

JISC update August – September 2016

How to measure the impact of early Liaison Psychiatry involvement on reducing length of stay?

From Bristol: Has anyone got any suggestions as to how to measure the impact of early Liaison Psychiatry involvement on reducing length of stay? Is there a more efficient/accurate way of doing it than comparing similar groups of patients before and after our service was set up? We are also going to use FROM-LP, but it doesn't measure what our commissioners want us to i.e. an impact on LOS.

Response from Oxford: 'You can't prove it unless everything else stayed the same – or you randomise. I suggest you provide some good case examples'.

Further response: there is a temptation to cherry pick data and say it proves it. But there are other reasons for a service – does neurology have to justify itself on cost savings?

- Huge unmet need – equity of provision
- Integration – an NHS priority
- Reduce risk from disturbed behaviour
- Support over stressed staff
- Simply the right thing to do

Another perspective: The appropriate evaluation approach is interrupted time series analysis. Put <interrupted time series BMJ> into Google Scholar and there are examples of its use to evaluate policy and service changes. It's an old technique (Campbell and Cook Reforms as experiments. American Psychologist. 1969 Apr;24(4):409) now transformed by modern computing power. The problem isn't that there isn't a research method; it's that it requires a degree of expertise in handling and analysing routine NHS data that is typically only available in universities; and that the commissioners who ask the question may not want to pay for.

From Leeds: 'It's impossible:

- Once a service is introduced, you have no baseline against which to compare on an ongoing basis.
- The RAID evaluations found negligible reduction in LOS for people with mental health conditions who WERE seen by the liaison psychiatry teams
- They found appreciable reduction in LOS for people with mental health conditions who WERE NOT seen by the liaison psychiatry teams
- They called this the "RAID effect" and argued that the people who are sufficiently complex to need referral are too complex for there to be much impact on LOS.
- The assertion is that the presence of a liaison psychiatry dept. improves staff's confidence at addressing mental health needs via modelling, coaching and explicit training sessions, thereby ensuring care progresses in a timely fashion.
- Another potential mechanism is that the presence of mental health leadership in the acute trust allows both the identification and improvement of hold-ups/bottlenecks in care pathways, so that the overall experience of care becomes smoother.

- Furthermore the RAID evaluations required some complex case-control matching and were carried out by the London School of Economics at substantial cost.
- Therefore, unless you look at ALL patients with MH needs, and do sophisticated matching and economic analysis requiring substantial cost and expertise, you're not going to be able to demonstrate savings in LOS.'

From NW London: They had this discussion with their CCG a couple of years ago and are about to embark upon the same discussion with acute trust partners. It's not all negative, though:

- There is a nationally recommended approach to outcome measurement in liaison psychiatry, via both the Centre for Mental Health Report and the RCPsych FROM-LP report and they are proposing to use these.
- They are also proposing that any outcomes framework for their dept is also consistent with existing outcomes frameworks for other specialties which don't have inpatient beds, such as nephrology, ophthalmology, neurology, radiology and microbiology.
- They are also collaborating to increase coding accuracy for inpatient admissions, which increases the number of patients on intermediate/high complexity/comorbidity tariffs.

Is there experience of bringing together 2 existing liaison teams?

From the West Country: I wondered if anyone had experience of bringing together 2 existing liaison teams - AOWA and Later Life and what logistical/operational issues need to be addressed.

This is an established team (AOWA) largely employed by the acute trust and there is a newer LL team employed by the MH trust. As a result they have developed along different lines, have different management structures, differing lines of accountability and different systems (in terms of referrals, record keeping etc).

They are hoping to move in together over the next few months, and are wondering how far to integrate in other ways; to work more closely to benefit patients and acute trust colleagues, but not to dilute specific expertise, and are mindful that these patient groups are quite different (AOWA - often ED focussed, LL have many long stay dementia patients) in their presentations and care; they don't want to amalgamate our systems if they don't work for each group.

Very helpful response: a service just down the road replied –who joined older age and working age teams together in October 2014 in order to deliver extended hours (following winter pressure money bidding). It was not organisationally going to work delivering a 24/7 without joining numbers. They found it impossible to keep separate management, IT, governance, reporting etc. and now have joint team meetings, shared IT and governance and nurses work across both areas. They also share CQUINs. Skills have been spread, not really diluted, and they have a practice lead (band 7) in each area to develop specific competencies and guidelines.

What is the Antidepressant of choice in inflammatory bowel disease?

A Virginian – ‘My experience has been that mirtazapine has had no adverse effects in a variety of major GI diseases’

South London – ‘My experience is similar, in that I have used mirtazapine with several patients with inflammatory bowel disease without adverse GI effects’.

Salisbury: ‘I too endorse the other's view of no concerns. I often used it ... in people with various gut disorders who were more vulnerable to the nausea and GI disturbance from SSRIs. The only issues I can think of are the rare side effects of hepatic changes or neutropaenia which may also be side effects of the Crohns’.

Liaison and the media

Does anyone have any experience of TV/Media in relation to liaison psychiatry? In particular filming of patients?

This clinician tells us that the BBC is making a documentary about an enormous new hospital. Mental health has been overlooked and he wants to highlight the role of liaison psychiatry. The press office did seem interested when approached but they are now saying that if the TV crew won't be able to film patients then it isn't worth meeting with them as they want "patient stories". He is concerned about confidentiality and vulnerable patients being filmed. ‘Does anyone have any experience in making this happen or thoughts about how I can get a liaison angle included?’ He has also asked the RCPsych public engagement people for advice.

London: The TV series Bedlam was filmed in the South London and Maudsley trust, so the media department there may be able to offer advice

Bristol: The BBC has filmed there twice in 2016 on mental health issues, on both occasions the camera people turned up and followed staff hoping a patient would agree but we couldn't get patients consent so a consultant psychiatrist stood outside the A+E interview room when the patient was inside giving a brief synopsis of the case; then the BBC went out and found 2 patients who had been to A+E before and interviewed them on a park bench. (see it on catch up/youtube – it was Inside out – a half hour show put out by BBC points west). The other BBC show on Nathan Filer was filmed walking through the hospital talking to staff and (mainly relatives) about mental health. Essentially the camera crew have to come along and hope for the best, or if you know any previous patients willing to talk on camera you could approach them.

South London: We have had the ‘24hrs in A&E’ team filming in our ED for the past 3yrs. Initially, I was quite optimistic about being able to showcase Liaison Psychiatry and raise awareness of mental health issues. However, despite numerous meetings with the programmes producers – and their alleged interest – we have only ever managed to have one patient provide a retrospective piece to camera. My impression is that this series relies heavily on trauma (after all, sensationalism sells). I know that they would be interested in filming someone who is acutely psychotic/ manic as this too would undoubtedly be a ratings success. However, as you rightly assert these patients would be unable to provide the necessary consent to filming – and doing so without their agreement would constitute exploitation. During our initial discussions we did involve our Trusts communications department who were satisfied with the safeguards the production team had put in place to ensure consent to participate was regularly reviewed and assessed. Nevertheless, I suspect that ultimately psychiatry was not ‘sexy’ enough for them – preferring instead to focus on acute medical/ surgical issues that had a back-story.

Leeds: There's a programme about general practice that airs on Channel 5 and does well with people with less dramatic problems e.g. recurrent depression, carer strain, medically unexplained symptoms, not looking after diabetes properly and alcohol problems - [GPs behind closed doors](#). They seem to get consent but then it's to film talking with their GP. You might ask the practice (or the programme producers). My experience is that they want dramatic cases e.g. the last contacts I had they wanted conversion disorder and I asked a few people who all said No. However, you might pick cases where it's less awkward and talk e.g. to carer of somebody with delirium. Some people with recurrent SH might agree to talk e.g. about how they are treated?

Salisbury: One of the most successful programmes, in addition to the Bethlem one, was the BBC (still on iplayer or the web) 'My baby, psychosis and me' shown in February 2016 with Consultant Dr Alain Gregoire. It followed two women with severe postpartum psychosis.

Management advice – catatonia

I wonder whether anyone can help with a 19yr old with autism with a 1st episode of psychosis which evolved over a few weeks from a depressive picture after life events. Symptoms are mainly catatonic posturing and minimal speech.

There have been 3 significant episodes of neuroleptic malignant syndrome needing general medical admission.

On the first acute admission neurologists investigated extensively - NAD including limbic encephalitis Abs.

West London: For "unusual possibly organic" presentations this psychiatrist uses [The Diagnosis of Psychosis](#) by Cardinal & Bullmore:

This is an excellent reference text to guide comprehensive and structured approaches to investigation.

A few suggestions to consider:

- How robust was the diagnosis of NMS?
- If associated with elevated CK, were other causes of CK rise considered, particularly mitochondrial disorders (MELAS-type syndromes don't always present with classical MELAS)
- Have other metabolic/genetic disorders associated with deterioration in late adolescence been considered?
- Has he had investigation for the full spectrum of antineuronal antibodies e.g. anti-GAD (stiff person syndrome), or only the limbic encephalitis ones?
- Would EEG add anything during an episode (unlikely to be associated with seizure but may help to rule in/out encephalopathy associated with slow waves).

Pragmatically the likelihood of finding a rare disorder is slim and the treatment may well boil down to antipsychotics, benzodiazepines & a mood stabiliser +/- ECT.

Oz: Sounds like a first episode psychosis with prominent catatonic features. Obviously need to be concerned re organic causes, despite the opinion of the neurologists, but sounds like you've got

those covered. Arguably ECT was treatment of choice from the beginning, though, you know, I probably wouldn't have led with it. Now though with three antipsychotics having caused NMS I'd go with ECT unless the patient were competently refusing or there were reason to believe he would have refused had he been competent.

JAMA and frequent attendance in the ED

'For those who don't browse JAMA routinely, here's a comment on flagging frequent attenders in ED.....so often in liaison we are asked to come up with quick fixes for complex problems. Decision-supporting heuristics are tempting, but temptations can lead us astray. The reference in this piece on algorithms and the everyday is worth the minor digression.'

[Joy M, Clement T, Sisti D. The Ethics of Behavioural Health Information Technology: Frequent Flyer Icons and Implicit Bias. JAMA. Published online September 08, 2016. doi:10.1001/jama.2016.12534.](https://doi.org/10.1001/jama.2016.12534)

Oz: 'Great paper. I've got to check on Monday that we don't have a frequently flyer icon! I hope not.' Agree too with the fight against the quick fixes. This respondent published a paper last year reminding everyone including administrators that that is not a viable route. 'I know this is blatant self-promotion, but it did seem relevant to your comment. And sometimes it is useful to have a paper you can point to with, "See what these guys said". Here's the ref if interested. If you can't get it, let me know and I'll send you a copy.'

Ryan CJ, Large M, Gribble R, et al. Assessing and managing suicidal patients in the emergency department. *Australas Psychiatry* 2015; 23(5): 513-515.

Leeds: 'Perhaps we need an icon that says "This is a complex problem that can't be sorted out using a simple checklist; suggest you call a liaison psychiatrist" So the icon triggers a behaviour rather than evoking a stereotype'.

A study from 1993 on the power of compassionate care was cited

[A randomised trial of compassionate care for the homeless in an emergency department.](#)

Clozapine cessation and catatonia

'Is there experience of catatonia following abrupt discontinuation of Clozapine or after anaesthesia?'

A 40 year old man was well on Clozapine for many years and due to bowel obstruction had to undergo an operation one week ago. He has not woken up from the anaesthesia and all the investigations have been normal, including MRI, LP, EEG.

Neurologist has said that this presentation is not organic and has directed ITU to psychiatry. No history of catatonia.

So far there is no response to lorazepam.

Oz respondent:

...who recalls at least one case of catatonia secondary to abrupt cessation of clozapine. 'Catatonia secondary to sudden cessation of clozapine seems the most likely diagnosis and the situation is deteriorating, so I'd cease the lorazepam and give ECT (assuming the anaesthetists are on side)'. He

wouldn't restart clozapine. 'I don't think there is much evidence it will help in this situation. It might hurt and presumably it contributed to the original bowel obstruction.'

Dr Jackie Gordon

Worthing