JISC update October – November 2019

Psychology

Does anyone employ psychologists within a CORE24 liaison psychiatry service? We have an opportunity to look at this and I was keen to hear how this has worked out for others. What sort of work do you/they do - clinical, training, supervision? Has it been a good fit?

Response one: We are about to start having a band 8b with us. We were unsuccessful with a band 8a offer last year given the need to develop service links, wanting experience and governance oversight for supervision of other SMHP's in the team. The team then hope to deliver Brief psychosocial interventions or solution focused therapy "informed work" etc for LTC and MUS as well as helping with formulations and dynamics around risky or frequent presentations. This will also include teaching and support to wards as appropriate/ manageable.

I know Rapid Assessment Interface and Discharge and some London teams have one and that they can bring trainees and also 'mental health graduates- band 4?
Response two: We have a very able psychologist with our service who has proved to be of great benefit to the team and her capabilities and can-do attitude. We have allowed her role to evolve so that we could work out where her skills are best used. Her main roles in the service include:

- Psychological therapy for both inpatients and outpatients. The latter group is made up on either inpatients that the service has seen who would benefit from additional outpatient therapy; plus referrals passed on by me from my outpatient clinic.
- Autonomous and joint assessments of inpatients who would benefit from a psychological formulation and possible treatment, and follow-up of such patients.
- Lead for frequent attenders work.
- Providing teaching and supervision, both within the team and for hospital colleagues.
- Development of specific role and clinic for ITU patients.
- Generally helping out with assessments when things are busy.
- Other initiatives, e.g. compilation of a crisis leaflet that has proved to be of great use with ED and self-harm patients.

Response three: Our psychologist has shaped the role to fit the needs of the service:

1. Psychological assessments and work with inpatients (quite a lot of joint sessions with physios for patients whose anxiety is stopping them progressing etc)
2. Outpatient clinic for short term psychological therapy - patients referred by our team only, so who have been seen in ED or on wards
3. Work with the frequent attender service and supervising the assistant psychologist in this
team
4. Teaching
5. Schwartz round facilitator

6. Leads the team's reflective practice group
7. Advice/ case discussion/ general thoughtfulness and good sense provided to the rest of us

Personality disorder pathway

We are developing a personality disorder pathway locally and are looking to ensure the A&E interface is consistent with the rest of the care that is planned for individuals on the pathway. Does anybody have experience in using care plans in this way, applying them in emergency department and liaison psychiatry settings? I would be very interested if you could share your experience and if possible templates in this area.

Response one: Thinks this sounds positive; and has offered a few experience-based rather than evidence-based suggestions.

Firstly, it is important to anticipate, clearly challenge and debunk toxic myths about people with personality disorders from the outset – particularly regarding being 'attention-seeking' and arguments about 'rewarding' people who are in distress.

Secondly, my experience is that preventative care planning is more effective than anticipatory/response care planning. What has made the biggest difference at this hospital is when liaison psychiatry staff goes to the community mental health or community addiction services, and contribute to overall CPA / support care planning. Having a response plan which amounts to a set of instructions of what to do once someone has arrived in the dept. doesn't seem to make that much difference – on the other hand, reflective practice and case discussion does seem to be more helpful. We haven't yet gone to the extent of inviting a patient into their own case discussion meeting but I wonder whether this would be helpful.

Finally, I have had sight of various response plans from around the UK which say things like "Please treat this person respectfully" etc. I would suggest that a more valuable focus is on addressing hospital culture – for example supporting ED staff by regular delivery of suicide and self-harm awareness training, ensuring that liaison psychiatry staff are equipped with skills in brief psychosocial interventions such as safety planning etc. To that end I would suggest using the resources associated with www.stayingsafe.net

Response two: 'I think this topic is ripe for some debate.'

This team uses care plans for high utilisers; generally with mixed physical and mental health problems or MUS. Some will have a diagnosis of personality disorder, either diagnosed or suspected and many are not in touch with the CMHT.

We include a lot of the things that you suggest should be automatic, such as

- take a careful history and undertake a thorough physical examination
- discuss the contents of this care plan and consider previous sources of distress

Many of the people we use them for find this reassuring.

There is a loose background biographical and medical summary and sometimes a comprehensive appendix of previous investigations. We also spend time thinking about the persons reported life goals, as it is very likely that prolonged or repeated hospitalisations are interfering with those.

Each plan has a section for

- the patient
- the GP
- the ambulance / acute GP
- the ED
- what to do if admitted

All are reviewed and agreed by the patient and GP before wide circulation.

There are some tricky ethics when patient suggest that their usual access to prolonged hospital stays, opiates and investigations are being limited by the plan; but dealing with these through MDTs, family meetings, patient experience teams and reviewing the plan regularly, helps.

It also helps to have live data for the plans, which we have updated monthly from the hospital Information services. This service demonstrated a 60-75% reduction in a range of metrics, admissions, ED attendance, OPD, LOS over an average 18 month, before and after period for the 45 or so patients with plans that we have in place.

Other ethical challenges include; whether the ends justify the means, the lack of psychological or other support to replace that provided by hospitalisation, consent versus coercion versus encouragement when the plan feels challenging.

Core 24 all age

A hospital trust is developing its Psychiatric Liaison service so that its two largest sites meet core 24 minimum standards. They want to ensure that people coming into ED are seen/triaged within 1 hour instead of 4 hours from the point of referral. They are recruiting Psychologists, ANPs and 8a Service Managers who can develop the overall strategy and create strong links with their acute colleagues and senior management. We are also recruiting band 3 support workers for the first time. The plan is then to invest across the whole county for parity of service.

We also are preparing a business plan to make the service all-age by 2020 (and we really do mean all-age – not just 14 upwards for example). This has proved the hardest part because we do not want to just bolt on a CAMHS part but want it to be an integrated team. We have worked closely with the CAMHS service but many staff are anxious about changing their skill set etc. It is also costly as currently the provision for 24 hour CAMHS services is poor. Does anyone have any experience of doing this?

Respondent one: A liaison psychiatrist in Greater Manchester has a service

which has recently gone all age and gave her contact details to discuss with the enquirer.

How best to treat anxiety associated with COPD?

Respondent one: Advises Duloxetine 30 mg daily to start with; weekly reviews (cross titration to 60-90 mg daily)

Respondent two: There is a lot of interest in palliative care (in the context of breathlessness), and there is a mirtazapine trial taking place at present.
The breathing, thinking, functioning model is highly recommended:
https://www.nature.com/articles/s41533-017-0024-z

Respondent three: CBT

Respondent four: Thinks that consistently delivered non-pharmacological strategies works best in this population in their experience. Medication is disappointing. Best placed to deliver are specialist nurses - controlled breathing, mindfulness and cognitive-behavioural strategies.

Respondent five: There is some excellent work with COPD patients in Sunderland

Burns

'Does anyone have information on 3rd sector / peer support organisations or websites for people with burns?' This clinician is aware of 'changing faces' and thinks that they do link in with people where the scarring or difference is not just facial, though their focus is around facial difference. Is there support which is more broadly focussed?

A respondent has recommended: https://adultburnsupportuk.org/service-type/burn-charities/

Dr Jackie Gordon
Worthing Mental Health Liaison Team