Dokotela

MAKING SPECIALIST CARE MORE ACCESSIBLE

CONNECTIONS

THE DOKOTELA DOCTORS' NEWSLETTER

ISSUE 1 VOL 4

IN THIS ISSUE

MESSAGE FROM DOKOTELA MEDICAL DIRECTOR, DR ZELKO MUSTAC

Suicide Crisis Syndrome

One of the main medicolegal concerns that we have providing psychiatric treatment by means of videoconference is the risk of suicidal behaviour. Recently, research has validated the construct of the suicide crisis syndrome (SCS). This involves a change of thinking from the usual paradigms of asking patients regarding suicidal ideas and suicidal plans. For those of us doctors from a previous generation this results in a significant departure from usual practice.

The essence of this new construct is that the suicide crisis syndrome is a specific psychological state which may either precipitate suicidal behaviour or proceeds suicidal behaviour. What this means is that asking a patient if they have suicidal ideation or suicidal plans may often be misleading. Once a patient has decided to kill themselves they are often relieved. Recently, there was an incident in a Sydney hospital where a patient left for day leave and was smiling and chatting to patients prior to taking an overdose of the pesticide. Psychiatrists are well aware that the most risky time for suicidality is in the first week after admission to a psychiatric hospital in the first week after discharge from the psychiatric hospital. There is a whole debate going on with a hospitalisation results in any reduced rate of suicidality. In Australia 3128 Australians took their life in 2017 an increase of 262 from the previous year. The Australian suicide rate is 12.6 deaths per 100,000 people which is equal to the highest recorded rate in the past 10 years. Prior to this time the Australian suicide rate had been declining. A similar pattern has been observed in North America where the suicide rate has been increasing by 1% per annum.

The suicide crisis syndrome is being examined for inclusion in the next DSM diagnostic classification system is something to look for in patients in the same way as we examine for depression or bipolar disorder. In other words, we don't ask the patient if they have depression instead we ask questions regarding the symptoms of depression for example anhedonia, guilt, insomnia reduced motivation reduced sex drive et cetera. It is only at the end that we might ask the person if they are depressed and if they were to say that they are not depressed we would be entitled to be sceptical.

MESSAGE FROM THE DIRECTOR CONT.

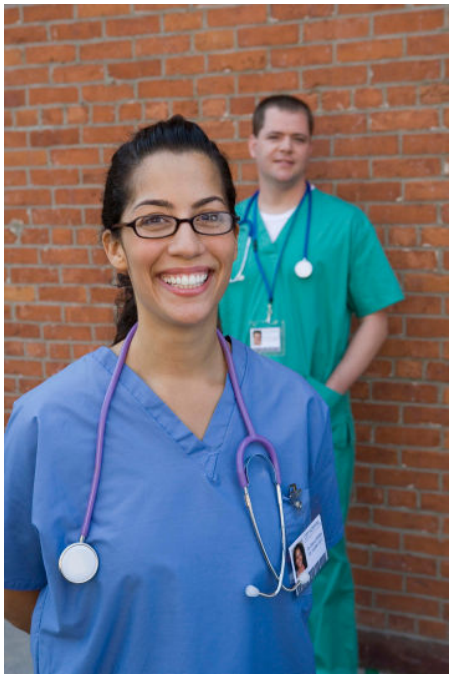
Suicide Crisis Syndrome

A similar process is used in the suicide crisis syndrome. In particular, we look to see if the patient feels trapped in their current situation and feels that there is no way out. This may be the reason that patients admitted to a psychiatric hospital become increasingly suicidal in their first week of admission. Questioning also involves assessing if the patient has intrusive thoughts regarding death or suicide that they are unable to control and that interfere with their sleep. A separate emotional component involves a panic dissociations syndrome where they feel that their emotions are overwhelming.

Assessment for the suicide crisis syndrome therefore reverses the former pattern of specifically asking regarding suicidal ideas or plans but instead focuses on asking your patient if they feel trapped, are they unable to control the intrusive suicidal thoughts or death wishes, are these thoughts intruding into their sleep and beyond their control. Are they associated with effective distress emotional pain and ruminative flooding. Only at the end of the ask about suicidal ideation or plans. The suggestion is that this should be separately assessed from any other psychiatric illness, because the features of this syndrome which are predictive of suicidal behaviour did not necessarily present in routine questioning.

A psychometric test has been developed for the suicide crisis inventory which is available. If you are interested, please get in touch and we would be pleased to provide.

MBS ITEMS FOR PATIENT-END SERVICES



It is good to note that your GP's and Nurses can also bill Medicare for the time they spend participating in the telehealth conference!

GPs can bill for MBS Item numbers 2100-2220, with bulk bill incentive items 10990 or 10991 billed in conjunction.

MBS Item 2195 = $142.50

Nurse Practitioners can bill 82220, 82221, 82222.

MBS Item 82222 = $67.15

Practice Nurses and Aboriginal Health Care Workers can bill for MBS Item 10983.

MBS Item 10983 = $32.40

DOCTOR IN FOCUS

DR SNEHA BHARADWAJ
CONSULTANT GERIATRICIAN

Dr Sneha Bharadwaj is a Consultant Geriatrician with 5 years of experience in the field.

Dr Bharadwaj holds current positions in both the public sector and private hospitals. She is also attached to the Australian Alzheimer's Research Foundation clinical trials division.

Dr Bharadwaj's areas of interest include cognitive decline, dementia syndromes, Parkinson's disease, bone health, general geriatrics, rational prescribing and palliative care in the elderly.

If you have any patients that you feel may benefit from a Geriatric review, please dont hesitate to get in touch!

NEW DOKOTELA SPECIALISTS
NON-INTERVENTIONIST CARDIOLOGIST

Are you searching for a Non-Interventionist Cardiologist for your patients? If you are, please get in touch!

Dokotela is always recruiting new Specialists. If you have a particular Specialist that is of need to your patients, please let us know and we will try out best to accommodate.

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