JISC update October – November 2016

Neuropsychiatric case

This is a young woman with no past psychiatric history. She experienced rapid onset visual hallucinations and bizarre behaviour after being with friends on holiday. She was reported to have had some alcohol but no drugs shortly before onset. There was one episode of visual hallucinations a few weeks before which resolved within 24hrs.

Over the next few days she became mute unresponsive and developed increased tone.

She developed bilateral PEs (potentially explicable by dehydration and a plane flight). Benign ovarian teratoma discovered and removed.

3 months down the line, she has had neuro investigations all normal; MRI, paraneoplastic antibodies, NMDAR, VGI1, CASPR, multiple LPs, trial of steroids immunoglobulins and I'm pretty sure plasma exchange, also all the usual HIV, syphilis, autoimmune screen. The auto antibodies have been repeated 3 times during the course of the illness. No drug testing at onset. Multiple EEGs including 1hr EEG normal - not encephalopathy and no evidence of seizure activity. No witnessed seizures. Not jerky. She has a sleep wake cycle and has resumed eating and drinking. Prior to that she had NG feeding and parenteral vitamins.

She was referred to Liaison Psychiatry 2 weeks ago. At that stage she had primitive reflexes. Bilateral increased tone. Some waxy flexibility of upper limbs. No posturing. She was eye tracking but not responsive to command or voice. No facial evidence of emotion.

She has been put on a low dose of lorazepam 1mg bd. Family say there has been improvement. Tone a little reduced and they think she is watching TV. Neuro team say there is volitional looking away when they talk to her and that she seems to be following conversations. Primitive reflexes have gone. Waxy flexibility less convincing. She still has increased tone with cog wheeling at ankles.

SPECT NAD, TFTs normal, No mannerisms, primitive reflexes weren't just grasp, CK always normal.

My thoughts are to treat as catatonia of unknown cause including going as far as ECT.

I'm beginning to wonder if she does have a psychotic state induced by novel psychoactive substances - we have seen prolonged psychosis/delirium.

Canada: How about ECT? Here is a more recent narrative review

Leeds: Would start with iv benzodiazepines – results can be dramatic in catatonia. If it works, try increasing oral; if it saves all the effort of ECT in somebody who can't consent then it's worth a trial.

Oz: Would also begin with iv benzodiazepines, hoping they'd work; but would consider ECT sooner rather than later.

North London: Seem to get a lot of catatonia and it's always got better with oral Lorazepam albeit sometimes quite high doses (20mg a day). However they recently had two cases that did not respond and needed ECT. 'They both recovered well after about 5-6 sessions. I couldn't find anything to guide us on how long to continue ECT so we stopped after the majority of the symptoms had gone. Likewise Lorazepam - nothing much on whether to continue during ECT treatment, or stop. We did omit the dose before ECT. We weaned it off slowly after they got better. I avoid antipsychotics if at all possible.'

Leeds: See reference - an approach I have followed = iv challenge followed by oral, with iv response a predictor of good oral response. Their doses are quite small. 'I used to trickle iv lorazepam (which might be up to 5mg over time) keeping an eye on incipient drowsiness and keep them in that state for 10-15 minutes before concluding it didn't work, and give oral doses up to what they could tolerate which was sometimes quite high. They stopped after 5 days lorazepam and after as many ECT as worked with no maintenance. I found if it went away it stayed away but my experience like theirs was of short-duration episodes.

How to best achieve CQUIN goal for frequent attenders?

Bristol: Have put in a business case via this CQUIN for a full time dual trained nurse and some *Consultant time* to support our steering group for repeat attenders (high impact users) but this is not MH specific, it's for anyone using ED a lot. We have a monthly HIU meeting with all interested parties and create ED care plans (or Personal Support Plans we call them so it's not confused with their CPA care plan) which are on the electronic alerts when they come in to ED. The idea is this nurse would also go to GP surgeries and firm up PSP's to reduce repeat attendance. I know other hospitals have a specialist nurse as well,

St Helier: A similar query was recently circulated via the PLAN* email network and the two responses are attached. The most recent project in my trust is a monthly Frequent Attenders MDT, instigated by the

commissioners and chaired by a senior member of acute nursing staff, and attended by representatives from liaison psychiatry, ED and ambulance, to discuss frequent attenders and ambulance callers. We have local agreements share information and draw up brief care plans, which include basic epidemiological data, professionals involved in the patient's care and recommendations for future attendances. This will be available to ED staff if patients re-attend. This project has more chance than most I have been involved in as it has senior acute trust buy-in.

***PLAN**

1. From an Assistant Psychologist employed full time as the coordinator of a Frequent Attenders project in Royal London Hospital. 'The Frequent Attenders project is a review body; as part of our work, we hold a fortnightly multi-disciplinary team meetings during which we discuss up to 10 Frequent Attenders at any one time. From this, there will be actions arising (e.g. referrals to other agencies, devising care plans, requesting medical reviews, liaising with other teams involved etc.). For many of the Frequent Attenders, we also devise a care plan that supports the management of patients in A&E. The meetings are attended by representatives from A&E staff, the Admissions Avoidance Team, the Drug and Alcohol Team, London Ambulance Service, community homeless charities, and several others. We analyse data on a monthly basis and, so far, there have been consistent and notable reductions in A&E attendances, with associated financial savings

As Frequent Attendance presents a challenge across London, and considering that some of our patients also frequently attend at other hospitals, we hope that in future we will manage to establish lines of communication between hospitals across the city so that we can work together to better support these patients, as well as A&E staff.'

2. We have a developed strategy for looking at how best to help patients who make High Impact Use of Emergency Services.

There is much published in regard to this in the alcohol liaison literature.

There is no simple easy fix; each patient will have unique needs that require holistic assessment and effective multiagency care planning.

There are routine things to do with all patients – are they a High Impact user? If so what is the driver / drivers of this? How can their needs be best met?

For the most prolific attenders we also operate a multiagency working group that looks at the overall picture and devises care plans for ED and involved community services.

We then escalate this to person specific meetings with the patients GP and appropriate other agencies when required.

Overall we get good results but this could be enhanced further.

From Cambridge: They had a frequent attenders team for a while a few years ago which worked with patients outsider the acute hospital. 'To my mind it was great but died eventually due to restrictions about getting data and being able to evaluate the service.'

This paper is recommended reading

MCA v MHA

This colleague is representing the RCPsych Liaison Psychiatry Faculty on a working group with the Law Commission, which is discussing potential changes to capacity legislation. On behalf of the group we would be interested to hear of cases where there has been uncertainty or debate about the choice of using either the Mental Capacity Act or Mental Health Act with a specific patient who lacks capacity and is judged to be deprived of their liberty.

Even within the working group it is apparent amongst the psychiatrists that we have experiences of different interpretations of the law.

'Please keep any examples brief if possible. Ideally these should be from the period following the 2014 Cheshire West ruling that lays out the 'acid test' of deprivation of liberty'

Clozapine errors

In an acute hospital the highest frequency and highest impact mental health related errors relate to the prescribing (or not) of clozapine. So far this year several patients have needed re-titration after clozapine has been omitted. The causes have varied from clinical staff failing to recognise the significance of this medicine, to patients forgetting to mention that they are taking it plus evading medicines reconciliation.

Has anyone else faced this issue and successfully addressed it?

Response 1: As part of our Systems Resilience funding a couple of years ago, we had a Liaison Pharmacist in the team for almost a year. The pharmacist had a foot in pharmacy in the acute trust and really raised awareness of psychotropic prescribing, with clozapine in particular. I think what was particularly good about having a pharmacist is that our RMN nursing staff, although very experienced; feel least confident when giving medication advice. So the pharmacist could support the nurses without the nurses having to find a doctor to ask. But our experience since then has been that having a Pharmacist on the team payroll is seen as an unaffordable luxury, when commissioners can't even meet Core 24 for doctors and nurses.

Response two: This well-known Midlands service worked closely with a pharmacist - a senior acute trust pharmacist with an interest in mental health so we didn't pay for her. We managed to persuade the acute trust pharmacy to ring-fence some of her time to take a lead on mental health, and flagged up various problem areas by doing audits e.g. antipsychotics in dementia, clozapine, lithium and cholinesterase inhibitors where patients were being put at risk by not being flagged up to liaison psychiatry or having their medication omitted. She partly tied it in with her academic work so was another reason the acute trust was more inclined to agree. It worked better for us to package the various issues together and then get acute trust buy in rather than focus on a single drug e.g. clozapine. She attended our weekly MDT, and was able to make referrals directly to us or would encourage the medical teams to refer. We got her an honorary contract so she could access mental health trust electronic notes which meant she could deal with minor psychotropic medication issues directly with pharmacy and ward staff and flag up urgent issues e.g. clozapine cessation and lithium toxicity to us immediately, often before the patient had been referred to us by clinicians.

'Our team felt supported and the acute trust loved it and ended up giving her an innovation award!'

CAMHS liaison

From Salford: 'I was wondering if anyone has a liaison team that provides CAMHs liaison services to A&E and PAU?'

Response One: In North London there is an OOH CAMHS crisis service which covers four acute hospitals and is not based at any of them. They do the best they can. His observations:

1. Commissioners need to be clear whether they are commissioning a liaison psychiatry service (dealing with physical/mental health interface, based on site) or a crisis service (dealing with overdoses, suicidal ideation only) and deciding to route OOH CAMHS emergencies via the hospital emergency dept.

2. An "in reach" service has all the problems of "in reach" services in adult psychiatry, i.e. no shared ownership of patients/governance arrangements, coming in to do "assessments" then leaving the patient where they are etc.

3. Although this may provide a prompt response, it won't remove the need to admit young people to paediatrics following self-harm. This is necessary for a number of reasons, including the need to review following "cooling off" and the need to assemble all necessary people including social services, parents/carers etc.

4. It also won't do anything about the long waits for inpatient CAMHS beds when necessary. In my experience even when a decision to admit is made at 1am, no inpatient CAMHS unit is even going to disclose whether or not they have a bed until after 9.30am.

I understand that there is an established multidisciplinary CAMHS liaison service at the Royal London Hospital, which will do such things as offer counselling to the parents of injured or chronically sick children, as well as providing both psychiatric and psychological interventions for the children themselves. There is also a dept at King's College Hospital in the same vein. These things take time to establish themselves – worth being clear about which needs are able to be met; and which are not; and keeping an eye on future needs.

Response two: Portsmouth paediatric liaison experience: This service will no longer exist as a team in 2017. The trust responsible for the nursing sessions withdrew 2 of the 3 sessions per week. This left the service as 2 medical sessions and 1 session of nursing staff; and it became no longer viable to offer the outpatient work and inpatient caseload that had been managed. The service was not formally commissioned nor the nursing time paid for, which left it too vulnerable. The only mental health practitioner in paediatrics from 2017 is a psychologist paid for from Best Practice tariff monies. Instead, there is expected to be an agreement that paediatric referrals will be accepted for an initial options appointment and the CAMHS duty system and community eating disorder clinicians will support the 2 wards.

Response three: From a senior trainee asks where the CAMHS Transformation money is within the Liaison Setting. Like the Portsmouth example, they see liaison staff being removed to pick up the burden of increased demand in the community. On a positive note, in his local training scheme (Tavistock and Portman), Paediatric Liaison is well recognised and seems pretty stable. The 3 general hospitals they cover (UCLH, Royal Free, Whittington) all have liaison teams which are embedded into the fabric of the paediatric set-up. He hopes that paediatric liaison psychiatry will follow a similar trajectory to adult liaison psychiatry.

More on CAMHS services – (which then expands into a service model and competencies discussion)

From south London and RCPsych: 'I recently represented the Royal College of Psychiatrists' Faculty of Liaison Psychiatry at a meeting with colleagues from the CAMHS Faculty who are looking to develop CAMHS liaison psychiatry services. We discussed the aim of ensuring that there is specialist CAMHS liaison provision for every general hospital. However, we recognised that we are long way from this in the UK and that initial assessments of children and young people may be undertaken by staff whose primary training and expertise is not in this area. I am writing to ask if any of you are aware of existing competences or training for non-CAMHS staff who are assessing children and adolescents in the general hospital setting, especially the Emergency Department.'

Response from the North East: There is a section within the Liaison Nurse Competency Framework (written by Eales et al, page 29), though it is probably insufficient and it is where her team feel they have a lack of skills. It's something she thinks needs developing.

A South West team: is expected to see 16 & 17 year olds with self-harm which amounts to about 75 referrals per year for a small DGH. Having complained about the lack of training and expertise for nurses, their local CAMHS have agreed to provide training sessions to access services staff. Also one of the PLAN requirements is that staff who deal with younger people have access to appropriate training, so that is a lever.

At another service: all young people who are in school year 11 or below are automatically admitted to a paediatric bed overnight. This enables assessment by a CAMHS professional on the next working day. The assessment by non-CAMHS staff is therefore the basics of the event and no more. This practice is in-keeping with NICE and Royal college guidance 'although I'm very aware of an increasing desire and pressure to change this'.

From Leeds: A subset of this question you might want to pursue – what competencies/training do people have in self-harm assessment? NICE guidelines say all children + adolescents should be admitted for assessment but national experience suggests that isn't happening (although still much commoner than for adults) which means they are being sent home, sometimes with a community CAMHS referral.

A reframe from North London: 'Perhaps a helpful way of framing this is 'the challenge of needing both specialist expertise and 24/7 cover in an acute hospital, common to other areas of practice. Rather than "Liaison Psychiatry" I'm thinking more and more along the lines of "Mental Health in Acute Hospitals". An acute hospital needs specialist expertise in:

- Adult liaison psychiatry
- Old age liaison psychiatry
- Perinatal psychiatry
- Addiction psychiatry
- Child and adolescent liaison psychiatry

It also needs 24/7 cover for all of these areas, but doesn't need five separate teams on duty 24/7 – nobody would fund them, and we couldn't staff them anyway. Therefore rather than having in-hours specialist teams and everything defaulting to whoever's on duty OOH, it would make more sense to have an integrated model where lines of responsibility, clinical standards and handover between shifts is clear. If this is being developed for the various adult and old age specialties, then I would argue that children and adolescents should be considered in an integrated 24/7 model: to my mind the benefits of being on site as an integrated hospital dept far outweigh the disadvantages of having specialist "in reach" staff roaming over several hospitals with no local relationship.

Is anyone else thinking along similar lines and has anyone actually developed a workable model for this?'

Leeds though thinks that "specialist expertise vs. 24/7 cover" isn't quite the right way to formulate this – 'it conflates two dilemmas:

Acute/emergency needs vs. planned care – you can't easily cover ED if you're in a clinic seeing people with medically unexplained syndromes. I don't like the style of managing this dilemma by having different services Psychological Medicine vs Acute Liaison. They need to be in the same department so the whole service can balance priorities properly (e.g. availability of consultant cover) and to avoid drift whereby (for example) the non-acute service has lower thresholds for involvement than the acute service, generating inefficiency and inequity of access. Office hours vs. 24/7 cover – the issue here isn't whether the hospital needs 24/7 cover, of course it does. The question is *who needs to provide it to ensure quality of care is the same all the time*. This is as you say the weekend-effect debate for our own specialty. The implicit argument behind Core24 seems to be that the answer is – enough nurses to provide one liaison nurse 24/7, especially linked to ED, and OOH cover from community MH services and you have the right service or at least an "adequate" one. I'm struck by how unspecified it is what is done by whom, for example in relation to age-related problems, response to emergencies and so on. My impression is that nobody is there with a fully integrated service of this sort although I suspect there are plenty of places who have that aspiration (including Leeds).'

A response: on the "emergency cover vs planned care approach": 'we 'new wave' liaison psychiatry depts. are almost all about emergency & inpatient cover – we don't necessarily have any clinics because we've been brought in primarily to keep things moving throughout the acute medical/surgical care system.'

LOVE the observation about "CMHT cover". I hadn't seen it that way before. On that note we have adapted the clinician-rated component of the FROM-LP to measure just how much CMHT cover we provide. In addition to the IRAC & CGI-I we've added three yes/no questions:

1. Did this episode involve alcohol or drug use?

- This gives us a rough-and-ready measure of how much "dual diagnosis" work we're doing which isn't specifically commissioned by Public Health and wouldn't be detected by relying on ICD coding alone

2. Did this patient receive any medical (i.e. non-mental health) treatment?

3. Did this patient receive investigations or medical monitoring for self-harm?

- These two questions provide a quick way of estimating which people seen in the ED actually have emergency medical needs. Asking about medical attention isn't helpful because it wouldn't detect people sent to ED "for medical clearance" who could be helped in other settings, nor all the people who end up having a blood test just because they're in an ED. AT

From south London and RCPsych: 'Many thanks to everyone who responded to this email thread about competences for non-CAMHS staff that may be assessing young people in the ED. Helpful resources were identified, as well as prompting a discussion about the nature of 24-hour age-inclusive services and the balance of emergency and ward work. These issues chime with discussions I have been involved with in a number of fora and there is certainly more to come. In the recent meeting with CAMHS Faculty representatives we discussed the difference between "an all-age service", implying that all staff can do everything, and "a service for all ages", with staff working within one service but having specific expertise (e.g. young people, older adults etc.).'

Medical unit proactive project

This team is about to run an in-reach project to their Acute Medical Unit. This involves having a higher profile at board rounds, proactively case finding, training staff around mental health and patient safety issues. They'll be using FROM-LP to tie it all in with national strategies.

'Has anyone done anything similar in their Trust? Any pointers or pitfalls to share with us?'

Response one: Newcastle has been doing this for 20 years. 'I left Liaison a couple of years ago but have just checked that they still do the morning pro-active sweep of MAU and the ED – join the ward round where able (I used to walk into work through ED and MAU).'

Response two: 'It sounds brilliant – though a small observation about the language. In my hospital we don't have any "in-reach" services; we talk about "already-here-reach" services. We are on site and aspire to function and be perceived as any other hospital dept. There is already much perception of "otherness" and distance about mental health services in an acute hospital and we should emphasise that we are simply another on-site specialty working alongside cardiology, rheumatology, urology etc.'

IAPT and liaison

This clinician has been asked to act as advisor to the NICE/NHSE/NCCMH working group aiming to specify how the new wave of IAPT (to be 'integrated' into medical service – primary and secondary) will work.

This is potentially greater capacity to provide psychological treatment to patients with chronic illness and medically unexplained symptoms. The challenge is how much IAPT will integrate. One important question for this group is how IAPT will work with what they are calling 'planned liaison psychiatry'. This is a big challenge and there are strong and differing opinions.

There was just one response – but a full one:

1. On integration with medical/health services: this clinician worked up a proposal to embed IAPT psychologists in local community diabetes/respiratory/heart failure clinics. The main barrier/concern was IAPT's strong focus on targets and throughput – while this is not a bad thing in itself, the need to maintain high volumes of patients seen limited the possibilities for travelling to housebound patients with CCF or COPD. It also took some negotiating to ensure that clinic space was available within the community health centres and wasn't charged to IAPT. The usual inter-organisational issues regarding governance, estates, clinical systems access, admin & clinic booking affecting liaison psychiatry depts. all apply.

2. On integration with liaison psychiatry: 'there are still very strong views about how or whether psychologists and psychiatrists can or should work together, and I've certainly heard psychologists raise objections to the notion of working in a dept with "psychiatry" in its title, preferring "liaison mental health" or similar. There are also

continued misunderstandings and assumptions that a department of liaison psychiatry is nothing more than an on-site crisis team.'

Dr Jackie Gordon, Worthing