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Chapter 23 Difficult and urgent situations Dealing with psychiatric emergencies It is a common misconception that there are no real emergencies in psych iatry. However, a psychiatrist in training is expected first and foremost to be a competent physician and needs to be up-to-date with basic resuscitation procedures and be familiar with the procedures in place for the manage ment of medical emergencies in the hospital they are working, as the level of on-site facilities will vary. Dealing with acute situations can feel like a lonely business, and doubts about the best management of given situations may get in the way of that much needed rest period. There is no substi tute for experience, but hopefully some of the guidance in the following section will allow a rational approach to a number of common (and not so common) difficult and urgent situations in a psychiatric setting. Keep the following principles in mind. 'Primum non nocere': above all, do no harm • Always ensure your own and other staff's safety. • If necessary facilities or expertise are not available, make appropriate arrangements to get the patient to them as soon as possible. • Always suspect (and as far as possible exclude) potential organic causes for psychiatric presentations. • Remember—patient confidentiality does not override issues of threatened harm to themselves or other individuals. Assess • Always make the fullest assessment possible—do not fail to ask about important issues just because you feel a person may not wish to talk about them. • Ensure that you have the best-quality information available. If other sources of information are available (e.g. previous notes, third-party information), use them! • Do not dawdle—if a situation requires immediate action, act. Consult • Do not assume anything. If in doubt, consult a senior colleague. • If it is possible to make a joint assessment, this can really help for difficult cases—both

as someone to help make the decision and also to fetch more help or make calls if needed. • Remember you are part of a team, and if there is a difficult decision to make, do not make it alone. Keep contemporaneous records • Clearly record your assessment, decisions made (and reasons), and the names of any other colleagues involved or consulted. Legally, if it has not been recorded, it has not been done.

Chapter 23 Difficult and urgent situations Dealing with crisis situations First principles • Speak to the staff who originated the call. • Obtain as much information in advance as possible about the situation, including accessing any electronic records. Forewarned is forearmed! • If the patient is from out of area, a quick call to that area can provide vital information about the background, risk, and current service involvement. • Establish what your expected role is. • Keep your own safety uppermost in your mind (no heroics). General aims • Attempt to put the patient at their ease; explain who you are and why you have been asked to speak to them. • Be clear in any questions you need to ask, and elicit useful information. • Achieve a safe, dignified resolution of the situation. Important communication principles • Be conscious of both verbal and non-verbal language. • Listen actively—assimilate and understand what is actually being said and interpret the various underlying meanings and messages. • Feedback—go back over what the patient has said with them to assure them that you understand what they are saying. • Empathy—appreciate the sharing of thoughts, feelings, and motives. • Content and feeling—note any difference between what is said verbally and what message is really being given. • Use checkpoint summaries—brief reviews of the main points discussed about issues and any demands. Important suggestions • Use open questions to give the patient an opportunity to ventilate what is on their mind (to help relieve tension, keep the patient talking, and allow you to assess the mental state). • Closed questions can be used later in the interview to clarify symptoms and to establish an accurate assessment of risk. • Listen carefully to what the patient is saying. This may provide further clues as to their actions. It also demonstrates concern for the patient's problem. This is much harder to do well than it sounds! • Be honest, upfront, and sincere—develop a trusting relationship. • Be neutral—avoid approval or disapproval unless necessary. • Orientate the patient to looking for alternative solutions together, without telling them how to act (unless asked). • Try to divert any negative train of thought. • Check with other team members before making any commitments. • If the police have been called, present the reason for their presence realistically, but neutrally. • Do not involve family members in negotiations. Ideally, speak to the patient on their own, and then speak to their family member (with permission) for a collateral history.

Dealing with crisis situations Suggestions for dealing with particular patients The patient responding to paranoid ideas/delusions • Avoid prolonged eye contact, and do not get too close. • The patient's need to explain may allow you to establish a degree of rapport. Allow them to talk, but try to stay with concrete topics. • Do not try to argue against delusions—ally yourself reflectively with their perspective (e.g. 'What you are saying is that you believe . . . x . . . '). • Avoid using family members who may be part of the delusional system. • Try to distance yourself from what may have happened in the past (e.g. 'I'm sorry that was your experience before . . . maybe this time we could manage things better . . . '). • Be aware that your offer of help may well be rejected. The patient with antisocial traits • A degree of flattery may facilitate discussion of alternative solutions (show you understand their need to communicate, how important their

opinions are, and your desire to work together to resolve things). • Encourage them to talk about what has led up to this situation. • Try to convince them that other ways of achieving their aims will be to their advantage—keep any negotiation reality-oriented. • Focus their attention on you as the means to achieve their aims. The patient with borderline traits • Provide 'understanding' and 'uncritical acceptance'. • Try to build self-esteem (e.g. 'You have done well coping with everything up to now . . . '). • Once trust is gained, you may be able to be more directive using their desire to be accepted (e.g. 'I really think it would be best if we . . . '). • Bear in mind that often the behaviour will be attention-seeking, and it may be worth asking: 'What is it you feel you need just now?' • Do not be surprised if the patient acts impulsively. • Try to keep an empathetic attitude towards the patient. Explain your decisions in a way that makes clear you are not 'abandoning' them. The depressed patient • Psychomotor retardation may slow response time—be patient. • The presence of friends or relatives may worsen their feelings of worthlessness and guilt. • Focus on the 'here and now'—avoid talking abstractly. • Acknowledge that they probably cannot imagine a positive future. • Be honest and straightforward—once rapport has been established, it may be appropriate to be explicitly directive. • Try to postpone the patient's plans, rather than dismiss them (e.g. 'Let's try this . . . and see how you feel in the morning . . . '). • Be prepared to repeat reassurances. The patient experiencing acute stress • Allow ventilation of feelings. • Try to get them to describe events as objectively as possible. • Have them go back over the options they have ruled out. • Review the description of events, and present a more objective, rational perspective.

Chapter 23 Difficult and urgent situations Managing suicide attempts in hospital Attempted overdose On psychiatric wards, the most likely means of attempted self-poisoning involves building up a stock of prescribed medication or bringing into the ward tablets to be taken at a later date (e.g. while out on pass). Often pa tients will volunteer to trusted nursing staff that they have taken an OD, or staff will notice the patient appears overtly drowsy and when challenged, the patient admits to OD. • Try to ascertain the type and quantity of tablets taken (look for empty bottles, medication strips, etc.). • Establish the likely time frame. • If the patient is unconscious or significantly drowsy, arrange immediate transfer to emergency medical services. Inform the medical team of the patient's diagnosis, the current mental state, the current status (informal/formal), and any other regular medications. • If the patient is asymptomatic, but a significant OD is suspected, arrange immediate transfer to emergency services: • Do not try to induce vomiting. • If available, consider giving activated charcoal (single dose of 50g with water) to reduce absorption (especially if NSAIDs or paracetamol). • If the patient is asymptomatic and a significant OD is unlikely: • Monitor closely (general observations, level of consciousness, evidence of nausea/vomiting, other possible signs of poisoning). • If paracetamol or salicylate (aspirin) suspected: perform routine bloods [FBC, U&Es, LFTs, HCO3, international normalized ratio (INR)] and request specific blood levels (4hr post-ingestion level for paracetamol). • If other psychiatric medications may have been taken, consider urgent blood levels (e.g. lithium, anticonvulsants; E Plasma level monitoring, p. 998). • Be aware that LFTs may be abnormal in patients on antipsychotic or antidepressant medication. • If in doubt, get advice or arrange for medical assessment. Deliberate self-harm Most episodes of deliberate self-harm involve superficial self-inflicted injury (e.g. scratching, cutting, burning, scalding) to the body or limbs. These may be easily treated on the ward, with little fuss (to avoid secondary reinforce ment of behaviour). • Any more significant injuries (e.g. stabbing, deep lacerations) should be referred to emergency medical services, with the patient returning to the psychiatric ward as soon as medically fit. • Medical advice should also be sought if: • You do not feel sufficiently competent to suture minor

lacerations. • Lacerations are to the face/other vulnerable areas (e.g. genitals) or where you cannot confirm the absence of damage to deeper structures (e.g. nerves, blood vessels, tendons). • The patient has swallowed/inserted sharp objects into their body (e.g. vagina, anus). • The patient has ingested potentially harmful chemicals.

Managing suicide attempts in hospital Attempted hanging Most victims of attempted hangings in hospitals do not use a strong enough noose or sufficient drop height to cause death through spinal cord injury ('judicial hanging'). Cerebral hypoxia through asphyxiation is the probable cause of death and should be the primary concern in treatment of this pa tient population. On being summoned to the scene • Support the patient's weight (if possible, enlist help). • Loosen/cut off the ligature. • Lower the patient to a flat surface, ensuring external stabilization of the neck, and begin the usual basic resuscitation [airway/breathing/ circulation (ABC), IV access, etc.]. • Emergency airway management is a priority—where available, administer 100% O2; if competent and indicated, use nasal or oral endotracheal intubation. • Assess conscious level, full neurological examination, and the degree of injury to soft tissues of the neck. • Arrange transfer to emergency medical services as soon as possible. Points to note • Aggressive resuscitation and treatment of post-anoxic brain injury are indicated, even in patients without evident neurological signs. • Cervical spine fractures should be considered if there is a possibility of a severe foot drop or evidence of focal neurological deficit. • Injury to the anterior soft tissues of the neck may cause respiratory obstruction. Close attention to the development of pulmonary complications is required. Attempted asphyxiation • Remove the source (ligature, polythene bag, etc.). • Give 100% O2. • If prolonged period of anoxia or impaired conscious level, arrange immediate transfer to emergency medical services. After the event Patient • Once the patient is fit for interview, formally assess the mental state and conduct an assessment of further suicide risk (E Assessment after self- harm, p. 848). • Establish the level of observation necessary to ensure the patient's safety, clearly communicate your decision to staff, and make a record in the patient's notes. (Note: hospital policy may vary, but levels of observation will range from timed checks, e.g. every 15mins, to having a member of staff within arm's length of the patient 24hrs/day). Staff For particularly traumatic events, it may be necessary to arrange a 'critical incident review' (at a later date) where all staff involved participate in a confidential debriefing session. This is not to apportion blame, but rather to review policy and to consider what measures (if any) might be taken to prevent similar events from occurring in the future.

Chapter 23 Difficult and urgent situations Severe behavioural disturbance This covers a vast range of presentations but will usually represent a qualita tive acute change in a person's normal behaviour that manifests primarily as antisocial behaviour, e.g. shouting, screaming, i (often disruptive/intrusive) activity, aggressive outbursts, threatening violence (to others or self). In extreme circumstances [e.g. person threatening to commit suicide by jumping from a height (out of a window, off a roof), where the person has an offensive weapon, or a hostage situation], this is a police matter and your responsibility does not extend to risking your own or other people's lives in trying to deal with the situation (although you have an ethical responsibility to raise the alarm/dial '999'/contact the appropriate authorities if you are first at the scene). Common causes • Acute confusional states (E Acute confusional state (delirium), p. 854). • Drug/alcohol intoxication. • Acute symptoms of psychiatric disorder (anxiety/panic, E Panic disorder 1: clinical features, p. 368; mania, E Mania/manic episode, p. 320; schizophrenia/other psychotic disorders, E Examination of the patient with psychotic symptoms, p. 192). • 'Challenging behaviour' in brain-injured or ID

patients (E Behavioural disorders and ‘challenging’ behaviour, p. 828). • Behaviour unrelated to a primary psychiatric disorder—this may reflect personality disorder, abnormal personality traits, or situational stressors (e.g. frustration). General approach • Sources of information will vary, depending on the setting (e.g. on the ward, in outpatients, emergency assessment of a new patient). Try to establish the context in which the behaviour has arisen. • Follow the guidelines outlined in E Dealing with psychiatric emergencies, p. 1042. • Look for evidence of a possible psychiatric disorder. • Look for evidence of a possible physical disorder. • Try to establish any possible triggers for the behaviour—environmental/ interpersonal stressors, use of drugs/alcohol, etc. Management This will depend upon the assessment made: • If physical cause suspected: • Follow the management of delirium (E Acute confusional state (delirium), p. 854). • Consider use of PRN sedative medication (E Notes on PRN medication, p. 1051) to allow proper examination, to facilitate transfer to medical care (if indicated), or to allow active (urgent) medical management. • If psychiatric cause suspected: • Consider pharmacological management of acute behavioural disturbance, including rapid tranquillization (RT), if indicated (E Additional notes, p. 1049 and E Rapid tranquillization 1—guidelines and use of PRNs, p. 1050).

Severe behavioural disturbance • Consider issues of consent (E Additional notes, p. 1049) and the need for compulsory detention. • Review current management plan, including observation level. • If no physical or psychiatric cause suspected, and behaviour is dangerous or seriously irresponsible, inform security or the police to have the person removed from the premises (and possibly charged if a criminal offence has been committed, e.g. assault, damage to property). Additional notes • There are often local protocols for RT (E Rapid tranquillization 2—options and monitoring, p. 1052) and for control and restraint/ use of other restrictive measures, and these should be followed where available. It is advisable to familiarize yourself with these guidelines before an emergency situation arises. • It is always good practice to discuss management with a senior colleague as soon as possible. Potential risks of pharmacological management • Over-sedation causing LOC, alertness, and compromise of airway. • Cardiovascular or respiratory collapse (raised risk where there is stress or extreme emotion or extreme physical exertion). • Interaction with prescribed or illicit medication. • Damage to therapeutic relationship. • Other (related or coincidental) physical disorders (e.g. congenital prolonged QTc syndromes, patient on medication lengthening QTc). Issues of consent Giving emergency treatment for acute behavioural disturbance is essentially treatment under common law (E Common law, p. 940). The justification rests on the judgement that no other management options are likely to be effective and that use of restraint, other restrictive practices, or tranquilliza tion will prevent the patient from harming themselves or others. Harm may include behaviour that is likely to endanger the physical health of the patient (e.g. not consenting to urgent treatment or investigations that are likely to be lifesaving) when capacity to give consent is judged to be impaired (E Treatment without consent, p. 938).

Chapter 23 Difficult and urgent situations Rapid tranquillization 1—guidelines and use of PRNs RT (or ‘urgent sedation’) is the use of injectable medication to calm and lightly sedate a patient who is in a highly distressed, agitated, aggressive, or behaviourally disturbed state in order to: (1) reduce the risk to self and/or others; and (2) allow psychiatric evaluation to take place (which will necessitate spoken communication). It is not ‘PRN’ medication (see Table 23.1) and should not be routinely prescribed (or prescribed as ‘PO/ IM’). RT is also not the induction of ‘deep sedation’ with reduced con sciousness and motor and sensory activity, and ultimately loss of airway control and

protective reflexes (requiring supportive measures), although this may be the result of repeated RT—hence the need for close physical monitoring (E Rapid tranquillization 2—options and monitoring, p. 1052). When deep sedation is required—to allow urgently necessary treatment or investigations when a patient is actively resisting (usually in A&E)—this should be achieved with the help of an anaesthetist, use of IV agents (e.g. BDZs, anaesthetics), resuscitation equipment, and additional trained per sonnel under common law (E Common law, p. 940). Hospitals should have their own local guidelines—the following pages outline the general principles common to many current protocols (see also E Severe behav ioural disturbance, p. 1048). Table 23.1 Typical PRN oral medications for acute behavioural disturbance Drug Usual doseb Max/24hrs Pharmacokinetics Onset Peak t1/2 Chlorpromazine 25/50mg 4-hourly 1g 30–60mins 1–4hrs 24–36hrs Diazepam 2/5mg 4-hourly 30mg 15mins 1hr 24–48hrs Haloperidol 1.5–5mg 4-hourly 30mg 1–2hrs 2–6hrs 21hrs Lorazepam 0.5/1mg 4-hourly 4mg 15–30mins 2hrs 12–15hrs Olanzapinea 5mg 6-hourly 20mg 72hrs 5–8hrs 30–50hrs Promethazine 25/50mg 6-hourly 100mg 15–30mins 1.5–3hrs 7–15hrs Quetiapinea 25/50mg 4-hourly 750mg 30–60mins 1.5–1.8hrs 6–7hrs Risperidonea 500mcg 4-hourly 16mg 30–60mins 2hrs 18hrs a Not approved for the treatment of dementia-related psychosis or behavioural disturbance. b As a general rule, doses in adults aged >65yrs, those with ID, and other groups sensitive to side effects of medication will be half the usual adult dose—always check the BNF for guidelines.

Rapid tranquillization 1—guidelines and use of PRNs Best practice • Consideration of the need for RT should be part of developing an individualized care plan, based on up-to-date risk assessments, discussed at an MDT/ward review, and documented as soon as possible after admission, with at least weekly review.1,2 • De-escalation and calming techniques should be utilized before RT, including: recognition of early signs of problems; use of distraction and relaxation techniques; ensuring adequate personal space; avoiding provocation with an appropriate and measured response; and utilization of PRN medication. • If this is unsuccessful and RT is necessary, then an incident form should be completed with a clear record of the rationale, target symptoms, timescales, triggers, total daily doses, response, side effects, and use of other restrictive measures such as restraint by trained staff. • Immediately arrange a debrief for the treating team and later for the service user, together with a medical review and risk assessment. • Consider the need for adjustments to the care plan and prescription, including use of an advance directive, and ensure appropriate paperwork is completed for those who are subject to the MHA (e.g. adjusting the formalized treatment plan or notification of use of emergency treatment). Notes on PRN medication ‘As required’, or PRN, medication is additional oral medication that is given in hospital only when circumstances require it. PRNs may be utilized in out patient settings for breakthrough symptoms, situational anxiety, or insomnia to limit the total regular medication load. In hospital settings, the following guidance should be followed: • Do not prescribe routinely or automatically on admission. • Tailor medication to individual needs, if possible following an open discussion with the patient, and record the rationale in a care plan. • Prescriptions should specify the indication, dose/24hrs, and the time interval between doses. This should not exceed the BNF limits or be outwith product licences (including regular doses and other formulations), unless a senior doctor agrees this in advance with the completion of appropriate off-licence documentation and high-dose monitoring forms. • Continued need for PRN medication should be reviewed at least weekly at an MDT/ward review. If not utilized, it should be discontinued. If used regularly, consider prescribing regularly or increasing regular medication. 1 National Institute for Health and Care Excellence (2015) Violence and aggression: short-term man agement in mental health, health and community

settings. NICE guideline [NG10]. M https://www. nice.org.uk/guidance/ng10 [accessed 8 July 2018]. 2 For an integrated view of all NICE guidance, see: M https://pathways.nice.org.uk/pathways/ violence-and-aggression [accessed 8 July 2018].

Chapter 23 Difficult and urgent situations Rapid tranquillization 2—options and monitoring Prior to rapid tranquillization • Ensure patient safety at all times—including appropriate environment. • Consider physical causes (E Common causes, p. 1048), especially intoxication and/or acute infection and known conditions (e.g. renal, liver, cardiac, respiratory, diabetes, pregnancy). • Review medicines administered in the last 24hrs, and if greater than the BNF max, discuss plans with a senior doctor. • Ensure oral medication has been offered prior to RT. • Utilize RT checklist and recording sheets (i.e. local protocols). Rapid tranquillization options (See Table 23.2.) If de-escalation methods and oral medications have been unsuccessful or cannot be implemented, or in cases of urgent necessity: Non-psychotic context • IM lorazepam 1–2mg (or IM promethazine 50mg in those with compromised respiratory function or known to be sensitive/tolerant to BDZs), and wait 30mins to assess response. Psychotic context • IM lorazepam 1–2mg (or IM promethazine 50mg), and wait 30mins to assess response. • If insufficient, add IM haloperidol 5mg (wait 1hr to assess response) or IM olanzapine 5–10mg (do not give IM lorazepam within 1hr of IM olanzapine) or IM aripiprazole 9.75mg (wait 2hrs to assess response). Table 23.2 Pharmacokinetics of RT injectables Drug Usual dosea Max/24hrs Pharmacokinetics Onset Peak t1/2 Lorazepam 1/2mg 30mins 4mg 15–30mins 60–90mins 12–15 hrs Haloperidol 5mg hourly 18mgb 15–30mins 20–45mins 21hrs Olanzapinec 5/10mg 2-hourly 20mg 15–30mins 15–45mins 30–50hrs Aripiprazolec 9.75mg 2-hourly Three doses/ 30mg 30mins 1–3hrs 75–146hrs Promethazine 50mg 30mins 100mg 1–2hrs 2–6hrs 7–15hrs a As a general rule, doses in adults aged >65yrs, those with ID, and other groups sensitive to side effects of medication will be 25–50% of the usual adult dose—always check the BNF for guidelines. b The bioavailability of PO and IM haloperidol is different—when considering the total dose per 24hrs, 5mg PO = 3mg IM. IV use has a high risk of arrhythmias and is not recommended. c Not approved for the treatment of dementia-related psychosis or behavioural disturbance.

Rapid tranquillization 2—options and monitoring Note: haloperidol is usually reserved for those with previous antipsychotic use and a normal ECG; SGAs are less likely to cause significant side effects in the antipsychotic-naive or those with evidence of cardiovascular disease, prolonged QTc, no ECG, on drugs that can affect QTc (E Box 22.11 The QTc question, p. 1034), or alcohol or illicit drug intoxication. Repeat, if necessary, up to the maximum BNF dose limits, monitoring closely. If no response, arrange an urgent team review or consult a more senior colleague. Alternative approaches (in consultation with senior colleague) • If lorazepam is not available, unlicensed IM clonazepam 0.5–2mg/hr may be used (max 4mg/24hrs)—onset 15–30mins, peak 3hrs, t1/2 20–60hrs. • If other measures have been ineffective, or if patient likely to be tolerant to BDZs, consider IM chlorpromazine 25–100mg every 30–60mins. (Note: danger of postural hypotension, and even fatality, if given inadvertently by IV injection—monitoring essential and nurse lying down.) • If repeated RT has been needed, consider IM depot zuclopenthixol acetate (Clopixol Acuphase®) 50–150mg—repeat every 2–3 days, if necessary, up to a maximum total dose of 400mg. (Note: this is not RT; it is a rapidly acting, sedating depot antipsychotic treatment, which is best avoided in antipsychotic-naive patients because of its long half- life—onset 2–8hrs; peak 24–36hrs; t1/2 60hrs.) Physical health monitoring during and after rapid tranquillization • Temperature, pulse, BP, O2 saturation, and respiratory rate (RR) should be recorded every 15mins for the first hour, then

hourly for 4hrs, then, depending on clinical need, every 4hrs for the next 12hrs. Local paperwork may be available. • If the patient is asleep, they should be woken, unless there is a good reason not to. At the very minimum, respiratory and pulse rates should be recorded and the reason for not doing more noted clearly. Common and serious side effects • EPSEs (especially acute dystonia following haloperidol) (E Dystonic reactions, p. 1016)—utilize IM procyclidine 5–10mg. • NMS (E Neuroleptic malignant syndrome, p. 1018)—will need immediate medical transfer. • Hypotension—lie the patient flat, and raise legs; monitor closely. • Respiratory depression—give O2, raise legs, if necessary ventilate mechanically. If RR drops below 10 breaths/min after BDZ administration, call for advanced emergency care: IV flumazenil 200mcg over 15s; if consciousness is not resumed within 60s, give 100mcg over 10s; repeat at 60s intervals; maximum dose 1mg/24hrs; continue close monitoring after RR returns to normal. (Note: as flumazenil has a short duration of action, further doses may be required and on waking, agitation and anxiety may be worse. Consider medical transfer.) 0 Remember: fatalities do occur during RT.

Chapter 23 Difficult and urgent situations The catatonic patient Catatonia is certainly less common in current clinical practice, thanks to the advent of effective treatments for many psychiatric disorders and earlier interventions. Nonetheless, the clinical presentation may be a cause for concern, particularly when a previously alert and orientated patient be comes mute and immobile. The bizarre motor presentations (e.g. pos turing) may also raise concerns about a serious acute neurological problem (hence, these patients may be encountered in a medical/liaison setting), and it is important that signs of catatonia are recognized. Equally, the ‘excited’ forms may be associated with sudden death (‘lethal’ or ‘malignant’ cata tonia), which may be preventable with timely interventions. Clinical presentation Characteristic signs • Mutism. • Posturing. • Negativism. • Staring. • Rigidity. • Echopraxia/echolalia. Typical forms • Stuporous/retarded. • Excited/delirious. Common causes • Mood disorder—more commonly associated with mania (accounts for up to 50% of cases) than depression. Often referred to as manic (or depressive) stupor (or excitement). • General medical disorder—often associated with delirium: • Metabolic disturbances. • Endocrine disorders. • Viral infections (including HIV). • Typhoid fever. • Heat stroke. • Autoimmune disorders. • Drug-related (antipsychotics, dopaminergic drugs, recreational drugs, BDZ withdrawal, opiate intoxication). • Neurological disorders: • Post-encephalitic states. • Parkinsonism. • Seizure disorder (e.g. non-convulsive status epilepticus). • Bilateral globus pallidus disease. • Lesions of the thalamus or parietal lobes. • Frontal lobe disease. • General paresis. • Schizophrenia (10–15% of cases)—classically catalepsy, mannerisms, posturing, and mutism (see catatonic schizophrenia in E The diagnosis of schizophrenia, p. 184).

The catatonic patient Differential diagnosis • Elective mutism—usually associated with pre-existing personality disorder, clear stressor, no other catatonic features, unresponsive to lorazepam. • Stroke—mutism associated with focal neurological signs and other stroke risk factors. ‘Locked-in’ syndrome (lesions of the ventral pons and cerebellum) is characterized by mutism and total immobility (apart from vertical eye movements and blinking). The patient will often try to communicate. • Stiff-person syndrome—painful spasms brought on by touch, noise, or emotional stimuli (may respond to baclofen, which can induce catatonia). • Malignant hyperthermia—occurs following exposure to anaesthetics and muscle relaxants in predisposed individuals (E Neuroleptic malignant syndrome, p. 1018). • Akinetic Parkinsonism—usually in patients with a history of Parkinsonian symptoms and dementia—may display mutism, immobility, and posturing. May respond to anticholinergics, not BDZs. Other recognized catatonia (and catatonia-like) subtypes •

Malignant catatonia—acute onset of excitement, delirium, fever, autonomic instability, and catalepsy—may be fatal. • NMS—E Neuroleptic malignant syndrome, p. 1018. • SS—E Serotonin syndrome, p. 1022. Management Assessment • Full history (often from third-party sources), including recent drug exposure, recent stressors, and known medical/psychiatric conditions. • Physical examination (including full neurological). • Investigations—temperature, BP, pulse, FBC, U&Es, LFTs, glucose, TFTs, cortisol, PRL; consider CT/MRI and EEG. Treatment • Symptomatic treatment of catatonia will allow you to assess any underlying disorder more fully (i.e. you will actually be able to talk to the patient). • Best evidence for use of BDZs (e.g. lorazepam 500mcg–1mg PO/IM—if effective, given regularly thereafter), barbiturates [e.g. amobarbital (Amytal®) 50–100mg), and ECT. • Alone or in combination, these effectively relieve catatonic symptoms, regardless of severity or aetiology in 70–80% of cases.3,4 • Address any underlying medical or psychiatric disorder. 3 Bush G, Fink M, Petrides G, et al. (1996) Catatonia II: treatment with lorazepam and electrocon vulsive therapy. Acta Psychiat Scand 93:137–43. 4 Ungvari GS, Kau LS, Wai-Kwong T, et al. (2001) The pharmacological treatment of catatonia: an overview. Eur Arch Psychiat Clin Neurosci 251(Suppl 1):31–4.

Chapter 23 Difficult and urgent situations The manipulative patient 1 Manipulation is a term that is generally used pejoratively, although some ethologists regard manipulative behaviour as ‘selfish but adaptive’ (i.e. the means by which we use others to further our own aims—which may be entirely laudable). In the context of psychiatric (and other medical) settings, manipulative behaviours are usually maladaptive and include: • Inappropriate or unreasonable demands: • More of your time than any other patient receives. • Wanting to deal with a specific doctor. • Only willing to accept one particular course of action (e.g. admission to hospital, a specific medication or other form of treatment). • Behavioural sequelae of failing to have these demands met: • Claims of additional symptoms they failed to mention previously. • Veiled or explicit threats of self-harm, lodging formal complaints, litigation, or violence. • Passive resistance (refusing to leave until satisfied with outcome of consultation). • Verbal or physical abuse of staff/damage to property. • Actual formal complaints relating to treatment (received or refused) or false accusations of misconduct against medical staff. • Pushing or breaking of agreed boundaries and rules. Key points • Patients DO have the right to expect appropriate assessment, care, and relief of distress. • Doctors DO have the right to refuse a course of action they judge to be inappropriate. • Action should always be a response to clinical need (based on a thorough assessment, diagnosis, and best evidence for management), NOT threats or other manipulative behaviours. • It is entirely possible that a patient who demonstrates manipulative behaviour DOES have a genuine problem (it is only their way of seeking help that is inappropriate). • Some of the most difficult patients tend to present at ‘awkward’ times (e.g. the end of the working day, early hours of the morning, weekends, public holidays, intake of new staff)—this is no accident! • Admitting a patient to hospital overnight (when you are left with no other option) is not a failure—some patients are very good at engineering this outcome. At worst, it reinforces inappropriate coping behaviours in the patient. (Critical colleagues would probably have done the same themselves in similar circumstances.) • If you have any doubts about what course of action to take, consult a senior colleague and discuss the case with them. Management principles New case • Make a full assessment to establish: psychiatric diagnosis and level of risk (to self and others); and whether other agencies are required (e.g. specific services: drug/alcohol problems; social work: housing/benefits/

The manipulative patient 1 social supports; counselling: for specific issues, e.g. debt/employment/ bereavement/alleged abuse). • Ask the patient what they think is the main problem. • Ask the patient what they were hoping you could do for them, e.g.: • Advice about what course of action to take. • Wanting their problem to be 'taken seriously'. • Wanting to be admitted to hospital. • Wanting a specific treatment. • Discuss with them your opinion of the best course of action, and establish whether they are willing to accept any alternatives offered (e.g. other agencies, outpatient treatment). The 'frequent attender'/chronic case • Do not take short cuts—always fully assess the current mental state, and make a risk assessment. • When available—always check previous notes, any written care plan, or 'crisis card'. • Establish the reason for presenting now (i.e. what has changed in their current situation). • Ask yourself, 'Is the clinical presentation significantly different so as to warrant a change to the previously agreed treatment plan?' • If not, go with what has been laid out in the treatment plan. (See Box 23.1 for pitfalls and how to avoid them.) Box 23.1 Pitfalls (and how to avoid them) • Try not to take your own frustrations (e.g. being busy, feeling 'dumped on' by other colleagues, lack of sleep, lack of information, vague histories) into an interview with a patient—your job is to make an objective assessment of the person's mental state and to treat each case you see on its own merits. • Try not to allow any preconceptions or the opinions of other colleagues colour your assessment of the current problems with which the patient presents (people and situations have a tendency to change with time, and what may have been true in the past may no longer be the case). • Watch out for the patient who appeals to your vanity by saying things like: 'You're much better than that other psychiatrist I saw . . . I can really talk to you . . . I feel you really understand'. They probably initially said the same things to 'that other psychiatrist' too! • Do not be drawn into being openly critical of other colleagues; remember you are only hearing one side of the story. Maintain a healthy regard for the professionalism of those whom you work beside— respect their opinions (even if you really do not agree with them). • If you encounter a particularly difficult patient, enlist the support of a colleague and conduct the assessment jointly. • NEVER acquiesce to a 'private' consultation with a patient of the opposite sex; do not make 'special' arrangements; and NEVER give out personal information or allow patients to contact you directly.

Chapter 23 Difficult and urgent situations The manipulative patient 2 Specific situations Patient demanding medication • There are really only two scenarios where there is an urgent need for medication: • The patient who is acutely unwell and requires admission to hospital anyway (e.g. with acute confusion, acute psychotic symptoms, severe depression, high risk of suicide). • The patient who is known and has genuinely run out of their usual medication (for whom a small supply may be dispensed to tide them over until they can obtain a repeat prescription). Patient demanding immediate admission • Clarify what the patient hopes to achieve by admission, and decide whether this could be reasonably achieved or if other agencies are better placed to meet these requests (E The role of the psychiatrist, p. 8). • If the patient is demanding admission due to drug/alcohol dependence, emphasize the need for clear motivation to stop and offer to arrange outpatient follow-up (the next day) (E Planning treatment in alcohol misuse, p. 588). • Always ask about any recent trouble with the police; it is not uncommon for hospital to be sought as a 'sanctuary' from an impending court appearance (but remember this can be a significant stressor for patients with current psychiatric problems). Additional complications Demanding relatives/other advocates • Assess the patient on their own initially, but allow those attending with the patient to have their say (this may clarify the 'why now' question, particularly if it involves the breakdown of usual social supports). • Ask the patient for their consent to discuss the outcome of

your consultation with those accompanying them (to avoid misunderstandings and improve compliance with the proposed treatment plan). Patient 'raising the stakes' • If a patient is dissatisfied with the outcome of your consultation, they may try a number of ways to change your mind (E The manipulative patient 1, p. 1056); they may even explicitly say 'What do I have to do to convince you?' before resorting to other manipulative behaviours. • This type of response only serves to confirm any suspicions of attempted manipulation and should be recorded as such in the notes (verbatim if possible). • Stick to your original management plan, and if the behaviour becomes passively, verbally, or physically aggressive, clearly inform them that unless they desist, you will have no other option than to have them removed (by the police, if necessary). • Equally, any threats of violence towards individuals present during the interview or elsewhere should be dealt with seriously, and the police (and the individual concerned) should be informed—patient confidentiality does not take precedence over ensuring the safety of others.

The manipulative patient 2 Suspected factitious illness • Try to obtain corroboration of the patient's story (or confirmation of your suspicions) from third-party sources (e.g. GP, relative, previous notes, including other hospitals where they claim to have been seen). • If your suspicions are confirmed, directly feed this information back to the patient, and clearly inform them of what course of action you plan to take (e.g. recording this in their notes, informing other agencies, etc.). • Do not feel 'defeated' if you decide to admit them to hospital. Record your suspicions in the notes, and inform the psychiatric team that the reason for admission is to assess how clinically significant the reported symptoms are (it will soon become clear in a ward environment, and it may take time to obtain third-party sources). Patient threatening suicide by telephone • Keep the person talking (E Dealing with crisis situations p. 1044). • Try to elicit useful information (name, where they are calling from, what they plan to do, risk to anyone else). • If you judge the patient to be at high risk of suicide, encourage them to come to hospital—if they refuse or are unable to do so, organize for emergency services to go to their location and bring them to hospital. • If the patient refuses to give you any information, inform the police who may have other means to determine the source of the call and respond. • Always document phone calls in the same way as you would any other patient contact (E Closure, see below). Closure • Clearly document your assessment, any discussion with senior colleagues, the outcome, and any treatment plan. • Record the agreement/disagreement of the patient and any other persons attending with them. • If appropriate, provide the patient with written information (e.g. appointment details, other contact numbers) to ensure clear communication. • Ensure that you have informed any other necessary parties (e.g. keyworkers/psychiatric team already involved with the patient, source of referral—which may be the GP, other carers, social workers, etc.). • If the assessment occurs out of hours, make arrangements for information to be passed on to the relevant parties in the morning (ideally try to do this yourself). • If you have suggested outpatient follow-up for a new patient, make sure you have a means of contacting the patient, to allow the relevant service to make arrangements to see them as planned. • If you think it is likely the patient will re-present to other services, inform them of your contact with the patient and the outcome of your assessment.

Chapter 23 Difficult and urgent situations Issues of child protection The treating doctor has a responsibility to consider the welfare not only of their patient, but also of the patient's dependents (in most cases, their chil dren). Where there are concerns relating to the welfare of children, this re sponsibility may be discharged both through actions you take yourself (e.g. admitting the patient to hospital) and through involvement of appropriate statutory agencies (e.g. child and

family social services). It is everyone’s re sponsibility to keep children safe, and it is important for different agencies to communicate with each other if there is any suspicion of child protection concern. Each case should be individually assessed; however, a number of scenarios can be recognized: • Necessary absence—when a patient is brought into hospital (e.g. for emergency assessment), the admitting doctor should clarify whether they have dependent children and, if so, what arrangements have been made for their care. If these are unsatisfactory or are disconcertingly vague (e.g. ‘with a friend’), child and family social services should be consulted. • Neglect of childcare responsibilities—in some circumstances, as a result of mental disorder, patients’ ability to provide the appropriate level of physical or emotional care may be impaired. This may relate to functional impairments (e.g. poor memory), continuing symptomatology (and medication side effects), or dependence on drugs or alcohol. Having a mental disorder does not preclude being a parent—what is important is that individual patients receive appropriate assessment to ascertain the type of additional support they may need and the level of monitoring required. • Risk of positive harm to child—certain disorders carry the risk of harm to the child by acts of commission, rather than omission. These include: • Psychotic disorders in which the patient holds abnormal beliefs about their child. • Severe depressive disorder with suicidal ideas, which involve killing the child (usually for altruistic reasons). • Drug misuse where there are drugs or drug paraphernalia left carelessly in the child’s environment. In these cases, a joint approach should be adopted, involving mental health (optimizing the patient’s management) and social services (addressing issues of child protection and welfare).

 Patients acting against medical advice 1: guiding principles In certain situations, doctors are faced with deciding whether or not to act against a patient’s stated wishes. This most commonly occurs when: • A patient does not consent to a particular treatment plan. • A patient wishes to leave hospital, despite medical advice that this is not in their best interests. For some common clinical scenarios, see E Patients acting against medical advice 2: clinical scenarios, p. 1064. Fundamental principles • An adult has the right to refuse treatment or to leave hospital, should they wish. • Doctors have a responsibility to discuss what they are proposing with the patient fully, to ensure that the patient is informed of the options and risks, and the preferred management (but not to enforce or coerce). Special circumstances In some circumstances, doctors have the power to act without the patient’s consent or override a patient’s expressed wishes when: • Consent cannot be obtained in an emergency situation and treatment may be given under common law (E Common law, p. 940). • A patient’s capacity is either temporarily or permanently impaired (E Consent to treatment, p. 936) and they are unable to give informed consent. The responsible doctor should act in the patient’s best interests (E Common law, p. 940)—consider treatment using incapacity legislation (E Mental Capacity Act: England and Wales, p. 942; E Incapacity Act: Scotland, p. 946; E Incapacity Act: Northern Ireland, p. 942; E Incapacity Act: Republic of Ireland, p. 948). • They are suffering from a mental disorder and their capacity to take decisions is impaired. Use of the MHA may be necessary to ensure their own (or other persons’) safety. Points to note • When a capable patient disagrees with a proposed course of action, this should be recorded clearly in the notes (with the reasons given by the patient). If this involves discharge from hospital, a ‘discharge against medical advice’ form may be useful (as a written record of the patient’s decision), even though such forms have no special legal status. • In emergency situations, the definition of ‘mental disorder’ is that of a layperson, not

whether ICD-10 or DSM-5 criteria are satisfied. • Incapacity legislation does not allow for detention in hospital; equally, detention under the MHA does not allow for compulsory treatment of physical disorders. • Always consider the balance of risks—ask yourself, 'What am I more likely to be criticized (or sued) for?'

1063 PATIENTS ACTING AGAINST MEDICAL ADVICE : GUIDING PRINCIPLES • Although the final decision in non-mentally ill, capable adults rests with them, in 'close-call' situations, it is better to err on the side of safety and review again later. (Such situations should always be discussed with a senior colleague.) • Remember that capacity is assessed on a decision-by-decision basis, and someone may have capacity for some decisions, but not for others. Patient wanting to leave a psychiatric ward The duty psychiatrist is often called to psychiatric wards when patients wish to take their own discharge. Although not wanting to be on a psychiatric ward may often seem the most rational response—particularly when there are other more behaviourally disturbed patients on the same ward—a prag matic approach should be adopted (i.e. balancing the need for assessment/ inpatient treatment against the additional stress caused by admission). Follow the general principles detailed here, focusing on managing risk and acting in the patient's 'best interests'. Note especially: • Deciding whether a patient is permitted to leave the ward will be informed by both an assessment of their current mental state and knowledge of any established management plans. • Often decisions regarding the course of action to take will have already been discussed by the responsible consultant with nursing staff. When there are concerns, the default position is often reassessment at the time the patient is asking to leave. • Explain clearly to the patient the reasons why we would want them to stay in hospital (for senior review or to arrange appropriate services, for example), and make sure they understand the risks of leaving against medical advice. • When a patient does elect to leave against medical advice, record this clearly in the notes with, at the very minimum, an agreement for a planned review (e.g. as an outpatient, by the GP) and the recommendation that, should the patient (or their relatives) feel the situation has become unsustainable at home, they should return to the hospital.

Chapter 23 Difficult and urgent situations Patients acting against medical advice 2: clinical scenarios Scenario 1 A 52-yr-old ♂ admitted with chest pain, who ought to remain in the hos pital for overnight telemetry, cardiac enzymes, and repeat ECG (in the morning) but does not wish to do so. He is not incapable and not suffering from a mental disorder. The decision rests with him (he has a right to refuse—even if you think he is acting foolishly). Scenario 2 A 22-yr-old ♀ who admits to taking 56 aspirin tablets, brought to the GP by a concerned friend, now refusing to get in an ambulance to go to hospital. Most people would agree that she is possibly suffering from a mental disorder (suggested by her recent OD); hence, there are grounds for use of the MHA, with emergency treatment under common law. Scenario 3 An 18-yr-old ♀ admitted after a paracetamol OD who needs further treat ment but wishes to leave. She has some depressive features and may pos sibly be under the influence of alcohol. There is sufficient suspicion of a mental disorder to detain under the MHA (perhaps more than in the previous scenario); treatment would be under common law. Scenario 4 A 34-yr-old ♀ with long history of anorexia nervosa, current weight under 6 stones, with clear physical complications of starvation (and biochemical abnormalities), refusing admission for medical management. Clear mental disorder, as well as a 'risk to themselves'—detain under the MHA; emergency treatment under common law. Scenario 5 A 53-yr-old ♂ previously seen in A&E following a fall while intoxicated, brought back up to A&E 6 days later by spouse, with fluctuating level of consciousness (also has been drinking heavily)—suspected

extradural, but angrily refusing CT head. Capacity impaired both by alcohol and a potentially serious underlying treat able physical disorder. Necessary urgent investigation warranted, as in patient's best interests—with use of sedation (if necessary) under common law. Scenario 6 A 67-yr-old ♂ with post-operative URTI who presents as confused, wishing to leave the ward because he is 'late for his brother's wedding'. There is a clear mental disorder, and he ought to be detained under the MHA; treat under common law (sedate if necessary).

1065 Patients acting against medical advice 2: clinical scenarios Scenario 7 A 23-yr-old ♂ admitted with psychotic illness, who wants to go home to confront the neighbours whom he believes have conspired with the police to get him 'banged up in a nut hut'. Clear mental disorder. Detain under MHA; emergency treatment, if required, under common law.

Chapter 23 Difficult and urgent situations The mental health of doctors 'Quis custodiet ipsos custodes?' Who will watch the watchmen? In general, doctors are in a pretty good state of health, with a lower preva lence of smoking, cardiovascular disease, and cancer and a longer life ex pectancy than the general population. With respect to mental health, however, the situation is reversed—with the incidence of most psychiatric disorders higher in doctors: • Surveys have found 725% of doctors have significant depressive symptoms, with i risk in: junior house officers/interns; junior doctors in obstetrics and gynaecology (O&G) and psychiatry; radiologists, anaesthetists, surgeons, and paediatricians. • Suicide rates are high, with depression, alcohol, and drug misuse as significant contributory factors. Specialties over-represented include anaesthetics, GP, psychiatry, and emergency medicine. • Problems of drug and alcohol dependence may affect as many as 1 in 15 doctors in the UK. Why are doctors more likely to have mental health problems? Individual factors • Personality—many of the qualities that make a 'good doctor' may also increase the risk of psychiatric problems (e.g. obsessionality, perfectionism, being ambitious, self-sacrifice, high expectations of self, low tolerance of uncertainty, difficulty expressing emotions). • Ways of thinking/coping styles, e.g. being overly self-critical, denial, minimization, rationalization, drinking culture, need to appear competent ('no problems'). Occupational factors • Long and disruptive work hours. • Exposure to traumatic events—dealing with death, ethical dilemmas. • Lack of support (particularly from senior colleagues). • Competing needs of patients and family. • Increasing expectations, with diminishing resources. • Professional and geographic isolation. Barriers to seeking help Doctors are notoriously bad at seeking help for their own medical problems—particularly psychiatric problems—often only presenting when a crisis arises. Reasons for this include: • Symptom concealment due to fears of hospitalization, loss of medical registration, and exposure to stigmatization. • Negative attitudes to psychiatry, psychiatrists, and people with psychiatric problems. • Lack of insight being a feature of many psychiatric disorders. This may lead to delayed referral, misdiagnosis, and not receiving the bene fits of early interventions.

The mental health of doctors What to do if you suspect a colleague has a problem You have a duty to take action (see Box 23.2), both in the interests of pa tient care and of your colleague's health (such actions are both ethically responsible and caring). Not to do so could both put patients at risk and deny your colleague treatment which might prevent further deterioration in health and performance. Usually a staged approach works best: • Confirm your suspicions by informal discussion with other colleagues. • If a clear pattern of behaviour is present, first consider discussing this observation with the colleague in question. • It is better if face-to-face discussion is

conducted by someone of the same grade. • If face-to-face discussion yields no results, speak to an impartial senior colleague and/or seek further advice about local procedures (see Box 23.2). • If the colleague is YOU, remember: responsible physicians put their patients first and take pride in looking after their own health (E Looking after your own mental health, p. 1068). Box 23.2 Duty to take action You must protect patients from risk of harm posed by another colleague's conduct, performance, or health. The safety of patients must come first at all times.1,2 If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an ap propriate person from your employing or contracting body and follow their procedures. If there are no appropriate local systems or the local systems do not resolve the problem, and you are still concerned about the safety of pa tients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organization, or the GMC for advice. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for, and follow, their advice about investigations, treatment, and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients. 1 General Medical Council (2006) Good medical practice, paragraphs 43 ,44, and 79. Available at: M https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical- practice [accessed 8 July 2018]. 2 It is worth noting that doctors referred to the GMC because of mental health problems can continue to practise, provided their problems are not judged to affect their professional abilities and they are suitably supervised in an agreed treatment regime.

Chapter 23 Difficult and urgent situations Looking after your own mental health You have a duty to yourself and your patients to act promptly if you feel there are early warning signs that your health may be affecting your performance. Signs to watch out for • Difficulties sleeping. • Becoming more impatient or irritable. • Difficulties concentrating. • Being unable to make decisions. • Drinking or smoking more. • Not enjoying food as much. • Being unable to relax or 'switch off'. • Feeling tense (may manifest as somatic symptoms, e.g. recurrent headache, aches and pains, GI upset, feeling sweaty, dry mouth, tachycardia). Developing good habits • Learn to relax—this can involve learning methods of progressive relaxation or simply setting aside time when you are not working to relax with a long bath, a quiet stroll, or listening to music. It also means living life less frantically—going to bed at a regular time and getting up 15–20mins earlier to prevent the feeling of 'always being in a rush'. • Take regular breaks at work—this includes regular meal breaks (away from work). Even when work is busy, try to give yourself a 5–10min break every few hours. • Escape the pager—in the day and age of being always obtainable, it is a good idea to be 'unobtainable' once or twice a week, to give yourself time to be alone and reflect. • Exercise—there is no doubt that regular exercise helps reduce the levels of stress. It will also keep you fit, help prevent heart disease, and improve the quality of sleep. • Drugs—tobacco and other recreational drugs are best avoided. Caffeine and alcohol should be used only in moderation. • Distraction—finding a pursuit that has no deadlines, no pressures, and which can be picked up or left easily can allow you to forget about your usual stresses. This might be a sport, a hobby, music, the movies, the theatre, or books. The important point is that it is not work-related. Organizing your own medical care • Register with a GP! Two-thirds of junior doctors have not done this. • Allow yourself to benefit from the same standards of care (including expert assessment, if this is felt to

be necessary) you would expect for your patients. • If you are having difficulties related to stress, anxiety, depression, or use of substances, consult your GP sooner rather than later. • Be willing to take advice. In particular, do not rely on your own judgement of your ability to continue working.

Looking after your own mental health • If your GP suggests speaking to a psychiatrist, and you feel uncomfortable with being seen locally, ask for an out-of-area consultation. • Utilize other sources of help and advice—both informal (friends, family, self-help books) and formal (E Sources of support and advice, see below). Remember you are certainly not the first doctor to have encountered these sorts of difficulties. Sources of support and advice • The Royal College of Psychiatrists offer a Psychiatrists' Support Service— telephone: 0207 245 0412; e-mail: pss@rcpsych.ac.uk; additional information may be found at: M https://www.rcpsych.ac.uk/ members/supporting-you/psychiatrists-support-service [accessed 23 January 2019]. • The British Medical Association offers free expert advice for members who may be affected by illness. More information is available at: M https://www.bma.org.uk/advice/work-life-support/your- wellbeing/bma-counselling-and-doctor-advisor-service [accessed 8 July 2018].

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