JISC update May - July 2020

Webinars

We have been indebted to Dr Alex Thomson for setting up a series of webinars during the COVID crisis. Hundreds of interested participants have registered weekly. Seminars have been national and international; I loved the New York Liaison perspective. The presentations have been of an extraordinarily high standard, and very interactive. Long may they continue - even when COVID departs this planet.

Rapid Tranquilisation policy

A Trust is updating its rapid tranquilisation policy based on BAP/NAPICU guidance, but they recognise that they find themselves needing to act very differently in an acute setting for many reasons; and so ask 'Does anyone have an RT/restraint policy for liaison or acute settings they could share please?'

Guidelines were shared, and the use of intramuscular olanzapine and aripiprazole discussed. A clinician uses aripiprazole where there may be concerns about prolonged QTc; and to good effect.

One service conducted an audit last year on use of RT for older people on their wards and without exception all were given IM medication in the context of a hyperactive delirium. This clinician emphasised the need for acute trust staff to refer to their Delirium policy. A recommendation for paediatric violence and aggression was shared:

PIER Rapid Tranquillisation - Management of Violent and Aggressive Patientsv4

More on this subject of Rapid Tranquilisation

A south coastal Liaison service describe a recent change in their ED rapid tranquilisation protocol – and ask whether other services have come across the use of midazolam i.v. as first line; rather than using i.m. lorazepam +- olanzapine/ haloperidol. Also, the use of Ketamine i.m. when it is not possible to establish iv access. The ED staff reason that this will speed up tranquilisation effect; and they have the ability to support airways/compromised patients if they need to. The ED wants to reduce the time that security staff spend restraining patients. Are other ED's proposing anything similar?

Response one: north London – is familiar with use of Ketamine in the ED for agitated delirium. It works quite quickly and reasonably well. However there is often later use of benzodiazepines - to smooth out the recovery – and so patients can end up being sedated for quite a long time; and are not assessable for a longer period potentially.

Response two: This clinician has had experience with some patients requiring 6-8 mg of Lorazepam I.M. and still remaining highly agitated – and wonders 'would this be a good alternative in severe agitation?'

Response three: In Wales, this ED has used IV Midazolam and IM Ketamine for excited Delirium type presentations. Benzodiazepines were also being used in addition. 'From my recollection this was in line with the RCEM summary of recommendations.'

Response four: This service has used Midazolam IV a couple of times for severely agitated patients; especially when tubes/lines etc are being pulled out. 'Ketamine is very rarely used due to side effects especially hallucinations.'

Response five: This clinician advises we look to RCEM guidance for doses.

Responses six and seven: These clinicians have concerns that this may be suboptimal good practice, citing NICE & BAP/NAPICU guidance. They have a joint mental health & acute Trust forum for quality & safety which can look at these kinds of issues & allows high level support to push back potential retrograde practice.

Response eight: A clinician from Sydney has recently looked into this as part of a working group. 'ED physicians and intensivists like it (ketamine) in their settings for good and compelling reasons but the consensus among psychiatrists is still that it shouldn't be a first line agent in mental health units or other liaison environments for our own equally good and compelling reasons'.

Response nine: ED consultants are familiar with using Ketamine (and also familiar with the airway compromise associated with benzo's). 'We also seem to be having a sharp increase in severely agitated patients –often secondary to dual pathology –including substance misuse.'

Because of social distancing secondary to COVID-19 ED's in the UK can now not tolerate crowding so managing complex situations in a more timely way is more critical

PPE, hearing problems and lip reading

A clinician was just wondering if anyone had managed to solve the problem of PPE masks that are suitable for teams who have deaf colleagues and patients who lip read?

A respondent has been advised that clear face masks are available from the 'national push delivery processes. Concerns though they may steam up.

Alternatives to im lorazepam

There is a shortage of injectable Lorazepam in this clinician's local area and asks this group 'do you have a problem with supplies and if so, do you have guidance for your local area about alternatives (e.g. Midazolam & dosage) for patients who will not tolerate antipsychotics or when antipsychotics are contra-indicated?

We already have a rapid tranquillisation (RT) policy.'

Response one: Promethazine tends to be the favoured drug when stocks of lorazepam are low.

Response two: Would be concerned about using Promethazine due to the anticholinergic burden – wondering if other consultants feel the same?

Response three: Who have a shortage in North Devon too, 'not sure about the wider southwest region. On discussion with pharmacy and paediatrics they are looking into midazolam if it does run out but it hasn't quite got to that yet. We would usually use promethazine as an alternative. There always seems to be a

shortage of injectable lorazepam but don't think we have ever actually run out (I vaguely remember midazolam being used as a temporary alternative a few years ago years ago)'.

Response four: For antipsychotics, they tend to use aripiprazole. Haloperidol has effectively been removed from the Grampian policy about 18 months ago as part of the "EU harmonisation process" although it is still regularly used in the acute sector. Here is a web link to the policy if interested: https://foi.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/Guide_NHSGRapTranq.pdf'

Response five: Shortly after starting our new service in Somerset, it quickly became apparent that there were some variable approaches to RT, so this clinician drafted some guidelines very much as others have done, including alternatives to im lorazepam.

Response six: this clinician shares any concern about antipsychotic use and recently had a patient develop NMS after im olanzapine and im promethazine (both can cause it).

Nurse skills training question

We are looking to develop an induction programme which includes development of specialist skills/competencies for Mental Health Liaison Nurses over say a 6-month period. To do this we need to establish what the standards should be. Has anyone else out there done anything similar or have a skills/competency list they can share please?

Response one:

https://pdfs.semanticscholar.org/6f8b/d3cd76b3fb713709f8be819b81ce056f205a.pdf

This was produced some time ago in London.

Response two: Please feel free to continue to use the 2014 liaison competencies in ways that suit your individual teams. A number of Trusts have developed programmes of education for band 5 upwards based upon them and they are also used for PDP's & appraisal. We are always interested to hear how people are using them. It is not uncommon to use them across disciplines as well. The 3rd edit is currently in development.

Psychology in Liaison

'I am new to this forum, and to Psych Liaison. The team have not had psychology input before and so I'm in the process of developing the role. It would be great to link up with other psychologists or psychological therapists who are working in PL and so wondering if anyone knows of a Psychology-in-Psych-Liaison network or forum I could join?'

Response one: Welcome to Liaison! Yes there is a LP psychologist's network; I'll pass your contact details on to the coordinator.

Response two: We have two different models of integrated psychology into liaison

- health psychology (commissioned in different services in the hospital) and overlapping/integrated work and
- clinical psychology within the liaison psychiatry service.

I am happy to share and put you in contact with our psychology lead.

Response three: We have exactly this set up as well in Devon across three DGH's. Having inherited traditional acute service led commissioning of health psychology into separate services - in a rather piecemeal way that leaves some pathways better resourced than others- depending on the physician's awareness or enthusiasm for psychological input and finding resources.

As for many issues in liaison, esp. where we are MH trusts working into acute, the creation of a mental health focussed steering group or similar in the acute trust and clearly linked to their governance is really useful to raise issues and drive liaison strategy. 'It took me a fair while to realise the real need for it until it was 'lost' in a re-structuring a few years back and I had to put effort in to get a forum back to get our voice heard formally. This helped to agree a 'jointly funded' 50:50 liaison psychology post between the MH and acute trust last year.'

Response four: We are in the same "negotiations". These are not easy but not impossible when people want to work together. The COVID, if anything in my experience, has brought the idea of integration/collaborative work more to the front but it takes time. Having a conversation with the Oxford team may help. Here, we have been working from two fronts (health psychology to and from LP and LP having psychology) to reduce the gap until we can all be fully integrated. It is a work in progress. The other way of closing the gap is by also asking support from the Mental Health Board in the acute trust and looking strategically how to fund integrated services from the start.

Response five: Regarding our experience Oxford University Hospitals, It certainly makes it easier to all be under one acute trust. Especially when the Trust directors insist that psychiatry and psychology are combined in a single directorate with a common leadership – then people mostly just get on with it. However it is of course also necessary to win hearts and minds. We worked at this by

Calling it something acceptable to and inclusive of all – in our case psychological medicine

Having a common mission that levels up to integrated working not down

Emphasizing that psychologists and psychiatrists have overlapping but different skills – both are valuable

Having psychiatrists and psychologists work side by side - e.g. in our trauma centre

Making sure that all team successes are shared and all contributions are valued.

Have folks spend time with each other socially

Re-feeding and restraint

In liaison psychiatry, we are quite used to having patients with Eating disorders who are admitted for refeeding with NG; most go uneventfully.

This service describes the difficulties with a young patient with AN, under section admitted for NG feeding who is resisting this. A degree of restraint both chemical and physical was used with worry about the tube not remaining in situ. ICU had been concerned to admit for any prolonged deeper sedation/anaesthesia. Suggestions/shared experiences on how to proceed with alternative care planning on a medical ward were invited.

Response one: Describes a similar situation. The NG tube was reinserted with IV Lorazepam frequently leading to benzodiazepine tolerance. Anaesthetists used Propofol in theatre to reinsert the tube.

When the tube was in, the things that worked were:

- 2:1 nursing to allow careful restraint
- Siting the tube upwards as it comes out of the nose and securing it over the hair, so that it was more difficult to pull on it
- Regular Haloperidol & Promethazine

This allowed for enough calories in and for BMI to improve. Once this happened the patient asked for fortisips; and it was possible to reduce both chemical and physical restraints.

Response two: Acknowledges that this is a highly controversial topic. Some will argue that in the absence of delirium or nutritional dementia, such patients should be considered to have sufficient capacity to refuse treatment. If they will not accept refeeding, they should be discharged. Just as one would discharge a patient who was not cognitively impaired or psychotic who refused surgery or other potentially life-saving treatment. That an intervention is life-saving in and of itself does not trump a competent patient's right to refuse treatment (at least in the US). Others of course will argue that such a patient clearly lacks capacity on grounds of a fundamentally irrational thought process. We do not permit patients to refuse the needed medical or surgical treatment needed in order to recover from a suicide attempt, no matter how "rationally" they refuse. 'In different cases at different stages of my career I have argued both positions. I have now reached a utilitarian position. If this is the first time this patient has reached life threatening malnutrition, I would proceed with refeeding. But if this patient has been through several intensive ED programs including residential, and still is engaging in the behavior, then I would argue little will be achieved except a very temporary reprieve.'

Response three: Has noticed that it is often the liaison doctors who manage this group of patients. 'I think making decisions involving full MDT including medics/liaison/eating disorders consultant & ensuring there is adequate advocacy e.g. IMHA, considering advance wishes in any form, and seeking legal advice/Court of Protection help if it's controversial or considering withdrawing life sustaining treatment.'

Response four: Would 'be very interested to know whether the patient had decision making capacity with respect to the refusal of the NG tube. If they did, I would take the view that they therefore could refuse the intervention. Almost

always - in fact all of the cases that I can remember where the patient had not had AN long - it is possible to negotiate a way through the crisis so that eventually the patient and we, the treating team, can come to some agreement as to how to go forward in a way that will provide nourishment. Very rarely in a person with long standing AN this means that the patient goes home without such an agreement. Of course, from time to time, patients in this position have lost decision-making capacity on the basis of either a delirium or a clear inability, due to their AN to understand the relevant information or to use and weigh information to come to a decision. Often this inability to understand manifests as something like - "I am not thin", when they clearly are extremely thin and inability to weigh manifests in circularity of thinking.

Some clinicians sometimes argue that such a refusal would be "fundamentally irrational" and therefore incompetent, but whether a decision can be regarded as "rational" is not determinative of capacity under UK law (or Australian) common law.

Also, this time echoing the UK, I would not discharge this patient on the basis of her competent refusal (if it came to that) without asking the opinion of the Court. There have been a number of, in my view, poor decisions in this area - see especially Re E (Medical Treatment: Anorexia) [2012] EWHC 1639 (COP) (we wrote this up in the two-page comment - Ryan CJ and Callaghan S. (2014) Treatment refusal in anorexia nervosa: the hardest of cases. Journal of Bioethical Inquiry 11: 43-45.).

Response five: USA - It would be good to speak to one of the eating disorder specialists. I know units like the Bethlem used to do force feeding without ICU.

Response six: Speaking as an eating disorders specialist in Scotland, we have always managed to do NG feeding, whether voluntary or under the MHA, on our Specialist ED Unit within a psychiatric hospital. Only when there are serious medical complications would we use a GI ward or HDU/ITU - for instance if there was an oesophageal tear where TPN might be needed or a serious co-morbidity such as liver failure.

In terms of using the MHA for patients with EDs, I wrote a CPD online module for the Royal College of Psychiatrists on precisely this topic. There are excellent guidelines to the Act in Scotland which discuss issues such as the nature of capacity in patients with severe Anorexia Nervosa - all available on the Mental Welfare Commission's webpage

https://www.mwcscot.org.uk/sites/default/files/2019-06/sidma.pdf

In Scotland some details of enactment of feeding are slightly different, and we use the term 'significantly impaired decision making' to describe the area of lack of capacity which is impaired in the presence of severe AN, albeit within otherwise intact global capacity. However, the principles are otherwise the same.

I would also draw your attention to the MARSIPAN guidelines of the Royal Colleges, which emphasise responsibility to save life and use the Act when necessary, and the benefits of having a partnership with a medical ward if the SEDU is full or unable to manage the medical complexity.

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr189.pdf?sfvrsn=6c2e7ada_2

It is absolutely crucial to provide one-to-one nursing care informed by a solid care plan that recognises (without 'blame') that the patient will have to engage in treatment-interfering behaviour because of the illness. In Aberdeen we have agreed protocols for medical and nursing colleagues and an information sheet for patients and their families.

Response seven: Also cites the case of Re E (Medical treatment: Anorexia) (Rev 1) [2012] EWCOP 1639 (15 June 2012). This concerned a woman with severe anorexia nervosa for whom a decision had been made to provide palliative care only, in line with her wishes. Mr Justice Peter Jackson in the Court of Protection overrode this, concluding that E lacked capacity, and that although she did not want to eat or be fed, providing life-sustaining treatment was in her best interests.

In terms of clinical care, it is important to consider the importance of trauma and traumatic/anxiety responses. There are two factors at play here. Firstly, however sensitively administered, physical restraint and forcible insertion of a nasogastric tube is terrifying and horrible. Where people have had this done to them in eating disorder units, even when carefully managed, they may develop post-traumatic symptoms, and may manifest a fight-or-flight response with severe anxiety and reflex physical resistance to further attempts. Secondly, people with eating disorders may have survived sexual violence.

In an emergency warranting life-saving intervention, trauma-related considerations are not a contraindication to intervening, but must be considered and handled appropriately. Despite the concerns of anaesthetists regarding sedation, feeding and airway management, if one were to put oneself in the shoes of a person who needed to be restrained and NG fed, sedation and reduced awareness may be less unpleasant than repeated restraint and physical measures in clear consciousness. The challenges in an acute hospital setting include identifying staff to appropriately restrain, and maintaining a level of sedation through repeated tranquillisation.

While this scenario may come up infrequently in any given hospital, it is worth maintaining relationships between intensive care, gastroenterology, dietetics, eating disorders and acute psychiatry wards in order to be able to move promptly when necessary. This is something we have found difficult locally – not so much for the goodwill, rather for the coordination and timing. In the past we have had to generate a significant amount of goodwill in order to persuade appropriately trained nurses from our co-located mental health unit to assist with initial restraint and sedation.

Response eight: Although the person is under the Mental Health Act this 'says nothing about her decision-making capacity, and doing a thorough assessment of this is an essential first step'.

If you decide that she lacks capacity, then this could be due to a longstanding effect of her anorexia, or an organic disturbance caused by her current physical state, or both. However, it is essential to be explicit about how the 'disturbance of the brain or mind' is causing the impairments in capacity.

I would suggest that the next step is to discuss the case with the Trust's Legal Department. Trust lawyers may recommend involving the Court of Protection. If this happens, the Official Solicitor will most likely become involved to represent the patient's interests, and the Official Solicitor commonly arranges an independent assessment of capacity and best interests. The Court of Protection can if necessary act rapidly.

Response nine: this north London consultant recalls a lecture at the conference last year where the speaker said "don't confuse articulateness for capacity" – which seems apt in this patient group.

Response 10: This clinician directs us to a specialist with wide expertise on capacity and ethics in anorexia nervosa.

Response 11: Anorexia nervosa is in effect a disorder of values which obliges the patient to fear weight gain more than they fear death, even though they certainly do fear death greatly.

Response 12: A colleague in Sydney makes this point - that a simple appeal to a AN being a disorder of values will not do the ethical or legal work to justify over-riding an adult's refusal to comply with what is widely deemed necessary treatment. (This is not to say that from time to time that people with AN cannot be justifiably restrained and have an NG tube inserted, it is just to say that a simple appeal to distorted values won't, on its own, provide that justification). Once psychiatry (and psychiatrists) get into a situation where we are claiming that some people's values (especially, in some cases, people's long held values) are pathological, then this is risky territory.

'To my mind, ensuring the rights and freedoms of people with anorexia nervosa as we try to offer them and their loved one's assistance, is one of the knottiest problems in psychiatry.'

Response 13: This clinician thinks there is a good test for capacity in AN – to test for ability to eat and gain weight.

'I have been suggested in my training to use 'a plate of food' to test this, meaning making an agreement with the patient to eat regularly and gain some weight on their own as it is usually default position of someone with anorexia'. If death or serious complications are less shameful than to eat and gain weight – then this clinician would argue that there is a mental disorder of sufficient nature and degree.

Response 14: In Scotland every Compulsory treatment order requires 2 independent psychiatric reports, a Mental Health Officer, and a Tribunal Hearing. The patient has state-funded legal representation and also advocacy as well as later rights to reviews and appeals. This is valuable in allowing individual debate each time and very strict monitoring of any deprivation of liberty. 'I really value this'. There are indeed times when the illness-driven values have become so intrinsic to the patient's personality that it feels futile and cruel to try to act against them. 'Probably the biggest dilemmas of my career have been around when it is right to treat assertively and hopefully'; and when such assertion/aggression seems not a compassionate stance.

Response 15: from Sydney thinks that Scotland's "significantly impaired" test is fascinating. 'Scotland was way out ahead of the pack on capacity-based mental health legislation, from memory only beaten in the common law world by Tasmania. The rights and protections afforded by the Scottish MHA are world class. However, I suspect the "significantly impaired" aspect of the capacity test will be seen as no longer up to the mark in the upcoming review and is likely to reformed so to better align with the standard common law test'.

COVID positive antibodies in Liaison

Bath – This clinician is curious to know what the rate of antibody positive tests is in other liaison teams. 'Although we are in a low COVID area we have held f2f contacts throughout and of the 14/16 clinicians in my team (tested to date) 5 are antibody positive. 3 had had non-specific symptoms necessitating a few days off work'.

Response one: In north East Lincs we have 10 staff – one tested positive after routine testing and another after symptoms – they are the only ones who also tested positive for antibody's – we also continued F2F throughout.

Response two: London – have had one member of staff who tested positive on swab after severe symptoms but all antibody tested negative so far; with many being tested. They have had high F2F contact, high rates of COVID positive patients, but good access to PPE. 'Given that people in ITU (staff) not falling prey, I think it is not about exposure but about PPE'.

Response three: In Kingston, four positive antibody tests in a team of 20, 'although I do not know how many of us requested tests.' At least three staff were ill very early on and probably became infected before or around the time PPE was introduced.

Response four: Scotland were not being antibody tested yet. 'We have continued f2f. We have fluid resistant surgical masks, scrubs, gloves. There has been a continuous good supply of this level of PPE. We have successfully resisted the suggestion that we along with other staff who don't touch patients don't need to use gloves. The PPE problem is availability of FFP3 masks. The current model doesn't fit anyone in the team and there is no plan to offer an alternative. I have explained in writing that this means that they cannot have a liaison psychiatry service going into red zones.'

Response five: In a south coast liaison service doing F2F assessments throughout, there were 3/10 COVID antibody positive results.

Remote consultations

Derbyshire - Can you please let me know about different platforms that you use for remote consultations and what has been your experience with those platforms?

Response one: Somerset have been using Attend Anywhere.

'It's a secure web-based platform (so no software downloads) and really simple to use'

The only slightly challenging thing is communicating the process for patients to sign in for their appointment in outpatients. For remote ward reviews it worked really well using a trust iPad.

Dr Jackie Gordon
Worthing Mental Health Liaison Team