

JISC update August - October 2020

Effect of Covid19 on Liaison Psychiatry presentations - and MUS

This discussion stemmed from a Cornish clinician asking about MUS post-COVID but became a broader discussion.

'A commissioner asked me an interesting question about whether, as part of planning for a surge in mental health issues during and post-Covid, anyone was considering MUS. Is anyone aware of any work on this, or giving it any thought?'

Response one: This service is thinking about it with their clinical health psychology colleagues – persistent fatigue and effects of ARDS/ITU cognitive impairment especially. Also, relevant - from SARS/MERS - the stigma of the long-term symptoms and problems with returning to pre-morbid functioning. 'These presentations sit across different commissioners/services too so complicated to ensure we are finding the people who need the services and what can be offered.'

Response two: Yorkshire - There's a discussion group of those interested in FND that's raised this topic but like everybody else they are rather waiting to see what happens. They are (as the name suggests) interested in neurology presentations.

Response three: North London - We were expecting more depression, anxiety and other post-trauma presentations, but what we have seen is a lot more psychosis. I think the majority of these are due to what is called "disruption in the community mental health offer" i.e. patients come to ED because there's a lot of working from home going on. This service has seen > 10 new onset psychosis in middle age & older adults.

Response four: Also London - echoes previous 3 service experience and says there are more MHAA than pre covid

Response five: Aberdeen - I have been on the out of hours on call rota during COVID and was amazed by the predominance of psychotic and bipolar disorders presenting. Most were known patients who had stopped medication or been unable to organise themselves to get it - or in a few cases lockdown had separated them from family who would provide support.

Response six: York – has seen more presentations of overdose, anxiety, depression and health anxieties.

Response seven: North London - where local residents are fortunate in that 'our colleagues in CMHTs have stepped up with seven day opening, remote video appointments and managing workload, so that we haven't seen a lot of unmet need from CMHTs'.

'Despite all the interest in neuropsychiatric complications of COVID-19, what we've seen more of is a psychosocial "COVID psychosis", triggered by stress,

isolation, debt of lockdown and particularly by insomnia, which has led to persistent hallucination, mood disturbance and, in some cases, self-harm.'

Response eight: Bristol - We, like many, were asked to make sure all our 'medically fit' patients could be seen outside of the ED; and moved very quickly to do so for 3 DGH's. Hubs all closely located in MH buildings were set up within a couple of weeks.

Some Devon DGH's have accepted that the acutely unwell still need liaison assessment in the ED and monitoring there even if 'medically cleared'; but other DGHs are less than happy with this, creating tensions between MH Liaison and the ED staff.

There was concern expressed about team energy and capacity being diverted to these hubs. 'As others have said the presentations are also becoming more complex and new psychosis is more frequent. We have had to use rapid tranquilisation in the hub and had property damage'. 'I think the ED/Hub interface is proving a step backwards in terms of liaison custom and practice in the DGH'.

Response nine: Leeds – Reminds us that ICD-9 contained a very useful diagnostic category "psychogenic psychosis" ...

Response 10: Wales - Has observed more "Covid anxiety" disorder than "Covid psychosis" and recommends data gathering collectively to reflect on true cases.

Response 11: London - suspects presentations will vary locally depending on how able CMHTs are to manage community patients. They have seen new psychoses, as well as people relapsing in psychosis who have been well for years. Their older adult community team is carrying a much greater level of acuity and risk at the moment, which is really challenging. Many patients with personality disorder diagnoses are breaking down in the community after weeks of isolation, and self-harm presentations are increasing. Also, they have noticed police bringing significantly more people to ED 'voluntarily' or 'under the MCA' (often in cuffs). Also, there have been more referrals from ITU; or patients recently stepped down from ITU.

Response 12: East London has seen more psychosis. Several NON-delirium Covid psychoses (men in 30s, no psych history, no drug use and IMHO, caused by the RNA virus and not stress-related), two new lupus psychoses, with other high protein in CSF psychosis presentations. When these are added to relapses in people with SMI who can't access their community teams, it is a significant burden on any liaison service.

Response 13: Bristol has seen more psychosis and several eating disorder patients; also, psychotic depression and a massive reduction in ECT capacity making it tricky to treat.

Response 14: MHAA across Luton and Bedfordshire doubled quite early on in COVID and have been that way ever since; with no sign of slowing down.

Response 15: Ashford – has definitely seeing more psychosis in older people – a mixture of new and with past history - in the context of COVID isolation. They have seen more MHAs in the last 2 weeks than in the last 3 months. They have also seeing more self-harm in older age groups. They have put in a bid to our new ARC-KSS to research self-harm and suicide in older people in the time of COVID using liaison and trust mortality data.

Response 16: Greenwich – Report that older age liaison is busier – with more cases of lithium toxicity.

Response 17: North London’s local residents are fortunate in that CMHTs have stepped up with seven day opening, remote video appointments and managing workload; they have not seen a lot of unmet need from CMHTs. Despite all the interest in neuropsychiatric complications of COVID-19, they have seen more psychosocial “COVID psychosis”, triggered by stress, isolation, debt of lockdown and particularly by insomnia, which has led to persistent hallucination, mood disturbance and, in some cases, self-harm. They are still working on changing the approach of “medically cleared” by the use of a streaming checklist to reduce unnecessary investigations, and on improving efficiency of Mental Health Act assessments, but are seeing this as an opportunity to improve mental health care across the whole acute hospital and address embedded custom and practice.

Response 18: Salisbury – has seen lots of lithium toxicity - five cases in a week. Like others we have seen what seems more than usual severe self-harm in working age adults and psychosis in older adults. The older adults do seem affected by the reduced community input and anxieties of Covid; the working age adults more struggling with the isolation of lockdown.

Response 19: This service has seen decompensating of dementia through isolation too.

Response 20: Queen’s Square - Regards the psychotic patients - I’ve had a covid positive patient with psychosis with a clear sensorium. Middle age. No previous psych history. CSF/PCR negative.

The emergence of Mental Health Emergency Centres/Hubs

Thread started from North West London:

The emergence of Mental Health Emergency Centres/Hubs presents both opportunities and threats to the practice of liaison psychiatry and to the provision of care in acute hospitals for people with mental health needs.

Locally, with a MHEC on the same site as an ED I can see benefits and drawbacks, particularly regarding cost effectiveness and the risk of it becoming a ‘holding pen’ for existing inefficient and duplicative pathways, rather than a centre for intervention and help.

Nationally there are substantial threats: in some areas, psychiatric liaison nurses have been pulled out of acute hospitals to staff non-co-located ‘hubs’, and liaison psychiatry has regressed to an ‘in reach’ model.

There are other considerable drawbacks, particularly where language reveals the underlying attitudes:

“Diversion” suggests a hardening of attitudes that people with mental health needs don’t belong in the ED; when the truth is that the majority of people seen by liaison psychiatry in the ED are there because they need concurrent mental health and medical attention.

“Assessment Centre” is problematic: we know that there is far too much ‘assessment’ and too little ‘assistance’ in mental health services – this is the reason that locally we’ve insisted on such places being called “Emergency Centres”

There is a risk that the gains we have seen in terms of improved attitudes and staff behavioural standards, increased service provision, and improved experience of care in acute hospitals slides backwards, with a focus on ‘diversion’ rather than service provision and prevention.

I know that it never really went away, but there’s also a risk that “medically cleared” starts rearing its head again, and the gains we have made in side-by-side working recede to a position where mental health services refuse to assist patients who are still receiving medical treatment. Unfortunately the launch of the RCPsych/RCN/RCEM/RCP consensus statement was somewhat derailed by the coronavirus pandemic but it’s important that this work continues.

On the other hand, there are potential benefits. My clinical experience locally has been that the MHEC has allowed us to address psychiatric emergencies associated with homelessness and deprivation more effectively, and that we’ve managed to initiate treatment and discharge a small number of people who otherwise might have been admitted.

I’m really interested to hear what people’s experiences have been locally – both advantages and disadvantages, and the longer term vision – and to discuss how to ensure that any hub model aligns with the need to provide 24/7 co-located liaison psychiatry. How do we move forward as a specialty?

Response one: ‘I agree with every single Pro and Con you have listed’.

In addition:

1. GPs seem to like this plan, as they have previously found access to MH services difficult: the MHEC seems to provide a more straightforward way of backdoor referrals to services, especially at a time when the rest of the community services are ‘remote working’. In other words, if we demonstrate success/ effectiveness of the ‘Hub’, it can become a victim of its own success.
2. Nowhere is the intertwining of physical health/ mental health/ social care issues more evident as it is for older adults who often end up having poor experience due to this ‘diversion’ and bear the brunt of poor clinical/ holistic decision-making. We have had to scale back older adults being diverted after a number of such clinical errors and near-misses.

3. The longer the hubs run, the harder it will be to scale them back: The concept of "If you build it, they will come" certainly seems to apply to MH services.
4. If the pre-triage/street-triage/ambulance-Police triage does not work well, often patients can be shunted back and forth and have a poor experience of their pathway to access.
5. The 'Hub' model is often accompanied by "support line" call centres, which are de-facto "Emergency single points of access" and interfacing with them from within and from outside the MH services is difficult.
6. Rather than freeing up frontline services, they only seem to move the throughput bottlenecks elsewhere.
7. I have heard of MHES services that started with chairs, later recliners, and eventually brought in hospital beds; as they could not find any inpatient beds now that they are back in full capacity.

Do you support that these MHES should continue, and if so, should they maintain the current scope and remit?

Response two: Hounslow - In our patch we have seen 10-15% diversion rates of patients from ED but arguably using 50% more resource – the security, the additional staff required from the mental health unit (usually someone from our crisis team), one PLN and the increased time it takes for all of this to be coordinated with the unit coordinator before the actual walk across the car park (of course) can occur.

I think diverting at the point of presentation for our service is cumbersome and risks diluting the resources to the main mental health services within the acute trust irreparably. The unintended consequence should anyone try and measure (for our service anyway); they probably spend more time in the department in total than they would have normally waiting for the diversion. Thus 'clogging' up the ED, which is the opposite of what it was designed to achieve. If we were able to divert 70% then I would see the point, but my worry is that we are inadvertently making ourselves less efficient for the patients that still have to go to the ED..

Response three: These are really important observations. Can I say something about the long-term vision?

The original premise of the Service Formerly Known As RAID, made more explicit in the NHS England rationale for increased liaison funding, was that liaison psychiatry was essentially a branch of the acute psychiatric services. Little or no mention was made of special clinical skills as opposed to 24/7 rapid availability. The job was to keep inappropriate attendances and admissions at bay, and when somebody did get into hospital the job was to get them out as quickly as possible.

At the time of the first LPSE survey, although there was some sort of liaison service in 168/179 acute hospitals, fewer than half did any work other than acute and fewer than a quarter ran specialist OP clinics. The subsequent surveys have not shown an increase in those proportions - the extra staffing has indeed gone into boosting acute response services.

Under these circumstances, liaison will inevitably be at the mercy of reconfiguration of the acute services. That is not a happy position, given that acute and community services aren't necessarily in great shape and we are entering a period of ferocious austerity.

Part of the long-term vision must therefore be to reassert the nature of liaison psychiatry as including specialist and shared care, for example in the management of multi-morbidity and MUS, and especially the more severe and complex cases that inevitably find their way into secondary acute hospital care. Maybe not every service can deliver in that area yet, but as a specialty we must resist service configurations that make such work harder in the long run - for clinical and economic reasons. In other words - the argument shouldn't just be focused on where liaison fits into acute care configurations.

Response four: - Kings - Locally we have set up a Crisis Assessment Unit jointly with our neighbouring liaison team. It is off site, on the mental health trust site. We have never been pulled out of the acute trust, but there is an expectation that we will manage the CAU as well as run a liaison service. Last week, we diverted 22% (20/90) of our MH presentations in ED.

In my view, it has created barriers to care for mental health patients. Patients are screened in ED, and then transferred if appropriate, meaning they need to repeat their story a number of times, and there is delay before they are fully assessed. The issue of "medical clearance" has reared its head again, and I worry that patients are being prematurely or superficially "cleared" before transfer. The feeling that mental health problems are not welcome in ED is creeping back in, and I think reflects further stigmatising of mental illness. Disagreements about how much agitation can be managed by the unit are now not infrequent and create friction. All of these are backwards steps.

Alongside my concerns about patient experience and quality/safety of care, there has been significant impact on staff. We are now trying to staff this unit, as well as maintain adequate staffing levels to see the (now quickly increasing) number of patients who need to remain in ED and who are referred from the wards. The staff resource required to staff the unit safely is disproportionate to the number of patients who are seen there, and *I think seems like a very costly way of assessing a relatively small number of people.*

I can see that for low risk patients with no acute physical health problems, or for those who are well known to CMHTs and are showing signs of relapse, there should be a better crisis option than ED, and perhaps this unit has provided this. However I am not convinced that this is what liaison psychiatry is about, which is surely about seeing mental and physical health as one, and providing more than just a mental health crisis assessment.

Response five: Exeter - Has anyone got any data on the numbers and diversion from ED to your new "Mental Health Hubs? We are doing another review- the first one in May was somewhat skewed by the overall drop in referrals from ED and so things were easier to manage. Since then we have had a number of incidents around the issue of patients staying longer than intended in a non-ward environment (longest 50 + hours with only recliner chair or mattress on a

floor) occasional need for restraint, fridge/food issues, im and oral medication issues etc.

Many things you'd expect when we develop an alternative super quick in a non-designed environment with liaison staff who have not worked on wards for a while and we work the training and issues out in real time.

I won't put all of our data on here- we have three sites and 3 DGH's in this trust- and it's become slightly complicated by the change in counting needed for those being diverted from ED and those now being brought directly to the Hub who have been bought by police or ambulance. The Trust has also set up a 24/7 helpline and telephone triage that these services and the general public can call. There are over 200 calls a day and if there is an acute need for F2F the patient is sent to the Hub where only liaison staff are 24/7.

Re data: We usually have around 400 referrals a month for Exeter liaison pre covid, split between inpatient wards and ED roughly 50:50.

Referral data: May in Hub

Number of ED referrals in May - 170

Number of patients assessed in the hub - 143

Number of patients assessed in ED -27

Percentage of ED referrals assessed in the hub – 84%

Generally, any re-deployment to help with running the hubs is being dismantled leaving the liaison staff to respond to all acute assessments- both from the DGH and bought separately to the Hubs for mental health acute work (no medical issues). Is that happening for anyone else?

It would be good to get a picture from outside Devon to discuss with our commissioners as we conduct this second review.

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