

## JISC UPDATE NOVEMBER 2011

### MEASURING LIAISON OUTCOMES IN OUPATIENTS

An out-patient based liaison psychiatrist uses HADS +/- BPI (Brief pain inventory - for musculoskeletal patients) scales pre and post treatment for outcome measures; but there are some concerns in the team whether these *are* the best outcome measures available. It is not uncommon to see a mismatch between clinical assessment and the patient's self rated scores on these scales - patients usually score higher than expected from clinical assessment. Also, many items in HADS reflect actual suffering of a physical illness (particularly a chronic musculoskeletal pain condition) rather than a depressive symptom (e.g. slowing down, ability to sit at ease and relax) etc. He wondered about using a relatively new scale - DAPOS (Depression, Anxiety, and Positive Outlook Scale (DAPOS) - to be used in patients with chronic pain. It has got some research evidence.

A respondent said there were indeed some concerns about validity of HADS in the patients with chronic pain and he enclosed some evidence for this assertion.



HADS PAPER 2.pdf



HADS paper.pdf

### ACs IN THE GENERAL HOSPITAL

In Leeds, the Acute Trust board formally adopted the MH Trusts list of ACs. Detained patients are *each allocated a liaison psychiatry consultant* as RC. OOH the duty psychiatry consultant becomes the deputy RC until the usual RC returns to duty.

### AN ACUTE TRUST REQUESTED A LIAISON PSYCHIATRIST GIVE A TALK ON DEBRIEFING IN THE ED

This Liaison psychiatrist wondered how to handle this as NICE tell us debriefing does not work.

A London based Emeritus Professor said there was very little robust evidence specifically on debriefing of healthcare professionals who have experienced trauma. 'Where a healthcare worker experiences a trauma e.g. being assaulted by a patient, debriefing often has a purpose beyond that in natural disasters, to try to establish how the traumatic incident occurred (given that policies and procedures should be in place to minimise this possibility). This can be very

important for the traumatised healthcare worker, and I suspect that it applies as much to A&E staff who have been assaulted as to staff working in psychiatric settings. In short, I think that there is a good case for regarding trauma against healthcare workers during the course of their work as being different from trauma due to natural disasters and probably even that due to violence against the person. However, in such instances, there is also a potential problem of trying to do too much with the debriefing (for example, using the debriefing to gather 'management information')

Another recommended the College PTSD and Coping with Trauma leaflets as a useful starting point.

Also, Cochrane reviewed this in 2009.

<http://summaries.cochrane.org/CD000560/psychological-debriefing-for-preventing-post-traumatic-stress-disorder-ptsd>

FINALLY, A USEFUL LIAISON REPORT

Can be found on

[http://www.centreformentalhealth.org.uk/news/2011\\_raid\\_report.aspx](http://www.centreformentalhealth.org.uk/news/2011_raid_report.aspx)

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