CRUNCH TIME

PSYCH

Acute Psychosis

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Acute psychosis can present with a wide array of symptoms
    - Sensory disturbances
    - Changes in motor behavior
    - Disorganization of thoughts and actions
- First, rule out organic causes and treat if present
    - An organic cause is more likely if the following are present:
        - Age >40 y at initial presentation
        - Focal neurological signs
        - Abnormal vitals
        - Recent memory loss
        - Psychomotor retardation
        - Disorientation
        - Visual hallucinations
        - Hyperthyroidism
        - Normal pressure hydrocephalus
        - Electrolyte imbalances
        - Encephalopathy

Clinical Findings

- Assess for self-inflicted injuries or signs of trauma
- Patient may be catatonic or restless and hypervigilant
- Third-party validation is important

Management

- First, protect the patient, ED staff, other patients, and yourself
- Screen for suicidal ideation
- Treat any reversible causes
- Consider head computed tomography (CT) and lumbar puncture (LP) if this is initial presentation
- Treat with antipsychotic medications
    - Remember that antipsychotics may prolong the QT interval or cause dystonic reactions
- Admit patient and consult psychiatric department

How You Will Be Tested

- CT and LP for first presentation, look for a reversible or treatable cause

Agitated Violent Patients

Vanessa Cardy MD and Mel Herbert, MD

Background

- Safety is the first priority
    - Ensure safety for yourself, ED staff, patient, and other patients
- Ways to avoid escalation of violent behavior include:
    - Verbal redirection
    - Placing the patient in a secure environment
        - Alone in a safe room
        - No access to dangerous objects
        - No access to own belongings (may have a weapon)

Management

- Assess patient properly to rule out any underlying organic causes
    - Consider hypoxia, hypoglycemia, central nervous system trauma or infection, intoxication, and toxidrome
- Apply restraints if necessary to protect patient and staff
    - Chemical restraints (calming agents), often administered intramuscularly because IV can be dangerous to place
        - Antipsychotics
        - Benzodiazepines
            - Can combine into single injection, +/- diphenhydramine
        - Ketamine for agitated delirium, violence, or failure to calm after multiple doses of antipsychotics and benzodiazepines
    - Physical restraints
        - Require close monitoring and position changes
        - Secure all four extremities, as partially tying the patient is more dangerous
    - Close monitoring and frequent reassessment for **all** restrained patients
    - Good documentation
    - May need consent from family if restraint is prolonged

How You Will Be Tested

- Do not miss an acute subdural hematoma by sedating a patient and not assessing a reversible cause

Alcohol & Drug-Induced Chronic Psychosis

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Chronic psychosis can result from recurrent substance abuse and intoxication syndrome (“this is your brain on drugs”) characterized by
    - Maladaptive behaviors (substance-seeking, impaired function)
    - Cognitive changes
    - Changes to executive function
    - Physical and psychological dependence on a substance
    - Withdrawal symptoms when substance use stops

Management

- Refrain from drug and alcohol use

How You Will Be Tested

Anxiety & Panic

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Anxiety (fears and apprehensions with some physical findings)
    - Up to 40% of patients with anxiety have an underlying organic cause
    - Generalized anxiety disorder denotes a condition that has continued for 6 mo
- Panic attacks (intense fear)
    - Symptoms arise quickly and resolve quickly
    - Attacks usually come out of the blue
    - Patient may have autonomic arousal: Shortness of breath, chest pain, tachycardia
    - With a panic disorder, patient has several attacks and worries about having more
    - Symptoms have often resolved by the time the patient presents to the ED, so history is key

Management

- Anxiety
    - Perform a complete history and physical
    - Check glucose and consider other labs as indicated
- Panic attacks
    - Consider obtaining a toxicity screen
    - Screen for patient safety

How You Will Be Tested

- The symptoms may seem to indicate a panic attack, but a panic attack is a rule-out diagnosis
    - Must rule out underlying medical disorders
    - Obtain a brief history and perform a physical, mental status exam, basic labs (especially glucose, as hypoglycemia can mimic a panic attack), and maybe a toxicology screen
- Screen for safety

Bipolar Disorder

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Lifelong disorder with episodes of mania/hypomania and depression
- Mania criteria
    - Elevated, expansive mood plus (need three):
        - Decreased need for sleep
        - Grandiosity
        - Pressured speech
        - Flight of ideas
        - Increased goal-directed activity
        - Distractibility
        - Excessive involvement in pleasurable activities
    - Often get into trouble
- Hypomania
    - Elevated mood but less extreme and generally not getting into trouble
- Cyclothymia
    - Mood swings but of modest degree, not meeting criteria for bipolar disorder
- May engage in high-risk behaviors while manic or depressed, so ask about
    - Sexually transmitted diseases (STDs)
    - Self-harm
    - Drug use
    - Other potentially harmful behavior
- Underlying organic disorders may precipitate episodes
- Third-party validation is important as patient may deny any issues

Clinical Findings

- Manic
    - May be gambling
    - Over-spending massive amounts of money
    - Relationships outside of their marriage or long-term relationships
- Depression
    - Typical depressive symptoms
- No findings on physical exam unless there is another cause

Management

- Screen for safety
- Assess for underlying organic causes: Check vital signs, obtain basic labs and thyroid results, and perform physical exam and toxicity screen if appropriate
- Screen for suicidal/homicidal ideation
- Assess for mood stabilizers

    - If applicable, check levels if patient is on a mood stabilizer (ie, valproic acid, lithium) to see if they have stopped their chronic drugs
- Perform an STD screen if they are having sex with many partners
- Conduct a psychiatric assessment
- Admit patient if they are psychotic

Functional Neurologic Disorder

Vanessa Cardy, MD; Mel Herbert, MD; and Jessie Werner, MD

Background

- This condition was once called “hysteria”, but is now known as “functional neurologic symptoms disorder”
- Consider organic causes of symptoms (systemic lupus erythematosus, Multiple sclerosis, Lyme disease, etc.)
    - “Conversion disorder” diagnosed in the ED is almost always wrong

Clinical Findings

- Abnormalities on neurological exam that do not fit with anatomical realities or known diagnoses
    - Patient unconsciously produces symptoms that cause some change or loss of function in response to some conflict or stressor in their life, eg, they cannot walk or move their arm but neurological exam does not support their complaint; other examples includes blindness or pseudo-seizures
    - Condition is most often seen in young, uneducated women with a history of physical or sexual abuse, often with a mood disorder
- Patients frequently exhibit “la belle indifference” ➔ apparent lack of concern for their symptoms

Management

- If the patient is a frequent flier, there is no need to repeat the workup over and over, but do rule out organic causes
- Regarding education, it is very difficult to convince patients that their problems are functional; psychotherapy is needed

How You Will Be Tested

- Know the definition

Delirium

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Medical emergency that increases mortality
- Acute confusional state (disordered cognition and attention) that waxes and wanes over a short period of time (in contrast to dementia) due to an organic cause
- Common causes
    - Number 1, 2, and 3 causes: Drugs, drugs, drugs (medications)
    - Metabolic causes
    - Infection
    - Congestive heart failure
    - Also trauma, postoperative causes, hypercapnia, toxins, seizures, wide range of organic causes

Clinical Findings

- Is due to neurologic dysfunction
    - Look for:
        - Distractibility
        - Cognitive impairment that comes and goes
    - Patient may have:
        - Hallucinations
        - Signs of underlying disorder with
            - Tachycardia
            - Hypertension
            - Hypotension
            - Tremor
            - Asterixis
            - Diaphoresis
            - Others

Management

- Identify and treat underlying cause(s)
- Obtain a careful history, including collateral information
- Perform a complete physical exam
- Obtain labs and imaging as needed
- Change the environment (family presence, quiet); a hospital is a terrible place for these patients
- Administer chemical sedation in cases of severe agitation
    - Haloperidol or benzodiazepines

How You Will Be Tested

- This topic will be thoroughly covered on the test so be prepared
- Do not just suppress the symptoms, look for the underlying cause
- Know the difference between delirium and dementia

Delusional Disorders

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Key features
    - More than one fixed, false belief (ie, everybody else knows that something is not true, but the patient is convinced it is)
    - Lasts longer than 1 mo
- Many types of delusions (grandiose, jealous, somatic, persecutory, erotomanic)

Clinical Findings

- Patient is otherwise normal with normal functioning
    - Lack of prominent psychotic/mood symptoms

Management

- Rule out organic disease or drug intoxication
- Assess for safety (suicidal or homicidal ideations)
- Majority of patients will not need any tests in the ED
- Most will need outpatient cognitive behavior therapy
- Some may need involuntary admission

How You Will Be Tested

- Know the definition

Depression

Vanessa Cardy, MD and Mel Herbert, MD

Background

- This condition often occurs in the elderly
    - Can cause pseudodementia in the elderly
- Lifetime suicide risk in untreated major depression is 15% (1 in 7)
- Dysthymia is considered major depression when it persists for more than 2 y with no symptom-free periods exceeding 2 mo

Clinical Findings

- Diagnosis
    - Depressed mood/anhedonia (inability to feel pleasure) for more than 2 wk **and** (5/8) SIGECAPS
        - Sleep - increased or decreased
        - Interest - decreased
        - Guilt/worthlessness
        - Energy - decreased or fatigued
        - Concentration - decreased, difficulty making decisions
        - Appetite and/or weight - increased or decreased
        - Psychomotor activity - increased or decreased
        - Suicidal ideation

Management

- Ask about
    - Family history
    - Post-traumatic stress disorder
    - Stressors
    - History of early childhood trauma
    - Seasonal affective disorder
    - Safety of any children at home
    - Drug and alcohol use
    - Access to firearms
    - History of previous suicide attempts
- Screen for postpartum depression
- Assess suicide risk and ask about firearms
- Intoxicated patients cannot be screened for depression/suicidality
- Rule out organic causes of depressive symptoms
- Utilize SAD scale for risk
- Admit patients who are actively suicidal or score $\geq$7 on SAD scale

- Start antidepressant medications
- Obtain a psychiatric consultation

How You Will Be Tested

- The only thing that has been proven to reduce suicide in these patients is removing access to firearms
- Rule out underlying medical disorders

Drug-Diversion Behavior

Vanessa Cardy, MD and Mel Herbert, MD

Background

- When the normal pathway of drug from manufacturer to patient is altered in any way
    - Drug is not used as prescribed
    - Patient is prescribed the medication but sells it to others
    - Patient is pretending to need the drug so another person can obtain/sell it
    - Drug-seeking behavior

Clinical Findings

- How to detect diversion
    - Review charts for red flags; check prescription drug-monitoring programs
    - Check whether patient is using different pharmacies
    - Watch for verbal cues
        - “I lost my meds” (or “My meds got stolen…again”)
        - “Only my Oxys fell down the toilet”
    - Ask them directly

Management

- Drug contracts or daily/weekly dispensing arranged with primary care
- Advise patient of resources
- Contact social work

How You Will Be Tested

- Recognition
- Setting a treatment program in progress

Anorexia & Bulimia

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Has the highest mortality rate of any psychiatric disorder
- Most common in females, can occur in males
- Anorexia
    - Refusal to keep body weight at 85% of the age-expected body weight
    - Have a fear of weight gain
    - Have a misperception of their actual weight
- Bulimia
    - This condition is characterized by a lack of self control with binge eating followed by compensatory purging
    - Patients are generally dissatisfied with their appearance and weight but may not have the misperception seen in anorexia
    - Diagnosis is based on at least two episodes of binging and purging per week for at least 3 mo
- Potential severe complications (cardiac complications, gastrointestinal issues, bone loss, amenorrhea, neurologic complications, electrolyte abnormalities, especially hypokalemia)
    - Bulimia is associated with serious electrolyte disorders

Clinical Findings

- Diagnosis
    - History and physical
        - Anorexia
            - Can have hypothermia
            - Hypotension
            - Bradycardia
            - Starvation ketosis
            - Sunken eyes
            - Temporal wasting
            - Dry skin
            - Lanugo hair (fine hair of newborns)
            - Brittle hair and nails
            - Peripheral edema (from low albumin)
            - Parotid hypertrophy
            - Peripheral neuropathies from vitamin deficiencies
        - Bulimia
            - Dental erosion from vomiting
            - Gingivitis
            - Mallory Weiss tears/gastrointestinal bleeds

            - Russell's sign: Calluses on the knuckles due to repeated self-induced vomiting over a long time
    - Labs: Electrolytes, human chorionic gonadotropin, thyroid-stimulating hormone, complete blood count, urinalysis
    - Electrocardiogram
        - Critical - determines whether patient needs to be admitted

Management

- Always screen for suicide
- Treatment includes:
    - Antidepressants (usually selective serotonin reuptake inhibitors)
    - Therapy, such as cognitive behavior therapy
    - Admission for medical complications
    - Admission for inpatient treatment in severe cases
        - Cardiovascular instability
        - Suicidal ideation
        - Weight <75% of normal weight
        - Serious electrolyte imbalances

How You Will Be Tested

- Know admission criteria

Grief Reaction

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Grief is normal but becomes pathologic when
    - Intense symptoms last for more than 1 y
    - Functioning is impaired
    - Patient has a morbid obsession with the deceased
    - Patient exhibits other signs of severe depression
- Patients may experience physical symptoms when processing grief
- Grief intensifies on anniversaries of the death or other meaningful events

Clinical Findings

- Intense sadness
    - Grief may mask an underlying depression
- Loss of appetite
- Insomnia
- Can have transient hallucinations
    - Common to see or hear someone who has recently died
- May have physical symptoms
    - Chest pain
    - Dyspnea
    - Fatigue

Management

- Screen for suicidality
- Look for firearms
- Consider psychotherapy referral
- Admit patient if there is concern for harm to self or others

How You Will Be Tested

Illness Anxiety Disorder

Vanessa Cardy, MD; Mel Herbert, MD; and Jessie Werner, MD

Background

- Patient believes they have a serious medical condition despite evidence to the contrary
- Patient is preoccupied with their own body and overall health and is convinced that they are sick
- These patients tend to exaggerate symptoms so their description may sound odd
- They often doctor shop, so if you have access to other EDs, you may find that they are looking for someone to believe them

Clinical Findings

- Thorough history and physical exam, as this is a rule-out diagnosis

Management

- Rule out underlying medical condition on initial presentation(s)
- Best treatment
    - Reassure without being patronizing
    - Acknowledge their symptoms
    - Recognize that they are convinced they are ill
    - Avoid prescribing medicines just to satisfy them
    - Set the patient up with primary care follow-up +/- therapy
    - Refer patient to outpatient therapy

How You Will Be Tested

- Will be about recognition
- Will either present a patient in which hypochondriasis is likely or present a patient who has a previous diagnosis of hypochondriasis and comes in febrile and confused and must not be called hypochondriacal on the basis of past labels

Interpersonal Violence (Child, Intimate Partner, & Elder)

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Patients may not admit that abuse is the real reason they are presenting to the ED
    - Ask all patients if they feel safe in their home
    - Males can be victims too
- Can be subtle, such as neglect, not providing food, or financial abuse
- Intimate partner violence (IPV) increases during pregnancy
    - Screen for this situation in any trauma during pregnancy and the postpartum period
    - IPV can take the form of physical, verbal, or emotional abuse
- Elder abuse takes many forms
    - Physical abuse
    - Neglect
    - Financial abuse

Clinical Findings

- Interview patient alone
    - History may be vague and changing
    - May complain of pain, which is the tip of the iceberg
- Provide discreet access to helplines/resource groups
- Screen for safety of others in the household (reporting is mandatory if children or elders are involved)

Management

- Screen for trauma
- Keep the partner or parent out of the room
- Get social work involved
- Give information discreetly; provide social resources as indicated
- Get firearms out of the house
- Treat mood disorders

How You Will Be Tested

- Recognition is key
- Often tested: If the partner or parent refuses to leave the room, this is a potential problem

Malingering

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Faking or feigning illness or creating symptoms for secondary gain, such as avoiding jail, getting time off from work or school, securing somewhere to stay if they are homeless, or avoiding homelife troubles
- Malingering is a behavior, **not** a psychiatric disorder

Clinical Findings

- Typical complaints include:
    - Heachache
    - Fibromyalgia
    - Chronic pain
    - Dental pain
    - Fatigue
- Be aware when patient is really uncooperative, eg, “don’t touch my rash”
- Evidence of self-inflicted trauma, such as a burn or cut or a hot washcloth to produce a “rash”

Management

- Try to find out what is motivating the behavior
- Investigate as indicated based on history, exam, and previous visits
- Conduct a chart review to assess for previous similar visits with negative tests with other providers
- There is no treatment other than to understand what is underlying their behavior

How You Will Be Tested

- Know the definition

Obsessive Compulsive Disorder

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Minor obsessive-compulsive behavior is normal, like double checking to see if the house is locked when you leave, but becomes a problem when you cannot leave the house because it requires that you check it a hundred times
- Obsessive (intrusive) thoughts cause anxiety, leading to compulsive behavior (rituals or routines) to alleviate the anxiety

Management

- Evaluation
    - Rule out medical issues
    - Assess degree of distress caused by obsessions
    - Screen for safety (patient and others in the household)
- Treatment
    - Cognitive behavioral therapy, selective serotonin reuptake inhibitors (prescribed by primary care or psychiatry)
    - Follow-up care with primary care and/or psychiatry

How You Will Be Tested

- Know the treatment

Personality Disorders

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Long-lasting patterns of rigid, dysfunctional, maladaptive traits and behaviors that
    - Impair function
    - Cause distress to the patient
- Three general types or clusters: A/B/C (also known as mad, bad, and sad)
    - A: ”Odd, erratic,” paranoid, schizoidal, and schizotypal
    - B: “Dramatic, emotional,” antisocial, borderline, histrionic, and narcissistic
    - C: “Anxious, fearful,” avoidant, dependent, and obsessive-compulsive

Clinical Findings

- This condition can create challenging doctor-patient relationships; develop strategies for dealing with these patients
- We all have these traits, but if you are functional, you do not have a disorder

Management

- Chronic disorder
- Likely no cure
- Outpatient psychiatry/psychology and social work

How You Will Be Tested

- Know the different types

Phobias

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Exposure to a feared situation or object causes intense anxiety
- Patients develop avoidant behavior to avoid dealing with the object of anxiety, eg., patients with a phobia of flying will not travel
- Virtually anything can become the object of the phobia

Clinical Findings

- We are all afraid of certain things, but when this fear impairs day-to-day functioning, it becomes pathologic
- Patient may arrive in the ED in a panic attack with autonomic arousal

Management

- Determine whether the phobia is creating functional difficulties or suicidal ideation
- Check thyroid
- Treatment
    - Referral to psychiatrist/psychologist for desensitization and exposure-response prevention therapy
    - Selective serotonin reuptake inhibitors, benzodiazepines

How You Will Be Tested

- Know the definition

Post-Traumatic Stress Disorder

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Repetitive, intrusive images of severe psychosocial stressor that
    - Cause distress and anxiety
    - Impair function
- Repeated reliving of the experience with vivid flashbacks of traumatic event along with
    - Hypervigilance
    - Increased arousal
    - Tendency to avoid stimuli associated with initial traumatic event
- Seen in first responders and victims of trauma

Management

- Rule out any medical illness
- Conduct a mental status exam
- Screen for any kind of abuse (self or external)
- Screen for safety and ongoing trauma/triggers (ie, interpersonal violence)
- Cannot be resolved in the ED; will require cognitive behavior therapy and potentially selective serotonin reuptake inhibitors and sleep medications
- Outpatient psychiatry referral

Schizophrenia

Vanessa Cardy, MD and Mel Herbert, MD

Background

- This is a chronic disease
- Lifetime suicide risk is 5%-10%, especially during treatment as they gain insight into their disorder
- This condition is associated with substance abuse (raising the question of which came first)
    - May be a form of self-medication to quiet the voices they hear
- Schizoid personality disorder is social withdrawal without psychotic behavior
- A “brief psychotic disorder” is one that lasts <4 wk and is usually a reaction to a specific stressful event, such as someone dying or getting fired; common after 9/11

Clinical Findings

- Positive and negative symptoms
    - Positive symptoms are feelings or behaviors that are not normally present (ie, hallucinations, usually auditory)
    - Negative symptoms are a loss of normal functioning (ie, flat affect)
        - Disorganized and paucity of speech and behavior
        - Social isolation
        - Progressive
- Diagnosis
    - Symptoms are present for 6 mo
    - Two or more active symptoms are present for at least 1 mo
    - Ensure that symptoms are not due to drugs or medication (which can be difficult to determine)
    - Patients will show a severe decline in level of functioning compared with their previous level

Management

- As with all psychotic disorders, exclude any medical illness
- Screen for safety (high lifetime risk of suicide) of both patient and staff
- Patient will need antipsychotic medication under psychiatric supervision
- Educate patients about
    - Neuroleptic malignant syndrome, serotonin syndrome
    - Extrapyramidal symptoms
- Psychiatry is needed for long-term management

How You Will Be Tested

- Will focus on being sure that this is not secondary to a medical illness
- Will also focus on acute side effects of neuroleptic drugs

Somatic Symptom Disorder

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Now known as “somatic symptom disorder” (reclassification with DSM-5)

Clinical Findings

- Patient presents with excessive focus/thoughts/feelings/behaviors concerning physical symptoms and
    - Their severity
    - Persistent excessive anxiety about somatic symptoms
    - Persistent excessive time and energy devoted to symptoms
    - Usually but not always pain symptoms
- Condition may fluctuate but must persist for at least 6 mo
- Symptoms impact functioning

Management

- Conduct a chart review
- Perform a mental status exam
- Patient requires outpatient follow-up with primary care provider
    - Therapy that minimizes the focus on physical symptoms
    - Patient needs to feel that they are being cared for
        - Family therapy
        - Psychotherapy education
        - May need antidepressants

How You Will Be Tested

- Know the definition

Staff & Patient Safety

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Take all possible measures to ensure that patients and staff are safe
- Remember, a violent patient who is not mentally or organically ill is the responsibility of the police!

Clinical Findings

- Patient is violent or aggressive

Management

- Use verbal de-escalation techniques; try to redirect or pivot issues
- Limit stimulation
- Staff have to feel safe and protected
- If the patient is medically cleared, do not keep them in the ED

Substance Abuse Disorder (Psychiatric Management)

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Problematic pattern of substance use over previous 12 mo
    - Causes problems of function or distress
    - Substance abuse disorder is not the recreational use of substances; if troublesome behaviors arise, such as the acquisition of substances, partner abuse, violent behavior, or withdrawal, this condition is a psychiatric disorder
    - Patients are at high risk of suicide and homicide

Clinical Findings

- Toxicology screen

Management

- Screen for underlying psychiatric disorders
- Screen for safety
- Conduct a physical exam to assess for changes that correlate with the substances used
- Mental status exam is needed to assess for cognitive or psychotic features
- Screen for anxiety, depression, and personality disorder (recognizing that people self-medicate)
- Treatment
    - Substance abuse programs
    - Support groups
    - Treatment and rehab centers
    - May require social work
    - Alcoholic Anonymous - type group referral

How You Will Be Tested

- Know the definition

Suicidal & Homicidal Risk

Vanessa Cardy, MD and Mel Herbert, MD

Background

- Most people who commit suicide have seen a health care professional in the 2 wk preceding their death
- Screen all patients with
    - Substance or alcohol abuse
    - Underlying medical/psychiatric conditions

Clinical Findings

- SAD PERSONS scale
    - Sex (male)
    - Age <19 y or >45 y
    - Depression
    - Previous attempt
    - Excessive alcohol or substance abuse
    - Rational thinking loss
    - Social supports lacking
    - Organized plan
    - No spouse
    - Sickness
- Ask about patient's
    - Plans (it is amazing how candid many people are about their intentions to commit suicide)
    - Access to firearms (greatly increases their risk) or other dangerous items

Management

- Hospitalize if patient
    - Is dangerous to self or others
    - Exhibits poor judgment/loss of self-control
- Recognize that suicide is often an impulsive decision that can be reversed

How You Will Be Tested

- Will focus on factors that increase the risk of successful suicide
- "Contract for safety:" If the patient is sad but low risk, the patient agrees to call a number if they feel worse and need help
- Removal of firearms