JISC update Jun-Jul 2019

Treating cognitive difficulties in MS

A clinician asks if there is recent literature or guidance on treating cognitive difficulties in Multiple sclerosis. She is aware of disease modifying therapy (DMT) and Ache-I.

Response one: There is related literature for brain injury and use of cognitive stimulants - Methyl Phenidate and Modafanil. There is limited evidence base 'for the usual reasons'. The best predictor for response is a slow processing speed; it can be effective for executive problems, but it does need careful consenting and monitoring due to the potential serious side effect profile.

Response two: That in addition to psychostimulants as suggested, there may well be some role for cognitive rehabilitation from either a psychologist with this training or an occupational therapist working in this area.

Liaison Clinical lead role

'I know there are many different service models out there in different stages of evolution. Here in West Sussex (2 biggish DGHs) I have been asked if I would like to be clinical lead for liaison across 2 sites – this has arisen due to increase in MH demand and increased demand and tensions between acute and MH trust. This would be a 3 session per week role; in addition to my usual work. My 3 sessions would be covered clinically.

My question to you all is – is this a role (or similar role) that others have taken on?

Response one: 'Yes lots of roles like this certainly in London. It is an opportunity to standardize care. But it will come with performance targets, attendance at multiple meetings etc I should imagine. Make sure you have adequate manager support and admin support. In west London we have three services, all fairly close together and it is three session officially but never is in reality. It requires very supportive and understanding clinical colleagues who are able to hold the clinical service in your absence'.

Response two: Is a liaison consultant in a big hospital (huge 8+ consultant and MDT dept of psychological medicine with consultants in most medical specialities - without a nominated 'clinical lead' in the hospital or trust, but people who've been around for a while and tend to take the lead with things) but soon to start as substantive consultant at another hospital with only 1 or 2 other liaison consultants… I suspect that your query will be relevant to me very soon'.

Alcohol liaison worker

'We are hoping to train our clinicians to do brief substance misuse interventions in addition to our general liaison role in ED. Does anyone else offer this? Any advice/suggestions would be welcome.

I am also looking for a job description for a substance misuse worker working with a liaison service, if anyone could help?'

Response: Has given a comprehensive JD content:

To work with individuals on a one-to-one basis in hospital and community settings.

To creatively engage with chronically excluded, multiple and complex needs clients.

To build trust and engagement with service users in order to support them to access services and meet their basic health and social needs.

To manage a caseload of individuals ensuring appropriate treatment and packages of aftercare support are delivered.

To address the needs of the whole person instilling hope and motivation for change.

To work in ways which promote health, wellbeing and harm minimisation.

To work alongside other health and social care professionals to integrate the service into existing protocols and pathways, in particular with Recovery where service users will be supported and encouraged to received support for substance misuse problems.

To build strong links with Housing Services in order to provide onwards housing options and reduce length of stay in hospital for anyone admitted.

Develop a direct pathway from hospital to access a 12-step abstinence based programme directly from discharge from hospital.

Support Management and Data team in identifying 'progress and blockages' to help have a better understanding about how outcomes can be measured and achieved.

Where necessary referring/supporting individuals to access specialist agencies such as veterans, homelessness and financial inclusion services with a particular emphasis on Safeguarding.

Support Management in the delivery of a service that meets quality standard and good practice protocol.

Present a professional image of Changing Lives at all times.

Comply with all legal and health and safety requirements.

To work to the performance standards provided and requested by Changing Lives.
To carry out any other reasonable requests as deemed appropriate by Management.

What is a CL Risk Register?

I have been asked to present and then prepare the "risk register" for CL psychiatry at our large tertiary referral teaching hospital in Australia.

Response one: Risk registers and RAG ratings are rife in the NHS – it's one of our favourite distractions (apologies for the alliteration)! A lot of them are dependent on resources which will be specific to your service (eg. consultation room with no ligature points, windows in the doors and patients are asked to wait accompanied for the clinician to arrive). Obviously there needs to be regular review and updating as each mitigation is put into place, the risk will change (we review ours monthly with obvious greater attention to the Red). Consultants are often asked to contribute or give their opinion, however, they are mostly done by the service manager, who often has a better oversight of the whole service.

Response two: In the UK now NHS safety is under review by a body called the HealthCare Safety Investigation Branch (HSIB) which recently produced a report about 24/7 mental health cover in ED you might want to browse.

Mental Health Act in A&E

I have asked this question before – and am asking again because A&E is so very busy with MH patients – a doubling of admissions in the last year, many patients waiting ++ for a psychiatric bed for >24 hours. Some patients are assessed under the MHAct – and applications not made until a MH bed located – so the AMHP needs to attend twice; and the patient whilst waiting is not actually detained. Do liaison services out there detain people to A&E – particularly if they have CORE 24? The argument is strong – we can then legally treat under MHAct, the AMHP isn't needing to come twice, transfer when MH bed identified is quick and easy.

Response one: Yes in Brighton if there is no obvious bed - though to CDU

Response two: 'We have seen an unprecedented increase in the of referrals over the last 6 months increasing a number requiring MHA assessments in A&E inc from 136s because the 136 suites are increasingly fully occupied so police bring to A&E. Over the past 3 months we have had a continuous bed crisis with no mental health beds and on two occasions I've been told "there are no private beds in the whole country".

Response three: Was from the West Country. I'd echo the point about the legality of subsequent detention to A&E, and similarly, we have a clinical decisions unit (CDU) at the back of A&E where people are occasionally admitted in the short term.

Response four: A similar increase in rates, with the same problems over legality here in Bristol. A couple of things seem to have helped. We drew up an escalation policy to find a psych bed. If there's a decision to admit and no bed found in 2 hours, then we call the mental health trust managers, and if not bed found after 4 hours, we contact the mental health trust execs. We encourage

the acute trust managers to make the calls to the mental health trust so it doesn't take up clinical time.

It's also applicable 24 hours, so we don't need to be in the building for the bed chasing to continue. I think one of the hesitations about allowing us to detain to the observation ward (equivalent of a CDU) was that the ED thought it would take longer to find a bed. Since we've helped them chase it themselves, they can see what is happening and have some control, we are more likely to be able to use an acute trust bed to detain a patient to, the patient is legally detained, and the AMHPS are happier to come because they know there is a bed in the acute trust ready to accept.

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