Viewpoint

Guidelines for the Assessment and Management of Colleagues and Co-workers Referred for Psychiatric Evaluation

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Dealing with our own colleagues and co-workers may be challenging particularly when they are referred for psychiatric evaluation. They may be unwilling and may question the referral in the first place. They may think that the referral was not required and they are the victims of internal politics. Being the employees of the same institute they may not feel very comfortable sharing very personal information about themselves. They may also feel that the assessment may not be fair and just and may be influenced by the people in the administration. The referral may be an indirect way to ease them out of the department or institute.

On the other hand, we as psychiatrists also may not feel very comfortable in dealing with our own colleagues and co-workers for a variety of reasons. Being the part of the same institute we may know them and may have positive or negative, somewhat biased attitude towards them. We may not be able to maintain objectivity in the assessment due to our own ideas about work culture and discipline.

While dealing with the individual who is referred, one may also have to deal with the people from the administration; the dean or the superintendent or the trustees of the hospital. Their priority may be the smooth working of the hospital and they may want to get rid of the people who have or who develop some psychiatric disorder and disturb the smooth and peaceful working of the hospital or the institute. Directly or indirectly they may pressurize for quick results, try to influence our decision or insist on making the referred person 'unfit' to work.

Therefore it may be useful if we have some guidelines for the assessment and management of the colleagues and co-workers referred for psychiatric evaluation.

Here are some suggestions and guidelines –

Clarify the purpose of referral

The referred individual may have many doubts about his referral. He may also be very perturbed, angry and hostile as he may not have been explained the purpose of his referral. In this kind of situation it may be a good idea to start by discussing the purpose of referral and help him to understand that the referral doesn't mean that people consider him insane. A psychiatric consultation is sought for a variety of reasons. It may be sought for a person who has been on a long leave without permission, for a person

who doesn't get along well and tends to lose his temper with his patients or his colleagues, for a person who has lost confidence and finds himself unable to operate or do some procedure on patients, for a person who comes on duty under the influence of alcohol or for a person who turns suspicious and paranoid. He may be conveyed that as a psychiatrist our intention is to listen to him, understand the difficulties he is facing, support him and help him overcome and resolve his problem.

As a part of good clinical practice, it is very important, not to coerce, intimidate, ridicule or threaten the person. Be very calm and polite and have an unconditional positive regard for him. If the person in not ready immediately for psychiatric consultation, please give him some time to think over and then come back when he has made up his mind for the same.

Address the concerns related to the psychiatric consultation

It is quite likely that the person who is referred to us would have a variety of concerns which may be related to the confidentiality, number of consultations which may be required, consultation fees which he may be expected to pay, the time of consultation which may be during or after the working hours, types of medications which he may be prescribed, the duration for which he may have to take them and also the side-effects and dependence potential of the medications. There may be other concerns about the effects of the psychiatric consultations on his service and service record.

It is very important, not to undermine his concerns and address each of the concerns carefully to his satisfaction. Some individuals may be repetitive and may keep on asking the same questions again and again. In such situations, have patience, try and address his concern in different ways and request him to come for a second visit after thinking over the matter.

Option to consult another psychiatrist or a mental health professional

If the referred individual does not want to consult the psychiatrist available in the institute and expresses his preference for another psychiatrist, he may be allowed to do so. We should not force ourselves on him; he has a right to consult a psychiatrist or a mental health professional of his own choice. At his request, he may be given a referral letter explaining the purpose of referral.

Involving a close family member, classmate, a room partner, friend or a colleague in the management

Whenever possible, it is always better to convince the referred person to bring in with him/her a close family member; who may be his wife, parent or guardian; sibling or his ward. When a family member is not available immediately, he may request his classmate, room partner, a friend or a colleague to be with him, help him and support him till one of his family members is available. We may not be in a position to monitor the referred individual round the clock and so it may be a good idea to delegate that duty to someone available and competent enough to do so when necessary.

Second opinion and sharing the responsibility

In certain types of situations when the referred individual is hostile or requires restrains or admission, or administration of mediations or ECTs against his wish, it may be

preferable to take a second opinion and share the responsibility with our colleague or any other mental health professional or someone deputed from the administration.

Prompt treatment

A stitch in time saves nine. What holds true for our regular patients also hold true for our own colleagues and co-workers who are referred for the treatment. When necessary, they should be promptly attended to and without any hesitation or delay, we should make sure that they receive the best possible treatment. The assessment and required treatment should not be delayed if the proper referral note or a memo from the office or medical officer is not available. The required treatment should be immediately initiated and the referred individual may be requested to complete the formalities in due course of time.

Financial assistance for investigations, hospitalization and treatment

In emergency situations, if it is necessary to carry out some costly investigations like CT-Scan or MRI, or if the referred individual needs hospitalization and some costly medications, the administration should bear the cost and provide necessary financial assistance for the same.A separate fund should be allocated by the hospital authorities for the welfare and treatment of their own employees.

Giving information about the referred individual to the person who has referred him

The individual may have been referred by the head of the unit or head of the department or the head of the institute. They may seek the information about the individual whom they have referred either verbally or in writing. After the consent from the referred individual, one may provide visit details such as whether he came for consultation or not and whether he is coming for regular therapy or not to the referring individuals without revealing the details of his illness and nature of the treatment given to him.

Special privileges, concessions and leave

Whenever deemed necessary, the referred individual should be given special privileges, concessions from work and leave for the treatment of his psychiatric disorder. He may be allowed to avoid night duties, may be considered for light duties or may be permitted to take leave for the treatment as long as necessary. There should be a provision for special leaves for medical problems which an employee may utilize as and when necessary at a recommendation of treating doctor.

Maintaining records

It may be necessary to prepare and maintain outdoor or indoor admission papers and records of visits and treatment for administrative and medico-legal purposes. This should be done as per the regular practice of the hospital.

Table 1 - Profile, treatment & outcome of the individuals referred for psychiatric evaluation

Student Employee	Age / Gender	Reason for referral	Diagnosis
Student nurse	23/Female	Odd behaviour	Acute psychotic episode
Medical student	20/Male	Not attending lectures	Major depression
Sweeper	48/Male	Reporting on work under influence of alcohol	Alcohol dependence
Ward boy	56/Male	On long leave without permission	No psychiatric disorder
Laboratory technician	52/Male	Stalking a female employee	Delusional disorder
Resident doctor	26/Male	Talking excessively and arguing a lot	Acute manic episode
Associate Professor	38/Male	Unable to operate	Anxiety disorder
Assistant professor	28/Female	Not getting along with the staff & colleagues and losing temper easily	Major depression, PMS

Table 2 - Profile and treatment outcomes

Student / Employee	Referred by	Accompanied by	Treatment and outcome
Student nurse	Matron	Initially by Roommate & later by parents	Admitted, treated with antipsychotics, recovered within a week, and could resume her studies in 15 days.
Medical student	Head of the department	Initially by classmate and friends. Later by parents	Counselling and antidepressants. Improved attendance
Sweeper	Sister-in-charge	Wife	Admission, treatment of withdrawal, anticraving agents, disulfiram, AA-group. Has not resumed on duty, does not take treatment.Continues to drink.
Ward boy	Administration	Son	Referred to occupational department for the assessment for fitness to work. Was found to be fit. Was given fitness certificate, resumed on duty.
Laboratory technician	Chairperson, Prevention of sexual harassment committee	Initially came alone, later, at our request came with his wife	Was started on antipsychotic medication after explaining the nature of illness and purpose of treatment to him and his wife. Was transferred to another department.
Resident doctor	Head of the unit	Initially by co-residents, later by his sister	Admission, Mood stabilizers. After recovery in 3 weeks was referred for the assessment of work fitness. Could resume on duty. On regular maintenance therapy and follow-up.
Associate Professor	Self-referral	Came alone	Started on cognitive behaviour therapy and medication. Head of the unit was requested to give him only outpatient duty for a period of 3 months till he recovers. With treatment he is much better and has started operating under supervision