Faculty of Liaison Psychiatry Newsletter

Summer Edition 2020

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Dear colleagues,

It is difficult to summarise the challenges we have all faced since our last newsletter, not only professionally but also personally. The COVID-19 pandemic has affected life in ways we could not have anticipated a few months back when we published our last edition.

We all faced the effects of the pandemic at the forefront, the many problems, the emotional toll, the fears for our own health and for those we love. We are trying to process the worst of it and sharing the hope that a second wave does not materialise.

However, many things have changed for the better. The NHS has adapted. It seems mental health and wellbeing is now more integrated than ever into the daily language of society and the health profession in general.

Our Faculty has responded proactively to these unprecedented times, we have engaged with others, created new roles and ways of working. We have supported our colleagues and enhanced our ability to face this challenge together.

This newsletter attempts to condense some of these developments. It contains an update by our Chair, Jim Bolton, highlighting where we stand and how services may be delivered after the pandemic. Jim mentions a few of the on-going studies that are monitoring the effects of the pandemic on mental health.

We are very grateful to Alex, Shammi and Em who have kept us all in touch and well informed of developments through the now famous liaison psychiatry webinars! We have included a refreshing and timely perspective on delirium and the non-pharmacological management of agitation. Many of us were involved in supporting our front-line colleagues. We are very pleased to be able to include some of these experiences in the newsletter.

Finally, we have added a link to ‘Don’t think of a pink elephant’ an inspiring short film of a teenage girl facing OCD urges.

This is the last edition for Sri, who is looking for new challenges abroad! She was instrumental in getting these editions of the newsletter going. Sri good luck and best wishes on behalf of our faculty!

Jim ended his summary on a note of reflection, and we would like to join him in wishing you all the very best.

Keep safe!

Once again, we rely on your support to continue publishing this newsletter. Articles should be no more than one to two pages long. Please include your name, title, place of work and contact details. Please note that this is neither a peer review process nor a scientific publication, but it gives a good platform to share good practice and ideas. 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 and Ratnu Vaidya for their support in preparing this Newsletter.

Editorial Team Liaison Faculty Newsletter

Dr Nora Turjanski

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COVID-19 and Liaison Psychiatry: what next?

Dr Jim Bolton
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During the pandemic I have tried to keep in touch with news, comments and resources that might be of interest to Liaison Psychiatry Faculty members, so I suspect that you may have heard quite enough from me on COVID-19 and its implications. However, I thought it might be helpful to highlight a few key resources and current initiatives, and to begin to think about what happens next.

Alternatives to the Emergency Department
I am grateful to all of you who, despite the pressures of work, took time to give your feedback on the new models of service that have been established as alternatives to Emergency Department assessments for patients presenting with primary mental health problems. Many thanks to Dr Nehal Parmar, SpR in Liaison Psychiatry, who compiled the survey on behalf of the Faculty. The report of the findings can be found here

The recommendations have already informed discussions between the College and NHS England. I hope that they will also be helpful in other local and regional reviews of service delivery during and after the pandemic.

Liaison Psychiatry Webinars
Drs Alex Thomson and Shammi Shetty, and Em McAllister, our Faculty Service User Representative, have done a great job in keeping us in touch and up to date via the weekly Liaison Psychiatry webinars. The webinars have gone some way to replace the educational content of our 2020 conference that we were forced to cancel, but we plan to go ahead with a virtual Trainees, New Consultants and Allied Health Professionals in Liaison Psychiatry Conference in November, and the Faculty Conference in 2021. Many thanks to Alex, Shammi and Em for their dedication and hard work in producing the webinars.

CoroNerve Surveillance Study
One topic discussed in the webinars has been the neuropsychiatric consequences of COVID-19 infection. As you are probably aware, there is a reporting system for such cases – the CoroNerve surveillance study. Please continue to submit cases online via the College website

MASH Self-harm Study
Concern about the mental health impact of the pandemic has been widely discussed within the profession and the media. To help identify any increase in rates of self harm and suicide, several Liaison Psychiatry services are taking part in a monitoring study led by Professor Nav Kapur and colleagues as part of the Manchester Self-Harm Project (MASH).

The future
So what next? Some of you may be working in areas where there has been a recent increase in cases. The rest of us will be hoping that we don't experience "a second wave". Overall, we are a long way from a return to normal working. I hope that this Newsletter will help us to reflect on what we have learned from the pandemic so far and to consider what areas of good practice we might want to continue in future.

Very best wishes to you all,

Jim Bolton

Delirium: A Liaison Psychiatry View

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Delirium is often described as an acute confusional state among a number of other descriptions. However, this definition underplays its true reality. A more scientific definition describes it as a complex neuropsychiatric syndrome that presents with a disruption across a host of cognitive domains. This comes closer to a more factual definition but also fails to truly encompass the myriad of effects it has, not only on the patients but to everyone in their wider circle. This includes their family, friends and relevant healthcare professionals. This article aims to expand on our experience of delirium as a liaison psychiatry team working at an acute general hospital. We have found that delirium tends to be underdiagnosed, treated with a non-evidence-based focus on pharmacological methods and poorly understood by the wider team and family. Nonetheless, we must aim to improve in our diagnosis and management, as delirium is common, serious, and can often be fatal.

In our experience of delirium on the ward, there is a sense amongst the team that it goes underdiagnosed. We often get referrals regarding challenging behaviour, patients with psychotic symptoms and patients with affective lability. The aim of the referring team often based around ruling out an acute psychotic or affective disorder. Yet, when we go see this patient, it is clear that there is an acutely delirious picture going on. This is in keeping with historical data, which highlights that delirium occurs in 10-60% of the older hospitalized population and is unrecognized in 32-66% of cases[1]. We have postulated as to why delirium may be going underdiagnosed.

Firstly, one of the problems inherent to a diagnosis of delirium is that it can present with a wide spectrum of symptoms. The Delirium Rating Scale-revised-98 (DRS-98) (one of three validated tools used to distinguish between delirium and dementia) has 13 domains (16 if you include optional diagnostic criteria) across which the severity of delirium can be assessed. These include but are not limited to impairment in attention, perceptual disturbances, delusions, lability of affect, orientation and memory[2]. Table 1 shows work by Maegher et al. which reveals how all of these symptoms were seen in their analysis of 100 delirious patients[3]. Therefore, it is easy to understand how many healthcare professionals, across a range of specialties, including geriatrics, can misdiagnose it. Though, even when it is diagnosed, it is often poorly treated.

Often, the medical team refer patients requesting pharmacological management of delirium. It is understandable why these referrals are made, as a patient going through the throes of delirium can present a unique management challenge. But, this intuition to reach for drugs has not got a significant evidence base in the literature and perhaps speaks to the clinician's bias to be seen to be doing *something.* Still, this "something" does not have to be pharmacological. There is time for this type of intervention; nevertheless, the literature suggests a more systematic approach.

Firstly, there must be an understanding of the severity of delirium. Delirium is a medical emergency and has been consistently associated with poorer outcomes including increasing morbidity and mortality[4].

Therefore, the first aim of management should be rapid identification and treatment of its causes[5]. After this, it is important to attempt environmental interventions. This can be split into three domains; providing support and orientation; providing an unambiguous environment and maintaining competence. An example of each can be found in box 1. There are no randomised control trials for these environmental interventions. Though, in our experience on the geriatric ward; these interventions can make a big difference. In support of this, patients who had recovered from an episode of delirium have described how simple but firm communication, reality orientation, a visible clock, and the presence of a relative all contributed to a sense of control during delirious episodes[8]. NICE guidance also supports this initial attempt at environmental intervention after finding and treating the underlying cause[9]. Despite this, one often comes onto a heavily lit, noisy ward, where patients are constantly moved around in order to make space. Moreover, there are often no orientating measures put in place on the ward and people's workload do not allow them the time orientate the

patient themselves. Thus, it must be stressed that the non pharmacological management of delirium is essential in the recovery process. As a result, pharmacological management should be demoted to the second line. Our role in liaising with the medical team is to remind them of how important these interventions are, before we escalate to pharmacological measures.

One common rebuttal to this approach is regarding patients who present a risk to themselves or others. Once again, the immediate intuition is to go for the pharmacological approach. However, NICE guidance suggests that these patients are often amenable to de-escalation by verbal and non-verbal approaches. Only, in the cases where this measure fails, are pharmacological measures recommended[9]. In those cases, it is important to remember that each drug has its own side effect profile and should be discussed with the relevant specialist. We often get called to assess patients who have been overly sedated with benzodiazepines or antipsychotics, which acts to obscure their true clinical presentation, which can make further management difficult.

On the whole, diagnosing and managing delirium is complex. This complexity, biases us towards a heavy handed approach when we encounter delirium. Yet, we hope on reading this article, next time you come across a delirious patient, our experience as a liaison psychiatric team proves instructive on better ways to engage these patients.

Table 1. Diagnosing delirium across 13 domains.[3]

DRS—R98 item	Present at any severity %	Moderate or severe severity %
Neuropsychiatric and behavioural		
Sleep—wake cycle disturbance	97	73
Perceptual disturbances and hallucinations	50	26
Delusions	31	9
Lability of affect	53	18
Language	57	25
Thought process abnormalities	54	22
Motor agitation	62	27
Motor retardation	62	37
Cognitive		
Orientation	76	42
Attention	97	73
Short-term memory	88	53
Long-term memory	89	64
Visuospatial Ability	87	64

Box 1. Non-pharmacological methods to treat delirium.[7]

Environmental factors in treating delirium
Providing support and orientation
Communicate clearly and concisely; give repeated verbal reminders of the day, time, location, and identity of key individuals, such as members of the treatment team and relatives
Provide clear signposts to patient's location including a clock, calendar, chart with the day's schedule
Have familiar objects from the patient's home in the room
Ensure consistency in staff (for example, a key nurse)
Use television or radio for relaxation and to help the patient maintain contact with the outside world
Involve family and caregivers to encourage feelings of security and orientation
Providing an unambiguous environment
Simplify care area by removing unnecessary objects; allow adequate space between beds
Consider using single rooms to aid rest and avoid extremes of sensory experience
Avoid using medical jargon in patient's presence because it may encourage paranoia
Ensure that lighting is adequate; provide a 40-60 W night light to reduce misperceptions
Control sources of excess noise (such as staff, equipment, visitors); aim for <45 decibels in the day and <20 decibels at night
Keep room temperature between 21.1°C to 23.8°C
Maintaining competence
Identify and correct sensory impairments; ensure patients have their glasses, hearing aid, dentures. Consider whether interpreter is needed
Encourage self-care and participation in treatment (for example, have patient give feedback on pain)
Arrange treatments to allow maximum periods of uninterrupted sleep
Maintain activity levels: ambulatory patients should walk three times each day; non-ambulatory patients should undergo a full range of movements for 15 minutes three times each day

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Experience of supporting acute hospital staff wellbeing during the COVID-19 Pandemic

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The global coronavirus pandemic which has eclipsed 2020 has impacted our lives a myriad of ways. Concern for the mental health of vital NHS staff caring for the nation has prompted national measures to support NHS staff wellbeing including a national mental health hotline for NHS workers by NHS England (2020). Locally, in Leicester liaison psychiatry we have worked with the intensive care, theatres, anaesthetics and pain (ITAPs) department, and focussed our limited resource on them due to our previous relationship with them and their position as front-line services. We chose to offer a peer to peer support group to accommodate staff skill mix, availability and usefulness. It was offered to both medics and nurses in a leadership or supportive role. Three sessions took place, between 22nd April 2020 and 6th June 2020. Seven staff attended three sessions. Themes that arose from these sessions included the emotional toll on staff having to support patients now relatives were unable to visit, and uncertainty of how to support peers. Having offered support and encouragement around this and reassurance of capability, huge relief was expressed by many staff members. Personal coping, and a sense of isolation of due to social distancing of staff at work was also touched upon.

ITAPs recognised the need to support staff mental health themselves by providing facilities to support a healthy working environment, mental health services, healthy lifestyle and good communication. A paper survey

was distributed during the week commencing 18th May 2020, with 102 responses to gauge staff's views on these interventions. Most, 42% described it as a vital service (Jackson, 2020). These were highly valued overall. Over 75% of respondents used some of the available facilities over 3 times per week.

The health working environment facilities comprised hot drink and food supplies equipment. Over 70% of staff used these facilities. And over 50% used the shower, quiet area and TV area.

The mental health services were comparatively less used. In addition to the peer support offered by liaison psychiatry were chaplaincy, recruitment to the role of mental health first aiders, peer to peer supporters offering drop-in sessions, regular support, self-help and signposting in the wellbeing retreat and wellbeing mentors. Over 80% of respondents were aware of these services. 12 % used them formally, the peer to peer support being the most well used. The psychology service offered telephone support and 6 staff members took this offer, between 23rd March and 6th June 2020.

As admissions for COVID-19 eased, we consulted staff whether they wanted to continue with peer support sessions. Due to lack of demand no further sessions are planned. The majority of support for ITAPs has come from organisational measures and staff supporting each other. This is to

be expected as not all those exposed to trauma develop mental health conditions or need expert assessment (National institute of Mental health, NIMH 2020.) In the same staff survey, over 50% either agreed or strongly agreed that their colleagues or managers helped and supported them and felt they had good mental health. The evidence is that allowing social support by ensuring space and time is available, reduces the likelihood of more serious mental illness developing such as post-traumatic stress following "critical incidents (De Boer et al, 2013.) Greenberg (2020), in his discussion of post traumatic mental ill health, reminds us that risk factors impacting on staff *after* the traumatic incident is over are most significant and measures including social support are mitigating. Moving forward, with the possible resurgence of COVID-19 in Winter 2020 (Academy of medical sciences 2020) and potential impact on staff wellbeing, the importance of these organisational measures to support staff must be remembered and maintained.

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Psychology Service and Mental Health Liaison Team contribution to the Trust's "Wellbeing Offer"

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As the pandemic started the Mental Health Liaison Team (MHLT) considered how best we could support staff through the unfolding crisis. The Health Psychology Department were keen to collaborate and we formed a COVID staff support steering group with Leadership and Organisational Development. Our response included two elements: the "Psychology" Link Workers and an Enhanced Individual Staff Support Service.

Enhanced Individual Staff Support Service included easier access to therapy for staff (appointments available within 48 hours including evenings and weekends), delivering high quality therapeutic support for staff members, rapid staff access to psychiatrist review if indicated.

Psychology Link Workers proactively forged links with teams in the hospital, trying to connect with every team, from Maternity to Mortuary. Where psychologists or MHLT staff were already embedded in teams these staff took on the link work, maintaining relationships. Health Psychology appointed a temporary WTE Psychologist dedicated to Critical Care to work intensively with that team.

The role of the link worker evolved to:

- Raise awareness of general psychological wellbeing messages and normalising staff experiences; "it's ok not be ok", "our strength is between us not within us", "distress is a normal response to abnormal events".

- Deliver and explain Trust documents about the Wellbeing Offer.
- Identify key challenges in each area and co-develop tailored interventions.
- Support the senior staff to support *their* staff; messages such as "you don't need to have a solution".
- Provide light touch support to individual staff and signpost to other services if needed.

Each area used the psychology link work input differently. Some examples:

- Supporting senior staff to implement ward huddles.
- Identifying common complaints e.g. "I can't sleep" and signposting to free apps.
- Ward drop-in sessions for staff to talk.
- Facilitating referrals to staff support service for additional input.
- Helping analyse data about staff redeployment patterns reported to be causing distress.
- Being a visible presence, in scrubs, alongside staff, and also working remotely.
- Providing supervision for staff offering helplines.
- Providing feedback to Leadership and Organisational Development about common themes.
- Identifying areas who could be helped by other people in the organisation, e.g. suggesting a Chief Exec visit.
- Responding to staff concerns about developing PTSD, educating about "debriefing" and a webinar on trauma.
- Offering group sessions for staff returning from redeployment.

Our reflections

We had opportunities to work with new teams and contacts across all levels of the trust and to integrate mental wellbeing and psychologically-informed ideas into their work. The contribution of psychology and mental health liaison was widely embraced and welcomed throughout the Trust, indeed the role of staff support and the psychologist link worker was put forward as being a significant contributory factor explaining why the absence rate of staff due to stress during the pandemic was amongst the lowest of neighbouring trusts. We were honoured to be included in a Royal Visit by the Trust, highlighting how our response was valued. As we face a future including COVID we are hopeful of new opportunities to contribute to psychologically-informed care for staff and patients as part of new care pathways.

Don’t Think of a Pink Elephant

*A film by **Suraya Raja***

Multi-award-winning short film, *Don’t Think of a Pink Elephant,* is the inspiring story of a teenage girl fighting against compulsive thoughts and urges. Layla is terrified by her potential to do harm, until challenged to face her darkest fears.

Created at the iconic National Film & Television School by Suraya Raja and her talented team of artists, Don't Think of a Pink Elephant has showcased at over 100 international festivals including 6 BAFTA and 4 Oscar accredited festivals. It has won 15 awards for Best Animation or Best Director, and received many more nominations.

The film featured as part of the exhibition, 'Herself: Girlhood in Stop-Motion Film' at the Atkinson Gallery, Santa Barbara, USA. The exhibit included animation classes for girls, as well as facilitated discussions around mental health. The film has also been featured as part of a presentation for the Royal College of Psychiatrists and at training events for psychiatrists.

Film: https://vimeo.com/429895816
Full Press Pack:
https://www.dropbox.com/sh/1n5p3xbjad7jl5e/AAAbQNoGknhBtmQLV-6nfVJTa?dl=0