

JISC update August-September 2019

CTOs

Does anyone have any experience of patients on CTO whose recall is specifically to the general hospital? This clinician had a case involving 3 different mental health teams - and there was a rationale for using the general hospital in this case (physical comorbidity).

Response one: Cites a patient with renal failure and schizophrenia. The community RC can recall to the general hospital. Once there, and someone has filled in the form to officially receive the patient, then the liaison psychiatrist becomes the RC. Once assessed by the liaison RC and an AMHP, they can have the CTO revoked and can then be treated, under Section if deemed necessary.

Response two: The way we have handled this is to ask the CMHT RC to revoke the CTO (within the 72 hours, and often as soon as possible) so that the patient is once more detained under Section 3, listing the acute hospital on the CTO5. At that point, one of the liaison consultants becomes the Responsible Clinician (as per the MHA), administering such treatments which require an approved clinician, and working with the wider team (acute trust medics, eating disorder specialists etc) as required, and as we do for all the other patients we manage under the MHA.

'The trickiest thing is to make sure the forms are correct. Officially receiving patients with the correct CTO form for example. And being sure who is the RC at the various stages; as the only person who can revoke is the RC.

Factitious and malingering

Can anyone recommend a medicolegal expert in factitious disorder and malingering? Grateful for recommendations for:

- A medical negligence solicitor in Scotland with expertise in mental health and factitious disorder
- Medicolegal expert witnesses (psychologists or psychiatrists) based anywhere in the UK who would be able to do a diagnostic assessment for factitious disorder and comment on the standard of practice of a general psychiatrist

Response: Chris Bass is someone I'd recommend for expertise on factitious disorders.

Prescribing question

I have two questions for the group and would appreciate your views.

I would like to know what the current practice is in terms of prescribing in the acute hospital. From experience, liaison teams usually have an advisory role and are not able to prescribe. Are there liaison doctors out there with honorary contracts for the acute Trust who can actively prescribe and if so, what has your experience been?

My second question is about 'medical fitness for discharge' as a boundary for a MHA assessment taking place in the acute hospital. It is common practice here for AMHPs to have this blanket rule whereby the patient

needs to be fit for discharge (irrespective of their condition) prior to them attending. Is this common practice elsewhere?

Response one: We prescribe. We (the psychiatrists in our team) have an agreement with the acute trust and honorary contracts and now prescribe through the Electronic records system. Although most of the time it is easiest/politest to advise the ward doctors and let them do it. It works well and we have not had any difficulties so far.

With regards to "fit for discharge" conversations: We have put a lot of effort in that the assessment fits the question being asked. So if we are considering admitting a patient to the mental health hospital under section we will wait till the patient has been medically cleared for transfer before asking for the MHA. Occasionally it is a barrier - but more in the contact of assessments out of hours where S12 doctors may feel that the medical team have not been as thorough in ruling out medical causes of presentations as they could have been. However sometimes we detain to the acute hospital - in these circumstances we discuss that with the AMHPs first.

Response two: We too have honorary contracts which specify that we may prescribe; I do this as a matter of routine now as my experience is that asking others to prescribe on my behalf leads to more back and forth that is necessary or helpful.

With regard to MHA prior to medical clearance, so long as the person has a mental disorder which requires detention under the act then I would never delay applying the MHA regardless of their medical fitness. The issue of when it is appropriate to transfer to psychiatric care then becomes a separate matter.

Response three: We have honorary contracts but because the team is small and not embedded in acute MDTs we never prescribe directly and I find this reduces confusion and risk associated with multiple people changing prescriptions. Our team would advise and usually discuss with a medic in the acute team re best approach as they may have medical plans we are not yet aware of, and this seems to work well.

Medical fitness (a terrible term!) - our crisis teams will only see people when they are ready for discharge, to consider home treatment or psych admission at that point.

Mental health act assessments can and do take place on medical wards before medical treatments are complete, but this is case by case. Sometimes we run into problems in A&E when blood results are awaited and the destination is uncertain, but usually these issues are clear by completion of assessment. We also have difficulty convincing police to consider S136 to facilitate safe assessment when needed.

This psychiatrist has seen a rise in MHA assessments in ED and wards, and detentions to acute trust - 'this year I did my first tribunal in this setting'.

Response four: We don't have honorary contracts. Any contractual arrangements should be specified in a service level agreement between the two organisations that are contracting for and supplying the staff.

In general we would not write on the prescription chart as a matter of professional courtesy and to ensure that the patient's responsible consultant is aware of all medicines changes. Therefore we usually just advise about medicines. In an emergency we work pragmatically, i.e. if a liaison psychiatry doctor is first on scene to someone in delirium tremens or in need of rapid tranquillisation then we would expect them to prescribe whatever is necessary for the patient's safety.

If we are proposing to detain someone to a medical bed then most of our AMHPs will come straight away. On the other hand if we are proposing to transfer someone to a mental health ward then the AMHPs will usually say that they will only see someone at the point where they no longer need inpatient medical treatment. Given the resourcing for AMHPs and their offsite location this seems reasonable. Otherwise they'd end up detaining people to the acute hospital and then we would struggle to ensure that they are transferred promptly.

Substance misuse, suicidality, A&E

Standards of behaviour in A&E when patient appears high risk but is behaving in irresponsible way e.g. possibly taking substances -how to manage?

Response one: Their crisis team reassesses all potential informal admissions and this aids gatekeeping and potential home treatment options greatly, though this process is frustrating to other clinicians who may be more senior in the first assessment. There must be some adherence to appropriate behaviour. 'I guess where behaviour and stated views are mismatched you have to make a judgement on whether risks can be managed differently, or the person should be supported to take more responsibility for their actions'.

Response two: This clinician might think about discharge based on the fact that their expression of hopelessness and suicidal intent does not necessarily fit with their behaviours or presentation. They have an acceptable behaviour contract, particularly with regards to our substance misuse patients, which may result in a patient's discharge if they continue to use in hospital, providing that the risk of doing so does not increase their risk of suicide. So I guess it would be a case by case scenario.

Response three: I would suggest that the key deciding point is your assessment of their presentation. If they are declaring suicidal intent with a view to avoiding responsibilities/consequences of their behaviour or with a view to obtaining comfort of some sort, then I would not recommend psychiatric admission but suggest that they seek help with their substance use. If they are presenting with apparent major mental illness, I would try to limit their access to friends/substances insofar as possible while expediting the bed. I guess what is important to establish is whether suicidal thoughts are a manifestation of cocaine crash or not (are there any other withdrawal symptoms present?). If this is a crash, then the risk of suicide is significant and can last for days. More chronic presentations may need a different approach. Now whether this should

be dealt with on a psychiatric ward or a rehab unit is up for debate. Regardless though, any behaviour that is not acceptable for hospital premises should be pointed out and this is not specific to substance misuse.

Time management

Our jobs are getting busier (so much busier) with A&E almost becoming like a psychiatric inpatient unit at times; and greater numbers of patients coming in. How do we as MHL teams best manage our time? Is there space for psychotherapeutic input esp in A&E or are we mainly assessing risk and signposting?

Response one: From Tavistock: - Keep in mind that there is a core therapeutic role for *non-mental health staff* to play, for example in deliberate self-poisoning

Response two: Unfortunately in this team we are only managing the risk assessment and signposting, and even that's difficult to do in a timely manner with our 1-hour to assess in A&E target. With the ongoing bed crisis (acute and mental health trust) , we are also often asked to review clinical decisions that have been made out of hours to admit informally to psychiatric bed (e.g. to consider less restrictive options even though just a few hours earlier they didn't seem viable) resulting in even more work with often duplicate assessments.

Response three:

This team will be doing the Connecting with People training for our team soon so I hope that despite busyness (>250 ED referrals a month) we will remain therapeutic while we assess risk and signpost. I don't think the two are mutually exclusive but of course it is challenging.

RMNs

Our acute trust in North London is interested in recruiting a team of RMNs and Mental health HCAs who would be able to do 1:1 nursing and perhaps act as a control and restraint response team. Do any of you have experience with this kind of thing? What works? What doesn't? Can you share any policies/documents?

Response one: We have tried recruiting bank RMNs in the past for 1:1 work on the wards in order to reduce the amount of agency costs. The main barrier is that most of them are in full-time employment with the MH trust and therefore availability is limited.

Not sure how it would work with a C&R response team, as you'd need a least 3 staff available at a time. If they were going to do 1:1 work as well, they wouldn't be able to also respond to C&R incidents. I'd also imagine that if there was a dedicated C&R team, there'd be quite a lot of down time when there isn't a C&R incident to respond to.

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