RFMC Behavioral Health Policies and Procedures

RFMC focuses on evidence-based treatment and recovery approaches for substance use disorders and co-occurring psychiatric disorders.
Educate the patients and influence policy on substance use, co-occurring psychiatric disorders and related issues
Provide treatment for substance use and other psychiatric disorders.
Reduce stigma of addiction in the patient population.
Increasing awareness that substance use disorders and other mental disorders often co-occur.
Discuss general concepts and terminology related to tobacco and nicotine use.
Assess for tobacco and nicotine use in their clinical practice.
Treat and improve patient-centered outcomes with respect to tobacco and nicotine. Helping people and their caregivers communicate and make informed health care decisions, questions that reflect patient-centered considerations include:
(1) “Given my personal characteristics, conditions and preferences, what should I expect will happen to me?”;
(2)“What are my options and what are the potential benefits and harms of those options?”; and (
3) “What can I do to improve the outcomes that are most important to me?”.
Consideration of patient priorities in weighing treatment patient motivation, choice, and education about treatment options are all important factors to appropriate counseling, prescribing, adherence, and recovery
Discuss health-related consequences of stimulant use and Stimulant Use Disorders (STUDs)
Behavioral interventions for treatment of STUD
Identify evidence supporting promising medications for treatment of STUDs and compare their advantages and disadvantages
Screening for co-occurring mental health conditions, including other substance use disorders.
Describe assessment of hazardous cannabis use and cannabis use disorder (CUD), co-occurring substance use disorders, and other co-occurring psychiatric and medical conditions.
Make appropriate treatment recommendations for hazardous cannabis use, CUD and cannabis withdrawal.
Explain the individual characteristics of potential medications for cannabis use disorder and cannabis withdrawal.
Available psychosocial treatments, referrals to appropriate providers, levels of care, or community-support groups.

MENTAL STATUS EXAM

The MSE provides information for diagnosis and assessment of disorder and response to treatment.

- A Mental Status Exam provides a snap shot at a point in time
- If another provider sees your patient it allows them to determine if the patients status has changed without previously seeing the patient
- To properly assess the MSE information about the patients history is needed including education, cultural and social factors
- It is important to ascertain what is normal for the patient. For example some people always speak fast!

Components of the Mental Status Exam

- Appearance
- Behavior
- Speech
- Mood
- Affect
- Thought process
- Thought content
- Cognition
- Insight/Judgment

Appearance: What do you see?

- Build, posture, dress, grooming, prominent physical abnormalities
- Level of alertness: Somnolent, alert
- Emotional facial expression
- Attitude toward the examiner: Cooperative, uncooperative

Behavior

- Eye contact: ex. poor, good, piercing
- Psychomotor activity: ex. retardation or agitation i.e.. hand wringing
- Movements: tremor, abnormal movements i.e.. stereotypies, gait

Speech

- Rate: increased/pressured, decreased/monosyllabic, latency
- Rhythm: articulation, prosody, dysarthria, monotone, slurred
- Volume: loud, soft, mute
- Content: fluent, loquacious, paucity, impoverished

Mood

- The prevalent emotional state the patient tells you they feel
- Often placed in quotes since it is what the patient tells you
- Examples “Fantastic, elated, depressed, anxious, sad, angry, irritable, good”

Affect

- The emotional state we observe
  - Type: euthymic (normal mood), dysphoric (depressed, irritable, angry), euphoric (elevated, elated) anxious
  - Range: full (normal) vs. restricted, blunted or flat, labile
  - Congruency: does it match the mood- (mood congruent vs. mood incongruent)

- Stability: stable vs. labile

Thought Process

- Describes the rate of thoughts, how they flow and are connected.
- Normal: tight, logical and linear, coherent and goal directed
- Abnormal: associations are not clear, organized, or coherent. Examples include circumstantial, tangential, loose, flight of ideas, word salad, clanging, thought blocking.

Thought Process: examples

- Circumstantial: provide unnecessary detail but eventually get to the point
- Tangential: Move from thought to thought that relate in some way but never get to the point
- Loose: Illogical shifting between unrelated topics
- Flight of ideas: Quickly moving from one idea to another- see with mania
- Thought blocking: thoughts are interrupted
- Perseveration: Repetition of words, phrases or ideas
- Word Salad: Randomly spoken words

Thought Content

- Refers to the themes that occupy the patient's thoughts and perceptual disturbances
- Examples include preoccupations, illusions, ideas of reference, hallucinations, derealization, delusions

Thought Content: examples

- Preoccupations: Suicidal or homicidal ideation (SI or HI), perseverations, obsessions or compulsions
- Illusions: Misinterpretations of environment
- Ideas of Reference (IOR): Misinterpretation of incidents and events in the outside world having direct personal reference to the patient
- Hallucinations: False sensory perceptions. Can be auditory (AH), visual (VH), tactile or olfactory
- Derealization: Feelings that the outer environment feels unreal
- Depersonalization: Sensation of unreality concerning oneself or parts of oneself
- Delusions: Fixed, false beliefs firmly held in spite of contradictory evidence
    - Control: outside forces are controlling actions
    - Erotomanic: a person, usually of higher status, is in love with the patient
    - Grandiose: inflated sense of self-worth, power or wealth
    - Somatic: patient has a physical defect
    - Reference: unrelated events apply to them
    - Persecutory: others are trying to cause harm

Cognition

- Level of consciousness
- Attention and concentration: the ability to focus, sustain and appropriately shift mental attention
- Memory: immediate, short and long term
- Abstraction: proverb interpretation

Mini-Mental State Exam

- PHQ-9 and PHQ-2 screening tool
- GAD-7 Screening tool

- Vanderbilt ADHD screening tool
- ASQ screening tool
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- Useful for documenting serial cognitive changes and cognitive impairment
- Document not only the total score but what items were missed on the MMSE

Insight/Judgment

- Insight: awareness of one's own illness and/or situation
- Judgment: the ability to anticipate the consequences of one's behavior and make decisions to safeguard one's well-being and that of others

Sample initial MSE of a patient with depression and psychotic features

- Appearance: Disheveled, somnolent, slouched down in chair, uncooperative
- Behavior: psychomotor retarded, poor eye contact
- Speech: moderate latency, soft, slow with paucity of content
- Mood: "really down"
- Affect: blunted, mood congruent

MSE continued

- Thought Process: linear and goal directed with paucity of content
- Thought Content: +SI, +AH, +paranoia, -VH, -IOR, -HI
- Cognition: Alert, focused, MMSE:24- missed recall of 2 objects, 2 orientation questions, 2 on serial sevens
- Insight: fair
- Judgment: poor