other: $

HOSPITALIZATION INSURANCE: Coverage including group insurance, Medicare, Medicaid, Military medical care, etc.

Policy No. or HIB	Name of Insurance Co.	Address	If group insurance, name & address of firm

MILITARY SERVICE:

Branch	Service Number	Dates of Service	Type Discharge	Monthly Pension	VA Claim N

FINANCIAL REPRESENTATIVE: (if applicable) List the name, address, and telephone numbers of the person to receive financial statements and other media related to the personal financial affairs on behalf of the patient.

Full Name	Relation to Patient	Address (Street, City, State, and Zip)	Telephone Number

NOTE: ADMINISTRATIVE PROCEDURE – FORMS:
Pursuant to S.C. Code § 44-52-50, if an Affidavit of Emergency Admission (Part I) has been completed, but the person cannot be examined by a licensed physician to complete the Certificate of Licensed Physician (Part II) without being taken into custody, a copy of Part I should be presented to the probate judge for the county in which the individual is present. The probate judge may issue an Order of Detention.

SCDMH FORM JUL 09 (REV. MAR. 19) MH-PCC-2 M-134 Pg. 2 OF 2

STATE OF SOUTH CAROLINA)
COUNTY OF)

IN THE PROBATE COURT

EX PARTE:

(Affiant)

IN THE MATTER OF:

(A Person Alleged to be Chemically Dependent)

ORDER OF DETENTION

Upon reading the attached Affidavit dated this ____ day of ____, 20__, it is

ORDERED, ADJUDGED, and DECREED that:

A. That any officer of the peace shall take ____, a person alleged to be chemically dependent, into custody for a period not to exceed twenty-four (24) hours, during which detention said person shall be examined by a licensed physician. If within the twenty-four (24) hours the person in custody is not examined by a licensed physician or, if upon examination, the physician does not execute the certification required, the proceedings must be terminated and the individual in custody must be immediately released, pursuant to S.C. Code § 44-52-50.

B. The Order automatically expires after seventy-two (72) hours from the date and time of issuance. If the above-named person is not taken into custody within those seventy-two hours, this Order is no longer valid.

Dated this ____ day of ____, 20__.

____, South Carolina

Judge of Probate Court

Part 2 Chemical Dependency (“Pink Papers”)

NOTE: THIS CERTIFICATE EXPIRES FORTY-EIGHT HOURS AFTER THE DATE OF THE EXAM.
A PERSON MAY NOT BE ADMITTED TO A HOSPITAL BASED ON THIS CERTIFICATE AFTER IT HAS EXPIRED.

PART II — **PAGE 1**

CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

NAME OF PERSON EXAMINED | SEX | COUNTY OF RESIDENSE | DATE OF BIRTH | AGE

PLACE OF EXAMINATION | HOUR AND DATE OF EXAMINATION

I, THE UNDERSIGNED LICENSED PHYSICIAN, have examined the above-named person and am of the opinion that the said individual is chemically dependent, and as a result of this condition, poses a substantial risk of physical harm to self or others if not immediately provided with involuntary emergency care and treatment.

Based on my examination of the above-named person, I am of the opinion that the immediacy of the above-named person's situation and the safety of the above-named person does not allow for initiation of judicial proceedings for an involuntary commitment as set forth in S.C. Code § 44-52-70.

My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate chemical dependency and probable risk of harm:

- ☐ Recent overt acts or recent expressed acts of violence;
- ☐ Episodes of recent serious physical problems related to the habitual and excessive use of drugs or alcohol, or both;
- ☐ Incapacitation by drugs or alcohol, or both, on a habitual and excessive basis as evidenced by numerous appearances before the Probate Court within the preceding twelve months, repeated incidents involving law enforcement, and/or multiple prior treatment episodes; and/or
- ☐ Other: ____________

Provide your reasons for selecting the above boxes, the specific symptoms exhibited by the above-named person that contributed to your finding that he/she is in need of immediate chemical dependency inpatient treatment, as well as the type, amount, and frequency of the substances used:

Are there prior admissions to SCDMH or other chemical dependency treatment facilities? ☐ YES ☐ NO ☐ UNKNOWN	Where?	When?
Are there prior admissions to SCDMH or other psychiatric treatment facilities? ☐ YES ☐ NO ☐ UNKNOWN	Where?	When?
Are there criminal charges? ☐ YES ☐ NO ☐ UNKNOWN	If yes, give details (including county and type of charge).	

The medical condition of the Person is (include statement of need of medical detoxification):

CERTIFICATE OF LICENSED PHYSICIAN — **PAGE 2**

Is the patient medicated or under the influence of alcohol and/or drugs prior to transporting? ☐ YES ☐ NO	If yes, give type, amount, route, and when last administered.
Prescribed medication(s) presently taking or within past three months:	

Blood Alcohol		Blood Pressure		Pulse		Temperature		Respiration	

HEALTH OF PATIENT

Disease	Yes	No	Date(s)	Disease	Yes	No	Dates(s)	Disease	Yes	No	Date(s)
Paralysis or Crippled Limbs	☐	☐		Cancer	☐	☐		Intellectual Disability or Dementia	☐	☐	
Blindness or Eye Trouble	☐	☐		TB or Lung Disease	☐	☐		Syphilis	☐	☐	
Deafness or Ear Trouble	☐	☐		Heart or High Blood Pressure	☐	☐		HIV +	☐	☐	
Epilepsy or Seizures	☐	☐		Tremors or Abnormal Movements	☐	☐		Homicidal or Suicidal Tendency	☐	☐	
Diabetes	☐	☐		Hepatitis or Liver Disease	☐	☐		Details of any homicidal or suicidal episodes:			
Serious Allergies	☐	☐		Head injury	☐	☐					
Delirium Tremens (DTs)	☐	☐		Alcohol Withdrawal	☐	☐		Drug Withdrawal	☐	☐	

Patient's Operations:

Name of Treatment Facility Accepting Admission:	Name of Treatment Facility Physician or Staff Member Authorizing Admission:

PHYSICIAN'S VERIFICATION

ON THE BASIS OF MY PERSONAL EXAMINATION, I BELIEVE THE CONDITION OF THIS PERSON REQUIRES INVOLUNTARY EMERGENCY ADMISSION FOR CHEMICAL DEPENDENCY TREATMENT.

☐ The person has no medical conditions or disabilities that presently require a general hospital or nursing home level of care and is medically stable and physically able to participate in chemical dependency treatment.

THE PERSON THEREFORE NEEDS TO BE TRANSPORTED TO THE FOLLOWING FACILITY FOR INVOLUNTARY EMERGENCY ADMISSION:

NAME OF PSYCHIATRIC HOSPITAL | ADDRESS

SIGNATURE OF LICENSED PHYSICIAN, M.D. | SC LICENSE NUMBER | NAME OF CENTER

TYPE OR PRINT NAME, M.D. | PHONE NUMBER | SIGNATURE OF FACE TO FACE SCREENER AND DATE

ADDRESS | PRINT NAME OF SCREENER, TITLE AND ID #

TO FRIENDS AND RELATIVES:

It is the responsibility of a law enforcement officer to provide timely transportation of the person alleged to be chemically dependent to the designated treatment facility. However, by freely signing this statement, you can choose to assume that responsibility. Transportation must begin immediately. You are not entitled to any reimbursement from the State for the cost of such transportation. **This form must be hand delivered by you to the admissions office of the designated treatment facility at the time of**

DATE | SIGNATURE

TO POLICE AND OTHER OFFICERS OF THE PEACE:

THIS CERTIFICATE OF LICENSED PHYSICIAN AUTHORIZES AND REQUIRES YOU TO TAKE THE PROPOSED PATIENT INTO CUSTODY AND TRANSPORT HIM/HER TO THE HOSPITAL DESIGNATED BY THE CERTIFICATION PURSUANT TO S.C. CODE § 44-52-50, UNLESS A FRIEND OR RELATIVE HAS SIGNED ABOVE AND IS WILLING TO TRANSPORT THE PATIENT.

NO FURTHER ORDER IS REQUIRED FOR YOU TO TRANSPORT THIS PATIENT. HOWEVER, NO PERSON SHALL BE TAKEN INTO CUSTODY AFTER THE EXPIRATION OF FORTY-EIGHT (48) HOURS FROM THE DATE OF THIS CERTIFICATION.

ANY OFFICER ACTING IN ACCORDANCE WITH THE PROVISIONS AS SET FORTH ABOVE SHALL BE IMMUNE FROM CIVIL LIABILITY.

When to use inability to consent

- Anytime a pt lacks capacity to make a reasonable and logical decision.
- This should be specific to a function not a vague statement like "lacks capacity to make medical decisions" as the pt may have capacity for some things but not others.
- There are 4 components to capacity
  - Ability to communicate a stable choice (consistent)
  - Ability to understand relevant information regarding diagnosis, treatments, benefits, risks and alternatives to the treatment
  - Appreciation for own situation and possible consequences
  - Ability to rationally manipulate information
- Must be signed by two physicians and a surrogate decision maker named (list of surrogate order is in the SC code of laws 44-66-30)
- Can become an ethical issue quickly if no surrogate available
- Capacity is NOT competency

I am…

I am not who I think I am

I am not who you think I am

I am who I think you think I am

~Cooley

I am…appropriate for depression screening

- Children/adolescents
  - http://www.gladpc.org/ This website has a depression screening toolkit for children/adolescents and how to treat this age group.
- Adults:
  - PHQ-9
    - **www.depression-primarycare.org/ap1.html**
  - PRIME MD (Canada)
    - **www.depression-primarycare.org/ap1.html**
- Geriatric
  - Geriatric Depression Scale (GDS), short form
    - **www.stanford.edu/~yesavage/GDS.html**

I am…5 of SIGECAPS for more than 2 weeks

- Sleep
  - Insomnia or hypersomnia
- Interest
  - Does the person still enjoy pleasurable activities
- Guilt
  - Is the guilt overwhelming
- Energy
  - Anergia

I am…5 of SIGECAPS cont.

- Concentration
  - Difficulty with remembering
- Appetite
  - Hyperphagia or hypophagia
- Psychomotor retardation
  - Lead feet
- Suicidal Ideation
  - Active or passive, current or past, is there a plan, does the patient have access to the plan, is there intent
    - Can a safety plan be established, if not then patient will need to be assessed by psychiatry

The difference between sadness, grief, and depression is the extent it is has on a persons life over a specific length of time.

I am…ready for help

The first and foremost thing to remember is medication is only half of the solution.

I am…ready for help, where to start?

- Is there a precipitating event?
- Is the patient experiencing pain or other somatic complaints?
- Is the patient experiencing anxiety?
- Does the patient have a family history of depression?
- Does the patient have a history of a traumatic event?
- Would the patient be agreeable to psychotherapy?

I am…ready for help, what medications?

- SSRIs- Selective Serotonin reuptake inhibitors (may take 4-6 weeks to feel the effects)
  - For the medication naive patient recommend starting with
    - **Zoloft (Sertraline)** - this medication is good for depression, anxiety, PTSD, panic disorder, OCD
      - Start at 50mg daily (in patients greater than 65 start at 25mg daily)
      - Can be increased by 50mg every 3-4 weeks for effectiveness to a max daily dose of 200mg
      - At higher doses the pt can experience sexual side effects (the number one reason patients will stop taking an antidepressant)
        - If pt doing well on medication and the sexual side effect is the only problem can augment with Wellbutrin XL 150mg daily
    - **Lexapro (escitalopram)**- this medication is good for depression, anxiety, PTSD, panic disorder, OCD
      - Start at 10mg daily (geriatric patients start at 5mg daily)
      - Can be increased by 5-10mg every 3-4 weeks for effectiveness to a max daily dose of 40mg
      - Celexa is the father of lexapro
    - **Prozac (fluoxetine)**- a good activator, has a long half life, would be good for patients that forget to take medication
      - Start at 20mg daily (geriatric 10mg daily)
      - Increase by 10-20m every 4-5 weeks to a max daily dose of 80mg
      - Monitor pt for activation

If the pt has cardiac disease the safest antidepressant is Zoloft. Avoid using Celexa.

Zoloft and Prozac are recommended for those requiring hemodialysis

I am…ready for help, medications continued

- SNRIs- Serotonin-Norepinephrine reuptake inhibitors
  - **Cymbalta (duloxetine)-** may see improvement in symptoms in 2-4 weeks
    - Great for patients with co occurring pain from fibromyalgia, diabetic peripheral neuropathic pain, and/or chronic musculoskeletal pain
    - Start at 30mg daily
    - Can be increased by 30mg every 3-4 weeks if needed to a max daily dose of 120mg. Doses can be split into 2 doses per day.
  - **Effexor (venlafaxine)**- good for co occurring anxiety, has terrible discontinuation side effects
    - Start at 37.5mg daily
    - Can be increased by 37.5mg every 3-4 weeks to a max daily dose of 375mg
      - Of note: 75-225mg can be mostly serotonergic in some, others may require the 225-375mg doses to feel the benefits of the dual effects of the SNRI
  - **Wellbutrin (bupropion)**
    - Great for persons that experience sexual side effects from any of the other medications and has been known to facilitate wt loss
    - Has been used in the past for smoking cessation
    - Three different forms immediate release, SR, XL
      - IR- start at 75mg bid then increase to 100mg bid then to 100mg tid max is 450mg/d. (usually used in patients needing medications crushed)
      - SR- start at 100mg bid and can be increased to 150mg bid in a week, then wait 4 weeks before increasing again max dose 400mg/d
      - XL-start at 150mg daily then increase to 300mg daily after 4 days wait 4 weeks before increasing max dose 450mg/d

SNRIs can increase BP monitor closely in those with HTN

Wellbutrin and Cymbalta contraindicated in patients with hx of seizures

I am…needing to Augment

- Insomnia
  - First sleep hygiene
  - First line: Melatonin 3-10mg at sunset, this is not a sleeping pill but assists with the natural circadian rhythm
  - Trazodone 25-50mg starting may increase up to 150mg at bedtime. This medication is serotonergic and is good to use in augmentation with previous medications discussed for depression.
- Anxiety
  - First line: Atarax 25-50mg every 6hrs as needed (may prolong the QTc, ECG recommended)
  - Use benzodiazepines sparingly, if needed then suggest only using for max of 4 weeks until SSRI/SNRI becomes effective.
  - If anxiety worsens or the pt becomes highly activated after initiation of an antidepressant this may be indicative of bipolar and need to refer to psychiatry

BEWARE of the Serotonin syndrome

- CRAPS and SHIVERS
  - Diarrhea
  - Shivering
  - Hyperreflexia
  - Increased temperature
  - Vital sign instability
  - Encephalopathy
  - Restlessness
  - Sweating

- Serotonergic medications used in primary practice
  - Zofran
  - Metoclopramide
  - Tramodol
  - Triptans (migraine)
  - Dextromethorphan
  - Levodopa, Amantadine
  - Linzolid

I am…in remission or not

- If effective then continue for a minimum of 6 months to a year at which time taper off and follow for symptom reoccurrence. Some patients may have situational depression and not require antidepressant treatment for the lifetime.
- If the patient has been on an SSRI and is not feeling better then would suggest trying a different SSRI or a SNRI
- If two medication trials fail, then suggest referring for psychiatric consultation as this may not be depression
- If the patient has an extremely elevated mood, hasn't slept in days, is talking fast, has racing thoughts, states they "feel high but didn't do any drugs" stop the SSRI/SNRI and refer to psychiatry

I am…tired of taking pills

- Discontinuation syndrome per Uptodate
  - Common Symptoms include dizziness, fatigue, headache, nausea, agitation, anxiety, chills, diaphoresis, dysphoria, insomnia, irritability, myalgias, parethesias, rhinorrhea, tremor
  - Less Common electric like shocks, ataxia, auditory and visual hallucinations, and HTN
- Symptoms can occur in 1-4 days with abrupt cessation or 1-7 days in a rapid taper.
- Symptoms will last about 2 weeks but have been known to continue for up to a month.
- It is rare that hospitalization would be required but the symptoms can be distressing and interfere with functioning

Take away from antidepressant treatment

- Medication is only the first part of the solution
  - Recommend commitment of 6 months to a year of medication use before weaning off
  - Attempt to "hit" as many symptoms with one medication as possible to help with compliance and decrease adverse effects of multiple medications
- Therapy is the second part to deal with the cause of the depression
- None of the afore mentioned medications is a "quick fix" most take up to 6 weeks before feeling the full effects
- Stopping or tapering to quickly can have negative consequences for the pt and this would need to be discussed with them prior to beginning