JISC update December 2016 – January 2017

Brain Injury case

A patient sustained a severe head injury (frontal and temporal contusions) and became agitated and cognitively impaired. She required neurorehabilitation; and her mobility was too poor for an acute psychiatric admission. 'Our local brain Injury Unit (in Bristol) is excellent, but oversubscribed therefore it will take some time to place her there.

Does anyone know of any other units in the country that can support patients like this?'

Responses have included the following:

1. Portsmouth Kite Unit on the St James hospital site.
2. Salisbury with a variety of provision possible.
3. Regional Rehabilitation Unit at Northwick Park which deals with movement/neurorehab
4. The London Brain Injury Consortium:

Lishman Unit (SLAM)

Royal Hospital for Neurodisability (Putney)

Blackheath Hospital

5. Priory Group have some neurorehab centres, and Cygnet may do as well

All have long waiting lists. 'I wonder if asking your local neuropsychiatrist to give interim clinical advice may be necessary'

Respiratory liaison setting

A clinician asks: Does anyone have any experience of working in a respiratory setting? 'We are showing a spike in frequent attenders in the ED in relation to respiratory patients and I'm interested in whether anyone has worked alongside the respiratory service and seen if liaison psychiatry had made a difference.

The angle I also want to cover is that I think that CO2 retaining patients are physiologically primed to experience panic and have sometimes experienced trauma in relation to not being able to breath; and may need quite assertive management pharmacologically to overcome that in addition to anything psychological'.

Respondent one: 'We run a joint clinic with our respiratory team. Initial audit of the results suggest that in that group a patients admissions have declined and more interestingly, steroid use has declined. Need to dig a little further to ensure results persist.'

Respondent two: has had success with reducing respiratory admissions 'usually due to either helping with unrecognized depression or arranging to help loneliness in older adults with COPD or using somatoform disorder containment strategies in 'brittle asthma'.

Respondent three: IAPT LTC includes COPD and you can find some literature there on depression and anxiety that might also be relevant for the more complex cases we tend to see in LP. The literature is dominated by this idea that the main issue is comorbid depression or anxiety and finding other angles is rather harder work; Respondent two's 'analogy with somatising is a good one and for example if you look up unexplained breathlessness you'll find that it isn't all about anxious hyperventilating'.

Eating Disorder cases

This clinician says: In the last year the Liaison team has had two women with known Anorexia Nervosa where the plan has been to use the Mental Health Act when their physical state is critical and admit them to the general hospital for 'medical stabilisation' prior to transfer to an eating disorder bed.

It has then taken around 2 months of repeated efforts by the Liaison Psychiatry team after the patient becomes medically safe to get a bed in an eating disorder unit, which seems especially challenging to achieve with the national allocation system for beds. Sometimes this is with units saying that since the patient is being NG fed in hospital (i.e. medically safe) they are not a priority and the bed is expected in about 3 months.

'Are others also now having the same experience or if it is more likely that local issues/processes are the key factor causing very prolonged delays in transferring out of a general hospital after becoming medically safe?'

Respondent one: 'I've seen is a slight variation on yours' - patients on ng feeding or peg feeding won't be accommodated on most eating disorders units. There then arises the somewhat paradoxical situation of a patient's anorexia nervosa being too severe to be admitted to an eating disorders unit. This means that while they are being re-fed on a medical ward they aren't getting active treatment from anorexia experts; and there is nowhere to send them to apart from back home with a feeding tube.

Respondent two: 'We have a good relationship with our eating disorder unit but this problem still arises. If the patient needs to be in an acute hospital for more than a few days then they have to release the bed and the patient has to wait again. I think there are considerable risks to keeping the patient in an acute hospital, so once the crisis is over it's hard to justify keeping them in hospital. Just because the EDU target BMI is 16 or something it doesn't mean that should be the goal for the acute trust admission. If electrolytes etc are stable and BMI is more than 13/14 then to discharge home with assertive community input is an alternative that should be considered. It does get harder when they have a NG / PEG but that too can be done in the community sometimes.'

Respondent three: 'We encounter the same problems as others; which is made worse by the commissioning and funding of services'.

In England eating disorder services are commissioned in from mental health trusts in by specialist national commissioning. Bizarrely this commissioning does not include general hospital care;' which we all know is sometimes needed. Patients admitted to our general hospital - including to ITU - are relatively few in number but may be there for weeks or months and use a lot of nursing and medical resources, costing tens of thousands of pounds. However, the general hospital services have not been commissioned for the role and if the admission there is coded as for a 'mental health condition' the acute trust only gets a few hundred pounds. The system has no incentive to facilitate a rapid transfer to an eating disorder service - a situation good for everyone - except the patient and acute trust both of whom are likely to be understandably unhappy.

He suggests - make the system work as well as it can by having a good relationship with the eating disorders service and make sure the acute admission is coded as a physical condition - e.g. starvation not as a mental health condition. But he concedes that 'a better answer would be to make sure future commissioning and reimbursement reflects clinical realities - patients with anorexia sometimes need expensive general hospital care.'

Dialysis and capacity

A clinician asks: Is there case law that says that it is not in the best interests of a resisting patient who lacks capacity to be forcibly dialysed? This question arose from a patient referral where forcible dialysis was likely to be both impractical and unsafe. There seemed little prospect of the patient recovering capacity in any realistic timeframe (chronic and intractable psychosis).

Respondent one: This clinician shares experience with a teenage patient who refused dialysis. He was deemed capacitous (after 2 assessments spaced about 3 months apart, first assessment he was deemed not to have capacity). We consulted widely both medically and medico-legally. It was a split opinion as to whether it would be in his best interests to continue with dialysis if he was actively resisting and non-capacitious and dialysis was withdrawn.

There was a similar case Case No: COP 1278226 that was around the same issue at Kings College Hospital 2 years' ago. The judge deemed the lady capacitous (again after split professional opinion about capacity) and dialysis was withdrawn.

Respondent two: Also cites KCH v A&C 2015 which addressed the issue of capacity. Comments about the burden of forced dialysis may help and it may also cite other helpful references:

Respondent three: 'I doubt very much that there is any case law, because best interests have to be decided on a case-by-case basis. I've certainly be involved in assessing people who lacked the capacity to decide on treatment and for whom the Court decided that it was not in their best interests to pursue treatment .'

Respondent four: Our American colleague is unaware of any legal precedents. He has chaired hospital ethics committees 'and we have been consulted in a few cases over the years in which intractably psychotic patients with schizophrenia refused dialysis. We essentially decided that regardless of the ethical issues, it was simply impossible to enforce chronic dialysis on a resisting patient. It would require essentially imprisoning the individual or kidnapping them three times a week and sedating him for the dialysis. I do think it can be ethically justified to force dialysis for a brief period when it is unclear whether the psychosis includes a component of uremic delirium. If your case came before our ethics committee, we would not advise pursuing a court's opinion. I believe we should go to court when the issue is primarily a legal one. Clinical matters should be decided by clinicians. Of course if a family member wished to pursue the legal route to force dialysis on the patient, that would be their prerogative, but I have not encountered that.'

Respondent five: Agrees that the main issue becomes the logistics. Forcible dialysis is not sustainable for any length of time. To do it in a conscious patient, even with sedation there really needs to be a degree of

acquiescence. It is surprising sometimes how having the legislation in place changes the patient's response. She cites a case where the core psychopathology underlying the loss of capacity & refusal of dialysis was a severe adjustment disorder. The act of using mental health legislation appeared to be one of the factors that led to the patient accepting just how serious the situation was. The patient later continued dialysis on a voluntary basis. She thinks this is unlikely to have been effective in the face of intractable psychosis.

UP TO HERE

Our respondent from Australia refers to five relevant documents:

1. Re D (Medical Treatment: Mentally Disabled Patient) [1998]

2. St George's Healthcare NHS Trust v P [2015] EWCOP 42 was a case that refused an application for a declaration on the lawfulness of doctors ceasing dialysis. It is interesting because of the apparent contrast to an earlier decision Re J (A Minor) (Child in Care: Medical Treatment) [1993] Fam 15 which found the court cannot compel medical professionals to provide treatment contrary to their professional judgement. There is a commentary the case - Youngs JC. Can the Courts Force the Doctor's Hand? *St George's Healthcare NHS Trust v P* [2015] EWCOP 42. Medical Law Review 2015; 24: 99-111.

3. People have already made reference to Kings College Hospital NHS Foundation Trust v C [2015] EWCOP 80. Those interested might also be interested in a commentary on this paper - Ryan C, Szmukler G, Large M. Kings College Hospital Trust v C: using and weighing information to assess capacity. *Lancet Psychiatry* 2016; 3: 917-919.

4. Dirty Blood is a commentary from the Hasting Centre Report about a gentleman who refused dialysis.

5. NHS Trust v A [2005] EWHC Civ 1145 - is a best interest case appealed to the High Court of an incompetent man apparently resisting dialysis.

Restraint and rapid tranquilisation (RT) policies – useful experience from Devon

This clinician describes ad hoc RT training of DGH staff for many years; ‘we have finally ratified and shared rapid tranquilisation policy for the DGH’s in Devon. We are finishing developing some laminated lanyard cards to go with this so the juniors have accurate and rapid information available’.

‘With regard to managing the RT process we are this year rolling out a comprehensive one day “managing distress” programme – developed in conjunction with Adult, OPMH and safeguarding leads and – this is key - DGH security staff and other stakeholders - to the ED, acute wards and other areas highlighted as frequent users of 1:1 supervision or IM antipsychotic medication. Training on this will be recorded on their ESR and is supported at high level management to allow the staff release for the training.

I would also ask a DGH pharmacist to do an audit how much and how often im meds are being used for this and useful to highlight to the DGH the training needs.’

Jackie Gordon

Worthing