

JISC update February – April 2020

Role of Liaison psychiatry in support of new Covid pandemic hospitals

Question - Does this group know what is in place for liaison psychiatric support for Nightingale Hospital?

Respondent one: 'Survivors will need to be extubated at some point – so the intensivists will need some assistance with difficult weaning from sedation and managing ITU delirium'.

Respondent two: Knows what the Nightingale Excel plan is:

Bearing in mind that expectation is that everyone at Excel would be ventilated; it would be about staff support. 'And staff support given the numbers of staff (mind boggling) and the austere environment (Mind blowing) has to be the key mission here. We have found that knowledge of military psychiatry – how to support a field hospital – is very helpful – not least because a lot of the key decision makers on the ground there are ex-military.'

Respondent three: Was the Mental Health/Psychological Care Lead for the Yorkshire Nightingale Hospital. Based in Harrogate (converting a conference facility), 500 beds; and responsibility for both patient and staff aspects. So far I have established that the MH scope will cover:

- a. Mental health of the inpatients.
- b. Step-down/psychological and mental health services at and after discharge.
- c. Staff psychological care and mental health - during.
- d. Staff psychological care and mental health - post...

He had visited the site, and also spent some very useful time with the Chief Nurse, Senior Ops people, Army (who are all over it with establishing the new environment), staff support, and briefly with Lead Intensivist, plus some others. So following that I just want to mention a few points from the perspective of the Yorkshire set-up, and what has been said today:

The intention had been for all patients to be sedated/unconscious and intubated/ventilated throughout. But the view now is that although they will arrive in that state, they will be extubated before discharge and so may be "up to 24 hours" post-extubation still in situ before discharge - which obviously changes things when thinking about the nature of, and potential amount of need for, mental health service in-put on site. The volume of work may be relatively small, but requiring rapid availability and response.

There wasn't going to be an area for crucial pre-shift team briefing, i.e. what needs to happen to set up expectations, provide honest preparatory communication, establish some team cohesion, and leadership, and pairing up etc; and also no space for end of shift ("non-psychological") team debrief and feedback. He has introduced the essential need for this space, and has been heard.

Respondents four and five: were from Manchester and Devon and Cornwall - and the plan was for these 6 leaders in the field to set up a separate communication stream.

Covid Well-being and Coping website

The new 'Wellbeing And Coping' website has been developed by 4 Mental Health and co-funded by NHS England. It has been designed to offer calming and practical advice for anyone emotionally struggling during the coronavirus pandemic and to more generally support people to find realistic ways to build their wellbeing. <https://wellbeingandcoping.net/>

Resuscitation and no PPE

Has anyone got an example of guidance for staff on what to do if an intervention is required but PPE not available (for whatever reason)?

Respondent: The Resus council guidance is very clear that PPE is needed before any attempt to resuscitate

<https://www.resus.org.uk/resources/assets/attachment/full/0/36100.pdf>

'Reiterated in my trust PPE training this week'

Possible psychological psychiatric sequelae post-ITU - which may be applicable post-covid

A liaison clinician reports rates of general low grade neurocognitive sequelae of ARDS and critical care are high with poor concentration, memory, chronic lethargy etc post ITU as well as polyneuropathy and myopathy (probably consequence of ITU) plus depression, anxiety and to a lesser extent PTSD. The post ITU mortality rates are also high for 12 months. Also the physical and psychological symptoms persist for many months (at least 12 months).

In Manchester the following were documented reasons for referral to Liaison Psychiatry:

- Pre-existing SMI
- Cessation of psychotropic meds (e.g. lithium or clozapine)(several patients had clozapine stopped and history of severe psychosis which only responds to clozapine-unable to restart the drug-some had a stay on ITU of several weeks)
- Side effects of clozapine (e.g. severe cardiomyopathy)
- Mental Health Act issues (e.g. transfer of patient on Section 3 from a different part of the region)
- Refusing ventilation-capacity- but also paranoia
- Suicidal act -cause of ITU admission
- Hallucinations, paranoia.
- Survivors of RTAs where family have died and they do not know-advice
- Survivors who have had both legs amputated and they do not know
- Violence episode SMI- followed by self-harm (e.g. stabbed wife and then severe suicidal attempt)

- Liaison psychiatry already involved and patient deteriorates and transferred to ITU from another ward.
- Alcohol related issues (management of tricky withdrawal)
- Repeated anxiety when weaning from ventilator
- Behavioural disturbance-usually in step-down rather than main ITU
- Severe distress, flashbacks, anxiety when in step-down

Most ITUs also introduced 3 month follow-up clinics many years ago, and rates of poor concentration, memory impairment, sluggishness, depression etc were very common.

There seems no clear link between benzos in ITU and PTSD. There are as many studies that have found no link as those that have found an association. Few studies have been able to control for the fact that benzos may be used more for more disturbed patients. Studies that have compared using less sedation and more waking for patients compared with less frequent waking have not found any benefit on PTSD. Hallucinations, paranoia on ITU however do predict later PTSD.

Request for drop in one to one staff support sessions to General Hospital staff

This liaison service has been asked to provide drop in sessions for acute hospital staff. They are working in collaboration with health psychology but their numbers are small. This is in addition to their supporting teams by attending huddles and in addition to staff having access to dedicated phone lines offering psychological first aid delivered by the local trauma service.

'Can I ask if other liaison psychiatry services are providing staff drop in sessions and if so - are you keeping records and if so what governance is in place?'

Respondent: Has been thinking of ways to ensure a degree of governance, consistency and that all support is somehow 'connected into' lines/work streams to ensure no rogue debriefing and not overly 'medicalised'. She has been concerned that some people are still advocating use of debriefing. She is looking to prepare a document.

Reducing f2f assessments

This service is devising a form to support teams to take increased risk in terms of reducing f2f assessments - either by trying to phone the patient on the ward/ED or by saying send home and we will phone there. They were unsure what to advise for elderly patients with severe agitation and current normal bloods and no physical symptoms of infection.

Respondent: This OPMH service is part of the acute trust so we are anticipating taking patients with dementia with severe agitation to our ward where their needs cannot be managed in the community. This would require a discussion with consultant psychiatrist to determine need and legal framework for transfer; obviously we need to preserve some capacity for direct community referrals. For patients with delirium they are following the BGS guidance, with telephone

support to ward staff if required. We'd see face to face where delirium is accompanied by significant distress. 'I'd probably lean towards a face to face for the older patients presenting with suicidal ideation and definitely for self-harm in this group.'

Dr Jackie Gordon
Worthing Mental Health Liaison Team