INTEGRATED MENTAL HEALTH ROTATION PACKET

Ambulatory Care Center

Community Regional Medical Center

Fall 2014

UCSF Fresno Psychiatry

Shawn B Hersevoort MD MPH

http://shawnhersevoortmd.com/Education.html

CONTENTS

Part 1: Rotation Information

Available in rotation packet, mental health resource box, and online at shawnhersevoortmd.com

Part 2: Attachments

A: Practice Tools

Available in mental health resource box and online at shawnhersevoortmd.com

- **Primary Care Psychiatry Interview**
- **8 Part Screening**
- **Primary Care Psychiatry Pocket Guide**

B: Rotation Articles

Available online at shawnhersevoortmd.com

1) **Physician-Patient Communication in the Primary Care Office: A Systematic Review**
2) **Evaluation of the Adequacy of Outpatient Antidepressant Treatment**
3) **Withdrawing Benzodiazepines in Primary Care**
4) **Treating Mood Disorders in Pregnancy – Not an Easy Decision**
5) **Adverse Reactions to Zolpidem – Case Reports and Review of the Literature**
6) **Recognizing, Managing Medical Consequences of Eating Disorders in Primary Care**
7) **Course and Treatment Outcomes of ADHD**

INTEGRATED MENTAL HEALTH ROTATION OUTLINE

This rotation is unique in that although it is a mental health service all of the treatment occurs in the environment of physical medicine. What this creates is somewhat of a hybrid between a hospital consultation-liaison and an outpatient psychiatric experience. Our patients will mostly be established in the primary care clinics in which we will see them and therefore already have ongoing treatment relationships with their doctors there. Our role is to assist these practitioners in identifying and managing mental health difficulties which they feel are outside of their comfort or training. For patients with mild to moderate mental health concerns, we will assist in creating a cohesive treatment plan and deliver them back into the care of the referring team. For those patients with severe mental health concerns, we will assist in their transfer to specialty mental health services, usually managed by the county of Fresno department of behavioral health. We work in conjunction with a team of mental health care managers who will provide patients with either brief psychotherapy or psychiatric social work support as needed.

Instructors

- Shawn Hersevoort MD MPH: shersevoort@fresno.ucsf.edu, cell phone: 415-225-7883
- Christine Obata MD, cobata@fresno.ucsf.edu

Text (optional)

- Lippincott's Primary Care Psychiatry

Integrated Mental Health Rotation Packet (online at: *http://shawnhersevoortmd.com/Education.html)*

- Rotation outline, pre/post-tests, review questions, and article summaries
- Practice Tools (Pocket Guide, Interview, and 8 part screening)
- Integrated Mental Health Articles

Patient care supervision schedule

Medical Students

- Week 1-2: Introduction, observation, and note writing
- Weeks 3-4: Supervised interviewing and note writing
- Weeks 5-15: Independent interviewing and note writing

Primary Care Residents

- Week 1: Introduction, observation, and note writing
- Week 2: Supervised interviewing and note writing
- Week 2-4: Independent interviewing and note writing

Psychiatry Residents

- Week 1: Introduction, observation, and note writing
- Week 2: Supervised interviewing and note writing
- Week 3-4: Independent interviewing and note writing
- Weeks 5-15: Supervision of primary care residents

INTEGRATED MENTAL HEALTH ROTATION PRE-TEST

What is integrated mental health -- and what are the 4 components of the I.M.P.A.C.T. model?

What are the 6 ways to contact the integrated mental health team at the ACC?

What are the 3 ways to access integrated mental health resources at the ACC?

What 10 points should be covered in a mental health evaluation?

What are 2 markers of a mental health treatment failure – of success?

What depression screening is most widely used in primary care -- and what score represents “severe?”

What anxiety screening is most widely used in primary care -- and what score represents “severe?”

What are the 3 aspects of suicide risk in order of least to most concern?

What are the 10 demographic risk factors for suicide -- and what is a “high risk” score?

What are the 8 criteria and time requirement for major depressive disorder?

What are the APA medication treatment recommendations for depression – and dose change timing?

What are the basic augmentations for the treatment of depression (sedation/overstimulation/sex)?

What defines a panic attack?

What are some of the most common chronic anxiety disorders seen in primary care?

What are the APA medication treatment recommendations for chronic anxiety – and dose change timing?

What are the basic augmentations for the treatment of anxiety (PTSD/alcohol-involved/general)?

What are the 7 diagnostic criteria and time requirement for bipolar disorder?

How can you distinguish between bipolar types 1 vs. 2?

What are the APA medication treatment recommendations for bipolar disorders 1 and 2 (2 each) – and dose change timing?

What are the most serious medication risks of the mood stabilizers -- and the recommended lab monitoring frequencies?

What are the 5 diagnostic criteria and time requirement for schizophrenia -- and 2 for schizoaffective disorders?

What are the APA medication treatment recommendations for schizophrenia – and dose change timing?

What are the 4 main Somatic Symptom Disorders – and what are their foci?

What is fibromyalgia -- and chronic fatigue?

What are the 2 medical treatment recommendations for somatic symptom disorders – 2 psychiatric?

What are the 2 additional medical treatment recommendations for SSD, neuropathic, and functional pain disorders?

What are the 4 components of primary insomnia – and what is the best screen tool?

What are the 4 primary AASM medication treatment recommendations for primary insomnia?

What are the 2 secondary AASM medication treatment recommendations for primary insomnia?

What are the 5 stages of change?

What is motivational interviewing -- and what are the 5 core principles?

What are the 2 most successful anti-craving medications for nicotine dependence in addition to 2 modes of NRT?

What are the 2 most successful anti-craving medications for alcohol dependence?

How can you best identify -- think about – and behave with a personality disordered patient?

How can you guarantee distress and failure for everyone involved when treating a patient with a PD?

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INTEGRATED MENTAL HEALTH ROTATION REVIEW QUESTIONS

These questions are intended to cover the material that should be learned during the integrated mental health rotation. The primary questions are intended for medical students, interns, and primary care residents. The advanced questions are intended for more advanced primary care residents as well as psychiatry residents.

INTRODUCTION: INTEGRATED MENTAL HEALTH

What is integrated mental health -- and what are the 4 components of the I.M.P.A.C.T. model?

- Integration: mental health services provided inside of primary care.
- Universal screening, stepped care, care manager, and consulting psychiatrist.

What are the 6 ways to contact the integrated mental health team at the ACC?

- Page psychiatrist, Vocera care manager, *Amb referral to IMPACT* from EPIC, *inbasket* messages, in person, or email shersevoort@fresno.ucsf.edu.

What are the 3 ways to access integrated mental health resources at the ACC?

- Mental health resources box on each unit, *flowsheets* then type PHQ-9 or GAD7 in EPIC, or website shawnhersevoortmd.com.

ADVANCED: What are the 3 levels of integration?

- Collaborative at a distance (no shared location or workflow), co-located (shared location but not workflow), and fully integrated (shared location and workflow).

THE MENTAL HEALTH INTERVIEW AND SCREENING

What 10 points should be covered in a mental health evaluation?

- Current symptoms: MAPSS: mood, anxiety, psychosis, somatic/substance, and suicide, history: ASTFS: admits, suicide attempts, past treatment, family history, and substance history.

What are 2 markers of a mental health treatment failure – of success?

- Ineffective/intolerable: no effect after 30 days at 50% maximum dose, or intolerance of side effects at any dose.
- Response/remission: greater than 50% improvement on screening exam, vs. below minimum threshold for screening or diagnosis.

What depression screening is most widely used in primary care -- and what score represents "severe?"

- The PHQ-9: Patient Health Questionnaire - 9 question. The answers are based on 0, 1, 2, and 3 (not at all, some days, most days, and nearly daily) x 9 questions = scores of 0-27.
- 20 is the lower cut-off for severe, 10 for moderate.

What anxiety screening is most widely used in primary care -- and what score represents "severe?"

- GAD-7: Generalized Anxiety Disorder - 7 question. The answers are based on 0, 1, 2, and 3 (not at all, some days, most days, and nearly daily) x 7 questions = scores of 0-21.
- 20 is the lower cut-off for severe, 10 for moderate.

ADVANCED: What other common mental health screenings are used in primary care?

- MDQ: Mood Disorders Questionnaire for Bipolar Disorder, Y-BOCS: Yale-Brown Obsessive-Compulsive Scale, PC-PTSD: Primary Care PTSD Screen, S.A.D. P.E.R.S.O.N.S. suicide risk scale, SBQ-R: Suicide Behaviors Questionnaire, Revised, MMSE: Mini-Mental Status Exam for delirium and dementia, MoCA: Montreal Cognitive Assessment for dementia, CAGE alcohol use scale, AUDIT: Alcohol Use Disorder Identification Test, DAST: Drug Abuse Screening Test, PHQ-15: Patient Health Questionnaire – 15 question for Somatic Symptom Disorders.

SUICIDE AND VIOLENCE

What are the 3 aspects of suicide risk in order of least to most concern?

- Suicidal ideation (thoughts), plan (method), and intent (pending action).

What are the 10 demographic risk factors for suicide -- and what is a "high risk" score?

- S.A.D.P.E.R.S.O.N.S.: Sex (male), Age (18, >65), Depression history, Previous attempt, Alcohol, Rational thought loss, Social supports low, Organized plan, No spouse, Sickness (particularly neurological). Note that this screening is more useful for long-term risk of harm, and less so in the acute crisis evaluation.
- 7 (three quarters of the risk factors) is a high risk score, and 5 (half of the risk factors) is a moderate risk

ADVANCED: What is the best screening for suicide risk assessment -- and why?

- SBQ-R: Suicide Behaviors Questionnaire, Revised.
- Focus: because it focuses on all 3 of the aspects of suicide and the #1 risk factor: ideation, plan, intent, and history. Have you ever thought or attempted (1-4), how often have you thought about it in the last year (1-5), have you ever told someone you would (1-3), how likely is it that you will in the future (0-6). A score of 7 is high risk for suicide. Note that this screening is amongst the most validated in predicting pending suicide in the acute crisis evaluation.

DEPRESSIVE DISORDERS

What are the 8 criteria and time requirement for major depressive disorder?

- Half of SIGECAPS for 2 weeks: disruption in Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor activity, and Suicidality.

What are the APA medication treatment recommendations for depression – and dose change timing?

- SSRI x2 or bupropion if no anxiety, SNRI x2, and then TCA.
- Monthly: 30 days then increase, augment, or change.

What are the basic augmentations for the treatment of depression (sedation/overstimulation/sex)?

- Bupropion for low energy, buspirone/clonazepam for overstimulation, and bupropion/sildenafil for libido/erection.

ADVANCED: What are the advanced augmentations for the treatment of depression (sedation/mood instability/sex/psychosis)?

- Methylphenidate for low energy, lamotrigine/lithium for mood instability, trazodone/nefazodone for sex side effects, and aripiprazole/quetiapine for paranoia/hallucination.

ANXIETY DISORDERS

What defines a panic attack?

- An abrupt and discrete episode of debilitating anxiety, with multiple physiological markers from any combinations of organ systems (4 out of 13 possible).

What are some of the most common chronic anxiety disorders seen in primary care?

- Generalized, Social, Panic Disorder, Agoraphobia, PTSD, OCD related.

What are the APA medication treatment recommendations for chronic anxiety – and dose change timing?

- SSRI x2 or buspirone if no depression, SNRI x2, then TCA.
- 30 days then increase, augment, or change.

What are the basic augmentations for the treatment of anxiety (PTSD/alcohol-involved/general)?

- Prazosin for PTSD, hydroxyzine/gabapentin for alcohol users, and lorazepam/clonazepam for the others.

ADVANCED: What are the full criteria for the most common chronic anxiety disorders in primary care?

- Generalized (50% of time, and multiple physiological markers), Social (fear of scrutiny and avoidance), Panic Disorder (unexpected attacks, fear of more, fear of meaning, and avoidance), Agoraphobia (intense fear outside of home and avoidance), PTSD (trauma, re-experiencing, hyperarousal, avoidance, and low mood), OCD related (obsessions and/or compulsions). 1 month for Panic and PTSD, 6 months for most everything else.

BIPOLAR DISORDER

What are the 7 diagnostic criteria and time requirement for bipolar disorder?

- Half of D.I.G.F.A.S.T. for 1 week: Distractible, Impulsive, Grandiose, Flight-of-ideas, Activity increased, Sleep decreased, and Talking increased.

How can you distinguish between bipolar types 1 vs. 2?

- Function: type 1 requires severe disruption often involving hospitalization, arrest, loss of function, or psychosis.

What are the APA medication treatment recommendations for bipolar disorders 1 and 2 (2 each) – and dose change timing?

- Mood stabilizers: type 1 has lithium and valproic acid, type 2 has lamotrigine and oxcarbazepine.
- Weekly: increase weekly to target blood level (do blood levels for bipolar 1 drugs)

What are the most serious medication risks of the mood stabilizers -- and the recommended lab monitoring frequencies?

- Lithium has renal/thyroid, valproic acid has liver, lamotrigine has rash, and oxcarbazepine has hyponatremia.
- 1-3-6-12: initially and then with dose changes or signs of toxicity at 1, 3, 6, and 12 months.

ADVANCED: What are the advanced treatments and their risks?

- Carbamazepine has liver toxicity/induction/agranulocytosis, and neuroleptics have motor/weight/cognitive.

ADVANCED: What looks like bipolar, but is NOT?

- Mood instability: from cluster B personality traits, substance use disorders, ADHD, and poor history taking.

PSYCHOTIC DISORDERS

What are the 5 diagnostic criteria and time requirement for schizophrenia -- and 2 for schizoaffective disorders?

- Half of HDSAN for 6 months: hallucinations, delusions, bizarre speech, bizarre appearance/behavior, negative symptoms. Alternative: HSAND.
- Timing: always has psychosis and sometimes mood symptoms. Psychosis worst at peak of mood symptoms.

What are the APA medication treatment recommendations for schizophrenia – and dose change timing?

- SGA: second generation/atypical antipsychotic.
- Weekly: increase weekly to symptom control.

ADVANCED: What are the treatments for akathisia, extrapyramidal side effects, and tardive dyskinesia?

- Beta blockers like propranolol, anticholinergics like benztropine/Cogentin, and less typical/lower potency neuroleptics like clozapine/Clozaril.

ADVANCED: What looks like schizophrenia, but is NOT?

- MDD/BPD with psychosis, substance (acute/chronic), delirium, complicated sleep disorder, or PTSD.

SOMATIC SYMPTOM, FUNCTIONAL PAIN, AND CHRONIC PAIN DISORDERS

What are the 4 main Somatic Symptom Disorders – and what are their foci?

- Somatic Symptom Disorder, SSD with prominent pain, Conversion Disorder, and Illness Anxiety Disorder.
- Body (often GI/GU), pain (any source), neurological (sensory or neuromuscular), worry only (not sensation).

What is fibromyalgia -- and chronic fatigue?

- Pain often with fatigue: 3 months, 4 quadrant pain, pressure to blanching, half of specific sites.
- Fatigue often with pain: 6 months, half of fatigue, memory, insomnia, pain in head, throat, axillary, joints, or muscles.

What are the 2 medical treatment recommendations for somatic symptom disorders – 2 psychiatric?

- Medical: workup/activity: full non-invasive medical workup, and graded physical activity.
- Psychiatric: antidepressant/therapy: SSRI/SNRI, and CBT or monthly brief supportive meetings with PCP.

What are the 2 additional medical treatment recommendations for SSD, neuropathic, and functional pain disorders?

- Same as SSDs, plus minimize opioids/muscle relaxants, maximize neuropathic pain meds including SNRIs, TCAs, or AEDs.

ADVANCED: What is the theorized common mechanism for SSDs, FPDs, and chronic pain?

- Neurochemical hypersensitivity secondary to cumulative genetic, mental, chemical, and mechanical stresses.

SLEEP-WAKE DISORDERS

What are the 4 components of primary insomnia – and what is the best screen tool?

- Difficulty initiating, maintaining, or non-restful sleep demonstrated by daytime fatigue.
- ESS: Epworth Sleepiness Scale.

What are the 4 primary AASM medication treatment recommendations for primary insomnia?

- Melatonin/zolpidem/trazodone/combine: MRA for initiation/early or BRA for late-night, and AD as next step.

What are the 2 secondary AASM medication treatment recommendations for primary insomnia?

- Older antidepressant/neuroleptic: TCA like doxepin, amitriptyline, or nortriptyline, or SGA like quetiapine or olanzapine (especially if PTSD or psychosis), or sleep evaluation.

ADVANCED: What are the common evidence based behavioral therapies for primary insomnia?

- CBT-I (relaxation/sleep hygiene/stimulus-response training/CBT), or light therapy.

SUBSTANCE USE DISORDERS

What are the 5 stages of change?

- Pre-contemplation, contemplation, planning, action, and maintenance. Some add relapse as a 6th stage.

What is motivational interviewing -- and what are the 5 core principles?

- Stage-based: a technique of helping the patient find their own reasons to get to the next stage of change.
- Empathy, find goal discrepancy, conflict avoidance, rolling with resistance, and self-efficacy.

What are the 2 most successful anti-craving medications for nicotine dependence in addition to 2 modes of NRT?

- Bupropion unless anxious, or varenicline unless depressed.

What are the 2 most successful anti-craving medications for alcohol dependence?

- Naltrexone is best unless liver problems, or acamprosate/Campral which is unfortunately dosed TID.

ADVANCED: What are the 2 second-line and emerging treatments for nicotine – and alcohol craving?

- Clonidine and nortriptyline both show significant benefit for nicotine craving.
- Gabapentin and baclofen both show significant benefit in some studies for alcohol craving.

PERSONALITY DISORDERS

How can you best identify – think about – and behave with a personality disordered patient?

- Distressing: you experience them as distressing as they are: 1) weird acting scared, 2) wild acting demanding, or 3) worried acting fussy.
- Suffering: Think about them suffering by always feeling: 1) unsafe, 2) unimportant, or 3) impotent
- Flexible: try to be flexible by giving in (slightly) to their "demands" while still providing reasonable boundaries. For example: try to minimize interaction with the weird/scared, try to tolerate some amount of drama from the wild/demanding, and try to include/empower the worried/fussy in the treatment planning.

How can you guarantee distress and failure for everyone involved when working with a PD patient?

- Battle the personality disorder. For example: forcing the weird/scared to interact extensively, scolding the behavior of the wild/demanding, and demanding a unilateral care plan with the worried/fussy. The weird/scared will run away, the wild/demanding will escalate and fight, and the worried/fussy will ignore your care plan.

ADVANCED: Where do personality disorders come from?

- Disordered early childhood experiences leading to interpersonal difficulties around boundaries and abnormal coping styles which may have some utility early on, but less so over time.

INTEGRATED MENTAL HEALTH ARTICLE SUMMARIES

These attached articles are intended to augment both the material that is covered in the didactic portion of the rotation as well as the skills learned during the patient care component. Below are the titles and primary learning points from each one. Please feel free to read the articles in their entirety for more details.

1) Physician-Patient Communication in the Primary Care Office: A Systematic Review

- The verbal and nonverbal behaviors which lead to the best patient outcomes
    - Verbal: interpersonal (empathy, reassurance, support, positive reinforcement, humor, information sharing, friendliness, and courtesy), professional (encounter length, patient orientation, and patient-centered questions), and educational (explanations, health education, and summarization and clarification).
    - Non-verbal: head nodding, forward lean, direct body orientation, uncrossed legs and arms, arm symmetry, and less mutual gaze.

2) Evaluation of the Adequacy of Outpatient Antidepressant Treatment

- The 4 most common mistakes made by primary care doctors treating depression
    1) Dosing: not increasing medication past starting dose to effective levels
    2) Timing: not giving medications for the 6-12 months it takes to prevent immediate relapse
    3) Selection: starting with drug classes other SSRIs which have the best patient adherence
    4) Collaboration: not working in collaboration with mental health

3) Withdrawing Benzodiazepines in Primary Care

- Safety
    - Short term use of benzodiazepines (weeks) is rarely harmful
    - Long term use of benzodiazepines is rarely, but sometimes, justified
    - Many patients show improvements in cognition, memory, and balance after discontinuation of long term use of benzodiazepines, particularly the elderly
- Discontinuation
    - Discontinuation of longer term use should always involve taper over a maximum of 6 months
    - The early phase of the taper is always more tolerable than the later phases, so go slower at the end
    - Pharmacological assistance during drug taper has demonstrated only weak evidence
    - Physician recommendation, patient education, and group therapy show some benefit

4) Treating Mood Disorders in Pregnancy – Not an Easy Decision

- Risks
    - There is no such thing as non-exposure – the fetus is going to exposed to the mother's illness, the medication, or both if the mother is inadequately treated
    - The fetus exposed to untreated depression can demonstrate deleterious lifelong mental and physical effects

- Untreated mood disorder during breastfeeding can persist or escalate interfering with maternal-child bonding and even contributing to real risk for the baby
- Remember that even significantly increasing the "odds" of a rare defect still yields a defect that will rarely occur – example: lithium increases Ebstein's anomaly from 1:20,000 to 1: 2000 if taken during the first trimester for bipolar disorder

- Recommendations
  - If the mother is successfully treated to remission the fetal exposure to illness and medication are both limited
  - Make the diagnosis, pick the best medication, and treat to remission

5) Adverse Reactions to Zolpidem – Case Reports and Review of the Literature

- Summary findings
  - Zolpidem is a very effective hypnotic with rare but unusual complex behavioral side effects
  - It is effective for both induction and maintenance of sleep with preservation of deep sleep and little rebound insomnia and little chance of dependency
  - Overall adverse effects are 1.1% with most common being headache, somnolence, and dizziness
  - Confusion or delirium may occur in less than 1%, hallucinations in 0.3%
  - Somnambulism or amnestic sleep-related behavior problems appear to range between 1 to 5%
  - Nocturnal eating has not been quantified but may be linked to underlying complex sleep disorders
- Prescribing variables
  - Gender: women have a higher serum concentration than men
  - Dose: adverse reactions are dose dependent
  - Albumin: drug is highly protein bound, so low albumin means higher level of free drug
  - Liver enzymes: cytochrome P450 inhibition by other drugs can increase concentrations

6) Recognizing, Managing Medical Consequences of Eating Disorders in Primary Care

- Starvation risks
  - Cardiac: sinus bradycardia, long QTc, low cardiac output, MVP, ventricular arrhythmia, and sudden death
  - Cerebral: reversible while matter, and potentially irreversible grey matter volume decreases leading to impaired cognitive function and decision making
  - Gastrointestinal: prolonged gastric and colonic emptying times, transient lactose/fructose intolerance, and steatosis accompanied by increase in AST and ALT
  - Endocrine: amenorrhea, hypothyroidism, and osteoporosis
- Purging risks
  - dental health, sialadenosis, electrolyte imbalances, and even renal failure
- Re-feeding syndrome
  - Can be life threatening and should only be managed in a hospital setting
  - Signs are tachycardia, hepatosplenomegaly, peripheral edema, altered mental status, and electrolyte abnormalities
  - Solution is lowering caloric intake and reducing fluid intake

- Men who had a history of childhood ADHD vs. men without demonstrated increased
    - ADHD diagnoses as adults (22% vs. 5%)
    - Antisocial personality disorder (16% vs. 0%)
    - Substance use disorders (14% vs. 5%)
    - Psychiatric admissions (24% vs. 6%)
- Medication reduces negative behaviors
    - Criminal behavior was reduced by 32% in men and 41% in women
    - Cigarette smoking was reduced by 13% in adolescents
- Perceptions
    - Parents were mixed with both positive and negative feelings about treatment prior to treatment
    - Children were overall very positive about their experience on medication