Surviving the Psychiatry JMO YEAR

A handbook for the JMO’s by the JMOs

INTRODUCTION

Dr S Sharma –Hails from Darwin where he used to fight crocodiles with bare hands as a little boy. He saw the brighter lights in GP land and decided to ditch the dark side.

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Every mother's dream son in law. Graduated with distinction in psychological medicine from one of the top two medical schools in New Zealand. He spends a lot of time on his couch thinking about how life should be.

We would like to acknowledge without naming individually the numerous colleagues and peers from whose practice we have shamelessly pinched those pearls of the art and science of psychiatry not readily found between the pages of a textbook.

In addition to this we would like to acknowledge the public patients of the South Australian Mental Health system who are an inspiration to us all in their daily fight for hope and wellness.
Above all, we would like to thank Jacob and Kirsteen, without whom none of these would have been possible.

CONTENTS

1.0 Organic Issues 6
- Medical Clearance

2.0 Common Investigations in Psychiatry 7

3.0 Psychiatric Interviewing 9

4.0 Legal Issues 12
- The Mental Health Act
- Inpatient Treatment Orders
- Community Treatment Orders
- Guardianship Board hearings

5.0 Documentation 15
- CBIS
- Discharge Summaries

6.0 Inpatient Psychiatry 16
- Closed v Open
- Medical Capabilities
- Morning meeting
- Ward Round
- Allied Health and Ancillary Staff

7.0 Staying Safe in Psychiatry 18

8.0 Killing me Softly (Suicide Risk Assessment) 20

9.0 This may be an Oxymoron (Psychiatric Emergencies) 22

10.0 We need some TLC … STAT! (Medication Matters) 25

11.0 Is this call important enough to disrupt my golf? 27
(Talking to the on call consultant).

12.0 Welcome to the Community 29
(An introduction to Community Psychiatry)

13.0 This ain't no Song for the broken hearted 31
(Striking life-work balance).

14.0 What the…??? Abbreviations and Acronyms 33

15.0 Useful contact numbers. 34

DON'T TRUST **YOUNG** *HANDSOME* **DOCTORS**

{ D I S C L A I M E R }

This is a guide book only. A quick and dirty handbook for you to look up when your cellphone is out of the internet range. This is not a textbook, we did not get paid to prepare this. We carefully composed this with due care, but there are bound to be mistakes and if in doubt, look it up yourself or ask someone who is likely to know.

The tone of the booklet is casual, and the humour may be iffy. We tried to make it as entertaining as possible – we hope you have as much fun reading this as we did making this. We call patients patients, not consumers or clients. We believe the only professions that call their customers clients are lawyers and prostitutes and we don't want to be either.

ORGANIC **ISSUES**

Psychiatry at times can seem somewhat removed from the general hospital environment but this does not mean that we can forget about "the rest of medicine". We are Doctors before anything else and it is that skill set that sets us apart and makes us unique in the multi-disciplinary team environment. Accordingly it is useful to have a practical understanding of the medical and organic issues that can affect mental health and at times masquerade as mental health issues.

The "Medical Clearance"

The Medical Clearance refers to a process, generally undertaken by Emergency Departments, Inpatient Teams or General Practitioners that is supposed to ensure that patients referred to mental health services don't have organic issues that are causing acute changes in their mental health. Ideally a medical clearance should include a focussed history, examination and ordering/review of appropriate investigations. Several ED's in Adelaide have proformas/templates for ED Medical Staff to fill out when assessing mental health patients and the "medical clearance" section is very often part of them. Once a patient has been "medically cleared" this should be documented within the patients case file. It is reasonable to request a "medical clearance" prior to accepting a referral as it generally should take place before the referral has been made to you.

When being medically cleared from a major metropolitan hospital it always pays to double check findings. "Medically cleared" is often quick speak for "patient won't keel over and die in the next 12 hours". Additionally it is good revision to keep one's medical skills up to date.

COMMON *INVESTIGATIONS* IN **PSYCHIATRY**

- Finger-prick glucose: Scenario: Agitation resulting in code black and parenteral sedation...Patient later found to be hypoglycaemic...It has/does still happen.
- Urine Dipstick/MCS: Mandatory for all elderly patients as UTI's are a common cause of delirium.
- Urine/Serum Beta HCG: Worth getting as a baseline.
- Full blood count: Useful if there are concerns re: infection. Also useful if a patient is on clozapine to ensure they are not neutropaenic.
- Urea, Electrolytes, Creatinine: Electrolyte abnormalities (eg. Hyponatraemia) are a common cause of delirium.
- Thyroid Function Tests: Both hypo and hyper thyroidism can present with changes in mental state.
- Liver Function Tests: Not generally part of the "Medical Clearance" but are useful to monitor especially for people with substance related disorders and periodically for others. Particularly for patients who have or are at risk of developing metabolic syndrome and its consequences (eg, fatty liver). Many patients on atypical antipsychotic medications will experience a transient elevation of liver enzymes.
- Iron studies, B12/folate: Iron studies are useful if a patient is anaemic or if hemochromatosis is being considered. B12/folate are useful as deficiencies of these micronutrients are a reversible cause of dementia and conditions that mimic psychosis.
- Syphilis serology: Not commonly ordered and thankfully not a common disease in South Australia. But worth thinking about in elderly patients and those patients who have or at risk of having unprotected intercourse.

- Fasting glucose/lipids: Useful to perform as a baseline in patients prior to commencing anti-psychotics and worth monitoring 3 to 6 monthly if not already being done so by a patients GP.

- CT Brain/MRI Brain/SPECT Scan: Although the diagnostic yield may be low, every patient with a first episode psychosis should have a CT Brain at baseline to rule out an intracranial cause for their presentation. This is mandatory for every psycho-geriatric admission to hospital with an acute change in mental state. These should be repeated as clinically indicated. If abnormalities are found, with the advice of senior colleagues it may be worth considering further investigation by way of MRI/SPECT.

- ECG: All patients should have a baseline ECG and repeated at least 3-6 monthly if on psychotropic medications (particularly atypical antipsychotics). The QTc is of particular interest and should be monitored (normal less than 430msec for adult men and less than 450 msec for adult women) as long QT syndrome is a risk factor for Torsades De Pointes which can progress to VT/VF and sudden death.

PSYCHIATRIC *INTERVIEWING*

Interviewing and history taking are core skills in psychiatry and it is worth spending some time thinking about the approach you will take. Everyone does things slightly differently and it is important you find a method you are comfortable with.

Psychiatric Interviewing takes many forms, from seeing an acutely unwell patient for the first time in the ED, to reviewing patients already admitted to the ward and seeing patients in the community setting (eg, at home or in an outpatient clinic). The template I will put forward is for the "Complete Psychiatric History and Mental State Exam" (often referred to as the "Maudsley") but it is worth noting that this can take a significant amount of time to perform and your approach needs to be tailored to one's practice setting and the clinical circumstances surrounding the interview, eg, emergencies and time limited situations.

When I interview a patient for the first time (eg in the ED or a new patient in outpatients) I like to keep a printed template (Double sided A4 paper) handy to prompt me. I try to keep writing to a minimum (only noting down important names/dates etc). My interview template includes:

1. Demographics: Housing situation (eg. House, apartment, rental, Housing SA, aged care home), Occupation or previous vocation, Source of Income (work, pension), Orders (eg. Community treatment orders, involuntary treatment orders), Assistance at home (eg services for cooking, cleaning, shopping, meals, medications), Marital Status, GP/Case Manager or Key Worker/Private Psychiatrist.

2. Presenting complaint.

3. History of presenting complaint (with focus on time course, stressors, precipitants).

4. Review of Symptoms (Mood, Anxiety/Panic, Psychotic, Suicidal, Homicidal, Organic).

5. Neurovegetative symptoms (Sleep, Appetite, Energy, Concentration).

6. Past Psychiatric History (Diagnoses, Inpatient stays, involvement with community teams, previous ECT).

7. Past Medical and Surgical History.

8. Medications (side effects, compliance, previous treatments, attitude towards, depot, webster pack).

9. Allergies.

10. Other substances (nicotine, ETOH, caffeine and other illicits).

11. Family History: (Of mental illness in particular. Also useful to draw a genogram in this section to give a pictorial representation of the family and where the patient sits in it).

12. Personal and developmental history (Life through the ages 0-3, 3-11, 11-18, 18 onwards, relationship to parents and siblings, domestic violence, other abuse, school performance, peer relations, educational attainment, employment history, significant relationships, forensic history).

My mental state exam includes mention of:

- Appearance
- Behaviour
- Speech
- Thought form
- Thought content (including Suicidal and homicidal ideation)
- Mood/Affect
- Perception
- Cognition
- Insight
- Judgement
- Rapport

A lot of the time due to time constraints, the entire Maudsley is difficult to perform and parts of the information you require are then obtained by collateral means (eg, previous discharge summaries, CBIS, interviewing friends and relatives).

Once you have documented your history and mental state, it is worth documenting a risk assessment (covered in another section of the handbook) and case formulation. The case formulation is a statement that summarises why this particular patient has presented in this particular way at this particular time. It is worth conceptualising it in the following way:

	Biological	Psychological	Social
Predisposing factors			
Precipitating factors			
Perpetuating factors			
Protective factors			

After the formulation it is worth outlining your clinical impression by way of a multi-axial diagnosis:

- Axis 1: Psychiatric diagnosis and differential diagnosis
- Axis 2: Personality traits/disorders
- Axis 3: Medical Co-morbidities
- Axis 4: Psycho-social stressors
- Axis 5: Global assessment of functioning (A scale from 1-100 reflecting the patient level of impairment but often in practice stated as mild, moderate or severe).

The importance of obtaining collateral is not often emphasized. Especially if making decisions regarding discharging a patient, who has been brought into hospital by other services, make sure you have obtained collateral history from individuals who know the patient well. Check to see your conceptualisation of safety issues matches that of those providing the collateral information and if at variance, always err on the side of caution prior to taking sole responsibility for discharging the patient.

LEGAL *ISSUES*

The Mental Health Act: Broadly speaking, the Mental Health Act is one of several pieces of legislation that inform the treatment of mental health patients in South Australia. It is of special significance to us in Psychiatry because it is arguably the piece of legislation that we have the most involvement with on a day-to-day basis.

Amongst other things it informs involuntary treatments in the community and inpatient setting as well as the provision of ECT where patients are unwilling or unable to provide consent. Though an in-depth understanding of the act is not necessary for daily practice, it is worth being familiar with its existence and purpose.

A google search for "SA Mental Health Act" will direct you to a copy of the most up to date act. It should also be available in hard copy in most mental health treatment facilities.

Inpatient Treatment Orders: (Formerly known as Detention and Treatment Orders) are the documents we fill out in order to keep patients in hospital involuntarily. Points to note:

- If you are considering detaining a patient this needs to be discussed with a consultant if you have not already done so.
- Somewhat confusingly there are 3 "levels" of detention. These "levels" do not coincide with "how much" detention the patient is under (as I once thought) rather they refer to the duration of the order.
- Any voluntary patient who is then detained is done so on a L1 ITO. These last for up to 7 days.
- L1 ITOs must be reviewed within 24 hours of being made by a Psychiatrist
- A patient already on a L1 ITO may have their detention extended by up to another 42 days if a L2 ITO is made (only a Psychiatrist can do this).
- A patient on a L2 ITO may have their detention extended by up to 12 months (adults only) if a Level 3 ITO application is made.
- All ITOs must expire on business days (eg. If you place a L1 ITO on someone on the weekend, it expires the following Friday, not on a Saturday or a Sunday or the following Monday).
- Patients may appeal any/all of their ITOs.

Community Treatment Orders: As the name suggests CTOs are used in the community setting to enhance compliance with treatment (predominantly depot medication) as well as to ensure appropriate follow up and attendance at appointments with mental health services.

- Again CTOs exist in 2 "levels" reflecting the duration of the orders.
- These should be made in consultation with a psychiatrist.
- Patients not on a CTO can be placed on a level 1 CTO which expires in 42 days.
- L1 CTOs must be reviewed within 24 hours by a Psychiatrist.
- An application may be made for a L2 CTO (generally for a patient who is already on a L1 CTO) which can extend the duration of the CTO for up to 12 months. Patients may appeal any/all of their CTOs.

Guardianship Board Hearings: You will have the opportunity to attend GSB hearings and in the beginning it is natural to be daunted by them. This gets better with time (but they are never really "enjoyable" experiences at the best of times).
Your purpose of attending a hearing will generally be:

- As part of the L3 ITO application process
- As part of the L1/L2 CTO application process
- As part of an appeal hearing
- As part of an application for ECT.

One is often called upon by the Guardianship Board to recap information that is likely to offend the most tolerant individuals and fracture any rapport one enjoys with the patient. Master the art of delivering critical information couched in palatable terms without frankly lying and things will become easier e.g. "My understanding of speaking to people who know Mr S well is that he is normally a very amiable and happy gentleman. This was far from how he presented to hospital when he broke his neighbours door. However as he has recovered in hospital I have had many opportunities to see instances of his former/normal personality".

Prepare the ground by warning the patient that you will have to say things about them, that this is not what you would like to do but is mandated by the GSB in such situations. Provide them with a face saving way out of their situation e.g. "The CTO allows you to access free medication and also means that health services take you seriously when you arrive looking for assistance".

GSB Hearing tips:

- If it is your first one, don't hesitate to ask a registrar or consultant to come with you.
- They are generally videotaped and/or audio recorded.
- Hearings for applications have 1 board member generally.
- Appeal hearings have 3 board members (generally a lawyer, a psychiatrist and a community member).
- If you are going as part of an application for an ITO, CTO or ECT ensure you have done your best prior to the hearing to explain to the patient (and guardian/carer if applicable) what your intention is of the application and try to get them on board as much as possible.
- Make sure you explain to the patient and guardian what their rights are prior to the hearing (these rights are written on the application forms).
- Document your discussion with the patient re: the above 2 points because you will be asked if you have or not during the hearing (if you haven't in some circumstances the hearing will be adjourned).

DOCUMENTATION

The dictum "if it's not written down it didn't happen" is a good one to live by.

Its good practice to aim to document every interaction you have with patients, carers and other members of the multidisciplinary team in the clinical record. Your records should ideally be legible, timely and include:

- The time and date of the entry
- Your name, designation and contact details

CBIS: If you are not already familiar with CBIS, prepare to become so. It is a computer program that is gradually replacing the written record in mental health facilities in SA. Ideally prior to starting work in Psychiatry in SA you should have a CBIS logon and have had some training in how to use it.

Discharge Summaries: If you are working in an inpatient unit you should make every effort to complete the majority of a patient's discharge summary prior to their discharge. This is even more important if the patient's care is going to be taken over by a GP and/or the community mental health team. Salient points to include are:

- Diagnosis and reason for admission
- Presence of any orders and any appeals made/pending
- Treatments used and doses of same (incl. due date for next depot)
- Reasons for why a particular treatment was chosen and mention if the patient failed to respond to a particular drug trail
- Major events during admission.

Very often GPs and community teams may not have access to OACIS (the program housing discharge summaries) so it is worth faxing them a copy of the discharge summary prior to the patient's discharge.

Another point to note is that in many inpatient units, though junior staff write the bulk of discharge summaries, they do not finalise them. This is left to the treating consultant who reviews and amends the summary as required beforehand.

Tips to make work lighter:

Pen the initial part of your discharge summary while doing your admission of a new patient while the facts are still fresh in your mind and saves you time when you do not have to re-refer to your previous notes. This then just leaves the course in hospital and final recommendations to be completed later.

Have you completed your discharge HONOS!!

INPATIENT *PSYCHIATRY*

Psychiatric Wards are similar to General Hospital Wards in many ways while being significantly different in other ways.

- Closed vs Open: As the name would suggest, some Psychiatric Wards are "open": meaning patients are free to come and go as they please, whilst others are "closed": patients are unable to leave unless someone lets them out. Other wards may be mixed with respective open and closed sections. Generally the decision as to whether a patient should be managed in an open or closed bed should be made by the treating psychiatrist, as should the decision as to when and if patients move between the two wards. N.B. Without exception, patients managed in closed wards are detained as it is a serious infringement of a person's fundamental rights to hold them against their will without mental Health Act orders in place to justify the same.

- Medical Capabilities: Psychiatric wards differ in their capability to manage patient's medical co-morbidities. Whilst some may be comfortable managing a patient with an IV infusion, others would ask that such patients be transferred to a more appropriate setting. This is generally reflective of the skill mix of the nursing staff and the actual infrastructure and resources on hand to manage a potentially unwell patient. The safest bet is to liaise with nursing staff on a patient-by-patient basis as to the acuity of medical co-morbidity they are able to manage. This may differ from day to day and shift to shift. N.B. You should make yourself familiar with the medical capability of the ward eg. Equipment for venepuncture, cannulation and presence/absence of crash cart + local hospital procedures to call code blues/MET calls.

- Morning Meeting: Ward staff (medical, nursing, allied health +/- admin) generally meets in a designated area every morning for handover where pertinent issues from the previous evening and night shift are handed over to the morning staff and daily plans discussed eg. Anticipated admissions, discharges, meetings and other business.

- Ward Round: Unlike other areas of medicine, you generally don't review each patient daily. You will usually find routinely reviewing them twice a week in detail and briefly more often, suffices. Most inpatient units have weekly "ward round"

meetings where each consultants patients are discussed in a paper round manner with medical, nursing and allied health staff present to discuss new patients, existing patients progress and discharge plan. Units differ in their ward round procedure but it is good to have a brief synopsis ready to present to the team for each of your patients outlining their diagnosis, length of stay, progress since last meeting and active issues preventing discharge.

- Allied Health and Ancillary Staff: Similar to other wards Psychiatric wards have a cohort of staff aside from the medics and nurses who ensure things run smoothly:

1. Social workers: Assist with accommodation, financial, custodial and legal matters for patients.

2. Occupational therapists: Assist with functional assessments and home based assessments for discharge planning.

3. Pharmacists: Assist with medication reconciliation and prescription of medications on discharge.

Do not fall prey to Chinese whispers! Information has often changed more than one hand before eventually arriving to you. Do not be shy about verifying information first hand with the parties directly involved if there is any dispute about veracity of reports made regarding a patient.

STAYING SAFE *IN PSYCHIATRY*

Psychiatry is unique in that the nature of the doctor patient relationship is often deeper and more complex than other areas of medicine. The emotional and psychological exchanges that occur between patient and practitioner put both parties at risk of blurring professional and personal boundaries with the potential for this to lead to boundary transgressions. There are steps you can take to optimise your safety:

1. Never reveal private or personal details about yourself to patients. eg. Home address, personal phone number, marital status, names of children. Patient enquiries into this side of your life should be politely discouraged with minimal disclosure on your behalf. If the patient is not happy with this, then it is their problem and not yours.

2. Live in a different region to the one you work. Many psychiatrists advocate this eg. If you work in the South of Adelaide, live somewhere in the West. This may be impractical for you but it does minimise the chances of seeing your patients outside of work.

3. Delist your phone number from the phone book.

4. Become a silent voter. There have been cases of psychiatrists being tracked down by patients at their home through the electoral role.

5. Always know how to operate your duress alarm and call a code black. Never hesitate to activate one or both. No one minds responding to a “false alarm” but everyone minds being asked to testify in court as part of a coronial inquest.

6. Interview safely: Ensure there are 2 exits in every room you interview. One for yourself and one for the patient. Don’t hesitate to have another person present in the room for the interview if this is safer (document the others presence as well). Don’t hesitate to call security prior to/during an interview if the patient is agitated or has the potential to become agitated during the interview due to the nature of what you are discussing (e.g. Detentions or community treatment orders).

7. After an episode of trying to manage an agitated patient or similar disturbance on the ward, do not leave until everybody is satisfied that things have returned to manageable levels.
8. Trust your gut feeling: If you are feeling unsafe, chances are there are good reasons for this. Do not ignore this intuition as it may well save your and other people's lives. If you feel unsafe with a majority of your patients take this up in discussion with your supervisor- there are probably anxiety issues that may impede your growth in psychiatry and that need to be dealt with expediently so as not to deter your progress.

KILLING ME SOFTLY
(SUICIDE RISK ASSESSMENT)

Risk can be divided into 4 categories; suicidal/self-harm, homicidal/aggression, absconding and vulnerability/self-neglect.

If there are any significant concerns in any of the above areas, detention may be warranted. Remember to always err on the side of caution as a junior doctor – your consultant can always revoke the detention tomorrow. You do not have the experience or the salary to take on that responsibility.

We will focus on the suicide risk assessment in this booklet, but the basic principles apply to all four areas mentioned below.

Detection

Up to 90% of people who die by suicide suffer from a diagnosable psychiatric illness. As a psychiatry doctor, there is no excuse not to assess your patient's suicide risk, every single time, even if it means briefly asking them if they thought of harming self or others lately.

Assessment

In addition to your-always-comprehensive psychiatry assessment, you need to focus on the following;

- Current mental state – depressed, psychotic (especially command hallucination and delusion of dying and nihilism), hopelessness and impulsivity.
- Suicidal thoughts/attempts – trigger (psychosocial situation), intent (letter, specific planning), degree of lethality, access to means (firearms, pills) and previous attempts (when, how).
- Substance – current intoxication = impaired judgement!
- Collateral history – can you verify what the patient is telling you? Degree of support.
- Reflective practice – quality of engagement, how confident do you feel?

Ask yourself, why are they suicidal now, and will that reason still be there when you discharge them? Some people may be chronically suicidal, but they can still be acutely suicidal (a bit like acute on chronic renal failure), in that case you need to treat them appropriately.

Risk Factors

"SAD PERSONS" to help you remember the following risk factors;

S: Male sex
A: Age <19 or >45 years
D: Depression or hopelessness
P: Previous suicidal attempts or psychiatric care
E: Excessive ethanol or drug use
R: Rational thinking loss (psychotic or organic illness)
S: Single, widowed or divorced
O: Organized or serious attempt
N: No social support
S: Stated future intent (determined to repeat or ambivalent)

Management

If you have any concern (including not being able to get collateral history because it's midnight), it is always safe to keep the patient in overnight.

If the patient is not cooperative, they need to be detained.
If you feel confident enough to discharge the patient, then;

- Discuss with your consultant first and document.
- Ensure that someone can look after them tonight, and there is a follow up by community mental health team/GP/private psychiatrist within the next couple of days.
- Give them an ACIS card to access urgent help if things change in the interim.

Unfortunately, we aren't very good at predicting who will suicide and who won't. Screening tools we use have little supporting evidence in terms of suicide predictability.

You can't prevent suicides long term. Your aim is to make sure that you can provide the safest environment possible for your patient in the least restrictive manner tonight.

Remember to always err on the side of caution.

Further Reading

Suicide Risk Assessment and Management Protocol by NSW Health. You can google and download this. More for community but very comprehensive.

Ryan et al. Clinical decisions in psychiatry should not be based on risk assessment. Australasian Psychiatry 2010; 18; 398-403. An interesting read to put things in perspectives.

THIS MAY BE AN OXYMORON *(PSYCHIATRIC EMERGENCIES)*

Under this heading, we will discuss about the conditions that can't be handed over till the home team gets back in the morning.

We will talk about serotonin syndrome, neuroleptic malignant syndrome, acute dystonia, lithium toxicity and QT prolongation. For the purpose of this guidebook, we will focus on what to look for in recognising these conditions and what you need to do before you call your consultant/med registrar and/or transfer the patient to ED.

Serotonin Syndrome

Look for:

- Usually occur within 6-8 hours of initiating/increasing serotonergic medications. This is more acute than NMS. However, be mindful of drugs with long half-lives such as fluoxetine.
- Interaction more likely than overdose. Common offenders include SSRIs, MAOIs as well as amphetamines.
- 3 major domains; autonomic changes (increase in vital signs, shakes and sweats.), mental status changes (restlessness, increased confusion and agitation, convulsions) and neurological changes (tremor, hyperrelexia, increased muscle tone LL>UL, ocular clonus, myoclonus).

Hunter Serotonin Toxicity Criteria: Decision Rules (sensitivity 84%, specificity 97%)

In the presence of a serotonergic agent:

1. Spontaneous clonus=yes THEN serotonin toxicity=YES
2. ELSE IF (inducible clonus=yes) AND [(agitation=yes) OR (diaphoresis=yes)] THEN serotonin toxicity=YES
3. ELSE IF (ocular clonus=yes) AND [(agitation=yes) OR (diaphoresis=yes)] THEN serotonin toxicity=YES
4. ELSE IF (tremor=yes) AND (hyperreflexia=yes) THEN serotonin toxicity=YES
5. ELSE IF (hypertonic=yes) AND (temperature > 38) AND [(ocular clonus=yes) OR (inducible clonus=yes)] then serotonin toxicity=YES
6. ELSE serotonin toxicity=NO

Treatment:
- Stop the offending medications.
- Call support – med registrar on call/ED/your consultant.
- Supportive care to stabilize vital signs eg. IV fluid, external cooling and benzodiazepine.
- Benzodiazepines to decreased hypertonicity and neurological excitability.
- If temperature is more than 41 degrees, patient should have an intubation.
- Cyproheptadine, a 5-HT inhibitor, to be considered for severe case. Obviously, you shouldn't be doing this on your own.

Neuroleptic Malignant Syndrome

Look for;
- High potency typical antipsychotics.
- Recent changes in dose, depot (but NMS has been reported in atypical antipsychotics as well.)
- Severe muscle rigidity, increased temperature, autonomic instability and confusion /delirium.
- Elevated Creatine Kinase, leucocytosis, altered LFT.

Treatment:
- Stop the offending medications, monitor the vital signs and ensure adequate hydration.
- May require benzodiazepine for agitation.
- Do/repeat CK, CBE and LFT.
- Call support – med registrar on call/ED/your consultant.
- May require rehydration, bromocriptine + dantrolene as well as ventilation.

Acute Dystonia

Look for:
- More common in young males, neuroleptic-naïve and high potency antipsychotics.
- Usually develops within minutes to days of administration of offending medication.
- Muscle spasm/sustained muscle contractions in any part of the body; eyes rolling upwards = oculogyric crisis, head and neck = torticollis.

Treatment:
- Benztropine 1-2mg IM stat.
- Should give immediate relief.
- Offending antipsychotic agents should be reviewed.

Acute Lithium Toxicity

Look for:

- At supratherapeutic concentration (usually higher than 2mmol/L), lithium can cause ataxia, vomiting, coarse tremor, confusion, coma, dysarthria and acute renal failure.
- Can be caused by anything that can compromise renal function; interaction with other drugs (eg. Diuretics, NSAIDS and ACE inhibitors), decreased fluid intake and increased fluid loss (eg. Diarrhoea and vomiting).

Treatment:

- Withhold lithium.
- Do serum lithium level. Repeat in 5 days. Also test EUC.
- Need to review lithium.
- If Li < 3 mmol – may require saline infusion to produce diuresis. If Li > 3mmol – renal dialysis is warranted.

QTc Prolongation

Look for:

- You usually get called to review ECG to find that the patient's QTc is prolonged (<430ms for men and <450ms for women). Patients are usually asymptomatic.
- We worry about this because prolonged QTc interval is associated with ventricular arrhythmia and sudden cardiac death.
- All antipsychotic medication can cause this, but especially atypical and in particular quetiapine.

Treatment:

- Make sure that ECG is done correctly – it doesn't hurt to ask for another one.
- If QTc is >440ms (men) or >470ms (women) but <500ms – call your consultant Antipsychotics will probably need to be reduced.
- QTc > 500ms – Stop antipsychotics. Refer to cardiology.
- Abnormal T wave – review treatment. Refer to cardiology.

Further Reading;

- Frank, C. Recognition and treatment of serotonin syndrome. Canadian Family Physician. 2008; 54:988-992.
- Therapeutic Guidelines Psychotropic Version 6 by Psychotropic Expert Group.
- The Maudsley Prescribing Guidelines 10th edition by Taylor et al.

WE NEED SOME TLC…STAT! *(MEDICATION MATTERS)*

Pro Re Nata

For ward:
The standard PRN for agitation is as follows:
- Lorazepam PO ,1-2mg, q2-6h, up to 6-10mg. (SA Health no longer have IM preparation)
- Olanzapine PO/IM,5-10mg, q2-4h, up to 30mg (or less depending on their normal medication regime)

Alternatively;
Chlorpromazine PO, 50-200mg, q2h, up to 600mg can be tried.

When nurses talk about “two and ten”, they are talking about 2mg of lorazepam and 10mg olanzapine.

For nicotine replacement therapy: Nicotine inhalers, INH, 10mg, q2h, up to 120mg. For heavy smokers, you can also prescribe; Nicotine Patch, TOP, 21mg, daily, up to 1 patch.

Technically, nicotine patches should be a long term treatment to aid with smoking cessation, but the reality of it is this is just another way of putting nicotine into patients’ system while they are in closed wards.

Behavioural Emergency

Try PO treatment as above first. If not effective;
- Consider IM: Midazolam, IM, 2.5 – 10mg, q20minutes, up to 20mg. NEED sedation monitoring for at least 4 hours; AND/OR
- Clonazapam, IM, 0.5-2mg, q6h, up to 4mg.

Also consider: Olanzapine, IM, 5-10mg, q2-4 hours.

IM benzodiazepines and IM olanzapine should not be used concurrently due to the risk of cardiorespiratory depression. There should be at least one hour between IM benzodiazepine and IM olanzapine. (There have been some fatalities in Australia).

If this does not work, contact your consultant and consider;

Zuclopenthixol acetate “Acuphase”, IM, 50-150mg, not to be repeated for 2 to 3 days, up to 300mg in 2 weeks.Patient may need IM midazolam at the same time.

Remember, it takes 8 hours for the Acuphase to reach its peak level and it will stay in the system for up to 72 hours. Benztropine should be on hand to administer should any acute EPSE occur.

After IM administrations, monitor vital signs every 15 minutes for an hour and every 30 minutes until patient is able to mobilise independently.

Patient should be discussed with the consultant before administering Acuphase.

Further Reading;

Thapa et al. P.R.N. (As-Needed) Orders and Exposure of Psychiatric Inpatients to Unnecessary Psychotropic Medications. Psychiatric Services. 2003: 54: 1282-1286.

A study that makes you think that you really are treating nurses rather than patients with PRNs.

Therapeutic Guidelines Psychotropic Version 6 by Psychotropic Expert Group.
The Maudsley Prescribing Guidelines 10th edition by Taylor et al.

IS THIS CALL IMPORTANT ENOUGH TO DISRUPT MY GOLF? *(TALKING TO ON CALL CONSULTANTS)*

First of all, have a low threshold. You are not even in training, for goodness sakes, you don't have the qualification nor experience to be making big calls. Sure, some psychiatrists can be scary (yes, scary psychiatrists), but they can be a lot scarier if you call them too late (or worse, someone else calling them for you).

We have included an ISBAR clinical communication tool to help you with presenting the patient to the on call consultant. You don't have to stick to this format, but it's a nice guide to give your phone presentation a structure. Keep it simple, don't speak too much. Consultants want to know what the clinical question is so that they can help you. Before you start, always be polite. "I am sorry to interrupt you. Can I have a minute of your time to discuss a patient?" Like my year 10 science teacher said, friendliness and politeness will get you a long way in life.

Identify – Introduce your name and your role. (eg. John Smith, RMO, working in RAH ED). Introduce your patient. (eg. Hello, Dr Johns, my name is John Smith, I am an RMO working in RAH ED tonight. I was wondering if I could have a minute of your time to discuss Jayne Smith, 35 year old woman with previous diagnosis of depression).

Situation – Why is the patient with you and why do you need to talk to him about the patient right now? (eg. She was brought in by her sister after attempting suicide by overdosing on her Seroquel tables. She reports that she has only taken a handful, but the officers found a couple of empty boxes near her bed. She texted her sister before taking the overdose. Her sister found her within an hour or so and called the ambulance.)

Background – Relevant history that the consultant should know about. (eg. She was diagnosed with depression 10 years ago and was prescribed Seroquel by her GP to help her sleep. She has previous history of 2 suicide attempts, one with overdose 2 years ago, discharged from ED, and another earlier this year by trying to gas herself in the car. She was found by a passer-by. She reports that this attempt was in context of a recent relationship break up. Her partner has moved out of the flat. She now lives alone but her sister is willing to staying with her for the next while. She has not been medically cleared yet.)

Assessment – Provisional diagnosis, relevant mental state examination, risk assessment. (eg. I believe that this is a suicidal attempt on background of known social stressor. I felt that she was reactive in affect with superficial rapport. She currently denies ongoing suicidal ideation.)

Recommendation – What is your clinical question? (eg. I believe that she can be discharged home under the care of her sister after medical clearance. We will give them an ACIS card, and arrange community team follow up for the next few days. I will fax my assessment to her GP and the patient will make an appointment to see him within a week with a view to gain a referral to a private psychiatrist. Her sister is aware of our contact details. I wanted to run this by to make sure you are OK with my discharging this patient tonight.)

WELCOME TO THE COMMUNITY
(AN INTRODUCTION TO COMMUNITY PSYCHIATRY)

In community psychiatry, your role as a doctor tends to be more valued because 1) you can detain people and 2) you can prescribe medication. Ironically, even though you work in a building with lots of allied health workers (key workers come with all sorts of different backgrounds including nurses, social workers, occupational therapists and psychologists), you need to work more independently than you would in a ward setting.

It is important to clearly establish who your go to person is – ie your supervising consultant. Initially, you need to ask them a lot of questions as for most of you, community setting is quite different from the training you have had so far.

Here are some tips on how to survive and enjoy the Community. After all, it is slightly nicer working environment where people are allowed to have more autonomy over coffee breaks and the dresses they wear.

- As stated above, the golden rule, as in any other setting, is ask if you are unsure. Ideally, it should be your supervising consultant, but if they are not available, ask any consultant.
- Key worker is your best friend. Be nice to them and they will be nice to you. They will do all the psychosocial stuff for you. In addition, they are the ones who can advise you on the "baseline mental state".
- Share the load. Share the responsibility. Discuss the case with your patient/ key worker, document the discussion. Don't feel like you need to take on all the responsibility, you are not a private psychiatrist yet.
- Assist nurses/other staff promptly – if you are asked to write scripts, do them now, rather than later. It will help the system run smoothly, staff will not be nagging you, happy staff equal happy work environment.
- Be flexible. Community is not as structured as ward environment, you need to be able to deal with unexpected presentation at unexpected time.
- Think twice before playing with medications – do you really need to do that? A lot of people in community have been stable on the same medication for years before you came along, so the basic philosophy remains – if it's not broken, don't try to fix it.
- In terms of follow up appointments, err on earlier side initially until you get to know the patient well, then you can prolong the appointment intervals as you build rapport with the patients.
- Think of an Intermediate Care Centre (ICC) as an option for respite. You don't always have to send patients to hospital.

- Learn to type fast. CBIS, in my humble opinion, is the best use of information technology since …. (insert your own choice here, Medical Education deleted mine during the drafting of this manual as it wasn't considered appropriate for all). Type in your assessment (clear documentation is important; every entry should include risk profile, mental state, current medication and management plan), copy and paste it to make the letter to GP and your assessment can be accessed anywhere anytime.
- You will likely to have a bit more down time in community. Make the most of it. Set up a project of some kind. For example, we created this booklet during our community placement.
- It can be scary at times because you need to learn to let people go home to their chaotic lives. Slowly, you will learn that people can, and people do, function in such environments. I suspect that it is similar to how our parents felt when they sent us to Med School, but you are often surprised by how much people can handle on their own.
- Having said that though, I can't emphasize this point enough - you will get uneasy feelings. But don't be a cowboy, even cowgirls get the blues. Share the blues. Be part of the team.

THIS AIN'T NO SONG FOR THE BROKEN-HEARTED *(STRIKING LIFE-WORK BALANCE)*

In The 7 Habits of Highly Effective People, Stephen R Covey asks "How many people on their deathbed wish they had spent more time at the office?" Think about that for a second, and maybe buy the book online. You can probably claim it on professional development (ask TAPPP Medical Education Officer).

Life-Work Balance isn't about using your "life" as an excuse for slacking off. It's about knowing what you want out of your life, having goals in your mind and be able to say no when you need to say no. This works both ways. If your goal is to improve your interviewing skills, then taking up extra shifts may be a great idea, but if your taking up too many shifts mean that you are irritable towards your wife, and maybe those extra shifts (and money) ain't worth it. You need to work up how much you are prepared to give for what you want. And probably more importantly, you need to know what you want and how you are going to get them.

Having an end point or a goal in mind is very important. Have you ever tried working without a watch? There is nothing more draining and tedious than doing work when you don't know how much you've more you've got left to go. Having a goal is about setting up the light at the end of the tunnel. It doesn't have to be the very end of the tunnel, you can set up little short term goals/lights along the way to shine the path that you are taking.

In more practical terms, here are a few tips to help you get through the year;

- Ask yourself, what do you want to achieve from this year? Work out what you need to achieve your goal. Write it down.
- Do the same thing for one thing that is not related to work. It might be to run a marathon, or to read 30 novels or play for the Socceroos. Write it down.
- Start working towards your goals.
- Plan your leave. You've got 5 weeks annual leave. Make sure you take them, have something to look forward to.
- Don't put too much pressure on yourself. The mental health system will not collapse if you don't come to work.

- Flip side of that is that your life will collapse if you collapse, so look after yourself. Try to eat well, try to get out and do some exercises. Try meditation if you like. You are a doctor for crying out loud, you know what you have to do, just do it.
- Seek help when you need to. This may be your supervisor, partner or DASSA. It doesn't matter, get help when you need to.
- Read The 7 Habits of Highly Effective People.
- When you are in trouble, remind yourself that, like Bon Jovi says, it's my life. You've got to get your priorities right, mate.

WHAT THE ... ???

ABBREVIATIONS AND ACRONYMS

1/52 One week per year
24/7 24 hours per day, 7 days per week
ACIS Assessment and Crisis Intervention Service
ATS Acute Treatment Service
BAS Bed Allocation System
CALDB Culturally and Linguistically Diverse
CAMHS Child and Adolescent Mental Health
CBIS Community Based Information System
CL Consultation Liaison
CPC Clinical Practice Co-ordinator
CSC Clinical Services Co-ordinator
CTT Community Treatment Team
DASSA Drug and Alcohol Services Council of South Australia
DBT Dialectical Behaviour Therapy
ECT Electro Convulsive Therapy
EDD Estimated date of discharge
HASP Housing and Accommodation Support Project
ICC Intermediate Care Centre
IMOC Integrated Model of Care
MAC Mobile Assertive Care
MDT Multi-Disciplinary Teams
MIFSA Mental Illness Fellowship of South Australia
OACIS Open Architecture Clinical Information System
OCS Ongoing Clinical Support Service
PECU Psychiatric Emergency Care Unit
PICU Psychiatric Intensive Care Unit
SAAS South Australian Ambulance Service
SAPOL South Australian Police
SRF Supported Residential Facility

Useful Contact Numbers

Name	Phone Number	Email
Dr Rebecca Kurlinkus Director of Clinical Training	0417 884 988	Rebecca.Kurlinkus@sa.gov.au
Debra Wisdom Medical Education Officer	0401 125 338	Debra.Wisdom@sa.gov.au www.psychiatryjmo.weebly.com
Shared Services Payroll	8372 7502 no 1	https://sharedservices.sa.gov.au
IT Help desk	1300 138 913	
CBIS Help desk	1300 769 084	HealthCBIShelpdesk@sa.gov.au
Sunrise	1800 174 088	Inside SA Health Homepage Search “Sunrise”

Service	Phone Number
SACAT South Australian Civil & Administrative Tribunal	1800 723 767
SAAS South Australian Ambulance Service	1300 136 272
SAPOL South Australian Police	131 444
OCP Office of the Chief Psychiatrist	8226 1091
Glenside Health Services	7087 1000
Lyell McEwin Hospital **(LMH)**	8182 9000
Modbury Hospital **(Mod)**	8161 2000
Queen Elizabeth Hospital **(TQEH)**	8222 6000
Royal Adelaide Hospital **(RAH)**	7074 000
Flinders Medical Centre **(FMC)**	8204 5511
Noarlunga Health Service **(NHS)**	8384 9222