

December 2017



Newsletter

Winter Edition of the Faculty of Liaison Psychiatry

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Editors:

Sridevi Sira Mahalingappa

Nora Turjanski

Editorial

Welcome to the winter edition of our newsletter. As always we have received a very positive response and submissions. We are very grateful to everyone who has contributed to this newsletter.

As you may be aware, Dr Jim Bolton and Dr Annabel Price have taken over the Faculty Chair and Vice Chair positions respectively and there are new additions to the Executive Committee. As our Faculty Chair reports, we are a "specialty in demand" and we hope that our Faculty continues to grow and expand.

Many of you will know Stella Galea, who has helped our Faculty for many years in her role as Faculty & Committee Manager. Following a review of the workload of the Faculty and Committee Managers Stella is no longer supporting the Liaison Faculty. We would like to send our massive thanks to her and welcome Stephanie Whitehead who has taken over from her.

The Liaison Faculty Conference held in London in May 2017 was a huge success. May we take this opportunity to formally give massive thanks to all the speakers at the event. Their contributions were enormously appreciated. The next Faculty Conference will be held on 16-18 May 2018 in Liverpool.

We are planning to improve our Faculty website. Please take a look at it and let us have your suggestions.

In future, the newsletter will be published three times a year in April, August and December. We are always looking for submissions that are relevant to liaison psychiatry including reports on service developments, education, training, audits, conferences and events. Articles should be no more than 1-2 pages long.

Please include your name, title, place of work and contact details. Please note that while the newsletter is not a scientific publication and does not use a peer review process, it does provide a platform to share good practice and other innovative ideas.

Submissions are warmly received. Please e-mail Stephanie Whitehead at Stephanie.Whitehead@rcpsych.ac.uk using "Liaison Faculty Newsletter" as the subject title.

We would like to thank Stephanie Whitehead for her support in preparing this Newsletter.

We hope you enjoy the newsletter. We wish you a Merry Christmas and a Happy New Year.

Editorial Team
Liaison Faculty Newsletter

Chair's report

Help!

Blimey, being Chair of the Liaison Faculty is a busy job. As soon as the results of the election were announced earlier this year, the avalanche of emails began. It was in full force by July when I took over from Peter Aitken, who had tried to warn me of what was to come.

I can confirm that we are a specialty in demand. Our expertise is requested for numerous projects, committees and press statements. This is because of the unique position we have in psychiatry, straddling the divide between mind and body, and mental and physical healthcare.

The role of the Chair of the Faculty is a privileged one as I get to work with a dedicated Executive Committee, where each member taking on key responsibilities. I certainly don't know the answer to every query I receive, but I can usually find someone who does.

I am pleased that Peter Aitken has remained on the Executive Committee as our outgoing Chair. I would like to thank him for helping me to settle into the role and for sharing his wisdom and experience to make the transition as easy as possible. As a professional body we have much to thank him for after all his work in developing commissioning guidelines for liaison psychiatry services and working with the College and NHS England to make us a priority in the NHS.

When I stood for election I welcomed our current growth, at least in some areas of the UK. I stated my aim of establishing us in public thinking as a core component of healthcare and not an optional extra, vulnerable to decommissioning when the political winds change. The Executive Committee will be working with the newly expanded College Communications Department to promote our "brand". To assist with this, I am seeking your help.

I know that you are an imaginative and enthusiastic group of colleagues, otherwise you wouldn't be current or prospective liaison psychiatrists. Please let me know if you have any suggestions for a strapline for our specialty – a short phrase that captures something of what we do. If we do find an apt slogan, we could then use this in our work and publicity to help embed us in public thinking. Send any suggestions to our Faculty Manager, Stephanie Whitehead: stephanie.whitehead@rcpsych.ac.uk

It only remains for me to wish you a very happy Christmas and New Year (flu epidemic permitting) and I look forward to seeing many of you at our annual conference in Liverpool in 2018.

Jim Bolton

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Psychiatry and the Complex Regional Pain Syndrome (CRPS) 1: The Role of Psychiatry in Diagnosis and Management of CRPS



George Ikkos

Consultant Psychiatrist in Liaison Psychiatry

Helen Cohen

Consultant Physician in Rheumatology and Pain Medicine

The Royal National Orthopaedic Hospital (RNOH) Departments of Liaison Psychiatry and Rheumatology Guidance (abbreviated)

INTRODUCTION

Typically affecting a limb, CRPS causes disproportionately intense pain associated with motor, sensory, autonomic, trophic (of hair, skin and nails) and bone abnormalities. It is classified in the ICD10 under the general category "Other Diseases of Bone" (M89) as an Algoneurodystrophy (M89.0), (World Health Organization, 1992). Although it is often first encountered and suspected by orthopaedic surgeons, it is usually assessed and treated by medical specialists in neurology, pain medicine, rheumatology and rehabilitation medicine and the multidisciplinary teams with whom they work. (Goebel et. Al, 2012). The Budapest Diagnostic Criteria (appendix) have been adopted by the International Association for the Study of Pain (IASP) and enjoy broad international consensus, though they are not entirely uncontroversial.

In 2015, the RCPsych Liaison Psychiatry Faculty nominated one of us (GI) to represent the College at the multi-professional working group to revise the "The Complex regional pain syndrome in adults: UK guidelines for diagnosis, referral and management in

primary and secondary care" (Goebel et. Al, 2012). In 2016 the College approved a draft chapter on referral to Psychiatrists. However, further changes demanded by the working group proved unacceptable and by mutual consent the Faculty withdrew from the group. The working group is due to publish its guidance in 2018.

Since withdrawal, the departments of Liaison Psychiatry and Rheumatology at RNOH have adopted the Faculty-approved guidance, with minor refinements. We present here abbreviated and amended extracts from the agreed guidance. The full guidance is available on request from GI (George.ikkos@rnoh.nhs.uk)

Complex Regional Pain Syndrome (CRPS)

The European incidence rate for CRPS derived from a Dutch population-based study is 16/100,000 person years (with inclusion of CRPS NOS the incidence rises 26/100,000) (de Moss et. al. 2007).

Although all patients suffer from pain, the clinical presentation of CRPS is varied and can change over time. The 'acute' phase is more often characterised by inflammatory symptoms and signs, whereas symptoms in the chronic phase are thought to reflect central neuroplasticity, such as sensory gain or loss, motor symptoms and body perception disturbance (Birklein et al, 2015). However, many patients do not go through typical phases. At the extremes, a patient may have a red, swollen, and sweaty hand and wrist (CRP/ESR being normal) which is painful to touch and difficult to move; whereas another patient may have a cold, blue, wasted non-functional limb

with skin dystrophic changes, allodynia and marked guarding behavior. CRPS can be subject to flares during which pain, symptoms and signs will be exacerbated. However, between flares or during a better spell, the limb may appear relatively normal. Most patients recover within a year but for a minority it is an incompletely understood long-term severely disabling condition.

In clinical practice the Budapest Diagnostic Criteria allow a diagnosis with at least one symptom in 3 of the 4 symptom/sign categories with the presence of signs in at least 2 categories. A diagnostic sensitivity of 0.85 and specificity of 0.69 have been found (Harden et al., 2010/8) in differentiating from non-CRPS neuropathic pain in pain clinics. There are tighter diagnostic criteria for research use in pain clinics where at least one symptom in each of all 4 symptom/sign categories and presence of physical signs in at least two categories are required, and a diagnostic sensitivity of 0.70 and specificity of 0.94 has been found (Harden et al., 2010/8).

Beyond the Budapest Diagnostic Criteria, some clinicians use the diagnostic category Complex Regional Pain Syndrome Not Otherwise Specified (CRPS-NOS). CRPS-NOS is not the same as clinical CRPS. The CRPS-NOS category is not well researched, diagnostic sensitivity/specificity are unknown and use of this diagnosis is more controversial.

There has been no research on the specificity and sensitivity of the Budapest Diagnostic Criteria in relation to differential diagnosis from psychiatric conditions. There may be

particularly significant issues in the differential diagnosis of CRPS-NOS from Somatoform/ Somatic Symptom Syndrome and related disorders.

CRPS and Psychiatric Diagnosis

As with other medical disorders, any psychiatric disorder may be comorbid with CRPS. Comorbid psychiatric disorder may have either preceded the CRPS onset or may have started following the onset of CRPS. There must be no assumption that presence of CRPS automatically implies the presence of psychiatric disorder, or where it is present, that psychiatric disorder has caused CRPS. While chronic pain is generally associated with certain psychiatric disorders, there is also some evidence that CRPS may specifically be associated with circumscribed neuropsychological/ neurocognitive dysfunctions (Cohen et al., 2013; Lewis et al., 2007/12/15; Shin et al., 2013).

CRPS and psychiatric comorbidity may be either co-incidental or may be aetiologically related (e.g. a patient develops depression because they have CRPS or CRPS is aggravated because of anxiety or depression). There is experimental evidence that immobilisation and profound disuse of an extremity, including early after trauma, can produce or enhance limb signs resembling CRPS (Guo et al., 2014; Singh and Davis 2006; Terkelsen et al., 2008); Conversely, there is evidence that early mobilization and appropriate advice may prevent the development of CRPS (Gillespie, S. et. al. 2016) Therefore, where any psychiatric disorder is shown to lead directly to immobilization and profound disuse of an extremity, psychiatrists should be aware that this might contribute to signs and symptoms of CRPS.

In some cases difficulties may be encountered in relation to assessing for the presence or coexistence of somatoform disorders, including somatoform pain disorders. The American Psychiatric Association Diagnostic and Statistical Manual 5th edition (DSM V) "Somatic Symptom and Related Disorders" (DSM V Diagnostic Code 161) is more helpful than the ICD10 in considering such cases.

Difficulties may particularly arise in a case where the diagnostic category CRPS NOS has been used, especially in the absence of clinician observed past or current physical signs.

On rare occasions patients present with deliberately self-induced signs mimicking CRPS signs (Mailis-Gagnon et al., 2008/2, Taskaynatan et al., 2005). Such behavior may be initiated +/- sustained by psychiatric morbidity. In medico-legal and other settings factitious disorder and malingering may be more common than in clinical practice, though relevant epidemiological data is lacking. The complexity of any case, even in the absence of physical signs, should not lead to an automatic assumption of factitious disorder or malingering. In both clinical and medicolegal cases, each referred patient must be assessed sensitively and in appropriately full detail by the psychiatrist.

In clinical practice, the role of the Psychiatrist is to aid patients, their carers and the clinical team to achieve optimum outcomes. Psychiatric diagnosis may be reached in many cases, although sometimes there is no diagnosable psychiatric disorder. Where this is the case, it should be stated. Psychiatrists may be able to contribute constructively even in cases where there is no psychiatric diagnosis.

Pain Medicine and Psychiatry Liaison

Though the most common scenario for psychiatrists is to see patients with CRPS when a diagnosis is already established, sometimes a psychiatrist may be the first to suspect CRPS. Psychiatrists, particularly if involved in liaison and addiction services, should therefore be familiar with the Budapest diagnostic criteria for CRPS. As it is generally not the psychiatrist's role to diagnose CRPS, suspected undiagnosed CRPS should be referred on to an appropriate specialist for further evaluation.

For best practice, Psychiatrists involved in the care of patients with CRPS and chronic pain in general should support the development of local treatment and communication pathways which detail

their involvement in multidisciplinary care for these patients.

Appendix - 1 Budapest Clinical Diagnostic Criteria for CRPS

1. Continuing pain, which is disproportionate to any inciting event
2. Must report at least one symptom in three of the four following categories:
 - Sensory: reports of hyperesthesia and/or allodynia
 - Vasomotor: reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry
 - Sudomotor/edema: reports of edema and/or sweating changes and/or sweating asymmetry
 - Motor/trophic: reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)
3. Must display at least one sign at time of evaluation in two or more of the following categories:
 - Sensory: evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement)
 - Vasomotor: evidence of temperature asymmetry and/or skin color changes and/or asymmetry
 - Sudomotor/edema: evidence of edema and/or sweating changes and/or sweating asymmetry
 - Motor/trophic: evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)
4. There is no other diagnosis that better explains the signs and symptoms

Adapted from Harden RN, Bruehl S, Perez RS, et. Al. Validation of proposed diagnostic criteria (the "Budapest Criteria") for Complex Regional Pain Syndrome. Pain 2010/8; 150: 268-274. References

Please note that references on this article can be obtained from the author George. Ikkos at George.Ikkos@rnh.nhs.uk



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Nurse Consultant

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In November 2014 I took up the role of Nurse Consultant in a busy comprehensive liaison service in the North East of England. The role of nurse consultant varies dependent on the clinical area but within liaison is detailed as follows:-

Expert clinical practice

1. A Responsible Clinician may be relevant if there are a significant number of people detained and requiring management within the acute hospital. For my area this is not the case.
2. Non-medical prescribing is complex so medical knowledge is required and needs to be constantly updated.
3. Liaison Team - as part of the daily MDT I provide senior nursing leadership which allows me the opportunity to provide ad-hoc teaching and offer alternative perspectives for ongoing care for those patients seen within the last 24 hours in the ED pathway. Within the liaison pathway an opportunity to influence treatment strategies presents itself for those complex cases.
4. Provide nursing leadership to nursing groups within the acute trust including support with breaking down stigma within teams, developing nursing policies where indicated and care plans

Developing a nurse led clinic utilising an eclectic approach where all roads seem to lead to EMDR treatment

bespoke to the mental health needs of the individual. Here, my involvement may be direct or indirect.

5. Complex cases – with regard to medical and mental health comorbidity requiring innovative treatment plans to create sustainable improvement and communication/ care planning with diverse teams.
6. Outpatient clinic development - as well as providing a specialist nurse consultant generic outpatient clinic, services as they evolve will be required to develop diverse outpatient clinics for long term conditions and medically unexplained symptoms.

Professional leadership and consultancy, including clinical supervision

1. Leadership across the mental health trust, acute trust, links with commissioning and influencing at a national level have been central to the success and reputation of liaison services within NTW (in particular Sunderland). This work is ongoing and will grow as other NTW liaison services expand and develop.
2. Influencing - the development of both the service at a local level and the liaison psychiatry agenda at regional and national forums.
3. Clinical Supervision - I supervise the clinical leads within the team as well as offering specialist therapeutic modality supervision to others. As such I provide the lead for the clinical supervision structure within a large nursing team.
4. Clinical supervision is also provided to specialist nurses in the acute

trust in an informal way in order to support them in developing their awareness and knowledge of mental health issues.

5. Supervision is also provided to visiting junior medical staff in an informal way.

Education, training and development of staff

My service has been instrumental in enhancing efficiencies through the development of training packages designed for the delivery of bespoke training to specific teams within the acute trust to enhance their skillset in terms of managing distress. These packages have been designed in such a way that they can be delivered within teams independently of liaison psychiatry in order that my service need only be involved with the most complex of cases.

National presence - enhancing the regional and national reputation of the growing nursing workforce within the field of liaison psychiatry by presenting at national conferences, the Liaison Faculty Conference, TNNC AMP's liaison conferences and other opportunities such as nurse led clinics conference, medically unexplained conferences, etc.

Research into various aspects of service provision and service evaluation involving this client group

1. Service outcomes, development of CROMS, PROMS and PREMS. Research development around the financial benefits of Liaison Psychiatry ensures that the service continues to develop year on year in terms of outcomes within a stagnant financial envelope.
2. Identify and influence opportunities to develop patient

advocates with 'lived experience' who may following treatment support in an enhanced understanding of the impact of living with a long term condition or with unexplained persistent physical symptoms across the wider health economy.

All of the above has allowed for an enjoyable, challenging and diverse role. I have experienced a steep learning curve in developing the role of nurse consultant within a new and developing service and I feel that I will continue to evolve within the role for as long as I remain in it. For me, my clinical work has probably represented my principal area growth. Firstly, it's important to note that I am not like other therapists when it comes to developing treatment strategies for individuals. I tend not to adhere rigidly to model fidelity, choosing instead to adopt a therapeutic approach that embraces the potential merits of a variety of modalities. This predilection became abundantly clear to me even as a student nurse wherein I recall being told by a nursing colleague that "what you do Kate is not traditional, you don't follow the rules, rather you develop innovative strategies which on the face of it seem unusual, but in reality are effective...don't change". In developing my clinic it initially seemed very simple to me. I instinctively felt that I was ideally suited to my role in that I regarded myself as someone in possession of a wide variety of therapeutic skills and not inclined to be phased by an inherently uncertain world.

My objective was to complete work already started on the wards and undertake complex assessments of patients with presentations that do not readily fit with existing service provision, e.g. persons too complex for IAPT and not obviously mentally ill in terms of diagnostic criteria. Herein lay the challenge of offering a service to all other medical outpatients, providing assessment and brief intervention for individuals who do not easily fit the mental health system and assessing and treating patients with medically unexplained symptoms or functional presentations, in particular those with chronic pain and offering interventions to patients with complex mental and physical health problems that are often too complex for IAPT. Additionally, opportunities were identified to assist patients presenting with problematic self-harm who do not easily fit into the remit of other services and to examine the most frequent attendees to help establish multi-agency joint working and integrated care planning. When developing the clinic I planned 2.5 clinics a week, allowing me to offer an average of 8 hours of sessions weekly. I estimated that around 4-6 sessions would suffice in terms of treatment and that this level of workload along with all the above responsibilities would be manageable.

The reality is that the majority of cases I see are indeed complex. People present with years of bouncing from one service to another. They have rarely had contact with mental health services and if they have their experience has been

largely uncomfortable as they have been misunderstood and haven't classically fitted with a particular pathway or diagnosis and as a result have been discharged quickly and with limited intervention. When such individuals come to me they have a tendency to feel wary, exhausted and frustrated by their ultimately fruitless experience of pinballing between services.

Eye Movement Desensitisation and reprocessing (EMDR) in Liaison Psychiatry

When difficult and unexpected problems occur for people the brain tends to be unable to process them properly. "Old disturbing memories can be stored in the brain in isolation; they get locked into the nervous system with the original images, sounds, thoughts and feelings involved..." (Shapiro, 2001). The effects of such stress can manifest in classic ways, as in cases of Post-Traumatic Stress Disorder where people may present as hypervigilant, anxious, experiencing flashbacks and nightmares, etc. Alternatively, trauma can get locked into the body which is what we often see in Liaison Psychiatry, with appearance of persistent and distressing physical symptoms.

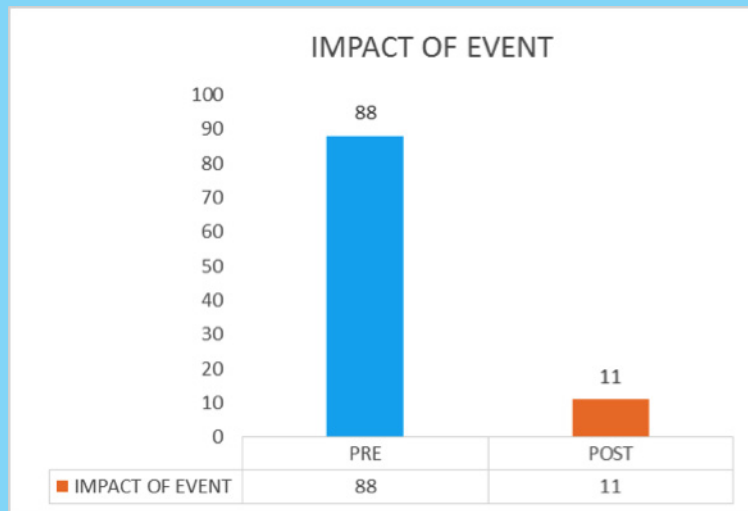
The brain struggles to connect with the resources that it ordinarily possesses in order to resolve the trauma and as a result, in the absence of treatment, the distressing and disturbing experiences continue, for example through non-epileptic seizures, chronic pain, etc. Once EMDR treatment starts, the bilateral stimulation itself allows the linking to takes place as described by Shapiro, 2001, and new information allows the problem to begin to resolve. EMDR has been widely used in the management of PTSD but there is growing evidence of successful outcomes and positive research for EMDR treatment for other trauma-related mental health disorders including chronic pain and somatic symptoms, etc.

Within my clinic I have completed treatment employing EMDR after having used a variety of complimentary interventions to achieve stabilisation quickly such as hypnotherapy, mindfulness practice and NLP techniques. In terms of outcomes and the number of sessions required, these vary. The range is between 4 and 20 with a mean of 11.2 depending on the complexity of the case. As each case is so different to the next it does make comparison difficult. That said, with the exception of one person, all cases have been discharged from my care and treatment without the need for mental health follow up and in most cases have also discharged from other medical outpatients. Despite the diversity of presentations I come into clinical contact with I would still like to provide an idea of the types of case I see. Below are two brief case studies.

Case study 1

35 year old married woman with two children, born outside of the UK and working as a chef. She had been involved in a car accident 2-3 weeks prior to referral and although the damage to the vehicle was such that she had to be cut out of it she was essentially physically unharmed. The patient presented with functional neurological problems / fainting episodes and had been admitted to hospital under the care of neurology. She needed a total of 4 sessions with me, which included the assessment and the stabilisation, following which she was discharged back to her GP with no further need for any outpatient follow up of any speciality service involvement. She has not been seen again by mental health services over the subsequent 2.5 year period.

Outcomes case study 1



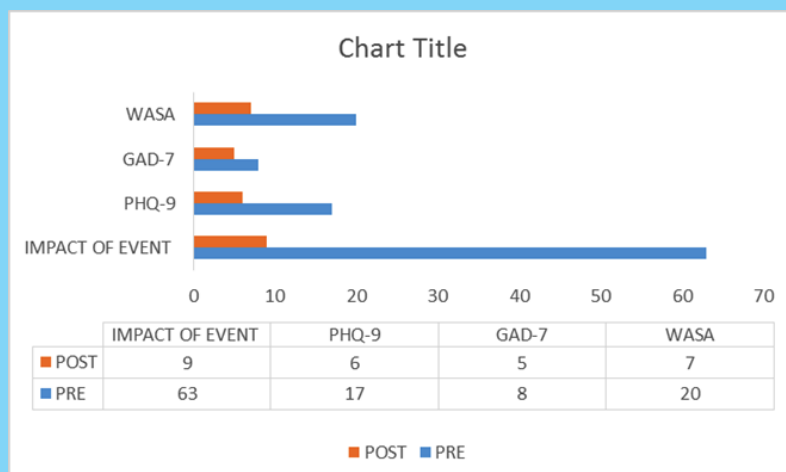
Case study 2

37 year old woman with no history of contact with mental health services referred from neurology with unexplained movement disorder (functional neurological disorder) and cluster headaches (“you have to tell them I am not mentally ill”).

The patient had been previously subject to MARAC referral but otherwise had no notes on the mental health system. She described having come from a very chaotic family wherein violence represented a prevalent theme. She lived within what became clear was a state of perpetual social crisis.

Outcomes case study 2

- Discharged back to GP after 20 sessions, very complex treatment plan.
- You have changed my life. I was anxious.
- No abnormal movements/ some physical ticks at times of stress/ no cluster headaches.
- Seen once since contact after overdose in relation to family stress.
-



Reference

Shapiro, F. (2001). Eye Movement Desensitization and Reprocessing, 2nd edition, N.Y.: The Guilford Press.



Information on CPD modules

Dr Adrian Flynn
Consultant Liaison s Psychiatrist
Cornwall Partnership NHS Foundation Trust

Know any interested physicians... Keen to learn more about psychiatry in the general hospital?

If you do then this is good news for you. The Royal College of Physicians (RCP), in conjunction with the Royal College of Psychiatrists' (RCPsych's) CPD Online and the Liaison Faculty, has just published six e-learning modules on its CPD site dedicated to this. The title of the series of modules is Psychiatry for the modern physician.

The e-learning modules were conceived in the context of ratifying the excellent College Report CR108: The Psychological Care of Medical Patients. It was felt that updating aspects of the document into an e-learning format could have the potential to reach far more of its target audience, principally practising hospital physicians.

The modules themselves have been edited and the process developed by Professor Khalida Ismail, Dr Anne Doherty and Dr Adrian Flynn.

We are incredibly grateful to the RCPsych and the RCP for their support in enabling this, particularly people from the eLearning department, communications and IT.

The e-modules will provide important clinical communication skills and facts when assessing and managing patients who might have a mental health disorder.

Each module provides:

- an overview of the topic and its epidemiology
- information on how to make a diagnosis and the management of the condition
- final segment examining how services may better meet the needs of patients with this comorbidity.

The modules topics and authors are:

1. **Self-harm for the general physician** - Dr Sean Cross and Dr Matthew Lowe
2. **Medically unexplained somatic symptoms – common and costly: a positive approach** - Dr Adrian Flynn, Dr Gopinath Ranjith and Dr Maurice Clancy
3. **Eating disorders** - Professor Janet Treasure and Dr Carol Kan
4. **Identifying and managing alcohol-related problems** - Dr Duncan Raistrick, Dr Sachin Jacob and Dr John Benjamin Alderson
5. **Diagnosing depression: a guide to care and treatment** - Professor Khalida Ismail, Dr Adrian Flynn and Dr Anne Doherty
6. **Managing acute confusion and dementia** - Dr Emma Abbey, Dr Baldeep Farmah and Dr Saurabh Saxena.

We would like to take this opportunity to thank the authors for the hard work and dedication that they have given to this project and to all those at RCP and RCPsych who have enabled it to come to fruition.

We are now in the process of publicising the e-modules as much as possible to raise awareness of their presence and to increase the uptake, with the ambition being that 10% of relevant physicians will have undertaken at least one of the modules within a year of publication.

Please publicise these high-quality modules, written by practising liaison psychiatrists and CPD approved, to your colleagues and use every available teaching and education session to draw them to the attention of your physician colleagues.

AUDIT



Samuel Pearce

5th year medical student

University of Birmingham

The adequacy of alcohol and substance use history taking and/or reporting by Queen Elizabeth Hospital Birmingham's RAID team

Alcohol misuse is a widespread issue in the U.K. and has many physical and psychiatric health impacts. Between 2014 and 2015, there were 1.1 million estimated hospital admissions where an "alcohol-related disease, injury or condition" was the primary reason for admission, or a secondary diagnosis. Screening for alcohol misuse, as well as dependency and alcohol-related disorders, if appropriate, is a key aspect of any psychiatric assessment. Psychiatric liaison teams assessing patients in acute hospitals perform psychiatric assessments on a daily basis, and should be reporting alcohol use and misuse in all assessment summaries.

To determine current alcohol consumption, recording both frequency

and volume – number of days consuming alcoholic beverages per week, and volume of alcohol consumed during these sessions – is considered to be the minimum standard. If the pattern of drinking is established to be hazardous (more than 14 units per week for both sexes), or harmful (more than 35 units per week for females and more than 50 units per week for males), dependency should be assessed.

An audit was undertaken in May 2017 to determine if such standards of alcohol and use history taking and reporting were carried out by both the nursing and medical staff in the RAID team at the Queen Elizabeth Hospital Birmingham, during April of the same year. Illicit drugs use reporting, alcohol and substance dependency

screening and notation of appropriate management were also audited for completeness.

Methods

100 consecutive referrals spanning one week in April 2017 were analysed using a traffic light system to (i) assess for the quality of alcohol and substance misuse histories, (ii) assess whether dependency was evaluated if appropriate, and (iii) assess whether an appropriate course of action was taken based on information gathered in the history.

Results

Alcohol: 36% of assessments did not have any report of alcohol intake in the assessment summary or corresponding progress note. 24% had

a satisfactory report of alcohol intake, with "satisfactory" referring to notation of both frequency and volume. 33% of the assessments had an incomplete reporting of alcohol intake. In these cases either frequency or volume were missing, or vague terminology was used. In a third of these incomplete cases, the patient was either acutely unwell or uncooperative. In the other 7% of assessments, it was unclear as to whether an alcohol history was taken. In these cases, the patient was known to mental health trust services, and thus the assessment summary had simply been copied from a previous assessment, but with no clear update as to whether the information was still relevant at the time of the most recent referral.

An example of alcohol misuse screening assessment which did meet the minimum criteria is "[the patient] is currently drinking 8-10 cans (500ml cans) of 4-5% lager a day (approximately 20 units/day). He reports sometimes feeling shaky or sweaty when not drinking". Examples of screening assessments which were deemed inadequate or incomplete are: "occasionally uses alcohol", "denies alcohol abuse", "denies excess alcohol", "socially drinks", "no problems [with drugs or alcohol]", "has problems with alcohol". Describing alcohol or drug use as a "problem" is rather ambiguous, and indeed, it would be preferable for health professionals to reference the patient's units-per-week consumption to the standardized, aforementioned non-harmful, hazardous, and harmful consumption categories instead.

Substance misuse:

There was no reference to a substance misuse history having been taken in 48% of assessments. In 37% of assessments, reporting of substance abuse was satisfactory, with both frequency and quantity noted. 11% of assessments were incomplete, in accordance with aforementioned standards. 4% of assessments were unclear as to whether they had been updated fully. An example of substance

misuse screening assessment which did meet the minimum criteria is "[Patient uses] cannabis since age of 16 (spends £2-10 per day with frequency of 3-4 days in week.)"

Dependency:

Dependency history taking and/or reporting was similar for both alcohol and illicit substances, with less than 40% of assessments satisfactorily addressing dependency where it would have been appropriate.

Management:

In the 24 out of 100 cases where significant alcohol or substance misuse had been positively screened, the appropriate management was offered, or reported as being offered in 50% of cases. One of these 24 cases was a patient in acute alcohol withdrawal, who was treated appropriately according to their management plan. The remaining 23 had harmful or dependent use. Around half of these cases had an explicit intervention detailed in their management plan, for example, a referral to a drug and alcohol service. There was no written evidence of brief intervention being offered to any of the patients with harmful or dependent use.

Conclusion

These results indicate a lack of a standardised framework amongst the RAID team members for inquiring about alcohol and drug use during assessments. Measuring the frequency and volume of alcohol consumed by patients in all assessments, and implementing a dependency screening tool, if appropriate, may improve the rates of detection of hazardous drinking, dependency and alcohol-related disorders. Recording the findings of such screenings in all patient notes will also improve consistency of notation standards across the team.

References:

1. *Statistics on Alcohol (England, 2016)* [Internet]. Health & Social Care Information Centre. 2016. Available from: <http://content.digital.nhs.uk/catalogue/PUB20999/alc-eng-2016-rep.pdf> [Accessed: 27th July 2017]
2. *Tasman A, Kay J, Lieberman J, First M, Riba M. Psychiatry, 2 Volume Set.* New York, NY: John Wiley & Sons; 2015.
3. *Alcohol-use disorders: prevention* [Internet]. NICE. 2017. Available from: <https://www.nice.org.uk/guidance/ph24/chapter/8-glossary> [Accessed: 29th July 2017]

Reaching Out

Four years ago, our mum underwent major heart surgery. The operation was a success in terms of the heart functioning more efficiently. The experience was worrying for all of us due to risk factors of such a procedure including the age of my mum 78 at the time. We prepared ourselves as best we could for possible eventualities. What we didn't prepare ourselves for was the psychological impact such an operation would have on our mum's mental health. At one stage we prepared for the worst as it seemed she may give up. The recovery process was incredibly stressful and my mum's mood deteriorated and it was difficult to know how best to support her, risking encouraging her too much to do physical challenges she was unable or not ready to do or not doing anything thus allowing the low mood to dictate a poor chance of recovery.

I have worked in Mental Health services and organisations for the past 12 years and at no point had I considered Liaison Psychiatry an option for help. Everyone seemed to be focusing on the physical recovery of my mum and the input was coming from the cardiologist team. I accompanied my mum to GP appointments and advised her of my concerns about my mum's mental health, anti-depressants were mentioned but no specialist services were discussed as the GP reassured us the cardiology team were best placed for all my mum's needs with her recovery.

What would have been helpful in hindsight is for us as a family to know and understand that Liaison psychiatry exists outside of Emergency departments and police stations (which I surmise most people think) and also the team treating our mum had signposted us when we discussed concerns about her mental health or referred to Liaison psychiatry for them to assess her. Liaison psychiatry is an outstanding service that I see first-hand mainly in ED and police department so is it time for our other services to embrace this and reach out to their patients by informing them of what as a holistic care package they can offer and supporting them to get this care?



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European Association of Psychosomatic Medicine (EAPM) - UPDATE

Dear colleagues,

We are delighted to announce the 6th conference of the European Association of Psychosomatic Medicine (EAPM) in Polo Zanotto, University of Verona - Verona, Italy, 27th - 30th June 2018.

We are pleased to inform you that REGISTRATIONS and the SYMPOSIUM ABSTRACTS SUBMISSION is now open online!

The abstract submission for ABSTRACT AND REGULAR PRESENTATIONS will be open on November 1st, 2017.

If you wish to register and upload an abstract for a Symposium please click on the links below:

Conference Registration: <http://www.eapmverona2018.com/index.php?p=registration>

Submit your abstract:

<http://www.eapmverona2018.com/index.php?p=abstract>

Please take a moment to check out the Verona website below and get an impression of the wonderful location we have chosen for our conference.

As always EAPM members and APM members profit from a reduced fee to the conference!

If you already know that you will attend the conference, please make sure you register as soon as possible and book your accommodation! Verona is very busy in June due to its great cultural offers like the operas and much more.

www.eapmverona2018.com

Please spread the information to your colleagues and professional networks.

We are looking forward to welcoming you to Verona.

Do not hesitate to contact us for any further information you might need.

Kind regards

From the Organizing Secretariat

Alessandra Farinati

PLAN Conference

*Improving Mental
Healthcare in
General Hospitals*

8 March 2018
Thursday
London

Join us at this event to discuss and debate key issues,
with interactive sessions delivered by expert clinicians,
patients and carers. Further details to follow!

Emily Patterson
Deputy Programme Manager
The Psychiatric Liaison Accreditation Network
The Royal College of Psychiatrists

FACULTY OF LIAISON PSYCHIATRY ANNUAL CONFERENCE 2018 LIVERPOOL

May 16 – May 18

CALL FOR POSTERS

The Faculty of Liaison Psychiatry invites all professionals to participate by sending abstracts. Please click on this link here for full instructions on submitting your abstract.

<http://www.rcpsychlpc.com/>

More details about the conference will be published on the Faculty Website.