

6. When working from home, ensuring privacy and confidentiality for workflow and patient consultations, as well as compliance with work health and safety requirements. This includes ergonomics, provision of specific equipment and software (antivirus-security, practice management, telehealth platform), furniture and so on.
7. Maintaining regular communication amongst practitioners and staff, coordinated through the practice manager and/or practice principal via secure electronic messaging.
8. Through temporary adoption, low activity period stress-testing of these operational methods.

We have outlined some of the measures we have found useful to enhance sustainability during the pandemic, and encourage colleagues to share further advice through the journal and the RANZCP.

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Information-seeking on pandemic health threats for persons with schizophrenia

Dear Sir,

With the recent bushfires and ongoing COVID-19 pandemic, the Australian community has been subjected to serious threats. Repeated waves of widespread SARS-CoV-2 outbreaks have been described as the biggest threat of the 21st Century, heightened by the recent emergence of the highly infectious Delta variant.¹ Therefore, it is useful to explore factors which may influence how people deal with health threats, including innate levels of optimism, cognitive style and access to a support person (<https://www.blackdoginstitute.org.au/news/10-tips-for-managing-anxiety-during-covid-19/>). We explored these issues in patients with schizophrenia, and general practice attendees, as part of a larger study on risk perception during the 2009 swine influenza pandemic.² We are not aware of a similar study during the current COVID-19 pandemic.

The sample included 48 patients with a diagnosis of schizophrenia (Scz) recruited from inpatient and community health care settings in the Australian Capital Territory, matched (age, gender, and employment status) with a sample of 48 patients from general practice (GP) settings without a diagnosis of schizophrenia. The mean age in both groups was 35 (SD =11; range = 19–65). Each group comprised 27 males. This study was ethically approved.

There were no statistically significant differences between the Scz and GP

groups for: optimism; having a support person to turn to; and having a tendency to avoiding thinking about threats when faced with them (Table 1). However, there were significantly fewer people with schizophrenia who reported seeking more information when faced with, and in order to deal with, a threat, compared with the GP group.

One in five people in both groups reported feeling optimistic none or only a little of the time. However, 61% of the people in the GP group saw themselves as being optimistic all or a lot of the time compared with only about 42% of people in the schizophrenia group. Approximately one in three responders in each group viewed themselves as having a tendency to push aside thoughts about new health threats confronting them. Only 58.7% of people with schizophrenia reported seeking to gather more information about a new health threat in order to work out the best way to deal with it, compared with 78.3% in the GP group. The majority (80%) of people in both groups reported having access to a support person some, a lot, or all of the time.

People with schizophrenia, already at greater risk from SARS-CoV-2 due to comorbidity, might benefit from encouragement and/or assistance from their psychiatrist, GP, and carers to seek information and advice on how to deal with new health threats. This should include guidance related to public health messaging, including vaccination hesitancy, related to the COVID-19 pandemic.

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Table 1. Survey items and responses ($n = 96$)


	(1) None of the time (%)		(2) A little of the time (%)		(3) Some of the time (%)		(4) A lot of the time (%)		(5) All of the time (%)		Statistic [#]
	Scz	GP	Scz	GP	Scz	GP	Scz	GP	Scz	GP	
Generally, are you an optimistic person?	8.9.	0.0	11.1	17.4	37.8	21.7	26.7	47.8	15.6	13.0	$\chi^2 = 0.07$ $p = 0.79$
Do you have someone you can turn to for support in times of need?	6.5	6.5	15.2	13.0	19.6	17.4	28.3	26.1	30.4	37.0	$\chi^2 = 0.07$ $p = 0.80$
	(1) Not at all (%)		(2) A little (%)		(3) Moderately well (%)		(4) Very well (%)		(5) Extremely well (%)		
	Scz	GP	Scz	GP	Scz	GP	Scz	GP	Scz	GP	
When confronted with some kind of new health threat or difficulty I like to find out more information about it so that I can work out the best way to deal with it. How well does this statement describe you?	8.7	6.5	32.6	15.2	28.3	43.5	17.4	17.4	13.0	17.4	$\chi^2 = 4.08$ $p < 0.04$
When confronted with some kind of new health threat or difficulty I tend to push it aside and try not to think about it. How well does this statement describe you?	19.6	26.1	47.8	30.4	19.6	15.2	8.7	10.9	4.3	6.5	$\chi^2 = 1.15$ $p = 0.28$


Scz = schizophrenia; GP = general practice.


[#] Chi square statistic: 2×2 table comparing Scz with GP for (1) + (2) versus (3) + (4) + (5) i.e. none or a little versus substantive amount of each item.

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Challenging flowers

Dear Sir,

Walking past the neighbour's garden, I noticed two Shasta daisies on the same bush (*Leucanthemum x Graptopetalum pentandrum* "Superbum") – 'Leu' being derived from the Greek word for white (Figure 1). One was white and the other pink/violet. I was puzzled – these blooms shared genes and environment (the major determinants of biological development) – so how could they be different colours? I asked a keen gardener and ultimately the Royal Botanical Gardens. They could not give a convincing

explanation, and I felt the rub of disconnection. Then, I remembered a pair of identical twins I had known, discordant for schizophrenia, and felt the hug of collegiality.

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Anaesthetic safety with undisclosed substance misuse during electroconvulsive therapy

Dear Sir,

Substance misuse can hamper the effectiveness of electroconvulsive therapy (ECT).¹ It can make anaesthetic induction challenging² and increase the risk of haemodynamic instability,³ but no reports of

induction-related difficulties exist in relation to ECT. We describe a case to illustrate this issue. The patient has provided a written informed consent for publication.

Case

A 35-year-old man with treatment-resistant schizophrenia and comorbid substance use disorder (cannabis, methamphetamine, alcohol and nicotine) improved with an acute course of ECT during his hospital admission, followed by maintenance treatment as an outpatient. During one maintenance ECT treatment, he had excessive perspiration before the treatment. On that day, he required a higher dose of Propofol (200 mg rather than 130–140 mg) for induction and exhibited tachycardia and hypertensive symptoms after treatment. Following his recovery, he informed the anaesthetist that he had used methamphetamine and alcohol 3 days prior to ECT. On that day, he required a higher dose of Propofol for induction (200 mg rather than 130–140 mg) and exhibited tachycardia and hypertensive symptoms after treatment.

Subsequent discussions with the community treating team confirmed his intermittent use of methamphetamine and alcohol (22 standard drinks in a week) and daily use of cannabis and nicotine. He agreed to cease substance use particularly because of the increased anaesthetic risk, and he remained mentally stable for 4 months. His Propofol requirements subsequently increased on four different occasions, and later he withdrew consent to further ECTs. After a further 2 months, he required an inpatient admission because of worsening of mental state when ECT was recommenced with good response.

Discussion

Our patient needed higher doses of Propofol because of substance misuse. Despite knowing the potential risk of adverse interactions, this patient had difficulties in maintaining abstinence from substance misuse while on ECT. In terms of medical risks during ECT, acute



Figure 1. Shasta daisies (*Leucanthemum x Graptopetalum pentandrum* "Superbum") – white and pink/violet.